Therapists' experiences of shame
An Interpretative Phenomenological Analysis

Sophia Kaimaklioti

Middlesex University and Metanoia Institute

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Abstract

Shame is a crucial issue frequently overlooked in the therapeutic context because it has many hiding places and inevitably reverberates with experiences of shame in the therapist. Therapists can be vulnerable to shame from multiple sources and without awareness of the activation of their shame, therapists risk reacting in ways that are not therapeutic. This, in turn, is likely to impact the therapeutic relationship and outcomes. The concealment and neglect of the therapist's shame is reflected in a lack of attention to this aspect of the subject in the literature.

This qualitative study explored how therapists conceptualise shame, how it presents in their practices and how they work with shame issues. Using Interpretative Phenomenological Analysis (IPA) eight psychological therapists were interviewed to elucidate their experiences of shame in the clinical encounter. Four superordinate themes that captured the key experiences of shame for therapists were identified: The Impact of Shame on the Self, Noticing Shame, Therapeutic Reactions to Shame, Shame and Issues of Power. The themes were developed through an intensive process in accordance with IPA framework.

Shame is portrayed as striking at the core of the self and causing physiological, behavioural, emotional and cognitive reactions which involve one's entire being. In all its forms, shame is considered relational. The findings highlighted the importance of empathic relationships with supervisors and colleagues in mitigating the debilitating effects of shame. Building shame resilience in therapists is underscored as critical in tolerating the vulnerability in meeting clients and colleagues in powerful affective states of being shamed and shaming. Therapists are encouraged to face into experiences of shame in themselves and with their clients, and to see these experiences as valuable opportunities for growth.

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CHAPTER 1

INTRODUCTION

1.0 Overview of chapter

This research focuses on exploring therapists' experiences of shame in their clinical work and how they make sense of such phenomena. In this first chapter I will set the scene for my study as I explain how I came to be interested in this topic, the clinical relevance of this research and my perspective about my contribution to the field.

1.1 My reasons for investigating shame

My motivation to research shame in psychotherapy emerged partly fifteen years ago during a clinical placement at National Deaf Services. My deaf clients would often share shame related emotional states in the context of feeling marginalised and excluded because of their deafness. Witnessing the powerful impact shame had on clients' sense of self and the ways it compromised their ability to self-regulate fuelled my motivation to deepening my knowledge of shame related issues. In supervision I came to realise my difficulty to 'stay with' my clients' shame and unsurprisingly in therapy I became aware that throughout life I avoided and neglected my own shame material. Becoming aware of the dynamics of shame both in my professional and personal life was a formative moment in my development as a psychological therapist as it helped me to appreciate the intricate nature of shame and to become aware of my shame about avoiding shame.

My reasons to research shame were also strengthened by my somewhat disturbing responses to clients' comments about Greece's socioeconomic crisis. My name, my accent, my complexion are all clues about my Greek heritage and naturally clients would make comments about 'my country' and its predicament. Further exploration in supervision and therapy led to deeper insights about my sense of shame about 'my country's demise' and my personal feelings of inferiority and inadequacy. As a result, in some cases I offered unsuccessful therapeutic interventions and two clients dropped out of therapy. Such experiences compelled me to appreciate the destabilising powers of shame in clinical settings namely the abrupt severing of therapeutic relational bonds with my clients who subsequently dropped out.

During my doctoral studies I became interested in reading influential publications about the therapeutic relationship and the 'realistic bond' (Kohut, 1971) between therapist and client that taught me to be aware of the subtle abuses of authority that can occur during therapy (Clarkson, 1995; Bateman & Holmes, 1995; Khan, 1991; Langs, 1992; Luca, 2004). I recall coming across writings about the risk of therapists not engaging with clients' material neither emotionally nor on an embodied manner because of their own struggles to tolerate such states themselves and therefore shutting the client's feelings down. Such writings would often leave me wondering how one as a clinician prepares herself for working with shame, particularly as it can be found as a pre-morbid or co-morbid phenomenon in so many psychological and mental health problems, as will see in the literature review.

In therapy I discovered that shame experiences, throughout my life, had restricted the ways I was relating to myself and/or others. My parents were not readily available to engage with my shame; my mother would often try to soothe my distress by renouncing my shame-related behaviours as unnecessary emotional exaggerations. At such moments I would feel alone, confused, unwanted and disconnected, unable to process the disruption of my relational bond with her. Predictably, I experienced similar disconcerting emotional states when confronted with Greece's economic devastation and with Brexit. Recognising and naming my own shame and its impact on my personal and professional life has been a tough undertaking that has allowed me to embrace my vulnerability and, in the process, paradoxically to gain a sense of strength.

Despite of my determination to research therapists' experiences of shame, I encountered several self-inducing hurdles in the completion of this project. Literature informed me that shame is mainly perceived as one of the most elusive emotions of the human psyche and widely neglected by the profession. The idea of researching a topic that has been widely neglected filled me with excitement but also with dread about the potentiality of failure and further exposure of my professional incompetence and inadequacy. My ambivalence was captured in preoccupations like: Am I going to be able to recruit volunteers? Who in their right minds would put themselves forward to discuss their personal experiences of shame in the clinical room? And what does that say about me? Do I really want to be known as the student who researches shame? Do I want to be seen as a 'shamenik'? (term used by Morrison, 2008), am I

at risk of shaming my participants? From very early on I became aware that I needed additional support and guidance throughout the different stages of my research, and I made use of personal therapy, clinical supervision, research supervision and peer discussions as facilitative spaces that helped me to maintain a position of enquiry. Exploring my research intentions as well as my anxieties and fears helped me to inform my design and to clarify my focus.

To summarise, as a Counselling Psychologist I have endeavoured to understand shame, identify its impact and its many faces, and to further explore how interventions can be made in clinical practice. I have become alert to the prevalence of shame not only in my personal life but also in my clinical practice. My experiences of shame in the therapeutic encounter made me wonder on how other therapists navigate such experiences and this inspired me to undertake this study.

1.2 Clinical relevance and my contribution to the field

Since H.B. Lewis's (1971) declaration that shame was by far the most prevalent of all emotions, many authors have explored the central issue of shame in psychopathology and therapeutic outcomes. Subsequently in recent years we have acquired a much better understanding of the role of shame dynamics in clinical presentations. Most empirical studies come from a positivist perspective and have focussed on the links between shame and the maintenance of psychological disturbance including eating disorders (Swan & Andrews, 2003), depression (Cheung, Gilbert, & Irons, 2004; Hook & Andrews, 2005), anxiety (Gilbert, 2000) and posttraumatic stress disorder (Black, Curran, & Dyer, 2013).

In recent years clinicians turned their attention to their own experiences of shame arising in the countertransference and how such experiences might be understood and used therapeutically (e.g., Hanh, 2000; Lansky, 2005; Morrison, 1984). Hahn (2000) offers therapists a powerful way to conceptualise their own experiences of shame in the countertransference, and a model for sorting out 'what belongs to whom' in the complex and often unconscious dynamics of shame. Although he states that in his model countertransference is understood to be "a joint creation in which both therapist's past conflicts and the patient's projected aspects create specific patterns of interaction with the therapeutic process" (Gabbard, 1993, p. 13, as cited in Hahn, 2000), he appears to overlook the therapist's projective contributions to the 'jointly

created' countertransference, as he only considers shame experiences that arise 'in reaction' to the client's projected experience of shame.

I see my contribution located in this gap, as empirical research on the subject is a somewhat unexplored area. I aim to offer empirical input in our understanding and knowledge of how therapists work with shame experiences whether it is with clients, supervisees, trainees, or themselves and it is therefore my intention, with the help of my participants, to promote a better understanding of the phenomenon. My view that further research is pivotal was strengthened by the lack of qualitative empirical literature on the topic. I am personally intrigued by the many faces of shame and the lack of systematic research on clinicians' experiences of shame even though it is thought to significantly influence the therapeutic relationship (Pope et al., 2006) and client outcome (Covert, Tangney, Maddux, & Heleno, 2003; Leith & Baumeister, 1998; Pope et al., 2006; Gilbert, 2011). I assert that further investigation on therapists' experiences of shame will assist us to further our understanding of shame dynamics especially since a therapist's sensitivity to the signs of shame in both herself and the client is vital for the maintenance of the therapeutic alliance, has a profound effect on therapists' interventions and is crucial to the advancement of the patient therapy (Ayers, 2003; Jacoby, 2009; H.B. Lewis, 1971; Morrison, 1989; Morrison & Stolorow, 1997; Rustomjee, 2009; Steiner, 2001).

An essential aspect of therapeutic presence is a therapist's capacity to by fully present in the moment on a multitude of levels, physically, emotionally, cognitively, spiritually, and relationally (Geller & Greenberg, 2002). Therapists' ability for non-defensive reflection that can offer opportunities for new insights and greater intimacy through negotiation of ruptures (Mitchell, 1988) lies at the heart of clinical practice. But this can be particularly challenging when a therapist's personal vulnerabilities are triggered by her client's material. As we will see in Chapter 2 the central focus in shame is on the negative image of the self that is created in the mind of the other (Gilbert, 1998). Shame has the potential to cause devastating ruptures to relational ties as the other constitutes a mirror for something that the afflicted person may try to avoid facing at any cost. This raises a core question for psychotherapeutic clinicians, and especially for Counselling Psychologists. The philosophy and empirical underpinnings of Counselling Psychology stipulate that the practitioner's relational skills and their ability to remain empathically engaged at the presence of emotional adversity is vital for the

preservation of a therapeutic process where any formation of dissociation, repression or of safety-behaviours are avoided through sensitive psychotherapeutic facilitation.

The literature review revealed a plethora of psychological theories and research concerned with understanding and conceiving shame's pathological variable, but a significantly smaller number of empirical papers appear to have focused on therapists' experiences of shame when it arises in therapeutic settings. This is a great omission as shame has the potential to collide with the very skills that are implemented across almost every psychological therapy, that is safety, openness, a connection between patient and clinician (Kahn, 1997). This is the focus of my research and I believe that it is in line with the British Psychological Society's definition of Counselling Psychology, which states that: (BPS 2005 Division of Counselling Psychology- Professional Practice Guidelines page 1): 'Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology. It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship.'

In short, even though there is plenty of research conceptualising forms of shame, there is also a need to research and evidence what clinically should be done with shame as it manifests relationally, and in particular what it presents the clinician with. My review of the literature suggests the need for further research that shifts attention away from the shame–based individual to include also the potential difficulties encountered by therapists working with shame experiences in clinical settings. Consistent with the lack of a substantial body of research and the BPS recommendations, this research project aims to do exactly that, it seeks to investigate therapists' experiences of shame in therapeutic settings, to further the evidence via analysing experiential accounts of clinicians in a structured qualitative research method which is phenomenological in its nature.

My intention is to understand the clinician's experience per se, and to integrate these experiences via interpretation into the context of counselling psychology practice, so that understandings can be gained which might allow to identify how clinicians can prepare for this work, and what they may have to prepared to work on within

themselves. The attempt to familiarise ourselves with therapists' shame might enable us to maintain dialogue and to enter sensitive areas that might never be entered into otherwise. Moreover, a clearer understanding of the nature of therapists' shame and how it influences the therapeutic work may help therapists to understand and better manage their own countertransference identifications. My clinical experiences have shown that denial and confusion about instances of shame in the therapist not only clouds our understanding of how shame in the therapist is experienced but undeniably it also pervades clinical thinking. I often find that if shame has been a feature of a patient's childhood experience then inevitably there is shame in the transference; both client and I usually experience it. The work of the psychologist can be challenging and demanding at the best of times and my research should facilitate developing further phenomenological ways of working, as the professional guidelines suggest, and it might highlight the training and supervision needs of both experienced therapists and trainees.

Chapter 2

Critical Literature Review

2.0 Overview of Chapter

In this chapter I aim to ground my research topic in the context of current research that addresses a similar query, therapists' experiences of shame in clinical settings, as well as in literature that contributes to the wider subject area of shame. Smith, Flowers and Larkin (2009) asserted that in Interpretative Phenomenological Analysis the engagement with the literature "…should be selective, not exhaustive" (ibid: 113). Therefore, in the review of the literature I will be drawing on a variety of sources that seek to conceptualise the topic and its role or relevance to the practice of Counselling Psychology and psychotherapy. I will start by presenting the results of my systematic search of databases, and this will be followed by a synopsis of conceptual problems in the definition of shame and methodological issues in researching shame. I will then offer a brief overview of relevant empirical papers on shame research and I shall go on to report my reflections and findings of relevant literature and empirical papers on therapists' experiences of shame. I will then turn our attention to the historical development of shame theories (psychoanalytic, cognitive attributional and functionalist theories) before I offer my insights on clinical practice and shame, briefly address the nature vs nurture debate I will then turn our attention to adaptive components of shame. This chapter will end with a rationale for the present study based on the conclusions that might be drawn from reviewing the relevant literature.

2.1 Presentation of my search results

I conducted a systematic database search to identify relevant papers. In my search I used the following online academic databases in psychology PsycINFO, PsychArticles and CINAHL. Once relevant articles were identified I would then move onto searching the reference lists of those articles to locate publications not brought up by previous searches. Additional searches were conducted using Google Scholar and online psychology and psychotherapy journals. The database research showed that the

empirical literature addressing shame was found to consist of mainly quantitative studies. For example, in PsychArticles from the total of 384 empirical papers on shame 257 are of a quantitative nature and similarly in PsychInfo out of 6,663 studies a total of 1,446 are qualitative investigations. As I narrowed the search onto therapists' experiences of shame the research results were significantly reduced in numbers.

Therefore, in order to thoroughly address the central question of 'what do we know about therapists' experiences of shame', I also made use of various theoretical reflections written by practitioners representing a broad spectrum of theoretical orientations including classical (Freud, 1914, 1923) , object relations, self-psychology and relational/intersubjective strands within the psychodynamic literature (e.g., Broucek, 1991; Carr, 1999; DeYoung, 2015; Hahn, 2000; Jacoby, 2009; Kaufman, 1989, 1992; Lansky, 1994; Morrison, 1989, 2014; Nathanson, 1987), functionalist theories (Barrett, 1995, 1998a; Barrett and Campos, 1987), and cognitive-attributional theories (Lewis, 2000, Weiner, 1986).

The following table captures the number of studies identified in my search of academic databases.

Table 1: Number of studies identified on academic databases

Search no	Search words	PsychInfo	PsychArticles	CINAHL
s1	**Shame**	12,909	591	4,384
	Database search Limits on **s1**			
	Empirical Study	6,663	384	111
	SubjectMajor: Shame	1,195	143	10
	Language English	12,015	589	101
	Linked to full text	1909	591	32
	Applying all search limits	149	100	32
s2	**Shame and Psychotherapy**	1986	88	230
	Database search Limits on **s2**			
	Empirical Study	683	42	18
	SubjectMajor: Shame	198	10	1
	Language English	1862	88	18
	Linked to full text	222	88	5
	Applying all search limits	6	10	1
s3	**IPA and Shame**	67	4	37
	Database search Limits on **s3**			
	Empirical Study	61	1	37
	SubjectMajor: Shame	7	0	4
	Language English	67	4	37
	Linked to full text	16	4	12
	Applying all search limits	2	0	2
s4	**Therapists' experiences of shame**	19	3	361
	Database search Limits on **s4**			
	Empirical Study	7	2	43
	SubjectMajor: Shame	12	3	5
	Language English	19	3	41
	Linked to full text	3	3	18
	Applying all search limits	1	2	5
s5	**Shame and psychotherapeutic processes**	482	26	2
	Database search Limits on **s5**			
	Empirical Study	93	11	2
	SubjectMajor: Shame	99	7	0
	Language English	443	11	2
	Linked to full text	49	7	1
	Applying all search limits	1	7	0

2.2 A brief overview of shame

There is consensus in the literature that shame is an intensely painful feeling associated with a desire to hide, a complex psychological construct with cognitive, emotional and behavioural elements: 'When asked to recall shameful eliciting events, individuals report wanting to hide, escape, disappear from view, and shrink into the floor during the experience, indicating the desire to flee the social situation and conceal the defective self from social scrutiny' (Dickerson, Gruenewald & Kemeny, 2004, p.1196). Shame is also considered to promote healthy social and moral development by teaching norms needed for survival and interpersonal success (Harper & Hoopes 1990; Tangney, Wagner, Hill-Barlow, Marshall & Gramzow, 1996b). It is thought about and commonly experienced as an emotion intricately linked to moral codes and decent behaviour.

A foundational assumption in the literature is that shame is a universal experience, that afflicts clients and therapists alike. Authors like Brown (2010b), Pines (1995) and many others state that everyone has it, is afraid to talk about it and the less somebody talks about it the more they have it. Morrison (2008), a prominent figure in the clinical literature on therapists' shame, states that therapist's shame largely remains off stage '…because it has been too painful for us therapists to entertain' (ibid:69). Similarly, Adelman (2016) summarised that 'Shame is a potent affect state that binds us [therapists] up in knots, with the power to obscure our thoughts and interfere with our actions' (ibid:216) and Retzinger (1998) argued that in a state of unacknowledged shame therapists may go into 'a holding pattern, repeating routine responses rather than finding new responses to a unique situation' (ibid:209).

Researchers have referred to shame as a silent epidemic because it affects everyone but has largely remained invisible in modern societies due to cultural taboo (Brown, 2008; Scheff, 2003). Rycroft described shame as "the Cinderella of the unpleasant emotions, having received much less attention than anxiety, guilt and depression" (Rycroft, 1968: 152). Moreover, it has been argued that because of the intensely painful nature of some shame states, these states are not experienced in consciousness and instead are unconscious (Lewis, 1971) and many authors have argued that although shame is ubiquitous, in clinical settings it remains largely invisible (Scheff, 1988). In clinical settings shame can arise from three sources: the client, the

therapeutic interaction, and the therapist herself or himself (Herman, 1992; Kaufman, 2004; Morrison, 2011).

Not a lot has been written about the countertransference of shame and only recently have psychodynamic clinicians (e.g., Hahn, 2000; Lansky, 1999; Morrison, 1994) started asking how they can recognize and therapeutically use their own experiences of shame arising in the countertransference. The concept of countertransference has undergone considerable evolution and revising, and many contemporary theorists take a "totalist" perspective, which includes so-called objective countertransference reactions, which any therapist would likely experience in response to a patient in a particular context, and subjective countertransference reactions, which are the idiosyncratic reactions of the therapist arising from the therapist's own personal conflicts (Tansey & Burke, 1989). "Countertransference shame is one of the more difficult experiences with which we must deal in our clinical work, for we face those very feelings of inferiority, ineptitude, and deficit that so much of our professional training has been aimed at eliminating" (Morrison, 1994: 31). In my research I have adopted a totalist position on countertransference as I aim to contribute further to our knowledge and understanding of therapists' experiences of shame in clinical settings whether these arise in relation to clients' material or from therapists' own life experiences.

2.3 Conceptual issues in defining the shame experience

As a starting point it feels pertinent to share that the review of the literature revealed that any attempt to find a satisfying definition that accurately reflects the meanings and complexities of shame experiences to be an arduous task. As the profession's interest on shame has evolved the word has come to have far-reaching meanings as a range of writers have included aspects of the shame experience (social anxiety, sense of inferiority, narcissistic injury, dread, humiliation, self-disgust, embarrassment, inadequacy) in their definitions that it makes it difficult to know '…what one is talking about when the shame word is used…' (Ayers, 2003:8). Inevitably, this made me wonder as to whether the use of a particular word to describe shame would adequately capture the essence of the experience. Nathanson (1987) argued that 'So variable are shame words used by the population at large, so different is the perception of these emotion states that it is not possible to use these names with any confidence that another person knows precisely what we mean when we talk about shame' (1987:4).

Shame has been described as a 'self-conscious emotion' (Tracy & Robins, 2006; Tangney & Fischer, 1995) that involves self-referential processes during which the self is evaluated against some standard. Self-conscious emotions, (embarrassment, guilt, pride, shame), are also referred to as the moral emotions or social emotions because they play a role in regulating social behaviour and norms (Leary et al, 2007). The distinctive characteristic about these emotions is the attentional focus on the self; however, this does not solve the problem of definition and levels of intensity between individual states. One exception is the distinction between shame and guilt. Lewis (1971), a psychoanalytic writer, was the first to differentiate shame and guilt in a clear way. She argued that 'The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation but rather the thing done or undone is the focus' (ibid, p. 30). Similarly, Wharton (1990) writes that "Peter's distress after betraying Jesus included both: guilt that he had hurt his friend, and shame as discovering that he was capable of such betrayal. A person feels guilty about what he does, and ashamed about what he is" (ibid:284).

Several articles suggest that shame functions at a number of different levels or acts differently within the context of serious pathologies. It has been argued that hidden dimensions of shame underlie clinical phenomena as pervasive as narcissism, social phobia, envy, domestic violence, addictions, identify diffusion, PTSD, dissociation, masochism and depression (Lansky & Morrison, 1997a). Shame is also linked to complex affective states such as rage, envy, despair, and hopelessness (Morrison, 1989; Wurmser, 1997), pride, conceit, and ambition (Broucek, 1982; Nathanson, 1992). Many authors make a distinction between types of shame; for example, Lewis (1971) defined three types of shame experience, consciously experienced shame, unidentified or unacknowledged shame and bypassed shame. Kaufman (1992) differentiates primary from secondary shame, whereas primary shame is intrapsychic and internal and secondary shame is described as feeling ashamed of reacting strongly with shame. Wurmser (1997) distinguishes between the affect of shame, which is developmentally possible after the resolution of the Oedipus complex, and shame anxiety, which is the primitive form of shame that comes along before the oedipal stage. Lansky (2005) discriminates between the overt conscious experiences of shame and shame that is hidden, the result of defensive activity and compromise formation. He concludes that shame emphasises weakness, vulnerability, and the

likelihood of rejection- so much so that its acknowledgment often generates more shame.

There is consensus, however, between the different theories that the experience of shame is a universal phenomenon felt by patients and therapists alike and that it involves a complex combination of emotions, physiological responses and imagery associated with the real or imagined rupture of interpersonal ties (Pines, 1995; Lewis, 1987; Spero, 1984; Tangney, 1993). Non-verbal signs of shame include hanging the head down, eyes cast downward, and letting hair cover one's eyes. Behaviours that typically occur when a person feels ashamed are withdrawal, avoidance of others, and hiding the self (Mills, 2005). The impulse is to run, to hide or cover up in order to cope and defend against shame and this creates the danger of one feeling abandoned within their intra and inter - personal matrix. Kaufman (1992) emphasised that what adds to the complexity of shame is that paradoxically the person afflicted by shame must be healed in a relationship.

At the early stages of the literature review I often got confused and overwhelmed by the different terms used and I started to become mindful of the many nuances of shame experiences. This raised further questions about the phenomenon, for example, do such concepts represent a spectrum and therefore describe a range of intensity levels? Is shame at the heart of all these concepts? What are the similarities and differences between these emotional states, and can they coincide? I also noted that authors made use of the terms affect, emotion, and feeling interchangeably, when referring to shame experiences, even though some writers stated that these terms should be conceptualised and presented as distinct from one another (Shouse, 2005).

The attempt to distinguish between terms that illustrate shame-related states further convinced me about the impossibility of capturing the different nuances of meaning. This brings to mind Kaufman's argument that the systematic neglect of shame concerns the lack of an adequate language "…with which to accurately perceive, describe, and so bring into meaningful relationship this most elusive of human affect…" (2004:4). The difficulty of conveying inner complex emotional states through language enabled me to reach the conclusion that any research into the shame experience would have to allow for a range of individual understandings of the emotion. Hence, I opted for a qualitative research approach which aimed to explore

my participants' individual perspectives; the objective of my research was to explore how my participants understand and manage experiences of shame when evoked in therapeutic settings.

An additional problem in defining shame has been its resemblance with similar phenomena such as guilt and embarrassment. Lewis (1971), a psychoanalytic writer, was the first to differentiate shame and guilt in a clear way. She argued that '…The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation but rather the thing done or undone is the focus…' (ibid, p. 30). Elison (2005) and Tangney, Miller, Flicker, Barlow (1996a) further explored such overlaps, whereby Elison (2005) discriminated between shame and guilt, whilst Tangney et al (1996) included embarrassment in their definitional study. Tangney et al (1996a) used self-report scales and their findings supported their claim that embarrassment is an emotion distinct from shame, but their evidence did not offer a clear and coherent dividing line between shame and guilt. They concluded that although there are definitional similarities between shame, guilt and embarrassment, shame tends to appear in public situations where the person was on their own, whilst embarrassment was likely to occur more interpersonally. The authors argued that shame either leads to disconnection from the other or emerges in the disconnected moment, because the disconnection is interpreted maladaptively. Although their study offered interesting empirical data about the similarities and differences between shame, guilt and embarrassment from a clinician's perspective I am left wondering whether shame is conceptualised as a healthy developmental construct or as a pathological development and whether it can actually be defined.

Another effort in defining shame experiences using Likert scales comes from Young et al (2003). Young et al (2003) claimed to have established a shame/deficiency schema and they used a Likert scale to determine this schema in a person. According to this theory a person with a shame/deficiency schema would identify with the following, as taken from the YSQ-L2 (Young 2003): 'No man/woman I desire could love me once he/she saw my defects'; 'No one I desire would want to stay close to me if they knew the real me'; 'I am inherently flawed and defective'; 'I'm unworthy of the love, attention, and respect of others'; 'I feel that I'm not lovable'; 'I am too unacceptable in very basic ways to reveal myself to other people'; 'It is my fault that my parent(s) could not love me enough'; 'One of my greatest fears is that my defects

will be exposed'. It is evident that Young et al (2003) conceptualised shame as a denigrating experience that causes disconnection from others and it seems to adequately capture the pathological nature of the experience. However, it excludes developmentally healthy shame, which I will be discussing later, and hence it cannot be regarded as a general or global definition of the phenomenon.

To summarise, even though psychology has paid significant attention to shame it has so far failed to offer a clear operational definition of the phenomenon. Gilbert & Andrews (1998) leading researchers in the field, have written extensively about the problems that arise in trying to conceptualise or define shame for the purpose of research. Gilbert (1998) offers a variety of conceptualisations, e.g., shame as an affect, an emotion, a social affect, a phenomenon with certain behavioural and cognitive aspects, whereas Andrews (1998) concludes that “we do not yet have the methodologies to explore these differences empirically" (Gilbert & Andrews 1998 p.3). The one aspect that appears clear in most of these selected approaches of defining shame is that shame is a phenomenon that manifest itself in our relation to ourselves and others. As the researcher of this study when I use the word shame, I am referring to a range of phenomena that may be captured by shame experiences such as feeling bad about oneself, feeling inadequate or inferior, powerless, and exposed, feeling a need to hide, and run away. However, even though I may hold the above descriptions in mind, these do not constitute a working definition of shame, as shame in this study is mainly defined by my participants’ responses when prompted to think about the phenomenon.

2.4 Methodological issues in researching shame

The review of the literature revealed that conceptual and methodological issues also arise in the empirical measurement of shame. Strongman (1987) argued that the central issue in the measurement of shame concerns the difficulty that researchers face in general in devising scales that can distinguish specific emotions. Similarly, Tangney (1996) a prominent figure in shame research stated that shame is an internal affective state that is difficult if not impossible to assess directly. Broadly speaking measures of shame can be classified into two categories, those that assess emotional states in the moment (e.g., Differential Emotional Scale (DES), Izard, 1977; Mosher & White, 1981), and those that assess emotional traits and dispositions, shame-

proneness (e.g., Test of Self-Conscious Affect (TOSCA), Tangney, Wagner, & Gramzow, 1989; Internalised Shame Scale (ISS), Cook, 1989).

The most popular measure that assesses shame in the moment is the DES (Izzard, 1977) but even though it is high on face validity it relies heavily on participants' ability to distinguish between the terms shame and guilt and "…without explicitly referring to a specific behaviour, there remain some questions about the degree to which this approach can truly tap Lewis' (1971) shame-about-self vs guilt-about-behaviour distinction" (Tangney, 1996: 751). Therefore, it is somewhat uncertain as to whether the DES is actually measuring shame or other related emotions (i.e. guilt) and this inevitably casts doubts about its efficacy. There have also been several attempts to assess shame in the moment by developing schemes for coding shame in narrative accounts and running texts. Lewis (1971) used the coding system created by Gottschalk and Gleser (1969) to score guilt and shame markers in recorded psychotherapy sessions but evidence for the reliability and validity of such coding methods have been disappointing (Binder, 1970; Crouppen, 1977; Smith, 1972). Tangney concluded that coding schemes may never produce reliable evidence because "…people rarely articulate shame experiences spontaneously, without pointed inquiry from an interviewer" (Tangney, 1996: 752).

Dispositional measures of shame-proneness mainly fall within two categories, those that have been developed to assess and distinguish between shame and guilt (Tangney, 1992), and those that assess the construct without a consideration for guilt proneness (Cook, 1989) or vice versa (Buss & Durkee, 1957; Klass, 1987; Kugler & Jones, 1992). In the Test of Self-Conscious Affect (TOSCA) (Tangney, Wagner, & Gramzow, 1989), which is a widely used scale for shame-proneness and guilt-proneness, participants are shown brief hypothetical scenarios involving social and moral transgressions followed by four common reactions that include shame and guilt as defined by the researchers, and they are asked to rate how likely they would be to react in each of the ways described. The authors, in line with Lewis's contributions (1971) conceptualize shame as a negative evaluation involving the entire self. Another popular measure, Internalised Shame Scale (ISS), was devised by Cook (1989) and was mainly based on Kaufman's (1985, 1989) shame theory. Cook (1989) defines internalised shame as an "enduring, chronic shame that has become internalised as part of one's identity and which can be most succinctly characterized as a deep sense

of inferiority, inadequacy, or deficiency" (cited in Tangney, 1996: 745). All measures of dispositional shame include several different, but related, manifestations of the construct in one scale, with no direct reference to the construct under investigation. That is, items specifically mentioning the word 'shame' are hardly included. Items in the most used scales contain at least some elements found to be specific to shame in the empirical research, along with other items derived from theory.

Therefore, I concur with Andrews's observations (1998), that the importance given to different shame experiences varies depending on the measure, as different authors of such measures hold different conceptualisations about the characteristics of high-shame individuals. Andrews (1998) also highlighted additional doubts about the efficacy of shame scales as he questioned whether shame measures assess shame per se, or only in a specific manifestation, and he underlined the empirical problems that have occurred when comparing such scales. For example, Kinsman (1997) compared TOSCA and ISS, two popular quantitative shame scales, which have empirically constituted internal validity, and showed that participants receiving group therapy improved on one of them (ISS) but not on the other (TOSCA) despite both being evidence-based assessment tools. The results raise doubts not only about the validity of the claimed internal validity of both questionnaires but also whether the two scales measure something slightly different, diverse aspects related to shame rather than shame itself, otherwise outcomes should have been convergent amongst these scales. The findings support Andrews' (1998) argument that meanings of shame within these scales are preconceived and assigned already to a specific rather than a universal context.

To summarize, meanings of shame within the existing shame scales are preconceived and assigned to a specific rather than a universal context and most of the research into shame has being conducted from a stance of specific intentionality and not from a phenomenological ontology, as demonstrated in the design of self-report Likert scales in the TOSCA and ISS measures. Andrews (1998) highlights this inherent issue in quantitative shame research when he argued that "…it appears that the content of the most commonly used questionnaire scales does not always conform to phenomenological experiences specific to shame that are identified in empirical enquiries…shame appears to be an elusive concept that, like other emotions, does not lend itself easily to being operationalised." (Gilbert & Andrews 1998:48-49).

Therefore, as the researcher of this study I infer that shame might only ever be fully understood by implementing a more phenomenological and contextual and less reductive approach in order to understand the idiosyncrasies of what is actually being investigated. What this indicates for the present study, is a need to research shame within a qualitative phenomenological method.

2.5 A review of empirical papers on shame

The overarching purpose of this section is to present an overview of empirical papers that address key points about shame as described in the literature review. I will present a synopsis of key research papers addressing the following points: early experiences and the development of shame, shame and psychopathology, shame and guilt, and culture-gender-social rank and shame.

2.5.1 Early experiences and development of shame

Attachment researchers Kelley, Brownell and Campbell (2000) showed that critical and negative maternal attitudes during a challenging task at 24 months were related to the experience of shame and avoidance at 36 months. On the contrary, positive maternal evaluations predicted higher determination and motivation in solving challenging tasks. Likewise, Gilbert, Allan and Goss (1996) discovered that the memory of being put down and belittled by caregivers during childhood is related to shame-proneness in adulthood. Claesson and Sohlberg (2002) studied memories of early interpersonal interactions and their findings revealed an association between memories of a blaming, attacking, and ignoring mother and shame. They asked participants to recall how their mother acted toward them when they were 5 to 10 years old and they discovered that memories of an ignoring and abandoning mother were more highly associated with shame than the memories of mothers who blamed and attacked. They concluded that an ignoring (m)other implies absence and lack of attunement, 'kind of unseeing quality' (ibid: 281), that turns the individual 'to its state of primary isolation' (Nathanson, 1992: 234). Their findings support the theoretical viewpoints of authors like Kohut (1971, 1986) and his notion of the mirroring self-object and Winnicott's (1988) concept of lack of empathic attunement. However, the study fails to draw a clear distinction as to whether the results show how early patterns of interaction lead to internalised shame or if people who are prone to shame tend to experience people around them as ignoring and rejecting, casting doubt to the overall

legitimacy of the findings. Moreover, the empirical assessment of this study relied on self-reports, which as we have already seen can be problematic, and most likely not reliable in the case of accounting for unacknowledged or hidden shame, whether it is overt and undifferentiated or bypassed (Eterovic, 2020). To conclude although this research showed a clear association between the memories of early interactions with the main caregiver and the experience of internalised shame in adulthood, the causality offered is somewhat questionable.

Andrews's research (1995, 1998, 2002) indicated that shame-proneness stems from experiences of enduring abuse in childhood and her findings showed a direct association between trauma and shame experiences. Matos and Pinto-Gouveia (2010) further explored the premise that early shame episodes can have properties of traumatic memories, 'involving intrusions, flashbacks, strong emotional avoidance, hyper arousal, fragmented states of mind and dissociation' (ibid: 299). Their results showed that early shame experiences revealed traumatic memory characteristics which are associated with feelings of internal and external shame in adulthood. They also found that those individuals whose shame memories displayed more traumatic characteristics exhibited more depressive symptoms, a finding that showed that current shame and depression were significantly related. This research, albeit its limitations (use of self-reports questionnaires and the likelihood of selective memories in participant's retrospective accounts) showed that shame influences vulnerability to psychopathology and influences the person's ability to disclose painful information, which has rather significant implications for clinical work.

The cognitive-attributional model suggests that elicitation of shame is associated with internal, stable, global attributions (M. Lewis, 1992, 2003; Mills, 2005) and Barrett, Zahn-Waxler and Cole (1993) demonstrated that two-year-old children displayed shame-relevant behaviour, such as avoidance and hiding, or guilt-like behaviour, such as approach and mending, when they broke the experimenter's (rigged) clown rag doll. M. Lewis, Alessandri and Sullivan, (1992) found that three-year-old children are cognitively able to evaluate task difficulty and to rate their performance accordingly. Their results indicated that children who failed to perform well in an easy task showed greater signs of shame than children who failed to perform well on a difficult task. Thus, according to this study, failure itself did not evoke shame as only the children who failed the easy task experienced shame, which is in line with the cognitive-attributional

theoretical position that shame is not activated in response to a specific situation but by a person's interpretation of a negative event. However, in children, these attributions may differ; what I mean is that perhaps children as young as 2 or 3 years of age may not understand traits as characteristics reflecting some underlying motivation until later in life. Hence one can argue that shame states in toddlerhood may be somewhat short-lived, involving less thinking about the defectiveness of the global self. Further research could explore these reciprocal influences between shame experiences and social-cognitive patterns.

2.5.2 Shame and Psychopathology

Several investigations have pointed out the roles that shame may play in the development and maintenance of psychological problems. For example, shame and shame proneness have been found to be associated with depression (Tangney et al., 1992; Kim et al., 2011), social phobia and generalised anxiety disorder (Fergus et al, 2010), bipolar disorder (Highfield, Markham, Skinner & Neal, 2010), eating disorders (Grabhorn, Stenner, Stangier & Kaufohold, 2006; Hayaki, Friedman & Brownell, 2002), and with personality disorders (Brown, Linehan, Comtois, Murray & Chapman,2009; Rusch et al., 2007).

Tangney et al (1992) in two studies of 245 undergraduates found associations between shame and depression. Likewise, Gilbert, Pehl and Allan (1994) asked 125 students to complete measures of depression, fear of negative evaluation, shame and guilt proneness, and of submissive behaviour and they found that shame correlated with fear of negative evaluation and measures of submissive behaviour, concluding that shame is related to submissive behaviour and that submissive behaviour is related to depression. Cheung, Gilbert and Irons (2004) in a study of 125 undergraduates found that social rank and shame are highly correlated and that both are significantly correlated with depression. Andrews, Qian and Valentine (2002) showed that shame was associated with depressive symptoms, and that it predicted additional significant variance in a future evaluation, therefore suggesting that shame may play a significant role in the onset and course of depression (Candea and Szentagotai, 2013). De Rubeis and Hollestein (2009) shared similar findings that showed that shame proneness was a significant predictor of depressive symptoms, both concurrently and over the course of twelve months. Gilbert and Procter (2006) and Gilbert and Miles

(2000) investigated the role of self-criticism in relation to shame and depression and they found that self-criticism is significantly associated with shame proneness. However, it is worth noting that many of the studies investigating the link between shame and depression are based on undergraduate student samples and use correlational data. Studies on undergraduates are not necessarily applicable to the general population and data from correlational studies may imply a relationship but do not delineate cause; nevertheless, these studies have offered useful findings and have contributed to our understanding of the relationship between shame and depression.

Several empirical studies have specifically examined the relationship of shame-related constructs with suicide ideation and suicidal behaviour. Two studies found that current and future suicide ideation is associated with shame (Hastings, Northman, & Tangney, 2000; Lester, 1998) and negative self-concept (Kaplan & Pokorny, 1976). Negative self-concept predicted, independently of depression, both suicide attempts (Lewinsohn, Rohde, & Seeley, 1994) and suicide (Beck & Stewart, 1989). One longitudinal study found that shame-proneness in the 5th grade predicted later suicide attempts by young adulthood (Tangney & Dearing, 2002). Three studies showed that a substantial proportion of overdoses occurred in the presence of shame-related thoughts and emotions: 45% of overdoses were reported to occur when participants were feeling lonely or unwanted (e.g., sadness and shame), 45% occurred when participants were feeling like a ‘‘failure’’ (e.g., shame) (Bancroft, Skrimshire, & Simkins, 1976; Birtchnell & Alarcon, 1971; Hawton, Cole, O’Grady, & Osborn, 1982).

Shame also appears to play a key role in anxiety disorders; an investigation conducted by Fergus et al. (2010) looked at the association between shame and guilt proneness and anxiety disorder symptoms using data from 124 patients with primary anxiety disorder diagnoses. The findings showed that symptoms of generalised anxiety disorder and social anxiety disorder share significant relations with shame proneness; moreover, changes in shame-proneness during treatment were found to share significant relations with changes in obsessive compulsive disorder, social anxiety disorder and generalised anxiety disorder. Studies have shown that shame influences the course of other mental disorders like eating disorders. Burney and Irwin (2000) found that shame in eating contexts and body shame were related to the severity of eating disturbance in a community sample. Hayaki et al (2002), in a study of undergraduates showed that shame-proneness was associated with higher levels of

bulimic symptoms when controlling both for guilt and depressed mood. Kaufman stressed that eating disorders are '…rooted in significant interpersonal failure and display a characteristic pattern for reproducing shame…" (Kaufman, 1992: 188). Conradt et al. (2007) discovered body related shame in a nonclinical sample of obese individuals and Grabhorn, Stenner, Stangier and Kaufhold (2006) found higher levels of internalised shame and social anxiety in patients with anorexia and bulimia nervosa than in patients with anxiety disorders and depressions.

The role of shame in psychotic illness has also been investigated and a recent study by Keen, George, Scragg, and Peters (2017) examined the role of shame and its relationship to depression in schizophrenia. They implemented a cross-sectional design with three groups 1) individuals with a diagnosis of schizophrenia, 2) depression, and 3) rheumatoid arthritis, sixty individuals participated in the study (20 per group). The groups were compared on questionnaires assessing external shame, trait shame and guilt, and depression. Their data showed that both the schizophrenia and depression groups displayed higher levels of external shame or seeing others as shaming, than the medical group. For individuals with schizophrenia, seeing others as shaming was associated with higher levels of depression, a relationship not found in either control group. The findings highlight the importance of shame in schizophrenia and how stigma associated with a diagnosis of a psychotic illness can have negative emotional consequences that may impede recovery and engagement with treatment.

Some attention has also been given to the role of shame in bipolar disorder; it has been suggested that individuals with a diagnosis of bipolar disorder may experience shame in response to uncharacteristic behaviour engaged in during manic episodes (Mansell, Colom, & Scott, 2005), as well as a result of the psychosocial consequences of these manic behaviours (Goodwin & Jamison, 1990). Fowke et al (2012) looked at the association between childhood maltreatment and internalised shame in adults with a diagnosis of bipolar disorder. A sample of 35 adult participants with a diagnosis of bipolar disorder and a control group of 35 participants with no psychiatric diagnoses completed measures of childhood abuse and neglect, and internalised shame. The findings showed that participants in the bipolar disorder group reported significantly greater frequency of childhood emotional abuse and neglect. Levels of internalised shame were also significantly higher amongst participants in the bipolar disorder group. Although the results of this study provide a valuable contribution to the existing

literature about the role of shame in bipolar disorder, they cannot demonstrate any causal relationships between childhood trauma and shame amongst bipolar disorder participants. Further longitudinal studies would be useful to further explore these factors. Nevertheless, the results demonstrate an interesting and significant association between these variables.

Moreover, Schoenleber and Berenbaum (2010) found associations between shame proneness and cluster C personalities, namely those defined by the DSM 5 as Avoidant, Dependent and Obsessive-Compulsive Personality Disorders (American Psychiatric Association, 2013). Shame is considered to be a central emotion in Borderline Personality Disorder and has been related to self-injurious behaviour, chronic suicidality, non-suicidal self-injury, anger-hostility, and impulsivity (Stiglmayr et al., 2005). Recent studies have also documented an association between shame and posttraumatic symptoms. Leskela, Dieperink and Thuras (2002) found that shame proneness correlated positively with the severity of post-traumatic stress disorder and Andrews, Brewin, Rose & Kirk (2000) discovered that shame and anger were the only independent predictors of PTSD within one month of the incident, whereas at six months follow-up shame was the only predictor of PTSD symptoms.

To summarise empirical literature suggests a strong association between shame and psychopathology as it has been found to be a contributing factor to various psychological problems. However, we need to be cautious as some of these studies do not allow conclusions about the direction of the relationship between shame and psychopathology. Moreover, Michels (1997) warned against viewing shame as the central affect and stated that although shame may be useful to understanding individual cases it cannot be viewed as an exclusive or chosen way of organising developmental and clinical information.

2.5.3 Shame and guilt

The idea that shame and guilt are distinct emotional experiences is supported empirically by several studies utilising a variety of different methodologies, for example, studies using quantitative ratings of shame and guilt experiences (Tangney et al, 1996a), content analyses of shame and guilt narratives (Tangney, 1992) and qualitative case studies (Lewis, 1971). Tangney et al (1992) in their study examined guilt and shame narratives and they found that individuals consistently described

shame as more emotionally painful than guilt. More specifically, during feelings of shame, individuals felt their entire self being painfully scrutinised and negatively evaluated, which led to feelings of worthlessness and powerlessness. When individuals experienced guilt, they tended to feel tense and remorseful about the 'bad thing' that was done. The study also showed that feelings associated with guilt and shame result in different behavioural motivations. For shame, a desire to hide or escape is typically present, whereas feelings of guilt tend to motivate people to want to apologise and repair (Tangney et al, 1992). Despite the presence of negative affect in both shame and guilt, the focus of attention in these emotional states is quite different, resulting in critical distinctions in the thoughts, feelings and behavioural reactions associated with these emotions (Tangney et al, 1996a). Lewis (1987) noted that shame is difficult to separate from guilt because one can trigger the other or both can be triggered by a single event since the focus of attention in guilt is the "other" whom one has hurt or wronged while in shame is the self.

It is evident from the above that most theorists and researchers consider guilt to be the more adaptive emotion – viewed as a private emotion-, as it promotes reparative strategies with corrective behaviours being undertaken, whereas shame – viewed as a public emotion - promotes more hiding and withdrawal strategies. It is worth noting that the empirical support for the public versus private nature of shame/guilt is contradictory. Smith et al (2002) found that when participants' failings were witnessed by others, they felt a stronger sense of shame than they did of guilt. However, in a study conducted by Tangney et al (1996), one hundred eighty-two undergraduates were asked to describe personal experiences of embarrassment, guilt, and shame and to rate them on structural and phenomenological dimensions, and their findings indicated that shame is not a more public emotion when compared to guilt.

2.5.4. Social rank, cultural and gender differences

Empirical findings have shown that shame is highly correlated with feelings of inferiority/submissiveness (Birchwood et al, 2006) and significantly associated with perceptions of low social rank and expressions of submissive actions (Gilbert, 2000). Interestingly, Dickerson et al (2004), found that HIV patients who felt stigmatised and rejected because of their sexual orientation died on average two years before those who did not feel stigmatised. But HIV patients who experienced other negative

emotions like anger, anxiety or sadness did not experience a CD4 T-Cell decline over seven years. In other words, the findings of this study imply that shame is the only negative emotion that can forecast health problems and decline in people who have been shunned and rejected.

Wallbott and Scherer (1995) showed that shame is experienced differently in collectivist cultures such as Mexico, Venezuela, India, Brazil and Chile and in individualist cultures like Sweden, Norway, Finland, New Zealand and the USA. The findings showed that the experience of shame in collectivist cultures had shorter duration and a less negative impact on self-esteem when compared to individualistic cultures. Greenwald and Harder (1998) argued that in these cultures shame is not an individual experience but is linked with cultural values and standards and conforming to the cultural and societal rules is essential for avoiding feelings of shame. Not following the rules not only generates shame for the individual but it brings shame to their communities and usually the culprits get punished harshly in an attempt to restore the lost honour (Cohen et al, 1998).

In many collectivist cultures shame is understood to be constructive, adaptive, informational, and motivational (Edelstein and Shaver, 2007). Rozin (2003) found that 43.5% of Indian students conceptualised shame as more similar to happiness than to anger, whereas, the majority of American students viewed shame to be more similar to anger with only 6% reporting a similarity between shame and happiness. Similarly, a study by Wong and Tsai (2007) showed that Chinese parents are more likely to use shame strategies in parenting than American parents, because they view shaming methods as rehabilitating. Also research has shown that culture affects how people respond to shame experiences; for example, Bagozzi et al (2003), found that the experience of shame for Filipino salespeople, who come from an interdependent-oriented culture, is linked with social involvement and an attempt to rebuild social contacts with customers, whereas, their Dutch counterparts, who come from an independent-oriented culture, tend to employ defensive strategies such as avoiding conversations with customers in order to protect their self-image after shame incidents (Sedighimornani, 2018).

Research on shame and demographic characteristics has shown that shame decreases from adolescence to middle-age and then increases into old age;

additionally, wealthy people report feeling less shame in comparison to less privileged individuals (Orth, Robins, & Soto, 2010). Social class, even for working class educated people who have achieved high status in society, generates shame; individuals may feel shame merely because of being poor or because of being stigmatised for being poor (Power, Cole & Fredrickson, 2010).

Women report more shame than men (M. Lewis, 1992; Orth et al., 2010); Benetti-McQuoid and Bursik (2005) found that regardless of gender, those individuals with a feminine gender role feel higher levels of shame when compared to those with a masculine gender role. M. Lewis (1992) argued that women are socialised differently from men and indeed, Brown (2012) asserted that her research on shame and vulnerability revealed that one of the main triggers of shame for women is their appearance, whereas for men it is their weakness; men do not want to be viewed as weak or girly, which is exactly what culture, and the media impose and promote: an extensive focus on women's appearance and men's masculinity (ibid). Tiggermann and Boundy (2008) found that even a compliment about one's appearance increases body shame among those who are high in self-objectification. Especially in the current context of 'reality TV' which is highly appearance oriented, societal sexual objectifications that mainly target young women more than men, get amplified as women are forced to evaluate their value based on their physical attributes and appearance. Since the idealised appearance and body are impossible to attain as standards are narrow and rigorous, women are more likely and prone to experience body shame than men, and often tend to be judged negatively at work, school, social interactions merely because of their appearance regardless of their academic achievements experience, performance, and personality traits (Roberts and Goldenberg, 2007). It is not unreasonable, therefore, to posit that such experiences evoke painful shame states that likely contribute to the development of psychopathology such as Body Dysmorphic Disorder, anxiety disorders, depression, and eating disorders.

2.6 Therapists' Experiences of Shame – an overview of theory and empirical research

2.6.1. Overview of theoretical contributions on therapists' experiences of shame

In recent years there has been an explosion of psychotherapeutic interest in shame, but little attention has been given to therapists' experiences of shame. Morrison (2014) suggests that the mutual collusion to avoid the consideration of shame stems from the aggressively contagious nature of shame where it is difficult to consider our patients' shame without being reminded of our own shame experiences. '…Our own repressed expansiveness or disavowed conviction of defect is inevitably engaged in the intense relationship we co-construct with our patients. At times we recognize attributes in ourselves, enlisted in contact or combat with our patients, that generate shame in our sense of self-as-therapist, equivalent to feelings that accrue in psychotherapy within our 'other' in his or her role as patient…' (Morrison and Stolorow, 1997: 82). Similarly, Ayers (2003) pointed out that shame is a very provocative and contagious affect that may incite the therapist to overreact as '…the nature of the very early material contained in shame creates a strange relationship between the unconscious and of the patient and that of the therapist…' (ibid:207). She argues that projective identification dominates the process and seduces the clinician to replicate the terrible aspects of the (m)other because '…the petrifying occurrence of shame also demands its re-enactment over and over again in an attempt to discharge unbearable tensions…' (ibid). Shame is most likely to surface when the therapist's misattunement resembles maternal failures and as a result the client will feel '…fragmented, disconnected, or dismissed…We all defend against the awful sting of shame, but if the therapist defends or has not been treated on her issues of shame, it will be hard to recognize, much less access. The therapist must resist her own feelings of shame lest she dismisses something important or worse, impinges' (ibid: 208). Hence, countertransference appears to hold a significant role in direct explorations of shame experiences.

However, the countertransference of shame has received little attention maybe because as Morrison (2008) argues the psychoanalytic concept of countertransference in regard to shame has been too painful for the profession to entertain. He wrote extensively about various types of shame including the

countertransference of shame where shame is triggered by the therapist's identification with the patient which leads to 'the mutual collusion to avoid the consideration of shame' (Morrison, 1998, p.68). The second type of shame is activated by the therapist's fear of treatment failure, which refers to the experience of shame that a therapist may feel due to the notion that they are not helping the client therapeutically. The third type occurs in relation to colleagues when comparing oneself or competing with them. A fourth type relates to the therapist alone experiencing 'universal limitations of life' which includes aging and declining health (Morrison, 2011:40)

He described some potentially shaming situations for therapists, for example when we are being repeatedly told by certain patients that we are not being helpful, when we think that we are not being helpful and that we are impeding the therapeutic process, when a patient quits prematurely and without adequate explanation, when we are presenting our clinical work to our supervisors. He stated that "instances of shame in the clinical encounter –images of comparison of actual self with the analytic ideal self- involve the shame of falling short of one's professional ideals and goals. Most of them reflect comparison of self to idealised other as well and thus represent instances of humiliation: I am not a good analyst. What will my colleagues think of me?" (ibid, 2008:71). He also wrote about personal shame events that afflict our families: for example, a son's failure at college, a divorce (Morrison, 2008). He alerted us to the fact that countertransference shame has been less studied because of 'the intersubjective reverberation of shame between analyst and analysand' (Morrison, 2008:68). Intersubjective reverberation of shame refers to the unequal balance of power inherent in the therapeutic relationship, the implied superiority of the therapist, and the potential for a shaming effect on the client due to therapist interpretations.

Similarly, Gabbard (1993) described the mutual activation that can occur amongst therapist and client when working with shame, where patients may project aspects of their shameful feelings that they are unable to contain and in some instances the therapist's internal shame experience can be activated through identification with the client's internal experience. An example of this phenomenon is when the therapist's shameful feelings about losing their job are evoked from her client's story. As a result, some therapists may feel a sense of inadequacy, others may experience feelings complementary to their client's experience. Racker (1968) described concordant

countertransference identifications as occurring when the therapist identifies closely with the client's negative self-perceptions. Complementary countertransference identification occurs when the therapist identifies with disavowed or rejected aspects of the client's experience.

Hahn (2000) argued that in treating shame both types of countertransference identifications operate in tandem with the patients 'devalued introjects' and 'devaluing introjects' (ibid:12). 'Introjects' are lasting patterns of relating established in interactions with the early caregivers. Devalued introjects relate to a representation of the self that is pervasively negative often experienced as a profound sense of inadequacy. Devaluing introjects externalise shame by perceiving others as critical and condemning. Acting out of concordant countertransference the therapist may enact the client's shame driven behaviours of hiding or being aggressive by becoming distant and/or angry with the patient. Without awareness of the countertransference, it is easy to see how shame can escalate and both client and therapist can so easily feel misunderstood and how, regretfully, the therapy can end prematurely.

Lanksy and Morrison (1997) in line with Lewis's (1987a) contributions about resistance claimed that resistance in clients can stem from a disavowal shame affect and it can evoke shame in the therapist who may begin to feel incompetent if the client does not show signs of improvement. Steiner (2011) wrote about clients' need to create hiding spaces, which he called psychic retreats. In conceptualising resistance within the context of psychic retreats Steiner stated that 'the intensely uncomfortable experiences of embarrassment, shame, and humiliation are the most immediate problems facing the patient as he begins to emerge from the psychic retreat' (ibid:6). Steiner warns therapists to abstain from misinterpreting feelings of shame and embarrassment with guilt and loss as he proposes that clients need to work through a stage in which being seen leads to shame and embarrassment before they can face depressive anxieties.

Therapists can also bring their own personal shame to the relationship that may have nothing to do with the client. For example, a therapist may be struggling with sources of therapist shame mentioned above (Morrison, 2008) or she may be trying to make recovery after feeling shamed by a previous client. Orange, an intersubjective psychotherapist, suggests that there is no such thing as a patient and there is no such

thing as the patient's or the analyst's shame (Orange, 2002). She states that "…while shame maybe experienced individually, it is relational and systemic phenomenon in its genesis, maintenance, and consequences…shame in the therapeutic system belongs neither to the patient nor to the therapist, but it is intersubjectively generated…" (Orange, 2008:88). She offers an interesting insight into the peculiar complexity of shame when she argues that although "its origins must lie in intersubjective systems, because none of us is born ashamed, it is often, if not always, experienced as personal inadequacy, degradation, or self-loathing" (ibid).

As clients can struggle with revealing weaknesses to a therapist, so can supervisees be challenged to do the same with their supervisors (Alonso & Rutan, 1988). One can argue that the therapist's level of resilience towards shame has a significant bearing on her functioning within therapeutic, supervisory, and collegial contexts. Talbot (1995) identified three main sources of shame in the supervisory relationship: the first arising from the relationship between therapist and client includes countertransference that may be evoked when the client considers the therapist inadequate. The second source relates to the therapist's fear, of, or experience of disapproval or lack of admiration by, an idealised supervisor. Discussion is rarely focused on the supervisor's shaming behaviours towards their supervisees, although it may not be uncommon for these to occur. The third and final source is the revelation of personal weaknesses, idiosyncrasies, inadequacies or what may seem trivial in the supervisory relationship. To counter the hidden nature of shame Talbot advocated both supervisor and supervisee adopt an active uncovering approach to supervisory material. Similarly, perceiving the vulnerability of trainees to exposure and humiliation Alonso and Rutan (1988) suggested a range of strategies for shame reduction.

2.6.2. Overview of empirical research on therapists' experiences of shame

Empirical research has shown that some shame states are not experienced in consciousness and instead are unconscious. Lewis (1971), a psychoanalyst and research psychologist, in her seminal work on shame analysed transcripts of several hundred psychotherapy sessions and she discovered that shame was overwhelmingly the most prevalent emotion surpassing anxiety, grief, pride, love, anger, and fear. Lewis (1971) was the first to differentiate shame and guilt in a clear way. Her contribution brought attention to shame experiences as she concluded that shame is

the most dominant emotion that pervades human relationships. Moreover, her work implied that shame dynamics dominate most psychotherapeutic work. Lewis's research showed that important emotions take place outside the patient's awareness and she used the term unacknowledged shame to describe the phenomenon. She further conceptualised unacknowledged shame in the forms of overt, undifferentiated shame and bypassed shame. In the case of overt-undifferentiated shame there is conscious awareness of emotional distress, typically accompanied by unwanted physical responses like blushing, rapid heartbeat, or sweating. *But the emotional experience is denied through misnaming shame through the use of codewords such as feeling insecure, uncomfortable, weird, hurt (Scheff & Retzinger,1991) and instead of saying that 'I felt embarrassed' the person says, 'it was an uncomfortable experience for me'. Lewis suggests that in overt, undifferentiated shame instances there are two kinds of misnaming involved, denial of shame and projecting from within oneself to the outer world 'It was not I who was embarrassed; it was the moment that was awkward' (Lewis, 1971:196-197).*

In the second type of unacknowledged shame, which she called bypassed, there is little awareness of emotional distress. Instances of 'bypassed shame' involve some conscious thought about how one looks to others or that one is inferior, but all that is consciously available may be a 'wince', a 'blow', or a 'jolt' (Lewis 1971, p.197) with no awareness of the shame feeling. She describes the excruciating pain of shame and how it disappears in treatment because it is so painful to bring to awareness. She claims that therapists and clients can together bypass shame in a regular basis. According to Lewis the ideation of bypassed shame involves doubt about the self's image from the 'other's viewpoint' (ibid, 1971: 197). Moreover the experience of bypassed shame is durable and refuses to subside as the afflicted person engages in compulsive cognitive activity whereas compulsive replaying of a scene, 'the interior theatre' of the mind' (ibid), is one of the most frequent defenses against bypassed shame (Scheff and Retzinger, 1997).

One of the first qualitative empirical studies investigating clinicians' experiences of shame was conducted by Dunn (1986,1987). That study analysed 28 shame events among psychoanalytic therapists and showed that participants' shame related to themes of sexuality, inadequate empathy and altered boundaries. The findings showed that clinicians' shame often got entangled with clients' material and that

therapists failed to empathise with their clients' shame. Scheff (1987, 1998) and Retzinger (1998) examined transcripts of therapy sessions using discourse analysis to trace the thread of therapists' shame through the therapeutic dialogue and showed the threat of shame occurring outside the therapist's awareness. Similarly, Livingston and Farber (1996) investigated the clinical implications of therapists' shame in a quantitative study where they assessed the relationship between a therapist's vulnerability to shame, measured by a shame proneness scale, and the therapist's response to shame affect expressed by clients. The findings revealed that individual therapists with higher shame proneness felt more unnerved by clients' angry shame affect. What these studies have shown is that therapists' experiences of shame can be a compelling dynamic in the therapeutic relationship, harmful or useful, depending on how the feelings are understood and processed.

In an attempt to further explore the possible impact of therapist reactions to clients, Dorahy, Gorgas, Hanna and Wingaard (2015) studied the responses of 55 non-clinical participants to various therapists' responses to shame disclosures, so that the helpfulness of the responses could be ascertained. Their findings indicated that both withdrawal and non-withdrawal (staying directly with the experienced affect) were both deemed unhelpful, with management of the affect being the favoured approach. Such results highlight the absolute complexity of working with shame and the need for therapists to fine tune their responses. Pope, Sonne and Green (2006) advised therapists to acknowledge, accept and understand their own uncomfortable feelings and reactions arising out of embarrassing and shameful moments, as a lack of awareness will have an unknown effect on the client. Researchers Safran and Muran (2000) argued that the therapists' recognition of their own shame can be critical in shaping therapeutic outcomes. Tangney & Dearing (2002) reported empirical evidence that shame experiences interfere with the afflicted person's empathy, which directly challenges one of the fundamental elements of psychotherapeutic practice. Moreover, research conducted by Gilbert and Procter (2006) showed that therapists' shame reactions, like defensiveness and withdrawal, can cause ruptures and further shame to clients.

Klinger, Ladany and Kulp (2012) asked 93 therapists and supervisors with clinical experience ranging from 6 months to 40 years to 'describe an event in which they felt embarrassment or shame during a therapy session and how they reacted to the event'

(p.558). Their findings identified a total of 16 ‘therapist embarrassing and shameful events’, like, ‘a scheduling mistake, forgetting or confusing client information, being visibly tired, falling asleep and arriving late’ (ibid, p.554). The study matched these sources of shame with the therapist’s reactions. They identified a mix of moving towards and moving away (hiding) responses by therapists including, apologising, ignoring the event, processing with client, avoidance, recurring thoughts about the event. This study covered a range of experiences and in the main it reflected therapists’ perceptions of errors or perceived failings but a notable absence in the study is countertransference shame. The results appear to reflect Morrison’s (2011) suggestion that shame exists in the gap between our ‘ideal self’ who has professional efficacy and our ‘actual self’.

The literature review revealed two recent studies that examined therapists’ shame from a phenomenological perspective using Interpretative Phenomenological Analysis (Miller & Draghi-Lorenz, 2005; Kissaun, 2017). Miller and Draghi-Lorenz (2005) conducted an Interpretative Phenomenological Analysis research on seven therapists and their findings highlighted the importance of understanding shame in the relational settings that it manifests; their data also showed that to avoid therapeutic derailments clinicians need to be aware of their own shame proneness. The authors identified two superordinate themes, 1) Shame coming alive in a session – disorientation and misalignment and 2) Managing shame – reorienting and realigning. The first superordinate theme consisted of three subordinate themes: a) not felling a good enough therapist, b) shame coming into awareness and c) experiencing the therapist's self on a split screen. The second superordinate theme had seven subordinate themes: a) struggling to contain feelings and return to the client, b) figuring out what belongs to whom, c) using shame, d) retreating into safe mode when feelings are too hot, e) getting stuck in shame and f) afterward -the power of talking about shame. What I found particularly useful about this study is that it focuses on how shame influences relational practice as it offers evidence that we as clinicians are subject to experiencing our own shame, and it also highlights that it is vital that we do not defensively abandon our clients during shame work.

Kissaun (2017) explored how Maltese therapists understand and manage feelings of shame evoked in the therapeutic encounter. Semi-structured interviews were conducted with ten participants and the interviews were analysed using Interpretative

Phenomenological Analysis (IPA). Kissaun (2017) identified four superordinate themes a) The Therapist's World of Shame, b) Be-holding Patients' Shame, c) A Shared Experience, and d) The Island of Shame. The findings echoed the contributions of Miller and Drag hi-Lorenz (2005) as Kissaun (2017) illustrated the benefit of therapists' understanding their own and their patients' shame signals and triggers during therapy. This study, however, added valuable empirical evidence and expanded our understanding of how cultural dynamics serve to augment feelings of shame that can lead to the loss of a psychotherapist's sense of authenticity.

The focus and research question of my investigation, although it bears similarities with these two phenomenological studies, it differs in terms of the actual contribution that I want to make. For example, although I concur with Miller's and Draghi-Lorenz's (2005) position that it is important to understand shame within a relational setting as this is where it manifests, their study is different from the present study in that it pro-actively seeks out shame activated in the clinician and/or the client, mainly investigating managing countertransferential elements of shame as they rise in the clinical encounter, with less focus on the experience per se. My study has many similarities with the work conducted by Kissaun (2017), who embarked on a comparable quest to mine, namely, to investigate therapists' experiences of shame and uncovering how it impacts the clinical work done. However, Kissaun's focus was to explore such experiences within therapists who shared the Maltese heritage and culture. In stark difference, my sample consists of clinicians who shared adherence to intersubjective relational practices. Therefore, my research plan is distinctive in its potential contribution to the practice field, as I contend that since my participants' clinical practices fall within relational psychotherapy, their training views would differ from those of the therapists' in Kissaun's (2017) and in Miller's and Draghi-Lorenz's (2005) studies, as their samples included practitioners trained in various modalities, i.e., CBT, Psychodynamic, Gestalt. Although I anticipate that my findings may echo the results reported by these researchers, I envisage that my contribution will highlight intra-psychic and inter-psychic elements or other internal and interpersonal or inter-subjective aspects of shame experiences and will look at how these influence our being with others.

As a concluding remark I would like to highlight that the above studies have further supported my belief that a qualitative method appears to generate more descriptive

data in this field than quantitative investigations and more specifically helped me to cement my decision that IPA is an appropriate method to research shame.

2.7 A synopsis of early psychoanalytic conceptualisations about shame

Freud (1893) argued that painful emotions were kept from consciousness by means of the defence mechanism of repression and he associated shame with the resolution of the Oedipus complex and the need to keep sexual impulses repressed. In this context shame was viewed as a social affect, related to being seen or found out by someone, with its essential role being the upholding of the structure of society together (Morrison, 1989). In almost every instance in which he undertook an analysis of the shame experience, Freud elaborated a reaction-formation concept of shame as a defence against the sexual-exhibitionistic drive. The following passage is characteristic of Freud's comments on shame as reaction-formation: '…During the period of life which may be called the period of 'sexual latency'—i.e., from the completion of the fifth year to the first manifestations of puberty (round about the eleventh year)—reaction-formations, or counter-forces, such as shame, disgust and morality, are created in the mind. They are actually formed at the expense of the excitations proceeding from the erotogenic zones, and they rise like dams to oppose the later activity of the sexual instincts…' (1908:171). Freud's view of shame as reaction-formation implies a specific relationship between shame and guilt. As I understand it, his theoretical stance suggests that reaction-formation appears at the behest of the superego in order to block impulse expressions that would arouse guilt; therefore, shame as reaction-formation was viewed as a defence against guilt.

Freud (1914) regarded shame as the ego's response to social disapproval and hence it was considered as an emotional state of less importance to guilt and subsequently received little attention. It is not surprising therefore, that the Index to the Standard Edition of Freud's work contains 36 references to shame, compared with the 140 references to guilt (Wharton, 1990: 284). Morrison (2008) argues that although with the development of structural theory (Freud, 1914, 1923) and the development of the constructs of super-ego and ego-ideal there was potential for an understanding of shame, Freud's focus on libido and conflict theory meant that he was more interested in the development of guilt in relation to Oedipal strivings.

In his later writings he linked shame to genital deficiency in women and to urination. He viewed the origin of shame in relation to genital visibility and in relation to genital

deficiency in women (1933) with shame emerging primarily as a feminine characteristic: 'Shame, which is considered to be a feminine characteristic *par excellence* but is far more a matter of convention than might be supposed, has as its purpose, we believe, concealment of genital deficiency.' (1933: 132). In a paper on the relationship between shame and urination, Freud (1932a) speculated that the domestication of fire led humans to control the desire to urinate on it and put it out, he noted that 'it is very remarkable that the reaction of shame should be so intimately connected with involuntary emptying of the bladder and not equally so, as one would have expected, with incontinence of the bowels' (1918b, p.92).

Contemporary writers have closely examined why Freud directed his attention away from shame experiences. Thrane (1980) argued that Freud's ideas about genital deficiency were similar to Adler's 'organ inferiority' and 'inferiority complex' suggesting that he may have avoided shame in part because of its proximity to Adler's contributions. Pines (1987) noted that guilt fits more neatly into Freud's tripartite structural model because guilt is less connected with self-referential properties than is shame: 'since shame is so largely connected with the whole feeling about oneself, it brings immediately into focus questions such as those of self and identity, with which psychoanalysis has found it hard to grapple. Shame is not experienced by the ego but by the self.' (Pines, 1987: 17). Pines also stated that Freud was a shame-sensitive person, and he supported this notion by referring to Freud's dislike of his own visual appearance and to Freud's shame about his Jewish identity. Similarly, Lansky and Morrison (1997a) argued that Freud himself seemed to be exquisitely shame sensitive, as it revealed in his dreams. This sensitivity may well have played a part in his turning from shame to guilt in the structural theory (ibid). Unequivocally, Freud's exclusive emphasis on guilt played a large part in slowing the clinical attention to shame.

2.8 Developmental theories of shame

A review of the literature showed that there are three general theoretical orientations about the developmental origins of shame: the functionalist, the cognitive attributional and the object relational/attachment. I will aim to briefly describe the main representatives of these orientations.

2.8.1 A Functionalist Perspective

Functionalist theories are based on Darwin's evolution theory with its main focus being on the adaptive function of shame in serving a person's goal and also on its function regulating processes within and between the self and others. Emotions begin when the person appraises an event as significant to some goal. Such appraisals can be learned and can be conscious or unconscious. Functionalist writers argue that an emotion mobilizes and organizes the person's adaptive response to events by influencing thought and behaviour, a process they termed action tendencies. They conclude that emotions can only be defined by their adaptive functions and the action tendencies that serve them. (Barrett and Campos, 1987).

In Barrett's (1995, 1998a) functionalist developmental model of shame the adaptive function of shame is to maintain other's acceptance and preserve self-esteem, by learning and maintaining social standards and submitting to others. In this model shame has three tasks: 'behaviour-regulatory (reducing exposure to evaluation by disengaging or distancing the self), internal-regulatory (focusing attention on social standards and self-attributes), and social-regulatory (communicating deference to others). The action tendencies associated with shame are to withdraw, avoid others, and hide the self' (Mills, 2005, p.28).

This perspective posits that the development of shame comes about progressively through cognitive development and socialisation. As children develop cognitively and socially, they develop new skills and abilities relevant to coping and emotional responding, and also, they become more self-aware and capable of self-evaluation. As a result more situations can elicit shame reactions and the child's ability to control these reactions increases because: 'Through its internal-regulatory function, shame draws attention to the self, activates self-evaluation, and contributes to the development of self-knowledge; this in turn, plays an important role in moral conduct and interpersonal relationships' (ibid, p. 29).

Functionalist theories have also suggested that social-regulatory function of emotion may play a key role in the emergence of shame. Campos, Thein and Owen (2004) argue that emotional communication not only regulates emotions, but it can also be constitutive of emotions. They propose that shame may be constituted by reflected appraisals communicated through disappointment, anger, disapproval, or disgust

expressed by care givers and significant others. They state that a precursor to shame may 'the disappointment and frustration experienced by a child when encountering failure at a task' (Campos, Frankel and Camras, 2004, p. 384). Shame development occurs as reflected appraisals come to hold more meaning and are internalised and as the sense of self develops.

2.8.2 Cognitive-Attributional theories

According to cognitive attributional models (Lewis, 2000, Weiner, 1986) shame is activated by negative cognitive evaluative processes. Lewis (1992) proposes a developmental cognitive attributional model that integrates attribution theory with several of H.B. Lewis's (1971) conceptualisations. This model makes a distinction between emotional states, which can emerge with little or no cognitive processing, and the experience of emotional states, which are conscious or unconscious evaluations of emotional states (Lewis & Michalson, 1983). Emotional experiences require cognitive processing and the model states that different types of self-attribution are accompanied by different emotions: negative self-attributions about the whole self elicit shame whereas negative attributions about a specific action elicit guilt. This theory suggests that shame has three prerequisites: self-consciousness, socialization, and internal & external attributions.

The capacity for objective self-awareness, self-consciousness, which does not emerge until 1 ½ to 2 years of age, alongside the process of socialisation enables the child to internalise the standards, rules and goals prescribed by its cultural context. Once standards get internalised, a process that continues across the life span, the child can anticipate other's reactions, they can evaluate themselves against imagined reactions, and experience shame. This occurs in the toddler period, between 2 ½ and 3 years of age.

The nature of self-evaluation depends on internal attributions (whether the self is responsible) or external attributions (not responsible). Internal attributions activate an evaluation of success or failure that is either global or specific. Shame is elicited by a global self-attribution of failure, an experience of the self as undesirable, unworthy or fundamentally flawed. Hence, shame is conceptualised as an individual phenomenon emerging intrapersonally and not as an interpersonal social phenomenon. Object relational and attachment theories help me to bridge the tension between these two

positions. This model also discriminates between felt and unfelt shame (Lewis, 1992). Felt shame can be managed in various ways (shifting the attention to something else, using laughter, or confession) to put the emotion at a distance. It can also be reflected upon, understood and used to change behaviour or re-evaluate experience. Unfelt shame is pushed from awareness and substituted by a less intense emotion like sadness and anger.

2.8.3 The importance of the interpersonal - Self psychology, Object Relations and Attachment theory on shame

Kohut's (1971, 1977) theory of self-psychology deviated from the traditional Freudian psychoanalytic position that the sense of self develops from the need to discharge drives and he proposed a theory that was interested in how external relationships with significant others develop and maintain self-esteem. The primary motivation guiding human behaviour, according to Kohut (1966) , is self-cohesion and he argued that narcissistic needs persist throughout life. He highlighted the role of empathy in the development of the self, emphasizing his belief that the goal of human maturation involves differentiation within empathic relationships (ibid). He introduced the term selfobject (Kohut, 1971, 1984) to describe the experience of impersonal functions provided by another as part of the self, such as soothing and validating. Contemporary self-psychology writers criticised Kohut for not offering an explicit elaboration about the place of shame in self-experience and the role of the self-ideal in shame experiences (Morrison and Lansky, 1997). However, there is an agreement within scholars that Kohut's contributions brought attention to the importance of dealing with shame in psychoanalytic psychotherapy (ibid).

Kernberg (1976) like Kohut (1971), he obtained his theoretical assumptions from the transference reactions manifested by severely disturbed patients. Kernberg (1976) viewed narcissistic disorder as a specific pathological formation rather than a type of developmental arrest and although he agreed with Kohut that such patients have been treated in a cold, detached way by their early care-givers, he differentiated his theory when he did not consider only such environmental factors as the main cause of the pathology; instead, he also considered the mistrust, hunger and guilt about the rage induced by such environmental treatment (Moore and Fine, 1995). Rage seems to be a central idea in Kernberg's theory. He suggested that narcissism is a defence against rage, which is pure and so full of hate that it threatens to destroy the vital relationship

of self and other. Kernberg (1975) linked narcissistic rage to feelings of shame and he asserted that the function of narcissism is that of a defence deployed to ward off shame in the face of failure and the humiliation of feeling bad and unloved. Individuals with these defences thus tend to vacillate between feelings of inflated grandiosity and a sense of inferiority and inadequacy (Kernberg, 1986).

Erikson (1950), in his age-stage theory of personality development, argued that in the third year of life the child faces the polarity between 'shame and doubt' and a sense of 'autonomy'. He observes that lack of self-control and over-control by parents lead to a lifelong tendency for shame; he states that this feeling emerges from feeling exposed and conscious of being looked at. Erikson (1995) concludes that 'doubt is the brother of shame' (p.253) adding that doubt has to do with continuing uncertainty about who (the parent or the child) is in charge of the child's sense of agency and sphincteric control: 'From a sense of self-control without loss of self-esteem comes a lasting sense of good will and pride; from a sense of loss of control and of foreign over-control comes a lasting propensity for doubt and shame' (Erikson, 1995: 228).

Silvan Tomkins (1963, 1987) in his affect theory placed shame among the basic innate affects our human systems produce (Tomkins, 1963) and he conceptualised affect as a primary innate biological motivating mechanism more urgent than physical pain and drives associated with deprivation or pleasure. Tomkins (1987) proposed that the purpose of shame is to help us define the boundaries of our positive pursuits. It puts limits on the pursue of excitement and joy, it helps the self to learn when to stop and why, to recognise the problem and to deal with it. Because shame is conceptualised as an auxiliary of positive affects it occurs whenever positive affects show up and it is ubiquitous and inevitable (Tomkins, 1963). Shame has a unique role of regulating other affects when a positive interpersonal interaction is interrupted and/or ruptured because of lack of attunement. Tomkins stated that the other must be a valued person if we are to be shamed by their evaluation, and a desire for reparation usually follows. If this wish for reparation ceases then shame will be replaced by disgust and anger (Tomkins, 1962).

Schore (1998) argued that shame makes its initial appearance at 14 to 16 months of age and that shame and the parasympathetic nervous system provide a braking system, a buffer, that can protect the child, to inhibit what might get them into trouble. He added that it can only be an effective system if the main caregiver(s) soothe and

repair the state of shame highlighting that caregivers have a major role in regulating a child's emotional state. Misattunement, an inaccurate reflection of emotion, violates the child's expectation of the shared positive affect, which causes sudden deflation in positive affect and rapid shift to a negative state, which is referred to as state shame (Schore, 1996). In the repeated absence of attuned repair, the child learns that shame states are overwhelming and dysregulating, others are inconsistent and/or unavailable, and they are not able to get their affective needs met (Schore, 1994). Similarly, Cozolino (2014, p. xiii) argues that it is in looking beyond the individual that we find shame. Shame is about bonds and relationships and how we imagine we exist in the minds of others, which is tied to our safety and survival. 'For social animals like ourselves, the fundamental question of "Am I safe?" has become woven together with the answer to the question "Am I loveable?" (ibid, p. 285).

Likewise, Judith Jordan (1997), a self-in-relation therapist, described shame as '…a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others…There is a loss of the sense of empathic possibility, others are not experienced as empathic, and the capacity for self-empathy is lost' (ibid:147). De Young (2015) argues that shame in all its forms its relational: 'Shame is the experience of self-in-relation when "in-relation" is ruptured or disconnected' (ibid:18). These two writers differentiate themselves from the notion that shame stems from a failure to meet our needs for recognition, admiration or adoration which results in lack of self-respect and self-esteem; instead, they argue that shame gets activated because our need for connection and emotional joining has not been met. De Young (2015) proposed a definition, which is in agreement with previous theories that honour the impact on the 'self' as well as the role of the 'relationship' in the experience of shame: 'Shame is the experience of one's felt sense of self disintegrating in relation to a dysregulating other' (ibid:18).

2.9 Adaptive Components to Shame

Several theorists and researchers have paid attention to adaptive components to shame, for example, Tomkins (1963), Nathanson (1992) and Schore (1998) all proposed that shame serves an adaptive purpose to curb excessive interest and excitement, particularly in a child's interactions with a primary caregiver during early

development (Tangney, 1999). It is believed that when a caregiver ignores a child's attention seeking, or when a significant caregiver-child social exchange is interrupted, the shame these experiences elicits helps the child learn appropriate social disengagement (Tangney, 1999). Several other psychologists have noted the evolutionary functions shame plays in social appeasement (Tangney, 1999). For example, overt displays of shame and humiliation (e.g., blushing) help diffuse anger and aggression among humans and non-human primates (Tangney, 1999). Buechler (2008) also remarked on the power of shame to bring about interpersonal connection, though only when it is not also accompanied by fear. Thus, shame appears to serve an important role in social functioning.

Likewise, many writers have pointed out that shame helps with moral regulation, as the emotional pain that accompanies shame helps individuals control their behaviour and avoid wrongdoings (Tangney, 1999). Shiekh and Janoff-Bulman (2010) identified two distinct self-regulatory systems, an approach system, that involves an 'activation action tendency' that moves the self toward a goal or desired end state (ibid: 214), and an avoidance system, which involves an 'inhibition action tendency' that moves the self away from an 'antigoal' or undesired end state (ibid: 214). The authors argue that both systems motivate behaviour, but one generates action while the others one constrains action. Janoff-Bulman, Sheikh, and Hepp (2009) applied this regulatory system model to explain moral regulation. They identify the presence of two moral regulation systems, one proscriptive and the other prescriptive. Janoff-Bulman et al. explained that proscriptive regulation is an avoidance system that is sensitive to negative results, based on behavioural inhibition and thus focused on what not to do. On the other hand, the prescriptive system is sensitive to positive results, based on activating behaviour and is focused on what to do (Sheikh & Janoff-Bulman, 2010). Sheikh and Janoff-Bulman (2010) used this approach to develop the first studies to assess the "regulatory underpinnings" of guilt and shame (ibid:216). They suggested that shame and guilt might be further differentiated by the proscriptive and prescriptive regulatory systems, respectively. They conducted three studies that demonstrated consistent associations between shame and proscriptive self-regulation as well as guilt and prescriptive self-regulation. Therefore, "guilt's prescriptive moral underpinnings" promote moral behaviours by generating the positive desire to behave properly, whereas shame's proscriptive moral underpinnings decrease immoral behaviours by

inhibiting desires and temptations to engage in wrongdoing (Sheikh & Janoff-Bulman, 2010:213). Hence, shame appears to play an adaptive, though nuanced, role in moral regulation by means of the proscriptive self-regulation system. To summarise, it seems shame's inhibitory action tendencies are at the root of its potential for adaptive functioning.

Yet, despite shame's capacity for adaptive purposes, it can also have detrimental effects in individuals' lives. Tomasz Czub (2013) spoke about the dual function of shame as both adaptive and maladaptive in identity formation depending on individuals' shame proneness and regulation strategies. Czub emphasized that shame's motivational components (e.g., to eliminate and avoid unpleasant emotional states) and self-evaluative components are adaptive for the continual self-exploration inherent in identity formation. He found that to achieve integration of such components in identity formation the self must have acquired adaptive shame regulation strategies, for example modifying and adjusting behaviour to meet sociocultural standards that create acceptance, which is crucial for "proper development and adaptation" (Czub, 2013: 246). On the other hand, Czub asserted that high proneness to shame and maladaptive shame regulation strategies, including defensive withdrawal, lead to an unstable identity marked with uncertainty and excessive self-exploration. Similarly, Nathanson stated that, "Mild withdrawal and mild avoidance are considered quite normal, while those whose reactions to shame induce the greatest degrees of remoteness or self-aggrandizement are considered truly ill" (Nathanson, 1992: 313). What gets highlighted here regarding withdrawal behaviour is that This is also consistent with Cohen et al.'s (2011) findings regarding withdrawal behaviour and further indicates that endorsement of a more rigid withdrawal coping style is predictive of problematic levels of shame and psychopathology.

2.10 Shame in Clinical Practice

According to Lewis (1971) addressing shame directly in the psychotherapy relationship facilitates therapeutic work, by normalising shame reactions by offering clients a relational framework for containing and understanding them. Similarly, Herman (2012) posited that understanding that shame is a normal reaction to disrupted social bonds allows clients to emerge from the feeling trap in which they feel ashamed of being ashamed. Both of these authors urge therapists to pay attention to

the client's shame reactions as they happen, noticing the bowed head and averted gaze, and to invite clients to move out of the shamed position, to make eye contact and to life her head, and to experience the restorative empathic connection of the treatment relationship.

Many authors have shed light at the pivotal role of caregivers in the regulation of shame experiences and how an overwhelming sense of defectiveness can arise from chronic misattunement during shame states, which according to some writers result in defensive strategies such as contempt, withdrawal, blaming and denial that may allow for the feeling of shame to be consciously avoided or bypassed (Nathanson, 1992; Kaufman, 1989; Lewis 1971). The acknowledgement of shame may be more challenging for certain people because they consider the experience of shame and related behaviours to be a sign of weakness and/or vulnerability (Lewis, 1971; Scheff & Retzinger, 1991). Individuals who might be particularly prone to experience shame about shame are those who tend to defend against and avoid painful emotions (Sabag-Cohen, 2009).

Courtois (1988) noted that, in her work with incest survivors, shame may be difficult to address directly because of the way it affects the transference. The client may struggle to believe her therapist's positive regard because she expects her therapist to feel the same intensity of disgust and contempt for her that she has for herself. Courtois advises that it may be necessary for the therapist to challenge this distorted perception gently but directly. Shame also affects the countertransference, as Lewis argued shame is a contagious emotion and the therapist may avoid addressing shame directly because of her own discomfort. Retzinger (1988) argued that active noticing of shame experiences by therapists is essential so that shame can be detected and used in understanding the countertransference and therapy failures. Meeting a person in their shame is challenging and creates a sense of vulnerability. '…Vulnerability is not a weakness, and the uncertainty, risk, and emotional exposure we face every day are not optional…Our only choice is a question of engagement. Our willingness to own and engage with our vulnerability determines the depth of courage and clarity of purpose; the level to which we protect ourselves from being vulnerable is a measure of our fear and disconnection…' (Brown et al., 2011:2).

In her contribution to the article by Miller et al. (1999) Jordan claimed that mutual empathy is a vital part of authenticity that creates a sense of connection and as such is a core relational dynamic leading to growth through therapy. Mutual empathy involves the client knowing she has an impact on the therapist through observation and experiencing those responses of the therapist that tell her she matters. Such relational responsiveness contrasts with traditional modes of psychotherapy in which neutrality and non-disclosure are advocated. Nathanson argues that '…therapeutic passivity – the decision to remain silent in the face of a humiliated, withdrawn patient – will always magnify shame because it confirms the patient's affect-driven belief that isolation is justified…'(1992:325). Empathy involves an ability to see the world of another from their perspective. It can be considered an antidote for shame; however, this is not such an easy remedy as it may first appear. Shame's self-focus has been shown to obstruct empathy for others who may have been mistreated (Tangney and Dearing, 2002; Tangney et al., 2007a). This has major implications for therapists, most of whom consider empathy as one of their tools of trade.

Gilbert argues that '…compassion with its focus on acceptance, understanding, and affiliation, can be a powerful antidote to the alienating experiences of shame (2010:339). Citing Rogers (1957) Gilbert (2010) noted core aspects of the therapeutic relationship: positive regard, genuineness, and empathy as constituting compassion. Gilbert (2011) believed that self-compassion needs to be taught to people with high shame and he developed Compassionate Mind-Training in which early trauma gets explored and self-attacking is replaced with compassionate images, warmth towards the self, self-reassurance and self-soothing (Gilbert and Procter, 2006). Similarly, DeYoung (2015) posits that '…if we practice from a developmental/relational perspective we believe our clients internalise the capacities for emotional regulation, mentalisation, and compassion that are embedded in how we relate to them…' (2015:173). Scheff (1987) cautioned that if therapists are insensitive to unacknowledged shame-rage spirals that take place between therapist and client, the client risks being shamed further, and this may lead to therapeutic rupture and failure. This echoes Lewis's (1971) contribution about the devastating impact that unacknowledged shame can have on the therapeutic bond as if it remains evoked and not dispelled the therapist and client may become entangled in a hostile exchange where both parties engage in acting out.

Cloitre, Cohen and Koenen (2006), in their manual for treatment of survivors of childhood abuse, dedicate a chapter to the creation of narratives of shame. They emphasize that '…in the same way that narratives of fear must be titrated so that the client experiences mastery over fear rather than a reinstatement of it, so too narratives of shame should be titrated so that the client experiences dignity rather than humiliation in the telling…' (ibid:290). These authors point out that shame perpetuates the bond with the perpetrator, for as long as the client shields her shameful secrets, she may feel that the perpetrator is the only person who knows her intimately. Similarly, Herman (2007) posits that disclosure in the context of a therapy relationship is a mastery experience that leads to greater self-knowledge, greater self-compassion and reduced feelings of alienation.

Kaufman (1993) maintained that self-disclosure is fraught with shame for therapists; yet Brown (2010a) and others have advocated that 'me too' are two of the most powerful words when it comes to meeting others in shame. Ayers (2003) in agreement with Morrison and Stolorow's (1997) 'three-person psychology' (ibid:82) encourages clinicians to employ an empathic response and to remain in touch with all aspects of the relationship including their own shame; here emotion is viewed as a co-creation between client and therapist and emergent shame becomes 'an affective theme in the intersubjective system that we call psychotherapy' (ibid). Envisioning a therapeutic situation where intrapsychic dynamics also become part of the intersubjective could prove useful when considering shame.

2.11 Conclusion

In summary psychodynamic and attachment approaches consider shame as arising from the early child-parent interactions during which the child experiences a failure in parental attunement, leading to the development of internal negative self-object representations (Schore, 1991). Cognitive theorists conceptualise shame as part of evaluation anxiety, deriving from the belief of a negative self-image in the eyes of potential evaluators and comparisons between the self and others are central to the experience of shame (M. Lewis , 2000). Gilbert (1992) associates shame to rank and status judgements where the person experiences shame when one feels inferior, powerless, or bad compared with others, whereas Tangney (1996) advocated the understanding of shame as a situation specific emotion. However, regardless of

theoretical approach most authors agreed that attention to the relational aspect of the patient therapist dyad constitutes good practice for shame-related difficulties. The literature review also revealed that shame is highly represented as a pre- and a co-morbid variable in conceptualisations of pathologies that Counselling Psychologists work with.

In trying to elicit a rationale for the present study I have considered the lack of definitional clarity of what shame is, I noted the absence of empirical methods that have fully addressed this problem, and shame's presence in theories of psychopathology. Therefore, the present research argues that a phenomenological investigation on therapists' experiences of shame is needed as more empirical evidence is required to augment our clinical understanding and therapeutic interventions when confronted with shame issues in clinical settings. The research question 'how do therapists understand their experiences of working with shame in clinical settings' aims not to deliver a clear definition of shame nor to determine its role in developmental or pathological theory but to investigate how therapists work with shame, whether it is with clients, supervisees, trainees, or themselves. I am personally and clinically intrigued by the many faces of shame and whilst it is pleasing to note that several authors have begun to address the issue of therapist's shame there remains a gap in the empirical literature which I hope this study will go some way to filling as I believe that an increased focus on therapist's shame experiences may have important implications for therapists' personal therapy, training, and supervision.

CHAPTER 3

3.0 Methodology and Method

3.0 Introduction

In this chapter I aim to consider the implications of the research question for methodology, and to describe the process undertaken to arrive at a chosen method for conducting research that asks psychologists and psychotherapists to speak about their experiences of shame in clinical settings. I will start by offering an overview of my rationale for qualitative research and I will then introduce my epistemological and ontological position, before I direct my focus on conducting research into participants' experiences and meanings of a phenomenon such as shame, which has been shown in the previous chapter to be difficult to speak of and to define, and hence exploring which research perspective might be more or less helpful. Having elucidated the case for implementing a hermeneutic, exploratory approach, I will then move on to describe the rationale behind the process for choosing a specific method of research, by providing an overview of the methods considered and dismissed, before arriving at the chosen method of IPA. An outline of the theoretical underpinnings, and the strengths and limitations associated with this method is provided. Finally, the research design and the exact procedures that were followed in the implementation of this study will then be outlined and discussed in relation to ethical considerations and quality in qualitative research.

3.1 Rationale for choosing an explorative methodology – an overview

The following synopsis gives a brief outline of how I reached the rationale for an explorative phenomenological qualitative methodology. At the early stages of this study initial consideration focused upon the selection of either qualitative or quantitative approach to data collection and analysis. These approaches are often described as being divergent and opposing in social sciences (Clarke, 2001), among massive ongoing debate about the nature of knowledge (McLeod, 2003), through which questioning of ontology ('What is there to know?') and epistemology ('How can we know?') are argued (Willig, 2008). Quantitative research has been the traditional dominant paradigm, often driven by the ready assumption that research equals

science and therefore scientific methods, looking for causal relationships between variables, represent the acceptable means of generating knowledge (McLeod, 2003). Gordon Allport (1937) introduced the terms idiographic and nomothetic to represent two perspectives and methodologies for doing research in psychology.

Researchers who adopt the nomothetic approach are mainly concerned with studying what we share with others (i.e., similarities between people), aiming to establish laws or generalizations that apply to all people. This approach typically uses scientific methods such as experiments and observations to obtain quantitative data. The nomothetic approach has been accused of losing sight of the 'whole person' as its main focus is usually with the so-called objective definition of the truth, an essential aspect of its underlying philosophy, positivism (Al Rubaie, 2006). The positivist philosophy of science endorses the belief that all phenomena from physics to human behaviour can be explained by a single set of natural laws (McLeod, 2003), attained by way of reason, science, or technology (Al Rubaie, 2006). Although it is acknowledged that scientific research has much to offer, for example, in the physical sciences, it is clearly not felt to be appropriate when considering something like the idiosyncrasies of human experience with regard, for instance, to the phenomenon of shame.

McLeod (2011) suggests there are a number of specific issues for researchers to question, including: Is the aim of research the prediction of outcomes or the development of insight and understanding? What kind of research is most relevant for practice? Furthermore, Morrow-Bradley & Elliott (1986) state that traditional research methodologies derived from the physical sciences, are not, in the main, appropriate for investigating psychotherapy and Heaton (2001) argues that '…evidence-based medicine has little relevance to psychotherapy and counselling…' (ibid:237). As the nature of the enquiry of this study is explorative, and not comparative or based on a hypothesis, and it seeks to uncover subjective, and yet unknown experiential data, any quantitative method based on hypothetico-deductivism is deemed unsuitable, as no hypothesis exists, and as such cannot be tested.

Researchers interested in the idiographic aspect of experience want to discover what makes each of us unique. Here, no general laws are possible because of chance, free will and the uniqueness of individuals. The approach tends to include qualitative data,

investigating individuals in a personal and detailed way. A major strength of the idiographic approach is its focus on the individual. Qualitative research can offer adaptable methods for exploring meanings in areas of social life previously not investigated or well understood, producing nuanced accounts that are respectful of experience and contributing a particular kind of knowledge, different from that generated by quantitative methods of inquiry (McLeod, 2011). Qualitative inquiry is often hermeneutic or interpretive in style, heavily influenced by classical phenomenology, and its aim is to describe and interpret meanings (McLeod 2003).

McLeod (2011) purported that qualitative research is a form of knowing specifically attuned to the study of how aspects of life, such as psychology and psychotherapy, are constructed and reconstructed: '…At its heart, qualitative research involves doing one's utmost to map and explore the meaning of an area of human experience…' (ibid: viii). According to McLeod psychotherapy and qualitative research share a variety of similar skills and techniques: eliciting people's stories, sensitive listening, building up an understanding, checking it out, generating knowledge, which McLeod (2011) believes is familiar to therapists: holistic, nuanced, personal, contextualised and incomplete.

Given the aims of this research described here, the fact that this research seeks to explore and to examine the lived experience of therapists' shame and this will entail exploring the dynamic emotional, physiological, and psychological dimensions of the experience, rather than quantify therapists' experiences, it was clear to the researcher that a qualitative phenomenological method would be much more appropriate for the type of research she was looking to undertake. That is, research that hopes to look and try to see and convey something of what is seen and aims to have value for developing therapeutic knowledge in practice. Therefore, the analysis process can be described as an inductive one, driven by the data, rather than a deductive approach, driven by existing theory and literature. I am not approaching this study with predetermined hypotheses to test, but instead one broad research question will form the framework of the exploration. Hence, an idiographic approach that will allow a more flexible, iterative style of eliciting and categorising responses to questions, rather than highly structured methods such as questionnaires, eliciting textual and not numerical data format will better serve its purposes. Furthermore, qualitative analysis

is particularly effective with topics for which there is little previous research and where there may be variables that are difficult to identify or are not yet identified (Morrow, 2007).

Although qualitative research gives me a sense of flexibility, as it allows for greater spontaneity and adaptation of the interaction between researcher and the study participant, it also has limitations. For example, Nevonen and Broberg (2000) argued that since such research often utilises structured reporting methods, participants can only comment upon what they are asked to respond to, and this may produce a fragmented picture. I aim to hold this in mind throughout the different stages of my research while considering how I can best address my research question**: *'How do therapists understand and make sense of shame experiences in clinical settings?*** *'*. Here, once more, I would also like to emphasise that attempting to explore the experience of therapists in relation to this phenomenon, that is often difficult to put into words, has implications for the research methodology, which I will explore in the following sections.

3.2 Epistemology and Ontology

Mcleod (2011) states that within the field of phenomenological research methods, as in any other qualitative paradigm, many subtle epistemological differences exist, and with particular reference to variety in phenomenological approaches, Langdrige (2007), and previously Moustakas (1994) outline subtle differences both in terms of ontology and epistemology. As Finlay (2009) argues, the main distinctions between these schools of phenomenology lie within differences between the exact intentionally of researcher, namely, is the researcher seeking a general scientific description of the phenomena in a normative and scientific sense, like i.e. Giorgi and Giorgi's (2003) approach, or is the researcher attempting a more idiographic analysis, to understand individual meanings in more depth, such as in IPA , in opposition to a general experiential structure. From there, further subtle distinctions arise, such the focus on boundaries between description and interpretation, or description versus interpretation. Therefore, whilst all phenomenological schools are argued by Finlay (2009) to start from a descriptive position, differences arise at the level of interpretive

or hermeneutic phenomenology, or phenomenology that seeks to stay closely to essential experience structures.

Qualitative research is not a homogeneous domain, as different qualitative research approaches and methods are based on different philosophical assumptions about how we should produce psychological knowledge and what can be known, which is also referred to as epistemology. Consequently, different approaches have different scientific goals and guidelines for good practice (Lyons & Coyle, 2007) and therefore, different qualitative methods are associated with different epistemologies. Crotty (1998) argued that researchers' beliefs about ontology, epistemology and methodology influence the way that they conduct research. Before I present my reflections about how my beliefs about the world and my assumptions about acquiring knowledge will shape the way I aim to conduct my research it feels pertinent to offer a description of the concepts of epistemology and ontology.

Epistemology: Epistemology is a branch of philosophy about the theory of knowledge and attempts to answer questions about how we can know and what we can know. According to Denzin and Lincoln (2005) epistemology poses the question 'How do I know the world? What is the relationship between the inquirer and known? Every epistemology…implies an ethical-moral stance towards the world and self of the researcher (Denzin & Lincoln, 2005a: 183). A researcher's epistemological stance is the first fundamental component of conducting qualitative research in the social sciences (Carter and Little, 2007). Broadly speaking there are two epistemological positions: the positivist/realist and the constructivist/interpretivist. The former is usually concerned with theory building and/or theory testing whereas the latter is mainly concerned with subjective reality. The constructivist-interpretivist perspective, which proposes a transactional subjectivist stance, highlights the constructed nature of reality, and maintains that the relationship between researcher and researched is vital to understanding the lived experience of the research participant (Kissaun, 2017). I share the view that '…social reality has a specific meaning and relevance structure for the being living, acting and thinking within it…' (Schutz, 1962:59) and since constructivist-interpretivist accepts that the world is constantly changing and that meanings are shifting and contested, I naturally position myself within this epistemological position as I share the notion that we have to accept that there is no

objective, pre-existing truth waiting to be discovered; meanings are co-constructed and are not objective.

Ontology: Mantzoukas (2004) argues that a researcher's epistemological stance is directly related to their ontological position and therefore this should also be clarified at the outset of the research process. Ontology is specifically concerned with the nature of the world (Thomas, 2009). When thinking ontologically, researchers should attempt to answer questions such as, 'what is there to know?' or 'what is the nature of *reality?'* (Willig, 2013). According to Guba and Lincoln (2005) the perspectives about ontology may be placed on a continuum ranging from naïve realism to critical realism, to historical realism to relativism, to participative/subjective-objective reality. As positivist paradigms derive from realist ontologies, a realist position would advocate the belief that there is a single, objective, independent reality and therefore a straightforward relationship between our perception of the world and the true world (Willig, 2013). Postpositivist approaches embrace a less extreme form of objectivism adopting a critical than naïve realist ontology, which proposes that although reality is real, it is only partially apprehensible (Guba & Lincoln, 2005). Critical realism challenges the traditional view of scientists as passive observes of natural laws and instead sees them as actively constructing laws (Kissaun, 2017), as constructivist-interpretivists do not believe in a single, true reality but hold that there exist multiple, constructed realities (Ponterotto, 2005).

Furthermore, Maxwell (2008) asserted that research needs to do more than establish a causal link between phenomena – it needs to understand also the process involved in that causal link. The literature review on shame in psychotherapy showed an abundance of causal inferences; for example, patient shame can evoke shame in the therapist, but there is a significant gap in the relevant theories in what way, for which therapist, in which situations and in which contexts such causal influence occurs (Kissaun, 2017). I am not proposing that through this research I can produce an objective true account of therapists' experiences of shame in the clinical encounter and that this will correspond to an external reality. Instead, I am adopting the belief that I can gain an understanding of how individual participants perceive and interpret this phenomenon from a subjective standpoint that echoes an interpretivist position.

My epistemological – ontological position: Attempting to conduct research that seeks to be an exploratory endeavour into uncovering and developing, not categorial truths, but rather, deepened understandings of what it is like for clinicians to engage with shame phenomena in their practice, raises a number of questions related to phenomenological and post-modern perspectives. The review of the literature highlighted certain issues with the experiences of shame, namely its occurrence within relationship, a relational phenomenon making it difficult to define and to speak of, and therefore, I need to consider how to enable my participants to speak of the potentially unspeakable. Consequently, issues arise over how to delve into participants' experiencing in a way that interrupts meanings and disrupts the discourse of the other in an attempt to avoid them escaping into theory and the continued speaking of that which has already been spoken (Holloway and Jefferson, 2000). I am, instead, seeking how to reveal that which is uncovered, and in doing so, potentially open up possibilities and raise questions that can lead to developing therapeutic knowledge in this area.

Madill et al (2000) described three different epistemological positions and argued that instead of these being viewed as distinct and unrelated, it is more appropriate to view them as positions on a continuum. On one end is the realist perspective which assumes that knowledge is pre-existing, and the researcher's role is to discover this through an objective and detached approach. On the other end is the radical constructionist perspective which rejects the notion of any knowledge existing outside of language and argues that knowledge is a social construction (Madill et al, 2000). Between these two extreme poles is the contextual constructionist perspective, which appeals to me because it echoes on a personal level how I view the world and on a professional level how I position myself clinically vis-à-vis my clients. My epistemological view supports the stance that every situation is co-created and subsequently there is no such thing as a universal truth since knowledge is intersubjectively co-constructed.

As I become emerged in the writings about epistemology and ontology, I become increasingly aware that an essential part of any research project is deciding what its objectives are and what kind of knowledge it claims to generate so that it can be evaluated in a meaningful way. It has been argued that what we know as knowledge is in fact a special kind of story, text, or discourse particular to a certain culture; Mitchell

(2006) proposed that traditions exist in communities that embrace and transmit them and thus knowledge is both social and communal. Lemke emphasised that '…different cultures can and do see the world in very different ways, all of which are believable and work in their own terms…' (Lemke 1994:67), highlighting that knowledge is intersubjectively co-constructed.

There are therefore many alternative or complementary definitions or understandings of reality, normally contextualised and local, contributing to various facets and reflecting the backgrounds and interests of those involved (McLeod, 2011). Meaning may be constructed by people in different ways, even in relation to the same phenomenon, developing 'knowledges' rather than 'knowledge', with no way of describing them being necessarily wrong (Willig, 2008). Considering meaning from this perspective, subject and object become partners in the generation of meaning (Crotty, 1998). In that regard, my research aims to uncover something of the tradition existing within the psychotherapy and psychology community concerning the phenomenon of shame. My study aspires to delve into participants' experiences and to allow therapists to discover something new that is meaningful to them in relation to their own professional and experiential knowledge during their intersubjective interactions with myself, the researcher.

3.2.1 Further reflections on the Co-construction of meaning

Jaeger and Rosnow (1988) maintain that it is impossible to view knowledge from a passive bystander perspective (as is assumed by the realist perspective) and instead people take an active role in constructing their understandings. I share the view that as people are always embedded within a specific context, all knowledge is context bound and therefore perspectival and standpoint dependent (Jaeger & Rosnow, 1988). Similarly, Madill et al (2000) argue that the same phenomena can be understood in different ways depending on the unique perspective of the person and therefore all knowledge is provisional and relative.

Hence, through research we can attempt to understand individual points of view, but this understanding will always be related to this particular person, in this particular context, at this particular time (Larkin et al, 2006). That is to say, that research findings are, therefore, variable and dependent on the context in which the data is gathered

and analysed (Madill et al, 2000). This emphasises the fact that the researcher is also an active contributor in the research process as the researcher is inevitably part of the context and therefore takes an active role in knowledge discovery and construction (Jaeger & Rosnow, 1988). Pidgeon and Henwood (1997) argue that knowledge produced by contextual constructionists can be influenced by participants' personal understandings, researchers' interpretations, and the cultural context in which both understandings are embedded. Consequently, researchers and participants together with ideologies and social structures are integral and dynamic parts of the context of the phenomena under investigation (Dallos and Draper, 2000).

*M*y epistemological position echoes the principles of contextual constructionism as I believe in a world where subject and object cannot be separated, and meaning is always intersubjectively co-created. I aim throughout the research process to remain reflective about the ways in which my questions, methods, and my own subject position, for example my race, ethnicity, class, sexuality, work impacts on the psychological knowledge produced in my research study. In this process I view the role of the researcher as twofold; on the one hand I aim to remain engaged and attuned to my participants' phenomenology and whilst I pay attention to intersubjective dynamics I will also attentively look out for hidden meanings in their narratives.

3.3 Consideration of Research methods

Following the ontological and epistemological argument for deciding to adopt a more phenomenological, hermeneutic approach to inform this study, the researcher turned her attention on deciding a method that felt suitable both for her and for the topic As already indicated above, the very nature of qualitative research has inevitably led to numerous methods within the field, each contributing to the development of this approach to human science. A number of qualitative methods including Grounded Theory, Discourse analysis and Narrative approaches were considered and will now be discussed further with regard to the researcher's consideration of them as possible methods of inquiry for this study, before moving on to IPA, the method ultimately chosen.

Grounded Theory (GT) was originally developed by Glaser and Strauss (1967) and aims to develop a theoretical account of a particular phenomenon by comparing

individual accounts of personal experience. Through a process of inductive theory building, grounded in the data itself, it seeks to discover a theory or a model about the phenomenon, emerging from concepts within the data and not from another source (Crotty, 1998). Grounded theory, claims Glaser (2001), is a well-established, widely recognized, credible and rigorous methodology. A feature of grounded theory is that researchers are encouraged to not review the literature prior to undertaking the study. This does not mean however that the researcher should have no prior knowledge of their subject area at all, no researcher would arrive without any knowledge, but rather would have their own perspectives from which to initiate the investigation. This existing knowledge enables theoretical sensitivity, supporting understanding of data collected throughout the research process (Glaser, 1978).

I contemplated the use of Grounded Theory, and in particular the constructivist version of grounded theory (CGT) as developed by Charmaz (2017), since it shifted from the positivist underpinnings of the classic Glaserian grounded theory to those of constructivism. Constructivist grounded theorists acknowledge that reality is a social construction (Ghezeljeh & Emami, 2009). CGT researchers do not deny the existence of objectively true worlds, but they are more concerned with the '…world made real in the minds and through the words and actions of its members…' (Charmaz, 2000; p. 523). CGT has a subjective epistemology in that it assumes that researchers are not separate from the research and that knowledge is cocreated (Charmaz, 2000). However, this method is mainly concerned to increase the understanding of and explain different social psychological processes rather than individual experience and sets out with the aim of developing a new theoretical-level account of a phenomenon (Willig, 2013). As the principal concern of the present study is to investigate, understand, and explore similarities and differences in the experiences of a group of clinicians that had encountered a similar phenomenon and not to formulate a distinctive theory that could be generalisable to wider populations, this approach was not deemed suitable for my study.

Discourse analysis was also considered. The focus on discourse analysis is how language is represented not as reflecting psychological and social reality but as constructing it (Lyons & Coyle, 2015:183). Attention is paid exclusively to the discourse itself, how it is constructed, its functions and the consequences that arise from different

discursive organisation (Potter & Wetherell, 1987: 178). In discourse analysis the researcher's focus is on the manner in which language is used to construct the speaker's world and on the action-oriented aspects of language, and it does not address experiences that participants may or may not be aware of (Lyons & Coyle, 2015). Therefore, this method was not deemed suitable for the present study because it does not provide the researcher with the tools to study non-linguistic dimensions of experience (Willig, 2013:179), such as reflecting on the dynamic nature of a person's understanding and the idiographic dimension of first-person meaning making.

Narrative analysis (NA) also implements a discursive analysis but unlike discourse analysis, is concerned with the inner experience of participants and the person is regarded as a "…a self-aware agent striving to achieve meaning, control and fulfilment in life…" (McLeod, 2011: 191). NA focuses on a small number of individuals or a group to offer insight into lived experience (Bruner, 1990). The main source of data in NA are the stories shared by participants, and the structure of the narrative is thought to generate a further level of meaning, which is conveyed by the story as-a-whole (McLeod, 2011). I was more inclined to analyse my participants' narratives by focusing on identifying themes and meanings within the story, which requires removing extracts out of the stories rather than analysing the meaning of the unfolding story as a whole. Furthermore, the use of semi-structured interviews differs from the interviewing style usually adopted by researchers in NA, where researchers pose a Single Question Used to Induce Narrative (Dali, 2013) at the beginning of the interview and then allow interviewees to talk freely. Subsequently, NA was not deemed suitable for my investigation.

An additional important consideration in choosing the methodology for the present study was deciding what approach might best generate data when exploring a topic that can be difficult to describe. I have discussed that shame experiences can evoke a heightened sense of vulnerability and can interfere with one's ability to remain interpersonally connected. Sometimes we feel vulnerable precisely because we cannot make sense of our anguish and distress. In such times it is what we know (conscious awareness) and do not know (unconscious communications) that gets expressed through behaviours and attitudes rather than words. Concepts such as "implicit relational knowing" (Lyons-Ruth, 1998), the "unthought known" (Bollas, 1987) and "the felt-sense" (Gendlin, 1981) provide alternative viewpoints about this realm of

embodied cognition. In addition, it has been argued that the systematic neglect of shame concerns the lack of an adequate language "…with which to accurately perceive, describe, and so bring into meaningful relationship this most elusive of human affect…" (Kaufman, 2004:4).

The consideration of the possible difficulties involved in conveying inner complex emotional states through language, enabled me to reach the conclusion, that any research into the shame experience would have to allow for an array of individual understandings of the emotion. I approach research in a similar way to how I work as a psychologist and I believe in the potential of empathic immersion and phenomenological inquiry as ways of developing knowledge, awareness, and new insights. Willig (2012) argues that an empathic approach aims to elaborate and amplify the meaning that is contained within the material that presents itself.

The chosen research method, Interpretative Phenomenological Analysis, will now be explicated in order to make clear its theoretical underpinnings and its perceived suitability, both for the research area and the researcher herself.

3.4 Interpretative Phenomenological Analysis (IPA)

In this section I will discuss the main principles of IPA starting with its relevance to the research question and a description of its theoretical underpinnings. I will then talk about my rationale for choosing IPA and I will conclude by offering a synopsis of its limitations.

3.4.1 IPA and my research question

An explorative qualitative approach seemed the most appropriate and effective in investigating and capturing psychologists and psychotherapists' experiences of working with shame. Finlay (2009) posits that even though all phenomenological approaches start from a descriptive description they differ at the level of hermeneutic or interpretative phenomenology, or phenomenology that pursues essential experiences structures. Interpretative Phenomenological Analysis (IPA) was chosen as the suitable method, from the field of qualitative phenomenological approaches, for my research question and topic.

One of the appealing aspects of IPA is that its focus is the in-depth exploration of personal experience and how people perceive, ascribe meaning to and make sense of their experiences (Smith & Osborn, 2008). Smith et al (2009), acknowledge that 'experience' is a complex term, but from an IPA researcher's point of view, the interest is in '…what happens when the everyday flow of lived experience takes on a particular significance for people…' (ibid:1). The assumption behind this premise, which reflects my epistemological and ontological beliefs, is that people are actively engaged in their world and are constantly reflecting on their experiences in order to understand them (Smith et al, 2009). Eatough and Smith (2006) applied IPA in their study of anger, and they highlighted the significance of considering emotions from the perspective of the person experiencing them, and they concluded that IPA is an effective tool for developing '…rich contextual understanding of the experiential dimension of emotion…' (ibid:494).

IPA highlights that meanings have to be understood in their social and historical context, and cannot be separated from it, as meanings emerge within a context and are not separate. In my research I am asking participants about their experiences of working with shame as a clinician; hence, my participants are asked how they experience shame in a context that already has an implied intentionality, namely helping someone. It is pertinent therefore that their narrative must be understood within that context, and even though elements of the personal inevitably shape professional views and practices, it was believed that IPA, through hermeneutics and idiography, would assist me to further unpack the embodied and experiential subtleties of participants' shame experiences within this context, and in turn would generate reach meaningful empirical insights about the practice of psychology and psychotherapy.

Moreover, Smith (2011a) claimed that IPA is ideal for studying therapists' experiences, and that there has been an exponential increase in such a focus. In addition, Reid et al (2005) argue that IPA is a particularly valuable approach to implement when researching an area that has previously lacked exploration. This seems particularly pertinent to this research as investigations aiming to explore therapists' experiences of shame appear to be particularly scarce. Moreover, the inductive nature of the approach means that I do not have to rely on existing literature to drive the analysis

process and instead the approach will allow for the possibility of novel and unexpected experiences arising. It was envisaged that IPA with its emphasis on the individual and double hermeneutics, along with the researcher's invested engagement with the intersubjective space and implicit relational knowing, could potentially help the researcher highlight that what might be absent (thus leading to bypassed/unacknowledged shame) in participants' contributions.

3.4.2 Theoretical concepts of IPA

Smith and colleagues stated that '…Interpretative phenomenological analysis is an approach to qualitative, experiential and psychological research that has been informed by concepts and debates from three key areas of philosophy of knowledge: phenomenology, hermeneutics and idiography…' (Smith, Flowers & Larkin, 2009:11). I will discuss these philosophical concepts below.

Phenomenology: Phenomenology is a philosophical movement which began in the early 1900s mainly advocating that the specific focus for phenomenological psychology is a return to people's perceptions of the world in which they live and what this means to them. There are many variations of phenomenology with different implications for the way in which one might build on these ideas in order to create a phenomenological methodology (Langdridge, 2007:4). Phenomenological approaches to generating knowledge range from descriptive approaches, which follow the philosophical traditions of Husserl, to interpretative or hermeneutic phenomenology, which reflects the work of Heidegger. Phenomenology, therefore, is not a unitary body of thought but instead has been developed and adapted by several key philosophical positions (Langdridge, 2007) and IPA is informed by the thinking of several prominent phenomenological philosophers.

Husserl can be described as the founder of the phenomenological approach and his endeavour has been labelled as 'transcendental phenomenology' (Larkin et al, 2011). Husserl argued that an essential feature of consciousness was 'intentionality'. He famously argued that to describe and fully understand any given phenomena 'we must go back to the things themselves' (Husserl, 1900/70, p.252). This is an important statement as Husserl argued that we often experience the world using the 'natural attitude', which means that we take our experiences for granted, do not fully focus on

them, and perceive them with regard to our pre-existing expectations (Langdridge, 2007). However, this way of living prevents objects from showing themselves fully and therefore to achieve a deeper understanding we must 'bracket' our presuppositions and preconceptions (Giorgi, 1997). Husserl thought it was possible to apprehend the 'essence' of any given phenomena in order to identify its essential qualities, structural features and therefore its underlying meaning (Husserl 1936/70). He argued that these 'essences' or invariable features should transcend any given individual or context and, thus, tell us something about the fundamental or universal meaning of a given phenomenon (Larkin et al, 2011).

Heidegger (1962/27) provided a critique of Husserl's work and initiated a more existential phenomenological approach. He believed that our engagement with the world was indeed intentional, however he argued that people cannot be meaningfully detached from their context (a world full of people, objects, language, and culture) (Langdridge, 2007). Heidegger (1962/27) coined the term 'dasein' to describe how our 'being-in-the-world' is always in relation to other people (also termed relatedness or 'being-with'), situated and perspectival. Therefore, interpretative phenomenology argues that people are unable to completely suspend their prior assumptions to achieve 'epoche' (Langdridge, 2007) and the consequences of that can be managed through reflective and reflexive awareness (Smith et al, 2009). I concur with Heidegger that it is not possible to fully bracket off our prior-knowledge, experience, and preconceptions, and only efforts, through reflective and reflexive thinking, can mitigate its potential impact on issues around quality of qualitative research.

Hence, although all phenomenology aims to describe rather than explain experience, debate exists around the appropriate way to embark on phenomenological research. For descriptive phenomenologists 'description is primary, and interpretation is a special type of description' (Giorgi & Giorgi, 2008:167) as they posit that through bracketing preconceptions minimize interpretation allowing the researcher to focus on 'that which lies before one in phenomenological purity' (Husserl, 1931:262). On the other hand, interpretative phenomenologists argue that all description constitutes a form of interpretation (Willig, 2013). Given that I share Heidegger's position about our inability to bracket off pre-existing assumptions about a phenomenon, I also concur with his existential hermeneutic philosophy that interpretation is an unavoidable, basic structure of our being-in-the-world, and that no observation or description is exempt

from the influence of the observer's experiences, prejudices, presuppositions, and projections (Moran 2000).

Therefore, in my study I will not be aiming to capture the universal 'essence' of the experience under study, like Husserl aspired to, but instead I will be aiming to understand personal perceptions and individual experiences. Heidegger has informed the idea of locating people within particular contexts and this research will therefore focus on what it is like to experience this particular phenomenon in this particular context. Contextual information can be considered on several levels including historical, situational, cultural and personal (Willig, 2013). Key influencing contextual factors concerning my research project, therefore, appear to include the profession's increasing interest on the concept of shame, the NHS cultural context in which the research was completed, the talking therapies context in which my participants are situated and the participants personal characteristics.

Hermeneutics: As the name suggests hermeneutics, can be described as the theory of interpretation (Langdridge, 2007). It was developed for the interpretation of biblical texts, but the focus has been gradually extended to provide the underpinning for the interpretation of a wider range of texts (ibid). Kearney (1991) writes: Hermeneutics is...a method for deciphering indirect meaning, a reflective practice of unmasking hidden meanings beneath apparent ones...it was radically redeployed by modern thinkers like Dilthey, Heidegger, Gadamer and Ricoeur to embrace man's general being in the world as an agent of language (1991:277). Smith et al (2009) draw on the works of Heidegger, Gadamer, Ricoeur and Schleiermacher to inform IPA's interpretative element. Smith (2007) highlights that although the text that psychological researchers draw on may be slightly different to the original focus of hermeneutics, the ideas are still widely applicable.

Heidegger (1962/27) bridges the gap between phenomenology and hermeneutics through the concept of 'dasein'. He argues that our engagement with the world and our understanding of the meaning of 'the things themselves' is always accessed through interpretation and we inevitably bring our prior experiences, assumptions and preconceptions to the process of interpretation. So, for Heidegger, hermeneutics was an important prerequisite of phenomenology (Shinebourne, 2011). Howitt (2016) provided a clear link between phenomenology and hermeneutics when he argued that

there are meanings to what is experienced that are hidden by the way the phenomenon manifests in consciousness. Smith et al also described this inter-connection, '…without the phenomenology, there would be nothing to interpret: without the hermeneutics, the phenomenon would not be seen…' (Smith, Flowers & Larkin, 2009: 37). For Heidegger, phenomenology was partly about the way the phenomenon manifests in consciousness and also about the meaning underlying this manner of appearing, "…an interpretation is never a presuppositionless apprehending of something presented to us…" (1962/27:191/192). Consequently, phenomenology must reveal what is hidden by the appearance of the phenomenon (Howitt, 2016). To conclude, Heidegger's philosophical method is concerned more with interpreting the meaning of the things in their appearing form, a position that is always grounded in the things themselves (Langdridge, 2007).

Gadamer (1975) and Ricoeur (1970;1976) followed Heidegger's hermeneutic phenomenology and their work has been particularly important. Gadamer (1975) in his contribution questions how much method might guarantee the truth that the scientist seeks, and he shares his scepticism about the value of scientific method. It is important to note that Gadamer is not anti-science; "…he does not simply advance a negative claim against scientific method as the purveyor of all truth…" but he also posits that other aspects of human existence give rise to truth (Langbridge, 2007: 43). The phenomenological literature describes how interpretation is based on what has gone before, in terms such as fore-having and fore-conception, highlighting that past experiences will unsurprisingly have an influence on experience. Gadamer (1975) described this process in terms of '…the fusion of horizons between subject and object…' emphasising the importance of making ourselves more transparent. This requires being aware of our social situatedness; that we experience and interpret the world from a particular perspective, and we never completely escape this subjectivity (Shaw, 2010). It is from our understanding of this involvement that we begin to interpret the meaning of the phenomenon (Howitt, 2016:317).

Ricoeur's work is similar to Gadamer's theoretical position about the embodied being-in-the-world of human beings, and he also provides an interpretative understanding of human nature through language. In accordance with Heidegger's hermeneutic phenomenology, which is concerned with interpretation designed to grasp the understanding of a research participant, Ricoeur (1970) introduced the hermeneutics

of empathy or meaning-recollection. He also conceptualised the hermeneutics of suspicion, which seeks to understand by peeling back the layers of meaning as it assumes that all is not what it seems. Ricoeur argued that what we encounter, what happens before us, is not the whole story; in fact, it is only the tip of the iceberg. Real understanding can only be gained by looking underneath as this approach to interpretation aims "…at demystifying a symbolism by unmasking the unavowed forces that are concealed within it…" (ibid, 1996:152). Ricoeur (1996) points out that the two approaches to interpretation produce different kinds of knowledge concerned with understanding (hermeneutics of empathy) and explanation (hermeneutics of suspicion). He also points out that neither of the two interpretative positions on its own can generate satisfactory insight and that a combination of the two is required. He argues that what is needed is a "dialectic of understanding and explanation" (ibid, 1996:153-154).

Schleiermacher (1998) proposes that interpreting text involves two distinct levels, grammatical (objective textual meaning) and psychological (subjective individuality of the author). He developed the concept of the 'hermeneutic circle' to show that whenever something is interpreted, the interpretation will be founded on foreconceptions. Therefore, an understanding of the part requires a grasp of the whole and an understanding of the whole requires a grasp of the parts. He described a circular movement where we examine and adjust assumptions accordingly as we consider evolving meanings. The hermeneutic circle is a concept which has a high level of significance to IPA and emphasises the interactive relationship between the part and the whole (Smith, 2007).

That is, the meaning of any given part can only be understood in relation to the whole and the meaning of the whole can only be understood in relation to the parts (Smith et al, 2009). This relationship operates on several levels (for example, single word versus sentence, sentence versus complete transcription and complete transcription versus the holistic research) and highlights that the process of interpretation in IPA is circular and requires a repeated process of engagement with the text. Hence, according to Willig: '…Instead of attempting to bracket presuppositions and assumptions about the world, the interpretative phenomenological researcher works with, and uses, them in an attempt to advance understanding…' (Willig, 2013. p. 86). Hermeneutic philosophers argue that our primary task is to give priority to the new object, namely

the evolving meanings, and our understanding mainly relies on recognition and awareness of our pre-understandings; that is to say, that in interpretation, priority should be given to the new object rather than one's preconception…' (Smith, Flowers and Larkin, 2009:25).

Smith (2011) described how the IPA researcher is engaged in a double hermeneutic '…whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them…', and as this is a complex endeavour, it requires a high level of involvement and interpretation on the part of the researcher…' (Smith, 2011:10). Thereby, the insights generated by such research are very much a product of the relationship between the researcher and the data (Willig 2013:86). Willig rightly argues that this does not mean that the research is biased, "…rather, it means that knowledge is only possible through the application of initial categories of meaning which the researcher then modifies through the process of interacting with the data…" (Willig, 2013:86). I also agree with Finlay's suggestion that the researcher's values and assumptions should be explicitly acknowledged and worked with reflexively: '…Our understanding of 'other-ness' arises through a process of making ourselves more transparent. If we do not examine ourselves, we run the risk of letting our predilections and prejudices dominate our research findings…' (Finlay, 2011:114).

Idiography: IPA is ideographic in nature and aims to focus on personal perspectives and the experiences of particular individuals rather than completely losing these accounts in order to make group level claims. Smith et al (2009) highlight that IPA can in fact make a valuable contribution by focusing on single cases, however, most researchers tend to achieve the idiographic element by focusing on the detailed examination of each individual case before moving on to search for convergence and divergence across participant accounts (Smith, 2011). For this research, the idiographic commitment will also be represented in the analysis write up by including transcript extracts for each participant in order to highlight individual experiences.

The objective of the idiographic approach of IPA is not to produce results which are generalisable but instead focuses on the potential transferability of findings from one group or context to another (Hefferon & Gil-Rodriguez, 2011). This has been termed 'theoretical generalisability' and involves encouraging the reader to adopt an active role, drawing on their existing knowledge and experience, in order to judge the

applicability of the findings and the possible implications for their own practice (Smith et al, 2009). It is therefore recognised that although the experiences presented are specifically applicable to the therapists under study, these can increase understanding and add to the already existing knowledge and research base. To conclude, the idiographic concern with the particular, the individual, appeals to me as I am keen to use a method that maintains the presence of the individual and not losing sight of them amongst codes and categories.

3.4.3 My Rationale for choosing my methodological approach – Interpretative Phenomenological Analysis (IPA)

In this section I will explore the argument for Interpretative Phenomenological Analysis. There are several different versions of phenomenological approaches that vary in their ideas, but they come together in their emphasis on focusing upon, 'lived experience'. Langdridge (2007) stated that phenomenological psychology should be seen as a label for a family of approaches, consisting of: a) descriptive phenomenology, which emerged in the 1970s with the work of Giorgi, b) Interpretative Phenomenological Analysis (IPA), which was developed by Smith in the 1990s, and it is perhaps the most known phenomenological methodology in UK, c) hermeneutic phenomenology, which is a family of different methods and the work of Max Van Manen (1990) is the most popular, and d) template analysis (TA), which is a lesser known methodology that is similar to IPA and was developed by Nigel King at the university of Sheffield. The main difference with IPA is that in TA the researcher can use a coding frame which is devised theoretically prior to the collection of data (Langdridge, 2007).

IPA is seen to be in the domain of being more hermeneutic, implying that identified meanings have to be understood in their historical and social context, and cannot be separated from it, as meanings emerge within a context and are not separate (Finlay, 2009). As the present study seeks to understand meaning making within a specific context, that is working with shame in the practice of psychology and psychotherapy, in a social context where meanings are already attributed to shame and to the profession, I have chosen IPA as I believe that through this method, meanings that will be identified by the analysis can be hermeneutically interpreted in this context, which will then make the results more meaningful.

To put it differently, a phenomenological approach that places less emphasis on the context of experience, would risk manipulating the findings in a way by which they become slightly decontextualised, and as such their meaning would alter. When asking therapists about their experiences of shame in clinical settings, they are not being simply asked to describe how they as an individual respond to the phenomenon of shame but are being asked to explain how they experience it as a clinician, in a context with an implied intentionality, this being helping someone. Therefore, it is argued, that their experience has to be understood within this context in order to prevent nuances getting lost, as it is exactly these subtleties that this research partially seeks to identify. If we dismiss the context of my participants' experiences, one might identify individuals' responses to shame, however it would be more difficult to then make these findings meaningful in a way that allows us to use them to further the practice of counselling psychology and psychotherapy.

Moreover, in the context of adhering to BPS guidelines, the choice of IPA is in accordance with the guidelines of the Division of Counselling Psychology, which promotes the use of phenomenological methods is addition to traditional research, in order to further evidence-base in the context of relational skills and interventions (BPS, 2017) and to provide further evidence to intersubjective knowledge. IPA as a research method has been scrutinised in terms of its scientific potential for rigorous data collection, sampling, and adherence to theoretical foundations. Brocki and Weardon (2006) systematically reviewed IPA studies and found it a suitable method for a variety of research topics that aim to understand experience. Miller and Drag hi-Lorenz (2005) and Kissaun (2017) conducted successful and informative IPA studies about clinicians' accounts of their own shame in the therapeutic setting, which equally merit IPA to be a suitable method for this study.

Additionally, IPA seemed the most appropriate to meet the aims of this study because it explicitly invites the interpretative activity of the researcher in addition to description. My focus of interest in this research is how my participants' experience is understood, subjectively experienced and contextualised. Such an exploration involves a combination of insights from both phenomenology and hermeneutics and, therefore, an interpretative phenomenological approach appears uniquely suited to a research

that aims to describe therapists' lived experiences of working with shame in clinical settings as offered by the participants and understood by the researcher.

The hermeneutic elements of IPA conceptualise the analysis process as a product of the interactions between the participants and the researcher, and it is both phenomenological (participants' accounts) and interpretative (researcher's interpretations of participants' accounts). For researchers to unravel the meaning of participants' experiences, they need to interpret meaningfully how the participants make sense of the world. Such interpretations are based on the researcher's own conceptions, expectations, beliefs, and experiences (Smith et al, 1999). Hence, I find IPA appealing because it highlights the co-construction of meaning in research, and it also draws attention to reflective and reflexive processes, as the researcher is expected to explicitly present her own perspectives.

Also, in terms of the present study, IPA offers a comprehensive theoretical and methodological framework with which to explore experiences of working with shame for a small number of participants. It aligns with my epistemological stance and as discussed is particularly appropriate to address my research question. In terms of the analysis process, IPA offers a comprehensive guide to help the researcher to work their way through a number of steps and stages (Smith et al, 2009). Having these guidelines on which to base the analysis appealed to me and this structure provided some reassurance and comfort. However, the emphasis on flexibility and the lack of strict prescription was also attractive and meant that my primary concern was not to complete the analysis in the 'right' way but to adhere to the general principles underpinning the process. The cyclical, interactive process also appeared inviting and seemed to offer something more dynamic than a linear approach, which meant that deep immersion in the data was possible and in fact *necessary.*

Also, IPA allows for the construction of semi-structured interview schedules, which means that on an IPA schedule I may be able to ask for the experience of certain phenomena related to the main phenomenon under investigation in order to understand as to whether practitioners resort to theory, or intuition, or both when working with shame. In traditional descriptive phenomenology, this would be conceived of as being directive, suggestive or manipulative of the data, and as such would not be possible (Finlay, 2009).

There appears to be a contentious debate about the epistemological underpinnings of IPA upon which a number of researchers have commented. For example, Larkin et al (2006) highlight that IPA is open to a number of epistemological positions and appear to present this as a strength of the approach. Conversely Chamberlain (2011) argues that this uncertainty can actually act as a barrier to conducting coherent research and pushes for more explicit discussions around this topic. Finally, Smith (2004) argues that IPA is itself a representation of an epistemological position. I would argue that my position of contextual constructionism is extremely complementary to the aims and philosophical underpinnings of IPA. This is due to the focus on context dependent knowledge (rather than objective knowledge) and the acknowledgement of the active, dynamic, and interpretative role of the researcher. Larkin et al (2006) also highlighted the complementary nature of contextual constructionism to the aims of IPA and this was yet another reason as to why IPA was deemed the most suitable approach for my study.

To summarise, IPA appeals to me because it echoes on a personal level how I view the world and on a professional level how I position myself clinically vis-à-vis my clients. A research method that acknowledges the influence of the researcher on the data and outcome resonates with my philosophical epistemological stance. IPA also fits well with my professional model; consistent with the phenomenological origins of IPA, in my clinical work I strive to understand what it is like from the point of view of my clients, to take their side to stay empathically attuned to them. At the same time, I am trying to stand back a little, to avoid collusion and over-identification, as I am examining whether something is going on that the client is less aware of. Again, this is in agreement with the IPA inquiry as both styles of interpretation can lead to richer analysis "…and to do greater justice to the totality of the person, warts and all…" (Smith & al, 2006).

Having described my reasons for choosing Interpretative Phenomenological Analysis I will now turn my focus on methodological limitations associated with IPA.

3.4.4 Limitations of IPA

The strength of IPA rests in its capability to identify meanings and develop understandings through sustained interpretative engagement (Finlay, 2011). However, as with all types of phenomenological research, research scholars have

underlined conceptual and methodological limitations associated with IPA. Below I consider some arguments and counterstatements regarding its limitations.

IPA aims to gain an insider's perspective on experience, and this is achieved through listening to and analysing the language participants use to describe their experiences. Dallos and Vetere (2005) argued that IPA relies on participants having the ability to articulate, possibly complex, thoughts and feelings and to reflect on their experiences. Similarly, Willig (2013) criticises IPA for not placing sufficient recognition to the integral role of language and the extent to which language constructs, rather than describes reality. Willig (2013) therefore argues that, through language, researchers can only gain an understanding of how people talk about their experiences rather than an understanding of the actual experience.

However, Smith et al (2009) responding to their critics reiterated that the primary focus in IPA is with understanding lived experience through the expressive function of language as '…our interpretations of experience are always shaped, limited and enabled by language…' (Smith, Flowers & Larkin, 2009:194). In my study I have recruited experienced psychologists and psychotherapists who were accustomed to articulating emotional states and to sharing their reflections and experiences, and therefore, the eventuality of encountering related issues is somewhat mitigated. Even though I acknowledge the critique outlined by Willig (2013), I will be taking the view that through language I can learn something about how the participants are experiencing a certain phenomenon and that they can in part describe their 'reality'.

Another criticism of IPA is its close association with cognition. Langbridge, argues that "…talk of cognition represents a desire to position IPA between traditional experimental cognitive and social psychology and discursive approaches, especially in health psychology, but it does make it difficult to ground IPA in phenomenological philosophy and/or recognise it as a true phenomenological method…" (2007:108). Willig (2013) states that Smith's (1999) version of the phenomenological method is based on a Cartesian conceptualisation of the individual with the aim of research being explication of such internal processes. She highlights that a concern with cognition is not compatible with phenomenological philosophy, which underlines the fact that

consciousness occurs in the relationship between people, and it is not internal to a person.

In response, Larkin et al (2011) stated that it is a '…misconception that IPA researchers claim to be investigating cognition directly, or simply to be doing cognitive psychology…' (ibid:13). From the perspective of IPA, cognitions are '…dilemmatic, affective and embodied…' (Smith et al, 2009:191) and not isolated separate functions but are intricately connected with our engagement with the world. Also, they are accessed indirectly through people's accounts and stories, through language, and ultimately meaning making (ibid). I concur with Finlay (2009) when she argues that it is at this point that relational-phenomenologists focus their attention on the belief that much of what we can learn and know about one another emerges within the intersubjective space between researcher and participant.

Another criticism of IPA is that it does not attempt to explain why people experience certain phenomena in certain ways. Instead, it is concerned with describing, exploring, and understanding individual perceptions. Langbridge (2007) argues that this is a potential drawback as the lack of explanation could in fact restrict our understanding of phenomena. Similarly, Willig (2013:95) claims that although phenomenological research describes and documents the lived experience of participants, it does not further our understanding by attempting to explain it. Smith et al (2009) have argued that IPA uses hermeneutic, idiographic, and contextual analysis to understand the cultural position of participants. They address this argument when illustrating how IPA conforms with Yardley's (2000) yardstick of sensitivity to context (one of Yardley's principles for assessing the quality of qualitative research). This is expanded upon later.

Brocki and Wearden (2006) carried out a systematic review of fifty-two articles published prior to 2005 and they found that studies rarely described the process of constructing the interview schedule. They concluded that this made it difficult to evaluate the quality of the interviews and the subsequent impact of this on the data and the findings. Smith and Osborn (2008) stated that training researchers in small groups will result to stronger methodological rigour. My attendance of training research seminars, that aimed at improving research skills at Metanoia Institute, were an invaluable source of learning about research design, pilot study, conducting interviews

and analysing data. Brocki and Wearden (2006) also highlighted a lack of researcher reflexivity in the analysis. I have tried to counteract this by critically appraising my interviewing style, including my style, my questions, and prompts, after each interview. I have also engaged in reflexivity throughout the analysis stage to increase the '…transparency and perhaps enhance rhetorical power…' as Brocki and Wearden (2006:101) recommended.

Another criticism comes from Giorgi (2010) when he asserted that IPA's non-prescriptive method makes it hard for another researcher to judge the value and rigour of the research. He claimed that Smith was causing confusion by the alternate use of terms like paraphrasing, interpreting, and associating and he called for more clarity regarding which one should be appropriate in which stage in the research process. Smith and Osborn (2008) argued that they intentionally stayed away from being highly prescriptive because '…there are no rules about what is commented upon, some of the comments are attempts at summarizing or paraphrasing, some will be associations or connections that come to mind, and others may be preliminary interpretations…' (ibid: p.67).

Giorgi (2010) also criticised Smith for being paradoxical in stating that he was non-prescriptive because he was in fact giving suggestions to IPA researchers. In response, Smith (2010) stated that he did not believe the meaning of the words 'prescriptions' and 'suggestions' to be the same. Giorgi (2010) also criticised IPA for not being scientific because it does not concern itself with the central tenet of science – replication. Smith (2010) defended his position by highlighting that replication is a criterion more strongly associated to quantitative paradigm and he drew attention to Yardley's (2000) assessment criteria and highlighted the importance of '…commitment, transparency, plausibility…' over replication (Smith, 2010:190).

To conclude, what I find enticing about IPA is its proposed balance between flexibility and structure, and in spite of its inevitable limitations, this method appears to serve the aim of my study sufficiently.

3.5 Method

In this section of the chapter the steps taken in order to carry out the research exploring clinicians experiencing of shame phenomena in therapeutic settings using IPA are described. Through developing the research question, completion of research proposal, and ethics applications, recruitment of participants, pilot study, conducting interviews and their subsequent transcription, the process undertaken in order to end up with the data for analysis is presented.

Developing the research question involved regular meetings with my research supervisor and fellow research peers. This process allowed for lengthy discussion and exploration of the subject area and for the explication and challenging of the researcher's own bias and vested interest in the research topic. As an individual struggling with her own issues around shame, it is of no surprise, but nonetheless important, to be mindful of how the researcher's own underlying biography, and her yearning for someone to provide the opportunity to reveal this inner turmoil, implicates her desire to question and explore psychotherapists' experience of engaging with shame issues in practice as described in the introduction.

Having developed the question, attention was then turned to the practical aspects of designing and conducting the study. The following outlines the steps I aim to undertake in order to both gather and transcribe the data.

3.5.1 Design

In this section I envisage to describe the steps taken in the design and implementation of my study. Therefore, I aim to offer an account of my proposed design as well as what I encountered when I went into the field work.

This study adhered to the principles of IPA (Smith, Flowers & Larkin, 2009); the IPA design underscores the relationship dynamic between researcher and participants and views the data collection from each participant as emerging in the shared intersubjective space between researcher and participant (Finlay & Evans, 2009). IPA is linked to small and homogeneous samples with emphasis being placed on depth rather than breath of data. Semi-structured interviews were used to collect data that were then transcribed verbatim. Transcripts were then analysed as per the IPA method to elicit and to identify key experiential themes in the participant's account (Smith,

Flowers & Larkin, 2009; Finlay, 2011). This resulted in an idiographic account of each participant's experience before moving on to the development of an ensuing analysis of similarities and differences within cases. The collective data was then methodically categorised into superordinate and subordinate themes that appeared to capture the essence of the participants' lived experiences.

3.5.2 Selection and Recruitment of Participants

Reid et al (2005) argue that '…IPA challenges the traditional linear relationship between 'number of participants and value of research…' (ibid:22) and Hefferon & Gil-Rodriguez (2011) add to this argument that "…more is not always more…" (ibid: 756). IPA is idiographic in nature and small sample sizes appear to be more appropriate as they allow for the in-depth analysis of individual cases and experiences. Once ethical approval was granted by the Metanoia Institute's Ethics Review Panel the recruitment process started. Following Smith et al.'s (2009) suggestions, a purposive homogeneous sample was chosen. As part of my recruitment process, I advertised my research in two counselling psychology training institutions, two psychotherapy training institutions and two inner-London Psychology Services. I sent an email outlining the aims of the study and asking those interested in participating to contact me in order to ensure that participation was voluntary. Participants came forward without the need for follow-up emails. Eight clinicians volunteered to take part to my study, and they all met the selection criteria for my research.

Smith et al (2009) highlight that students undertaking professional doctorates usually engage in four to ten interviews and for this reason my sample size of eight appears to be appropriate to the aims of the study. Smith and Osborne suggest that '…IPA researchers usually try to find a fairly homogenous sample [....], if one is interviewing, for example, six participants, it is not very helpful to think in terms of random or representative sampling…' (2003, p.54). They propose the idea of purposive sampling of a group of participants to whom the research topic is significant. Following this and in line with the researcher's intention to understand participants' experiences of working with shame, namely, to identify such experiences and to explore its impact on the therapeutic work, the recruitment of participants followed five criteria. The aim was to recruit a sample that met the criteria for homogeneity associated with IPA's inductive principles (Smith et al, 2009). The list of the inclusion criteria is as follows:

a) all participants are UKCP, BPS, or BACP registered psychologists / psychotherapists
b) they are practising within a process based/relational psychological approach
c) they have experience of process-based/relational supervision and process based/relational personal psychotherapy
d) they are currently receiving regular supervision
e) they are willing to take necessary steps to attend to matters arising during and/or after the interviews (for example, attendance of debriefing interviews, attendance of supervision and/or personal therapy)

The sample of this research consists of counselling/clinical psychologists and psychotherapists who have experienced working with shame issues in clinical settings. The decision to recruit psychologists and psychotherapists was based upon my interest to recruit participants who regard themselves as psychologists and psychotherapists, since I am training to qualify as a Chartered Counselling Psychologist and Integrative Psychotherapist. Moreover, shame is an emotive topic and it felt ethically appropriate to target clinicians who were already qualified and registered with a regulatory body, as this usually guarantees length and depth of clinical experience. I decided to pursue clinicians who subscribe to relational approaches as such approaches highlight the mutuality of the therapeutic process as a co-construction between therapist and client. The common ground between therapists who practice within a relational approach is their focus and interest on relational processes, which added to the criteria for homogeneity.

Also, since I was aiming to elicit data about my participants' lived experiences of shame in their clinical work, I advertised for therapists who were in receipt of regular supervision, as it is considered an essential part of good, ethical practice by both the UKCP (2019) and the British Psychology Society (BPS, 2017). Another important factor was that participants had experienced relational personal therapy, in anticipation that these clinicians possessed adequate levels of self-awareness and reflective thinking, as personal therapy arguably supports therapists' resilience and capacity to reflect on their psychological processes; also it was expected that , if necessary, participants would be prepared, to take steps towards looking after their well-being, by

accessing further therapy and/or attending debriefing interviews, to deal with difficult issues that might arise through participating in the research.

So, this study is designed to be based on the semi-structured interviews of eight participants between the ages of thirty and sixty-five years old. Four participants identified as white British, one participant identified as British of mixed heritage, and three participants identified as white other. The non-British volunteers were born and grown up in foreign countries. Out of the eight participants seven were female and one was male.

3.5.3 Pilot Study

A pilot study was conducted in order to gather information to inform decisions regarding the research. The main aims of this were to gain a better understanding of how therapists talk about their practice and to identify key experiences that appeared significant. This helped to develop a more in-depth understanding of the topic area or as Smith et al (2009) highlight, a “certain level of cultural competence... in order to properly understand our participants ‘terms of reference’ (p. 195). The pilot study also gave me an insight into the types of questions that elicit experiential data and the difficulties of ensuring questions are open and non-leading. From this I became more aware of the importance of having appropriate prompts and probes to help frame questions.

The method adopted for data collection was semi-structured interviewing and the reasons for this are highlighted later. Conducting a pilot interview gave me the opportunity to pilot my interview schedule (see appendix 3) and also my interview technique. Smith and Osborne (2003) suggest that the researcher must think in advance about the range of issues that may be covered, both in the psychological or intrapersonal world of the participant, as well as the social phenomena or intersubjective experiences, to address the relationality of experience. Based on that I developed an interview schedule aimed to open up both the personal and relational experience of encountering shame in clinical settings. One main development to arise from this was to include additional probes that were less general and more related to the topic under study (for example, how does that relate to the work you do to support yourself and/or your clients?). It was useful to reflect on the interview process and

encouraging to hear that my participant did not think any of the questions were too sensitive. I found the balance between active listening and remembering pertinent topics to revisit quite challenging. For this reason, the need to make accessible notes to facilitate this was highlighted for future interviews.

Through transcribing the interview, I also realised that I made too many verbal utterances that could have possibly been construed as leading (for example 'right' and 'makes sense'). This was an important reflection and learning point for the actual interviews. Finally, I analysed a section of this interview using IPA in order to practise and become more familiar with the process. Through the transcribing and the analysis of the pilot data I achieved a better insight into how complex, challenging and time consuming this process can be which helped me to think about appropriate time scales for completing the work.

3.5.4 Semi-structured Interviews

Smith et al (2009) suggested that IPA is best suited to a data collection method that will '…invite participants to offer a rich, detailed, first-person account of their experiences…' and '…facilitate the elicitation of stories, thoughts and feelings about the target phenomenon…' (ibid:56). Semi-structured interviewing appears to be the most widely adopted method for IPA researchers (Reid et al, 2005) and this was the method used for this research. This form of interviewing enables the participant and researcher to engage in a dialogue, whereby initial questions are adjusted by taking into consideration participants responses, and there is enough flexibility for the researcher to investigate any areas of interest that arise. I felt that this approach to data collection would offer the idiographic element that I wanted but also a supportive scaffold for myself (as opposed to un-structured interviews).

Holstein and Gubrium (1997) stated that interviews are social encounters in which both interviewer and interviewee are actively engaged in constructing knowledge. Likewise, Brinkmann and Kvale (2018) conceptualised interviews as active, interpretative, meaning-making endeavours during which interviewers and participants mutually influence each other whilst co-constructing knowledge. Instead of dictating interpretation, "the consciously active interviewer intentionally provokes responses by indicating – even suggesting – narrative positions, resources, orientations and

precedent" (Holstein & Gubrium, 1997, p.123). In line with the above, it can be argued that my interviews were meaning-making endeavours during which the participants and I influenced each other in our co-construction of knowledge and consequently, the interviews looked more like a dialogue between equals with both parties engaged in constructing knowledge.

Willig (2008) suggested that the collection of qualitative data must involve flexible and open-ended approaches that allow participants to speak freely and reflectively, in order to share their stories and to ensure there is space for unanticipated participant-generated meanings to emerge and to be heard. Kvale (1996) also advised that preparation for interviews is vital as it assists the researcher to steer and define the situation, but also argued that the more spontaneous and unrehearsed the structure of the interview, the more spontaneous and lively the responses are likely to be.

Therefore, the strength of semi-structured interviews is that they allow participants to speak freely and openly about topics which they feel are pertinent, whilst also ensuring that areas relevant to the research question are covered (Langbridge, 2007). Kvale (2007) argues that the term 'interview' suggests that two people are exchanging views and although I did not feel that my views were put forward, I did acknowledge my role in shaping the conversation through the questions asked. However, I was conscious not to share my personal connection with the topic area as I did not want this to influence the views expressed by the participants.

This approach to interviewing helped me to effectively manage issues between consistency and flexibility that best served the needs of my qualitative research. Consistency was maintained with the use of an interview schedule. An interview schedule was devised as a flexible tool to help guide the discussions in the interviews (see Appendix 3). The schedule was developed, refined, and updated during reflective discussions with my research buddies, in my meetings with my research supervisor, and through the use of the pilot study. In devising the schedule, I was able to think about how certain questions might be phrased and sequenced, for example more descriptive questions were at the start to help set the scene and more sensitive questions were saved until participants had become more comfortable with talking. The interview schedule was not followed rigidly and so not all questions were asked in each interview, nor were they always asked in the same order. Instead, participants

were encouraged to take the lead in influencing the direction of the discussions, and concerns that seemed important to their unique experiences were explored further.

Field work: During the design stage of my project, I became aware that an important factor during the collection of data was to establish rapport with the participants. Therefore, throughout the interviewing process I was mindful of potential power imbalance dynamics between my participants and myself and I tried to equalise the power dynamics by sharing my genuine interest about their meaning making as I was listening intently to their stories, and by promoting a collegial atmosphere to our interaction. The length of the interviews ranged from forty-five minutes to seventy minutes. After each interview I kept reflective notes about the encounter to aid with contextualising the analysis and to improve my interview technique. All the interviews were audio-recorded and transcribed to aid with analysis. I transcribed the interviews soon after having conducted them and even though this process was very labour-intensive, it proved to be worthwhile as by the end of it I had become familiar with the narratives. Lastly, although IPA focuses on the content of talk and therefore all prosodic aspects do not need to be transcribed (Smith et al, 2009), I did make a note of significant pauses and non-verbal utterances (for example, laughing) to aid with interpretation.

3.6 Ethical Considerations

In this section I aim to share some of my ethical considerations during the design and the implementation of my study. The literature review highlighted the elusive nature of shame, its toxic and contagious aspects, and demonstrated the potential threat of shame outside the therapist's awareness (Scheff & Retzinger,1997). This echoes Merleau-Ponty's (2003) assertion that our personal theories may be held consciously, or they may exist in the periphery of consciousness, in which case they may be described as implicit knowledge. The implicit nature of shame implies that it needs to be made visible before it can be subjected to scrutiny. This of course poses several ethical challenges, which will be thoroughly addressed here.

This research was conducted with regard to the Code of Human Research Ethics (BPS, 2017) and was granted ethical approval by the Metanoia Institute's Ethics Review Panel. I approached and conducted the interviews with an attitude of utter

respect ensuring that the research process was underpinned by a respectful and trustworthy approach, and particular regard was paid to ensuring consent, confidentiality, and the reduction of potential for harm. What follows is a summary of ethical issues risen during the implementation stage of my study.

Field work: All participants had the necessary competence to give consent to participate and they were fully and truthfully informed about all aspects of the research through the use of a Participant/Research Information Sheet (see Appendix 1). The clinicians were given time to process and reflect on this information before agreeing to participate. Written consent was obtained before each interview and as part of this process therapists had to indicate that they had read the Participant Information Sheet, understood that their participation was voluntary and understood that their responses would be anonymised (see Appendix 1, Appendix 2). They were also given the opportunity to ask any additional questions before agreeing to take part. Although written consent was obtained at a one-off time, ensuring continual consent was an ongoing process which involved remaining sensitive to the participants' verbal and non-verbal behaviour. Clinicians were informed on the Participant Information Sheet that they were free to withdraw at any time without explanation and this was emphasised before the start of each interview.

Personal information that could identify the participants remained strictly confidential and I was the only person who had access to this information. The data collected was handled in an anonymous form and this involved giving individual therapists a pseudonym instead of using their name or initials. The participants were informed that the interviews would be audio-recorded to aid with analysis and that the audio recordings and transcriptions would be securely stored and then destroyed after I had successfully completed my course. Whilst transcribing the interviews, personal information was removed. Information contained within the Participation Information Sheet and the consent form ensured that the therapists were aware of what I intended to do with the data after it had been anonymised and informed them of the steps that I was taking to ensure confidentiality.

The concept of confidentiality is associated to anonymity and suggests that private data identifying participants should not be reported. A significant number of my participants were employed by an inner London NHS psychology service. Working with such a small distinct group of clinicians created additional concerns around ensuring anonymity and confidentiality as the smallest of details relating to participants' particulars may make them identifiable, such as age, area of specialisation and qualifications. An assurance of anonymity, therefore, set the scene for my interviews and the writing up of the research, and further steps were introduced, as I opted to conceal identifiable information and abstained from sharing demographic information which could have compromised my participants' rights to anonymity and confidentiality. The possible impact of this decision on the data and findings will be expanded in the Discussion section.

One of the main challenges during the interviews was how best to create a safe interviewing environment for clinicians to share as much as they wanted to, but not more, and enough to allow the researcher access to their implication levels of processing. Gilbert (1998) asserted that shame involves processing on both procedural and implication levels, with the latter operating at a level not entirely conscious and difficult to access. Previous studies that explored shame noticed that it can be difficult for participants to name their shame and to talk openly about them. For example, Miller and Draghi-Lorenz (2005) stated that, due to the '…inevitably social nature of the interviews…', participants' descriptions in their study seemed to reflect the '…less threatening end of the spectrum of possible shame experiences…'(ibid:17). Similarly, Livingston and Farber (1996) found that therapists, particularly those with less clinical experience, may find it difficult to talk about intense feelings created by shame in a research situation and they argued that '…shame tends to evoke shame…' both in research and clinical practice (Livingston & Farber, 1996, p. 608; Macdonald & Morley, 2001). From the outset, I was aware that talking about shame experiences might evoke distressing feelings, and I was also mindful of the possibility that participants might opt to retract after the interview. Therefore, it was also important to me that their accounts be used in a way that respected their vulnerability but did not compromise the integrity of my analysis. I was also worried that questions on shame may cause them to come face to face with previously unexplored issues or to experience internal blocks during the interviews.

Led by Kvale's (2007) statement that the researcher needs to consider the consequences of the interview interaction for participants, I tried to communicate the importance of sharing only what they felt comfortable with and I drew on my sensitivity, empathy, and therapeutic skills to monitor how the interview was affecting each one of them. I also checked with participants throughout the process to make sure they were not unduly upset. Even though I anticipated that my sample, which consisted of trained therapists, who practice within a relational model and have personal experience of attending relational therapy and supervision, might find it easier to engage with my topic and to access and articulate their experiences, I also kept in mind the above statements during the collection and analysis of data. During the actual interviews, participants needed little encouragement as they spoke generously about their shame experiences. Thus, the additional prompting and probing questions that I had devised to encourage participants to talk in more depth and elaborate on points further, were rarely used.

In addition, in order to ensure my participants' well-being, the following measures were put in place: a) all participants were prompted to attend a debriefing interview after their involvement in the research, b) if a participant was to appear distressed, then the interview would be paused while I would try to ascertain with their help whether they were emotionally fit to continue or whether they would prefer to terminate the interview process, c) distressed participants would also be prompted to consider pursuing supervision and/or personal therapy to further explore any unsettling material evoked by the interview process. The above measures are in line with the guides on research ethics by the BPS and the UKCP and the possible effects of these decisions on the data and findings will be reviewed in the Strengths and Limitations section of the Discussion Chapter.

Furthermore, the literature review highlighted that shame is contagious: hearing of shame evokes shame even if only subtly and slightly. For that matter I followed the steps below in order to emotionally support myself and to maintain a position of inquiry: a) I used my personal therapy and supervision as facilitative spaces where I continued to closely examine my relationship with my own sense of shame. b) I had access to

debrief meetings with two designated research buddies after each interview if I felt that I needed it. c) I kept a written record of my overall experience of the interviews: this included my reflections and feelings about the interaction. d) I regularly re-visited the aim and purpose of my study in order to feel grounded in my research. This also assisted me to keep my motivation levels up and my stance of curiosity alive.

3.7 Data Analysis

The analysis of the data in IPA is iterative, inductive, fluid and emergent and Smith et al (2009:79) outline a helpful six-stage approach of 'common processes' for analysis. The analysis involved moving from a focus on the individual to a more shared understanding and from a descriptive level to a more interpretative one, a cyclical process, rather than a linear one, and it will also be approached with the hermeneutic circle in mind in order to understand part-whole relationships (Smith et al, 2009). What follows is a description of the stages involved during the data analysis as adapted from Smith et al (2009).

Step 1. Reading and re-reading

The process started with the close examination of one transcript. Whilst reading this I listened again to the audio-recording in order to really hear the experiences shared. By repeating this exercise a few times, I immersed myself in the text and I became familiar and aware of their stories and their modes of expression and tone. Recollections of the interview and initial comments were noted in my reflexive journal alongside the initial notes I had made about my experiences during the research interviews.

Step 2. Exploratory Commenting

This stage involved initial noting, in the margin of the text, to examine the content on a very exploratory level. Each description had a 'clear phenomenological focus' that captured the participant's core concern (Smith, Flowers & Larkin, 2009, p.83). It involved documenting topics of apparent importance and trying to capture the meaning of these, reflecting the process of the hermeneutic cycle where the emphasis is developing an empathic understanding of the participants' concerns. The exploratory comments were divided into three key areas: Descriptive comments: focusing on content and describing the objects of concern, Linguistic comments: reflecting on the

specific use of language and Conceptual comments: asking questions of the data and moving towards a more conceptual understanding of what it means to have these concerns in this context.

Step 3. Developing Emergent Themes

The aim of this stage was to focus on discrete chunks of text in order to recall what was learned through exploratory commenting. The data was reduced into a smaller number of concise statements, 'Emergent Themes', that related to the research question and were developed to capture and reflect understanding. These themes documented the essence of the participants experience together with my interpretation of this, a process that marks the intersection between description and interpretation (Larkin, Watts & Clifton, 2006). (See Appendix 4 for an example of exploratory commenting and emergent themes).

Step 4. Searching for connections across emergent themes

This stage introduced structure into the analysis. Emergent themes were drawn together by identifying common links between them using the concepts of abstraction (similar themes brought together), subsumption (emergent theme becomes subordinate theme), numeration (frequency in which theme is supported signifies importance) and function (what function it serves) (Smith et al, 2009). This produced a number of subordinate themes with related emergent themes.

Step 5. Moving to the next case

Once I completed steps 1-4 with the first transcript, I then passed on to the second interview and so forth using steps 1-4. In accordance with IPA's idiographic commitment, each case was approached in its own right, so that I could 'meet' each participant's experience on its own terms and to allow new themes to be developed.

Step 6. Looking for patterns across cases

This stage involved searching for connections across cases. As a result, I found strong connections between themes in certain areas and weaker links in terms of others, and through this process individual emergent and subordinate themes were relabelled and

reconfigured. The subordinate themes were drawn together, and this resulted in a number of superordinate themes for the group each with a number of related subordinate themes (see Appendix 5). Further reflections about the data analysis will be discussed in Findings, Chapter 4.

I will now turn my attention to issues of validity and quality as they emerged in the design and implementation of my study before I address ethical considerations concerning this research.

3.8 Validity and Quality

The terms reliability and validity are often used to evaluate the value of research and the rigour with which the study has been conducted. However, it is argued that these criteria are essentially related to a positivist, or realist, perspective of how we should view reality and knowledge (Willig, 2013). As a result, qualitative researchers have moved away from the postpositive paradigm in assessing the quality of qualitative studies and abstained from applying concepts like reliability, validity, and generalisability, which are mainly associated with quantitative research (Finlay, 2006). Terms such as credibility, quality and trustworthiness have increasingly been adopted by qualitative researchers in order to assess value (Golafshani, 2003).

Although it has been acknowledged that there is still considerable variability in how these concepts are actually realised in practice (Roulston, 2010), a number of flexible guidelines have been developed to provide a supporting scaffold (for example, Tracy, 2010; Yardley, 2000; Elliott et al, 1999). *These guidelines are intended to be applicable to all qualitative research, regardless of the specific methodology adopted. Smith et al (2009) favour approaches by Elliot, Fischer and Rennie (1999) or Yardley (2008) due to their '…sophisticated and pluralistic stance…' (Smith et al, 2009, p.179). I have reflected upon the key ideas proposed by all these researchers and I sought to comply with all four of Yardley's (2008) guidelines for assessing validity and quality in my research.*

Yardley (2000) argues that one way to facilitate credibility is to show sensitivity to the context in which the study was conducted and this can be achieved in a number of ways. Firstly, I ensured that I was aware of the wider context in which the research was situated. This involved familiarising myself with the extant literature on shame and immersing myself in literature relating to the theoretical underpinnings of IPA. My

analysis and interpretation implemented an idiographic focus on each individual participant's context in order to show sensitivity to my participants' accounts. Also, the inductive approach of IPA further emphasises that sensitivity to the data was an underpinning principle of this research. However, Smith et al (2009) argue that it is not only important to ground the claims in the data, but also present this data to the reader to allow them to reflect on the interpretations and possible alternatives. For this reason, I will be including verbatim extracts and quotations within the analysis section.

Another context that appeared appropriate to reflect upon with regard to this research was the context of the actual semi-structured interviews. Before each interview started, I spent time building rapport, through informal discussions, in order to put the participants at ease and help them to feel more comfortable. I was also aware of the potential power imbalance between myself as a researcher and the participants being interviewed. For this reason, I emphasised the semi-structured nature of the process, the fact that there were no right or wrong answers and that I was interested in hearing what they thought was relevant and important to their personal experiences. I hoped that this would give them some sense of power over the situation and the direction of the discussion. Throughout the interview I aimed to listen with a high level of interest and adopt a sensitive and empathetic approach. This involved observing the participants' verbal and non-verbal behaviour to ensure that their well-being was not being compromised by my lines of enquiry.

Yardley (2000) argues that another characteristic of valuable research involves approaching the process with commitment and rigour, and this involves engaging with the topic under investigation for a prolonged period. Undertaking a pilot study, and spending a prolonged period reading about how to conduct high-quality interviews and how to analyse data using IPA, along with my immersion to the research process and my use of reflexivity, is testament to my commitment. Tracy (2010) argues that rigour can be demonstrated by selecting a sample that is appropriate to achieving the aims of the research. As discussed in the design section, the homogeneity of the sample was in line with that expected in IPA research. Finally, Smith et al (2009) argue that the analysis undertaken should be thorough and interpretative, identifying the prevalence of each theme and showing extracts from a range of participants. I have attempted to achieve this throughout the analysis and write up stages.

Yardley (2000) highlighted that another quality of good research is transparency and coherence. In order to enhance transparency, I was interviewed by a research buddy about my own experiences of working with shame in clinical settings, prior to the pilot study, thus adding to the reflexive position. By means of my reflective research journal and also by being interviewed for this research, I strengthened my research transparency in terms of my own assumptions and values. I have also tried to be transparent about the procedures by including information about how the interview schedule was constructed, how the participants were selected, how the interviews were conducted and how the resulting data was analysed, and through these discussions I hope that the reader is able to see an appropriate fit between the research question and the methodology selected. I have also included transcript extracts in the findings section to allow the reader to reflect on my interpretations and consider possible alternatives and I have provided snapshots of the iterative stages of the analysis in the appendices. It is argued that the trustworthiness of a research project can be increased through credibility checks (Elliott et al, 1999) or audits (Smith et al, 2009). This was a process that was adopted during this project and involved my supervisor and research buddies looking through materials such as the data at different stages of the analysis process. The aim of this was to support with reflective and reflexive thinking and also to ensure that that I was following the principles of IPA in terms of method and methodology.

Transparency also appears to be characterised by self-reflexivity (Tracy, 2010) and owning one's perspective (Elliott et al, 1999). In view of this I would like to share my reflections about my decision to include in my research design a stage of 'member checking', which involved giving each participant the opportunity to read their transcripts before the analysis stage. All of them agreed to that and gave consent for their data to be used in the research. Retrospectively thinking I feel that this exercise helped to process any feelings of vulnerability and/or ambivalence that my participants may have been harbouring pre- or post-the semi-structure interviews. Also, since my sample consisted of psychotherapists and psychologists with personal experience of conducting research, I also felt 'interviewed – evaluated' by my participants and as a result my shame-related issues had to be further acknowledged and explored. My research journal became a vital part in my efforts to sustain my position of enquiry and to support the cyclical process of reflection.

Lastly, Yardley (2000) suggests that a final feature of good qualitative research is that it has a sense of importance and impact and that a piece of research should be judged by its impact and significance, since “it is not sufficient to develop a sensitive, thorough and plausible analysis, if the ideas propounded by the researcher have no influence on the beliefs of anyone else” (Yardley, 2000:223). Tracy (2010) highlights that this begins with selecting a worthy topic. I would argue that as shame has been identified as one of the most potent human emotions, anything that could support with increasing understanding as to how therapists make sense of their own experiences of shame in their clinical work, is indeed worthy for clinical practitioners and theorists alike. It is hoped that this research will be interesting and enlighten a previously somewhat shaded phenomenon. It is also hoped that this research will encourage people to reflect on possible implications for their own practice and inspire future researchers to continue with investigations in this area. After the completion of my research, I aim to actively promote its findings as a therapist, a supervisor and colleague.

On a final note, I would like to share, that throughout this study, I have been guided by my social responsibility as a researcher and this research was conducted while being continually mindful of issues of diversity and oppressive practice. Ethical issues were continually assessed and addressed throughout the process of research and writing up.

Chapter 4: Findings

4. Introduction

Having followed the stages involved in IPA data analysis as outlined by Smith et al (2009) four superordinate themes emerged from the interpretative analysis and each of them are present across participants' transcripts: 'The impact of Shame on the Self', 'Noticing Shame', 'Therapeutic Reactions to Shame', and 'Shame and Issues of Power'. Each theme contains subordinate themes demonstrating the essence of the participants' experience of shame in psychotherapy. Tables have been included to provide a visual representation of the prevalence of subordinate themes across cases. Although themes have been separated during the analysis process, many of them are related and this is apparent throughout the narrative account. It is therefore important to consider each theme in relation to the holistic experience and the hermeneutic circle. Transcript extracts in the form of quotations will be included to present the phenomenological core from which my interpretations have developed. I have aimed to sample the quotes proportionally across participants so that individual voices can be heard, and individual experiences can be illuminated. Extracts from at least half the participants who related to each subordinate theme will be included to support the claims made (Smith, 2011). My interpretative explications reflect my efforts to understand their sense-making endeavours, and therefore are in keeping with the double hermeneutic. Throughout the narrative I have aimed to explore both depth and breadth, whilst also highlighting both shared and distinct experiences, therefore capturing convergence and divergence between experiences.

4a) The Participants

As stated in the previous chapter most of my participants are employed by an inner London Acute NHS Trust, where they provide psychological support to patients (and their carers and families) who are suffering from emotional distress within the context of serious physical illness. To preserve their right to anonymity and confidentiality I have taken the decision to not include demographic details or information about their qualifications as the smallest of details relating to their particulars may compromise anonymity and confidentiality. The effects of these decisions on the data and findings will be reviewed in the Strengths and Limitations section of the discussion. I also

include, for each superordinate theme, tables that provide a visual representation of the most prevalent types of experiences recounted by them. Below I present a table of my participants pseudonyms, gender, working sector and clinical experience.

Table 1. Table of Participants

Participant Pseudonym	Gender	Working Sector	Individual / Couple and Family Work
Jane	F	NHS/Private	√
Kim	F	NHS/Private	√
Gavin	M	NHS/Private	√
Linda	F	NHS/Private	√
Charlotte	F	NHS/Private	√
Gill	F	NHS/Private	√
Amanda	F	NHS/Private	√
Julia	F	NHS/Private	√

4b) Superordinate and Subordinate Themes

Analysis of the data produced four superordinate themes, as shown in Table two below, with subordinate themes for each:

Table 2. Superordinate and subordinate themes

Superordinate Theme	Subordinate Theme
4.1 The impact of shame on the self	4.1a) Early experiences and shame 4.1b) Being-as-you-are is not acceptable 4.1c) Running away from it
4.2 Noticing Shame	4.2a) Physiological Responses 4.2b) Shame and the 'sick body' 4.2c) The elusiveness of shame
4.3 Therapeutic Reactions to Shame	4.3a) Striking a strong alliance 4.3b) Holding your own 4.3c) Being emotionally available and transparent 4.3d) Self Care and supportive systems
4.4 Shame and issues of Power	4.4a) Power dynamics in the therapeutic interaction 4.4b) Culture and Shame

4.1 Superordinate Theme: The impact of shame on the self

This superordinate theme portrays my participants' reflections about the impact of shame on their personal and professional lives and it captures their views of themselves as self-critical and shame-prone individuals, and also describes experiences that in their view led to the development of shame both in their personal and professional lives. Reflections about the dynamic interplay between the personal and the professional are explored as clinicians share vignettes from their work. See table 4.1a for the related types of shame experiences as described in the data and table 4.1b for the subordinate themes and the prevalence of these across participants.

Table 4.1a Types of shame experiences

Types of experience	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
Early memories of shame	√	√	√	√	√	√	√	√
Struggling staying with shame	√	√	√	√	√	√	√	√
I am not good enough	√	√	√	√	√	√	√	√
Shame and trauma work	√		√	√	√	√	√	√
Shame takes place between people	√	√	√	√	√	√	√	√
Countertransference shame	√	√	√	√	√	√	√	√
Shame about unacceptable thoughts and feelings			√	√	√	√	√	

Table 4.1b Subordinate Themes Relating to Superordinate Theme 1 (The impact of shame on the self)

Subordinate Theme	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
4.1a) Early experiences and shame	√	√	√	√	√	√	√	√
4.1b) Being-as- you-are is not acceptable	√	√	√	√	√	√	√	√
4.1c) Running away from it	√	√	√	√	√	√	√	√

4.1a) Early Experiences and shame

During the interviews most participants shared the belief that shame is an interpersonal phenomenon and that early experiences play an important role on one's ability to tackle shame in adulthood. For example, Gavin stated:

'Well yeah, would shame exist if there weren't other people?... What I'm saying is that the majority of shame is about other people and how that then reflects back on me…and yes it has a lot to do with my upbringing…'

Gavin shared that in his experience *'…shame always has an audience…*' and he shared a Sartrean tale to further support his argument:

'So the man looking through the keyhole at the woman undressing only feels the shame at the point that he hears footsteps coming up the stairs. Whether or not that person is actually going to come up the stairs and witness them is a different matter. It's the idea of being seen, of being caught'.

According to Gavin shame takes place in our interpersonal worlds in front of a real audience, but it can also happen internally as the tale indicates. Gavin wanted to emphasise the significance of the interplay between the external and the internal in shame experiences. Likewise, Amanda asserted that in her experience external events trigger shame and she proposed a distinction between indigenous shame, which gets developed over time and is linked to a person's early experiences, and contextual shame:

'…We can shame ourselves actually, but the roots of shame are always external I think, they are foisted upon us… So I think I would separate it so there's what I would call almost an indigenous shame so there's the shame that people have already experienced in their lives as a being through various experiences, so that's indigenous, they've developed that over the time. And then I think there's a second experience of shame which is contextual… So you can have both I think in the room…'.

There was consensus amongst participants that one's ability to cope and manage shame in adulthood is highly dependent on their early experiences. Participants shared personal events from their lives during which they felt ashamed, for example, Kim said that she has been grappling with shame throughout her life:

'[shame]…and has spanned my professional and personal life in the interface and it's often been something that I've been I suppose grappling with…And I also think I'm often very influenced by having come from a family where there is a lot of shame and where no one would talk about anything and certainly they wouldn't come along to therapy. So, I think I have that as a lens as well of being really aware...'

Kim went on to highlight how her history compromised her ability to tackle shame experiences in her adult life. She recalled that during childhood she would often being called 'selfish' whenever she expressed emotional needs or desires:

'…and I said that I did not want to sit next to my cousin because he was quite rough with his playing and he used to hit me. My mum's response was rather forceful…and dismissive and belittling 'don't be such a girl', 'stop being selfish' 'you will do as you are told'.'

Kim noted that such occurrences were frequent in her upbringing and she is still suffering aftereffects:

'…such experiences were so frequent that I feel that I have accumulated heaps of shame…I was a shy child …I am still struggling to assertively express my needs and opinions…'

Similarly, Charlotte spoke about her family's struggles to acknowledge shame and the impact on herself:

'…my mother came from a family where…they didn't approve of her mother and father's marriage So she was not allowed to play with her cousins, she didn't see her cousins, her aunts and uncles and grandparents treated her as if she was some kind of shameful secret… she always told us her father had died when she was very young and she told me about two years before she died that actually her parents had divorced. So, shame upon shame. And so always in our house there were lots of things that weren't spoken about, but you carry them around with you as a child. You know there's something going on…and it haunted me…'

Charlotte reflected on how these experiences of unspoken shame and secrecy affected her ways of relating to herself and to others:

'…Yeah I think it affected me a lot when I was younger because I would be quite defensive and angry about it. if anybody said anything to me, I'd be right in their face in a really defiant way, it was a bit 'fuck you'. In therapy I realised that I was actually trying to run away from my feelings of shame…'

Charlotte also revealed that her decision to become a psychological practitioner was markedly influenced by the above and by her strong desire to stop the

'…intergenerational contamination of shame…'. Charlotte argued that although prior generations did not have the resources to see what they were doing, intergenerational shame can be very damaging until the transmission cycle gets disrupted by a person's ability to face it and mitigate its effect on generations to come. Gill was reminded of her own early experiences of shame whilst recounting a client's story:

'I can think of another client pops into my head now who had enormous shame, again, very difficult upbringing... She's a patient that had difficulty going through chemo, that was what initially I started to see her for, and she had a very difficult upbringing in terms of her mother was bereaved, her father died in the war, and her mother was so guilt stricken she couldn't mother her. And she was brought up by her grandmother and an aunt but always repeatedly told 'Don't upset your mother' not to cry, not to feel any distress, it would upset her mother. So, she would feel enormous shame about expressing her feelings in the session…And yes just talking about it now I am certainly having associations to her feelings of shame…as I was also often called needy and bad…' (Gill)

She also recalled an event that took place in her early twenties, which caused her immense shame:

'…One of my moments of greatest shame I can remember was once being told by a partner of mine at the time I had been selfish in wanting to close the window because somebody amongst our group of friends we were sitting with, in those days one smoked, I didn't smoke but people were smoking in the room, and one of women was pregnant and I'd sort of forgot that for a moment and wanted to close the window because I was cold. And my partner said afterwards 'How could you not think that she was pregnant and breathing in the cigarette smoke?' and the rush of shame that I felt was acute and for a few seconds almost unbearable which connects to my childhood experiences of shame and being told I was a bad person…' (Gill)

Amanda shared a memory of her school days:

'I can remember I was so little…I was at primary school, I was maybe five or six and being late and having come into assembly late and being made to stand up in front of the whole school. And it was so shaming, it was terrible, and they did that a lot in my school.'

She also talked about witnessing other kids being humiliated and the impact that such experiences have had on her personal and professional self:

'…we were all so little, I think it was maybe the first year…. And other instances not associated to me, but I can remember very clearly once that there was a girl in my class who wet herself in class and again, she was hauled out in front of the class and exposed in front of everybody for wetting herself. That is so cruel… but…it was very common to punish people through shaming them. So those experiences are very early experiences, I think are always there when I listen to my clients' stories about feeling bad…and I know that sometimes I stay away from engaging with shame issues… it's because of my own again fear of engaging with that pain. Because for me it is a deeply painful experience…'.

Linda remembered that she was made to feel ashamed at home for menstruating at an early age:

'…my brothers would call me names and I felt very alone in my shame…my mum failed to give me the support that I was longing for…'.

Jane talked about distressing early memories of being compared to siblings and cousins where her mother would often remind her that she was lacking:

'…why can you not be like your older brother...'.

Jane commented that,

'…this belief that I-am-not-as-good-as was engrained in me and even now causes me incredible pain…and sometimes interferes with my clinical work…'.

Julia argued that some people are more prone to shame than others because of their early experiences:

'…There are sort of often many times where I feel shame in a therapeutic relationship. Mind you there's often times I feel shame in real life so it's probably an emotion I'm quite prone to experiencing… I do think some people are more likely to experience shame, like myself. Potentially really influenced by I guess their background, their own personal development…'

Participants' memories emerged organically during the interviews as they were trying to communicate the origins of their difficulties when confronted with shame. These early encounters with shame involved interactions with parents, siblings and teachers and were regarded by participants as painful and haunting. There was consensus amongst clinicians that unspoken shame is experienced as a burden by members of a family system, you carry it around with you, and even if it does not 'belong' to you it becomes part of your identity and it shapes your ways of being within oneself and with others. In their endeavour to make sense of their experiences, my participants inferred

that such early encounters become internalised, and in turn shape our adult ways of experiencing and coping with the phenomenon of shame. The findings also suggest that the emergence of shame, the emotional trigger so to speak, almost always takes place in the presence of a real or imaginary audience.

4.1b) Being-as-you-are is not acceptable

This theme aims to capture participants' efforts to share insights about the profound impact of shame on their clients' and their own personal and professional lives. Their narratives often moved from sharing clinical vignettes about clients' material to revealing personal struggles when confronted with shame dynamics in clinical work. There was consensus amongst clinicians that the self is the harshest judge evoking self-denigration and an insidious sense of inadequacy and unworthiness that expands itself to one's life in general. In their narratives clinicians shared experiences from their clinical work where clients appeared to suffer profound shame about not being good enough, being bad and not meeting internal and external expectations; participants also turned their attention to themselves and shared their personal struggles with such thoughts and feelings.

There was consensus amongst participants that clients reveal intense levels of shame when discussing their underlying needs to belong, to feel accepted, to feel loved and cared for and that such issues may inhibit a client's decision to seek help or to openly discuss matters in therapy. Participants identified clients' fears about not meeting other people's expectations as the main cause of shame within the interpersonal domain. For example, Jane made a case for a client:

'…who is going back to their profession after having been off on sick leave. And the shame of being seen as someone who is not able to manage…'.

Similarly, Kim states that when clients feel exposed as someone who is not *'…meeting expectations, not meeting the criteria for being good enough…*' causes intense vulnerability. Linda highlighted the shame involved in clients' failed attempts to strike healthy romantic relationships *'…the shame of not being loved…of being single…*'. Likewise, Charlotte shared the story of a client who struggled to discuss his shame about his *'…need to find a nice lady who will understand…*'. What also got underlined here was the view that clients often *'…feel it is something lacking in them…*' *(Charlotte)*, which causes absolute palpable loneliness and profuse sadness. Amanda

said that some clients have been shamed for having certain types of feelings: *'…I think shame comes up when people have what they consider to be unacceptable thoughts and feelings…'.* She argued that many of us have been shamed by significant others for having certain types of feelings like envy, anger or even when expressing enjoyment, excitement, or pride. Such experiences according to Amanda hinder our capacity to remain truthful and authentic in our interactions with others. A similar interesting point was raised by Linda who claimed that bereaved clients experience intense shame for feeling:

'…relieved…You love but you let go, how can you love and let go? Yeah, I guess in that sense it's just very difficult to get out of that paradox. And obviously shame is what makes it paradoxical…The shame of letting go, of moving on…making you a bad person'.

Linda argued that clients often feel overly concerned about not honouring the memory of the deceased in the eyes of their loved ones and this often results in hindering one's grieving process. Participants also stated that it is particularly important to listen for shame in a history that includes trauma. There was consensus amongst the therapists who raised shame in trauma work that clients' distress is often intertwined with a deep sense of self-blame, lack of self-worth and self-hatred. It was argued that shame may be attached to the story of what happened, or to how they responded to what happened, or to any aspects of their current being. For example, Jane shared that a client who suffered emotional torture in her country:

'…she told no one about having been threatened with being murdered during the Burmese troubles…and the shame she felt about it…she's been alone with it…'.

Jane added that isolating experiences can turn *'…painful events into pathology…'* which in turn can cause acute dysregulation and intense shame. Gill spoke about her work with a client who was a survivor of sexual abuse and *'…the shame of being used, of being treated like an object of another person's satisfaction…'* as she highlighted the challenges involved in helping clients with traumatic experiences *'…to being a person…feeling their sort of selfhood…*'. Shame was viewed as a core issue for survivors because usually *'…experiences of abuse that persist over time happen in relationships of dominance and subordination…*' (Amanda). It was also noted that for many victims of trauma shame runs to an even deeper place than the experience of having been degraded and ashamed. *'…clients suffer disconnections that leave them*

believing that they are unlovable…' (Gavin). Most participants agreed that survivors of sustained trauma have had their bids for emotional connection criticised, rebuffed or ignored, and this usually results in distorted views about self and other.

In the process of relaying clients' stories where the self is experienced as inadequate and flawed, participants also revealed personal experiences of shame that reverberated the notion of defectiveness. All interviewees acknowledged being familiar with the feeling of shame in themselves as they recalled memories of clinical work where their shame featured. They spoke of their harsh self- judgements and self-blame towards their inadequacies and failures to 'deliver'. Their judgements of themselves usually stemmed from clients triggering their own sore points or from having felt displeased with the quality of their work.

Jane said that she often experiences moments of self-doubt about her ability to: *'…enable a patient to open up about something…and my shame in therapy has been, my biggest worry has been wasting the client's time…*'. In a similar tone Kim shared that she also has moments where she suffers lack of confidence and she often feels that she is *'…not meeting the criteria for being good enough…*'. Gavin described his feelings of shame when he feels that he is not 'meeting' his clients in their distress: *'…it can be hard to meet the client in their shame…it's to do with inadequacy, feeling absolutely inadequate and that I am a bad therapist…so yeah I felt a sense of shame about that…'.* Julia stated that she often doubts her therapeutic effectiveness and that exacerbates her belief that she is failing at therapy *'…and the excruciating shame [therapists feel]… when the patient keeps coming even when we don't think that we are helping…*'.

Participants shared the view that experiences of objective countertransference are usually entangled with feelings of failure when treating difficult and demanding patients and this was linked to a noticeable struggle to maintain professional standards. Kim stated that she has experienced shame *'…when a client is very attacking…either overtly or implicitly…'.* Julia talked about her work with medically trained patients:

'…doctors who are very, very quick with any information you give them…and I worry they will walk away saying 'what did I get out of that? I didn't come away with anything tangible, I just talked a bit about my feelings…'.

My findings suggest that clinicians experience high levels of distress and inner torment when they struggle to preserve one's self-identity as a helping, nurturing, caring for others therapist. For example, Linda said that she experiences intense shame when she finds herself *'…being happy when you have a cancellation…*'. Similarly, Gill shared that when she realised that she could not see a patient with complex needs because '…*she'd been discharged the day before, I felt a momentary feeling of relief and shame about that…*'. Gill also described her work with a '*…disturbed…*' man:

'…I couldn't make the connection with him and then he left the therapy after four sessions and I felt a sense of shame that I hadn't been able to reach him, that I hadn't really wanted to reach him. So yeah, I felt a sense of shame about that…'.

Gill said that she felt tormented for days after the client's premature departure partly because she felt clinically inept to help him but mostly because she was acutely aware of her own resistance to emotionally approach him; Gill admitted to feeling ashamed when she cannot grasp something, when understanding escapes her. A common thread in participants' narratives appeared to be the belief that when they experience themselves being inadequate and emotionally unavailable to clients, usually triggers shame in clinical work, especially since their own expectations of themselves are high. Amanda, and Julia commented on their fears of being exposed as imposters. For example Amanda stated :

'…the fear of being discovered as an imposter when you kind of sit there and you think, I really don't know what I am doing, I have no right to be here meddling in people's lives and somebody in the end is going to find out that actually it's the emperor's new clothes and I am nothing underneath…is all an illusion that we've created for ourselves and actually underneath there really is nothing…of course that would be very shaming to be discovered to be…a fraud.'

Amanda shared that her goal in therapy is thinking about clients and understanding them and it appears that when she experiences intense self-doubt about her abilities and motives, she becomes overwhelmed and emotionally destabilised to the extent

that her vulnerability affects her capacity to remain connected to other areas of herself which are more positive. Likewise, Julia and Linda shared their shame experiences in the context of *'…not knowing something…'.*

'…But probably really about not knowing something that I should know, I think is probably the big shame that comes up. Feeling like my supervisor will say 'You should have done this' or 'you should have', so yeah there is certainly an experience. I think this kind of refers to that Global Imposter Syndrome…' (Julia)

'…the thing of being found out. Of being put on the spot…a client mentioned a name of medication she was taking and I said 'which one?' I asked for clarification and she said 'what you don't know that one?'…in a very judgemental way and I felt some form of shame for not knowing…' (Linda)

Julia and Linda stated that shame usually emerges when they feel like they have failed or let down their clients. Julia appears to imply that even in a particular difficult situation she tends to question whether she would have been more successful had she done something different with the client, which in turn activates self-doubt and feelings of failure. Linda's experience shows that she often feels ashamed when she does not know something because of her need to appear knowledgeable in the presence of clients, and in particular, demanding, and critical clients. According to participants the countertransference of inadequacy and incompetence can elicit shame, which in turn can impair the therapist's ability to carry on with the work. Fearing the exposure of intellectual defects and clinical flaws was highlighted as a source of shame for therapists irrespective of whether it gets caused by one's own subjective countertransference or gets instigated in the context *of clients' attacks (objective countertransference).* As a conclusive remark I would like to note that my findings also highlighted that both clients and therapists appear to suffer painful shame when they experience actual or perceived rejection of their basic interpersonal need for connection and acceptance.

4.1c) Running away from it

This theme is concerned with the intrinsic impulse to protect the self against shame as participants share such experiences in their professional capacity during the therapeutic encounter. It also presents unhelpful ways of relieving shame, for example in the form of avoidance, and highlights the important concept of bearing the pain and

tolerating the intolerable. Many participants noted how easily shame is overlooked by both clients and therapists because *'…its unbearable to connect with the feeling…*' (Kim) and *'…as it is difficult to talk about shame without feeling exposed…*' (Linda). The findings indicate that being in a state of shame involves intense psychic pain and an anticipation of being judged by an unsympathetic other. Gavin stated that as a result *'…many clients are very scared to talk about what they are ashamed of…*'. This appeared to have been the case in his own experience of personal therapy:

'…*so before I actually disclose the thing that I'm ashamed of, I'm afraid of judgement and I'm afraid of being misunderstood. So part of it is the delicacy of is this person actually going to let me articulate what it is rather than misunderstand, misinterpret and sort of change it, sort of bastardise the phenomenon…*'. (Gavin)

As I write about this, what comes to mind is the fine balance between distance and intimacy, as Gavin highlights his need for both when he explores shame in personal therapy. The use of the word 'bastardise' captures Gavin's fears of risking to be misunderstood and judged, which unequivocally would intensify his shame which:

'*…is the sort of feeling that makes us want to hide, to disappear, to not been seen…because to be seen while we feel ashamed is unbearable…*'(Gavin).

There was consensus amongst participants that the intensity of shame is not just intolerable to patients but also to themselves; therefore, staying with it remains a challenge as it may feel intrusive on behalf of the clinician to stay with the feeling, as they worry, they may have induced it. This fear is echoed by Amanda:

'…its such a painful feeling…more difficult to talk about than anger or guilt…I don't think I use the word with clients that much…'.

To introduce the concept of shame in a session feels dangerous and risky to Amanda; she elaborated that she tends to rely on:

'…words like belittling, degrading, demeaning, denigrating…it seems to me that its easier to use those words which are kind of smaller… less dangerous…Because to be shamed I think is a terrible exposing experience isn't it? You are almost stripped naked and of course lots of people do associate shame with physical humiliation and exposure'.

Participants shared that 'staying with shame' and 'not hiding from it' typically involved feeling '*emotional pain'(Gavin)*, '*feeling devastated'(Gill)*, '*moved'(Kim),*

'humbled'(Linda), 'shattered' (Amanda), 'discomforted'(Julia) and 'vulnerable'(Jane). For example, Gill shared that in her work with a client who suffered trauma:

'…I felt utterly overwhelmed and panicky …and what usually comes up for me is that disturbing feeling of …almost of not being able to be with oneself…is devastating when I actually get a sense of the depth of her pain…' .

This fear of not managing the moment was also shared by other participants as they described a state of not feeling in control, where the moment cannot be managed, and the intense anxiety that follows it. Individual clinicians named specific aspects of clinical work to this particular fear, such as *'…not having enough time to contain the amount of despair…' (Charlotte), '…fear that I won't be able to follow and understand the patient…' (Kim), '…fear of re-traumatising and as a result causing more pain…' (Linda), '…intense fear that I will fail the patient and therefore disappointing him…' (Jane).* The data did not reveal a solution, an easy way out of such experiences, but there was consensus that one must allow oneself to be overwhelmed in order to be able to stay in the moment and with the client; this will be further explored when we address the Superordinate Theme 'Therapeutic Reactions to Shame' and specifically when we look at the subordinate theme 'Being emotionally available and transparent'.

To summarise, staying with shame is a challenging task as it contains elements of exposure, violation, and intrusion and inevitably it involves working with one's resistance as the self is trying to defend against the sudden feeling of being denuded and laid bare for all the world to see.

4.2 Superordinate Theme: Noticing Shame

This superordinate theme describes clinicians' experiences about becoming aware of shame in the therapeutic encounter. Participants stated that certain phenomena help them to detect shame in their clients and in themselves (Physiological Responses). The data showed that the majority of participants noted shame experiences amongst clients with physical illness (Shame and the sick body). All participants strongly conveyed that noticing shame is a challenging and complex task as often it is hard to recognise its signals because of 'The elusiveness of Shame'. What is interesting about this theme is that according to the narratives shame penetrates clinicians, clients, and the space between them.

Table 4.2a Types of shame experiences

Types of experience	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
I feel it in my body	√	√	√	√	√	√	√	√
Clients' Shame about illness	√	√		√	√		√	
Clients' shame during recovery	√	√		√	√		√	
Hard to pin down	√	√	√	√	√	√	√	√
Shame is complex	√	√	√	√	√	√	√	√
Hard to decipher	√	√	√	√	√	√	√	√

Table 4.2b Subordinate Themes Relating to Superordinate Theme 2 (Noticing Shame)

Subordinate Theme	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
4.2a)Physiological Responses	√	√	√	√	√	√	√	√
4.2b) Shame and the 'sick body'	√	√		√	√		√	
4.2c) The elusiveness of shame	√	√	√	√	√	√	√	√

4.2a) Physiological Responses

Participants stated that shame is a physically driven sensation as well as an emotional one and they described a common set of nonverbal and physiological cues that may signal underlying shame in clients and in themselves. In terms of noticing shame in themselves they shared the following:

'…I think about shame in a visceral sense…When I first say shame, I think feeling sick to my stomach because that is what happens to me. When it's powerful it can very quickly affect me physiologically…' (Jane)

Similarly, Amanda stated:

'…*there's a physical feeling that goes with it, it's usually kind of real heat that I feel and burn up whether its visible or not… it's almost like a galvanising feeling, it's not like a freezing. I've become very rigid, and all the energy goes to just holding it together and becoming very hard and rigid but not in a frozen way, it's not numbing it's a very conscious gritting the teeth and clenching the fists and curling the toes…'*

Charlotte shared:

'I think of it as a heaviness. I mean I know when there are things that I have in my own life felt ashamed of. I've had that sense of, I mean in some ways I hold it in a knot in my stomach, but I feel it here, heavily, I feel it here (pointing at her stomach). And for me it is very much a physical thing'.

Other participants stated *'…I feel it in my bones…'* (Kim), *'…in the pit of my belly…*' (Julia), *'…in my cheeks and my heart is racing...'* (Linda). What was striking about those statements was the realisation that although shame was described as a profoundly internal experience it was also viewed as uniquely transparent and easily witnessed by others as showed in their clinical observations below.

Julia shared that when we are confronted with shame:

'…we blush, we avert our eyes, we shift in our chair, we cannot control or conceal… …the reddening… of our face…' (Julia).

Likewise, Gill talked about a clinical example where the client:

'…would shut her eyes, partly it was a sort of concentration, she would spend a lot of the session with her eyes shut…it was so difficult to talk about what she was talking about so that not wanting to be seen…there was a lot of shame…'.

In addition to facial signs of shame the data highlighted the *'…avoidance of staying with here-and-now material…*' (Charlotte), *'…self-deprecating and self-blaming*

comments…' (Gavin) and *'…rigid posture…stuttering…I think she goes to a very alone place separate from me… (Kim) '…she disconnects and goes into a sort of isolated nothingness space…*' (Gill), as cues that may signal underlying experiences of shame in clients.

All participants suggested that when shame overtakes us is a moment of total exposure where sustained eye contact with others becomes intolerable. Gavin stated that he senses shame quite intuitively:

'…it's more something that I pick up on intuitively. And the signs of shame are when somebody withdraws or sort of speaks more quietly. And looks, there is that look of shame, a tone of shame, an atmosphere of shame. … I guess there's a sort of unspoken understanding that this is what shame feels like…'

The indicators for shame entering the therapeutic encounter according to the data can be physically observed or physically felt in the body of the clinician and the client; they can also be observed by a sudden relational disconnection, such as avoidance of eye-contact, or it can be intuitively sensed or picked upon, often described by participants as sensing *'…an atmosphere or feeling in the room…' (Gavin) or '…despair and suffering…' (Gill).*

4.2b) Shame and the 'sick body'

It was argued that clients often suffer excruciating shame about serious physical illness because in many cases illness, and especially following a cancer diagnosis, is not only about the body malfunctioning but also about the ill person's character: what did one do to cause the illness and what is one not doing to cure it? A common thread in the data was that clients often believe that they are somehow at fault for getting ill and for continuing to be ill. For example, Jane shared that a client with severe emphysema:

'…was apologising about the state of their body and the fact that s/he had to walk slowly…'.

Similarly, Kim shared:

'...I suppose a lot of the time shame comes into people's ideas about why they got cancer…so whether they are… beliefs about being punished or beliefs about not looking after themselves well enough physically, or a sense that they have done something to contribute to this diagnosis…yes shame is often in the room…'

This was also echoed by Linda and by Jane:

'…and the shame of cancer, the shame of being ill in the eyes of the others…the fear of something being revealed and with cancer in particular I have been thinking a lot about the hair loss…that's when cancer becomes real, visible in the eyes of others…so there is shame there…' (Linda)

'…The shame of going back to work for someone who is going back to their profession after having been off on sick leave. And the shame of being emotional and not being able to manage often emotionally or sometimes through fatigue…' (Jane)

Amanda noted:

'…And then I think there's…shame…which is associated with illness...the shame of being a patient, the shame that's associated with the illness of somehow all the things that go particularly with an illness like cancer. So all of the things that are associated in a very primitive way really like contamination, like the sense of being unclean, of being somehow contaminated. All of those kinds of images of the cancer eating away at you.'

Amanda proposed that her cancer patients often express a form of existential shame *'…of somehow being mortal…almost that you were got at…'. She argued that this usually is accompanied by self-blaming beliefs along with intense envy and anger as the inevitable question of '…why me...' enters the consulting room.*

'…they feel shame that they might have thoughts or feelings about themselves and about others in relation to the illness, how come I got it and they haven't? And they feel ashamed again of their badness in being so envious, I think that comes up a lot and it's hard sometimes to own these feelings... Feeling angry towards people…'(Amanda)

The above clinical examples emphasise clients' tendency to self-blame and their anxieties about how others notice their difference and what they think of them. The data also showed that illness can make our bodies look different and change the way we function in the world and looking and acting differently can be a shame trigger. This was also discussed in the context of post-treatment life-long physiological changes; Jane shared the following:

'… I've got a few people in mind who have major physical scars, I had a head and neck (cancer) patient with huge change that he's aware won't be unchanged or

resolved or reversed. A woman whose breasts have been removed and you wouldn't know from observing but you know from her stories that it's causing a lot of distress and shame. People whose ability to cope with a medical procedure means a huge amount of shame if they can or can't do it that day, tolerating needles and tolerating examinations, especially intimate examinations…'

Likewise, Amanda stated:

'…Yeah and all those difficult experiences that people have both as a patient subjecting themselves to physical examination and then post illness and having to live with altered body or changed body image and people being ashamed of how they've been left really, scarred or changed or altered in some way…'

Charlotte also described a client's difficulty to come to terms with life changing surgical intervention:

'…But this particular patient, he had rectal cancer and he now has a stoma…there is a much bigger of issue of shame around is his stoma which he sees as a thing of absolute disgust… He talks about people being disgusted by him, but he is so disgusted by himself… and there is a huge degree of self-acceptance that needs to be done…'

It was acknowledged that post treatment emotional and physical *'…scars…'* can cause intense shame which can dramatically affect the cancer patient as they might be ever mindful of how they are presenting themselves to others. As a result:

'…I suppose there's when people come in and they don't feel like punching the air and saying either 'I've got the all-clear' or 'My treatment has ended and everyone thinks I should be happy and I don't, I feel awful'…And I think shame has a big link with that sense of responsibility that I should feel like that, why can't I?...I see it a lot in the couples work. You know I find that thing of when people get to a bit where things plateau a bit, after the end of treatment, and they can't be that grateful perfect partner that they feel they ought to be because their partner has given them so much and done so much…that kind of feeling of having failed them…' (Charlotte)

To conclude, participants shared the view that patients try hard to hide the differences that mark them upon diagnosis and after end of treatment. There was consensus that shame related to physical illness usually causes social withdrawal, inactivity and isolation making it more difficult for patients to receive the emotional and, in some cases, the medical support that they need. What is noticeably missing from participants accounts are their reflections about their own experiences of physical illness and this will be thought about in the Discussion section.

4.2c) The elusiveness of shame

This theme captures participants reflections about their observations regarding the difficulties involved in detecting shame in clinical work. A close look at the data showed that participants viewed shame as *'…a powerful part of the work that I think we do as therapists...*' (Jane) and experiences of shame were described as a much more powerful and pervasive phenomenon than most of us realise. Participants highlighted that shame:

'*It potentially is one of the most horrible emotions I imagine and a complex one*' *(Jane)* and one that is often experienced *'…as a heaviness...*' (Charlotte).

Jane stated that individual differences arise in the emotional regulation strategies used to cope with shame and that makes it hard to quantify it:

'…I think it's important …to acknowledge it's such a personal experience, I don't think we can kind of quantify really….there is something elusive about shame, it's difficult to come up with a clear distinct definition about it because it means so many different things to different people…' (Jane).

Similarly, Gavin commented: *'…it feels like something that's very difficult, it can feel quite intangible and hard to get a sense of...'* Similar statements were found in most transcripts and the use of specific language like '*elusive'* (Jane), *'unspoken'* (Kim), *'alienating'* (Linda),*'heaviness'* (Charlotte), *'shame is large'* (Gill), '*difficult'* (Amanda) made me realise that participants viewed shame as an obscure phenomenon that it is difficult to describe.

Participants also argued that the shared pain of shame between clients and therapists can often lead to a collusion to avoid acknowledging or identifying shame. In our rush to help:

'…I have tried to play down clients' shame by offering reassurance in order to make them feel better in the moment…I realised that I had unintentionally invalidated my client…'. (Jane)

'…the client has to feel met in some way in the shame and not left in it. And if that doesn't happen then I think therapeutically you're in a difficult ground of perhaps falling apart a bit…' (Gill).

There was consensus that shame is difficult to identify in clinical work:

… 'it can feel quite intangible and hard to get a sense of…shame to me feels like it's more of an insidious emotion that can go undetected…' (Kim),

'…you know it wears you out. Eats you up little by little without you actually realising it…and it's not really openly talked about…its hidden, it's just an underlying experience that sometimes you need to bring it up and name it…' (Linda).

There was agreement amongst participants that shame is an inner torment that remains undetected because it is *'…extremely difficult to be with, like a monster…'* (Gill). The use of powerful language that created the vivid image of an '*insidious' (Kim) 'monster' (Gill)* '*that eats you up little by little' (Linda)* emphasised the underlying intense levels of vulnerability involved in shame work, which signified the need for caution and sensitivity. Participants were remarkably consistent in their view of '*…how invisible [shame] might be in how we might not know that that's what's operating*…' (Julia). Also, what was highlighted was that:

'…sometimes its unspoken and you are aware that it's there but its sometimes difficult to approach as part of the work when people really don't want to go there. I mean I feel the defenses that are so strong sometimes…' (Charlotte).

The two statements together underline the untenable position of having to work through one's defenses, clients' and/or therapists', whilst confronted with the knowledge that such undertaking can potentially be a disconcerting experience for everyone involved. This will be further discussed under the Superordinate Theme Therapeutic Reactions to Shame. An additional barrier in detecting shame, according to the data, is its clinical resemblance to guilt as both mental states generate painful and negative self-representations and frequently are simultaneously present. Participants argued that the focus of attention in shame is quite different:

'So shame is a feeling of being bad. Guilt is also a feeling of being bad, but guilt is where you accept responsibility for what you've done, so the badness comes from having done something and believing that to have been a bad thing' (Amanda).

'And I guess it is linked with guilt but shame to me feels like it's …Yeah a strong sense that there's something wrong with you or something wrong with what you're feeling or something wrong with how you are' (Kim) and similarly, '…*I think shame has an element of self-loathing as well. Which is different to guilt'* (Linda).

So, although shame and guilt share similarities participants viewed shame as an attack towards one's sense of self, where the entire self is in contempt and defected. This theme has highlighted some of the challenges and the complexities involved in identifying shame dynamics because of its elusive nature. The data showed that even though shame is central in clinical practice it often remains invisible because clinicians

often are not aware that it is operating and when they do, they often struggle to find the words to describe the phenomenon.

4.3 Therapeutic Reactions to Shame

This superordinate theme captures the participants' descriptions of what follows the detection of shame dynamics in the therapeutic encounter. Participants shared reflections about the impact of shame on their clinical stance and on the therapeutic relationship. They also talked about their interventions and they highlighted certain conditions, which according to the data must be in place, before the exploration of shame can safely go on. Particular attention was given on pacing, managing strong countertransferential feelings, self-awareness, and self-care. The following table (Table 4.3a) gives a snapshot of the most prevalent experiences shared within this domain. See Table 4.3b for the subordinate themes and the prevalence of these across participants.

Table 4.3a Types of shame experiences

Types of experience	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
Follow clients' cues and pace	√	√	√	√	√	√	√	√
Establishing a safe space	√	√	√	√	√	√	√	√
Managing my anxiety and fears	√	√	√	√	√	√	√	√
Awareness of my own shame triggers	√	√	√	√	√	√	√	√
Recognizing my need for self-care	√	√	√	√	√	√	√	√
Access to containing supervision	√	√	√	√	√	√	√	√
Shame is a neglected topic in training	√	√		√			√	√
Feeling anxious in the interview		√		√			√	√

Table 4.3b Subordinate Themes Relating to Superordinate Theme 3 (Therapeutic Reactions to Shame)

Subordinate Theme	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
4.3a) Striking a strong alliance	√	√	√	√	√	√	√	√
4.3b) Holding your own	√	√	√	√	√		√	√
4.3c) Being emotionally available and transparent	√	√	√	√	√	√	√	√
4.3d) Self Care and supportive systems	√	√	√	√	√	√	√	√

4.3a) Striking a strong alliance

It was suggested that striking a strong alliance, a deep and meaningful relationship with clients, where *'…the patient seeing you as a non-threatening other in order for that [shame work] to take place…'* (Jane), is one of the prerequisites for safe and effective clinical work. In the context of discussing the importance of establishing a strong therapeutic bond, participants also named length of therapy, frequency of sessions and type of therapy as the main ingredients of a therapeutic frame that can encourage or prohibit a therapist's clinical decision in how to proceed when issues of shame arise. The data showed that contextual team-related issues affect clinical decisions about shame work. It has been argued that even the most mature clinicians may struggle to effectively work with shame if the frame, therapeutic and/or contextual, imposes certain limitations. For example, Gavin said that it is often not possible to strike a strong bond in short term work and he shares his experience of personal therapy:

'…I've known [my therapist] for a long time. So, we've got a very strong relationship so it's much, much easier for me to talk about things that I am ashamed about…'.

Likewise, Linda stated:

'…And I wonder in short term therapy how much can we do about that? [working with shame] …how much can we work with that in such a short period of time...'

It has also been emphasised that certain expectations of the wider contextual frame, for example service business demands and the subsequent pressures for delivering on '…*numbers*…' (Kim), can compromise the quality and depth of their work as it affects clinicians' efforts to *'…actually establish an alive relationship where we could affect and influence each other…'* (Gavin). All participants asserted that shame can only be addressed within a relational therapeutic frame where safety and containment are key ingredients. Hence the need for relational process-based therapies and not the:

'…the kind of one size fits all approaches that unfortunately get pushed more and more by economists…' (Kim) because exploring shame *'…has to be idiosyncratic and individual and it's something that gets created between a therapist and a client that can't be replicated or that goes beyond something concrete…'* (Amanda).

Participants shared the view that a first task in treatment is to help clients to access and acknowledge their shame and they were unanimous in emphasising the importance of developing a supportive, validating, empathic and affectively attuned relationship. Gavin argued that he:

'…follows the client's lead so the client does not become overwhelmed but instead feels empowered by recognising that he has a choice as to when and how much he wants to tell me…'.

Normalising patients' experiences was viewed as an essential part of the work:

'…because empathising with her discomfort and normalising her need to hide…kind of helped her to reclaim a sense of dignity about herself…' (Charlotte).

Similarly, Kim said that she tries to normalise clients' experiences when she talks about :

'…expectations and social norms as being one way of creating how people should be and being manmade and I suppose that's one of the ways that I try to address shame in externalising the ideas so that they are not so much within people…'.

A central point of the relevant statements has been for therapists to be sensitive to patients' shame and to not aggravate it. Participants emphasised that although their recommended interventions apply equally to other presenting issues, when shame is in the frame, these interventions would need to be used in a more delicate way. Gill captures this when she stated that patients may end up:

'…feeling exposed but being met in that and tolerated. And more than tolerated, somehow affirmed even in one's most base feeling. The feeling that one is not proud of…and still feeling the other person can accept that…'.

Working on connectedness and relationality were seen as being paramount to building relationships of trust and co-creating narratives in a safe therapeutic setting as clients need to be able to trust that '…*we will understand them from inside their story…*' (Gavin), not judge or criticize them from the outside. Jane said that what she tends to do is:

'…just slow that whole process down and get back to being connected as human beings…' as this often creates a safe and collaborative atmosphere in therapy and *'…I feel like I want them to know that if they are sharing it [issues of shame] with me I can help them hold it…and need to show them…that they can rely on me despite what comes out of their mouth and what comes out in therapy…'*.

Participants also highlighted the need for *'…carefully choosing the timing of addressing underlying feelings of shame and always follow the client's pace…*' (Amanda) in order to avoid ruptures by unintentionally intensifying a client's impulse to retreat and close down emotionally. Kim pointed out that with:

'…some people…in the room it can feel as though it is not possible to have that kind of conversation…and then in future sessions it's been possible to come back to it…'.

The data showed that often therapists feel anxious when they are *'…trying to work out how much to push and how much to stay with the level that the patient is at…*' (Kim). Assisting clients to verbalise shame-inducing events and associated experiences according to the data can help reduce the pain of shame as therapists can help clients come to realise that most flaws, setbacks, and transgressions do not warrant global feelings of worthlessness or shame. Gavin brings this to life in the following statement:

'…once they get to the point of disclosing their shame it's just a nice moment in therapy because by not judging them and validating their experiences it's just a very tangible powerful [moment] in therapy…'

There was consensus amongst practitioners that often clients feel totalised by their shame and that *'…there is a huge degree of self-acceptance that needs to be done…*' (Charlotte) within *'…a compassionate environment…*' (Julia) before actual shame work emerges.

4.3b) Holding your own

Participants emphasised that a therapist's first task is to attempt to overcome their own hesitation or embarrassment to speak about shame in order to be able to work with the phenomenon in the clinical encounter. This was nicely captured by Kim:

'…is about experience and experiencing myself feeling uncomfortable in the room or noticing the kind of process that's going on for me and that in mind trying not to act on my own shame in I guess trying to get closer to the things that are difficult rather than moving away from it…'.

However, the data showed that this is often an impossible job because shame reduces us each in stature, size, and self-esteem, such that we want to:

'…hide, needing to hide… [and]…we also possibly want to remove ourselves from a situation to avoid those things coming…and then there's something about anger that comes up is when you stay with it and say "Let's talk about it" often it turns to anger very quickly…' (Jane).

Jane not only emphasised the devastating impact that shame can have on one's interpersonal ties, but she also highlights that she would go to great extremes to overcome those shortcomings that lead to shame, and she indicates that if we cannot hide, we attempt to change the very attributes that have caused this distress. Charlotte talked about clinical dilemmas and how her decision to not extend therapy with a particular patient with whom she has had a challenging time made her question her motives:

'…I've chosen not to do that [extend] but with that comes a huge, what have I done?...and then I feel like a fraud in those moments…'.

Charlotte shared that she often felt overwhelmed by the client's story as it was similar to her own and she had become aware that she felt ashamed for over identifying with the client's material. Charlotte wanted to relay:

'…that is so easy you know…it happens all the time in shame work I think…well at least in my experience…difficult to decipher the personal from the professional…'.

Similarly, Julia stated that often she feels lost when in the presence of shame '…*I feel like, oh gosh what am I doing here? Where am I going? And sometimes that brings up the feelings of shame*…' when she opts for clinical decisions that oppose clients' demands and expectations. There was agreement amongst participants that if therapists want to do relational work with clients around shame they need to have faced and worked through their own shame. Knowing one's shame was viewed as a prerequisite because relating intimately with a shame-prone person often makes therapists vulnerable to powerful states of being ashamed, of shaming, and of feeling contemptuous themselves. Kim captures this notion nicely in the following segment:

'*…I'm always trying to keep in mind…how insidious shame can be and how in working relationally that actually I'm also in that system and in that context with the family or the client and so I can be left with those feelings too of kind of not going near something or it being difficult to open up in a way that feels safe or safe enough*…'

Likewise, Julia emphasised '…*the importance for us as therapists for having processed and continuing to work on processing our own shame…'* (Julia). It was also argued that it is vital for therapists to be aware of their *'…blind spots...*' (Gavin) as shame often involves retaliation. Linda shared that after experiencing a shaming attack from a client:

'…I banished the session in a way that I look more assertive instead of being me or more genuine, probably just to prove myself and maybe out of anger…'

Similarly, Amanda shared that shame has stopped her being emotionally available to her clients:

'…I think it contributes to the incongruence because it makes me harder, less receptive because I am drawing in…So by that time I have lost any kind of empathy…'.

Jane argued that during the early stages of her career she often struggled to regulate her own need to *'…fix…'* shame prone clients and she used to:

'…want to do more, which sounds ridiculous now. So now it's having confidence that actually being steady is more important…'.

What gets underlined by the findings is that therapists need to monitor their own natural tendency to collude with clients as they are vulnerable to countertransference enactments. Such practices were already discussed in the context of countertransferential experiences of inadequacy and failure under the theme Being-as-you-are is not acceptable (Superordinate theme: The Impact of Shame on the Self). However, what gets highlighted here is that clients with strong shame issues may powerfully shame their therapists. Therapists can be attacked for *'…not understanding, for not being competent and helpful...' (Charlotte), or '…for not agreeing to refer their children for surgical intervention…' (Kim).* The ability to contain and tolerate these disturbing states of mind without retaliation or retreat creates an environment of safety and invites patients to explore their own ashamed selves.

However, this is a hard task to achieve because:

'…trying to take up a position that's not polarised feels like that is very hard to sustain when there are these powerful attacks...,' (Kim).

In the context of discussing the importance of *'…keeping it together…'* in therapeutic work, Kim, Amanda, Linda and Julia spoke about feelings of inadequacy that came up for them during the interview. Julia appeared anxious about her performance during the initial stages of her interview *'…I hope that I am giving you what you need for your research…'* and I wondered whether her keenness to appear a competent contributor to my eyes was a cue to her anxiety about not meeting my expectations and subsequent shame. I sensitively approached this with her, and she admitted that: *'…So even in this interview there's a part of me that shame might be coming up…' and as we explored her '…default position of wanting to please…'* she appeared less

tense and more engaging; at the end of the interview, she revealed feeling settled in herself and happy that she had volunteered to the study. Similarly, Kim shared:

'…Yeah, I think talking about this topic feels personal and so yeah, I felt a bit nervous about coming today but having the conversation with you has felt good and I am glad that I have done it, so it's good…'

Amanda revealed feeling anxious about participating and by the end of the interview she came to realise:

'…So, I think as I'm talking to you what's coming up for me is about how little I've worked on my own shame really …'

Although she admitted feeling slightly shaken by that insight, she also shared her relief for having reached it, as she felt determined and keen to further work on her shame. Linda shared that:

'…I think that it's very difficult to talk about shame without feeling exposed because by accepting your shame you have to accept that you are at fault in a way. So, I think it's a good exercise to do this and learn something about the way that this is heard. Like by you and your empathy…'

Linda, Kim, Amanda and Julia revealed that talking about inefficiency, inadequacy, inferiority and clinical failings evoked their vulnerability and at times heightened their anxiety about their shame being roused. Additional support was offered to all of them, for example, follow-up debriefing sessions, but they declined as they reported feeling settled in themselves by the end of their interview.

4.3c) Being emotionally available and transparent

The data showed that without awareness of the countertransference, it is easy to see how shame can escalate and both therapist and client can so easily feel misunderstood and threatened by rejection and how, regretfully, the therapy can end prematurely. Participants pointed out that therapists must employ openness and transparency not only in their interactions with patients but also in regard to their own processes. Jane shared that:

'…if I am feeling something quite strongly, I mean obviously depending on what it is but quite often I will find a way of expressing that, If I feel it's all getting a bit much, I will tune into that and I will say something…'.

Likewise, Gavin stated that he tries to:

'…enhance clients' mentalising by sharing what I hold in mind of their subjective experience…I think that being transparent also enhances relational validation…'.

There was a shared view that the aim of therapy is for clients to come to know their own minds in their own emotional and relational selves with a clearer sense of agency, acceptance, and ownership. For this to be achieved therapists should abstain from:

'…imposing our own values and must try to balance issues of power and refuse the role of the expert…instead we must affirm the clients' strengths…'. (Amanda)

Participants argued that therapists must maintain a stance of:

'…empathic understanding, its I guess the quality of being with, that the person being able to feel you are with them or attempting to feel your way in them. To be where they are...' (Gill).

On a similar tone Julia stated that in her clinical work she takes:

'…a stand of empathic understanding because I know that the more shamed my clients are the less they will be helped by advice or strategies and the more they will need to feel empathically understood…'.

Charlotte argued that often experiences shame when clients leave the room in a distressing state:

'…one of those things that just really tears at me that putting someone back out in the world unprepared for being back out in the world...'.

Participants shared the view that there is shame in being the one to cause discomfort in our patients by asking them to tell us about painful or traumatic events and that there is shame in the realisation that our authority as therapist risks inflicting hurt that we may or may not recognise. Gill points this out when she said:

'…. we had silences in the session where I felt we were together in the room but there was one point she said to me she felt so alone…'.

The lack of recognition that the intervention was failing had an impact on therapy, the patient missed two sessions, and the therapist said that her countertransferential

reaction lingered past the event and she experienced persisting feelings of shame and recurring thoughts about the event. The data also showed that as clients come to know that therapists are accepting of them and of whatever they feel in any moment, defensive rigidities begin to soften, and intimacy and closeness become stronger. What was emphasised was that therapists must be capable to tolerate, accept, and hold clients' shame in order to provide them with an opportunity to constructively manage and resolve this most unpleasant emotion. However, maintaining openness and transparency at the face of shame is at times an impossible task and such lapses can cause intense shame that usually impairs their sense of clinical integrity and identity. For example, Amanda stated that she has noticed that when her clinical stance gets compromised:

'…I am working really hard to be accepting and non-judgemental and I don't feel like that at all…and I do feel a great deal of shame at my incongruence I think…incongruence is the worst ***thing*** *that you can do in a way, to be not genuine…it's like being a coward…and that's a shameful thing, cowardice is shameful…*'.

Participants commented that usually their attempts to restore their sense of clinical integrity often derails their clinical stance and disrupts relationality causing them to behave in uncharacteristic ways. For example, Linda stated that she becomes:

'…more defensive. In a way that I need to prove something else to compensate my failure…'.

Similarly, Julia shared that she tends to:

'…overcompensate by giving them more psycho-education handouts so they've got something to take away…'.

Charlotte notes that:

'…shame is so powerful…I do become quite anxious about noticing the time. Flagging up the time. Maybe trying to manage the conversation so we can turn the dial down…and then I feel like a fraud in those moments…'.

Clinical integrity also gets threatened during moments of unsafe exposure as captured by Amanda when she said:

'…I am not someone who never self-discloses…but once or twice I may have disclosed something…that was too exposing…and for me shame is associated with unsafe exposure and I have just felt really uncomfortable about having shared that thinking no this wasn't safe for me…'.

The data also showed that internal fears that we are not being helpful, *'…did I do that quite right? Did I so something wrong here? Did I cause the client to not come back...'* (Gill), that we have caused harm to our patients, '… *I have often wondered if that person will come back because they might be left with such strong feelings…*'(Kim), shake our professional honour, our integrity, as the most trustworthy, most sacred part of the professional self feels violated and soiled. Participants argued that the shame associated in those moments can be debilitating and haunting. Such experiences are often associated with fears of badmouthing from patients. For example, Amanda said that often she thinks:

'…oh my goodness that person is going to go away and they are going to make *a complaint...*'

Such anxieties, in most cases, make therapists feel threatened by the perceived damage to their reputations, and the subsequent intense shame of it, and inevitably their therapeutic stance becomes compromised because:

'…then I try to manage the damage, a bit like damage control, and yes, it is because I want to prevent the client from dropping out but to be honest I am actually trying to protect myself from an official complaint and then I become too accommodating, and at times I have colluded with clients in order to appease them…' (Julia).

There was consensus that shame prone clients need therapists who are willing to become deeply engaged with them and for this to be achieved therapists must possess certain levels of insight, to be aspired to connectedness and intersubjectivity, and to nurture healthy doses of curiosity and openness about their clients' and their own mental states. To summarise, participants argued that shame can be instigated within the therapist during moments when they get inundated with strong thoughts and feelings that they are failing to maintain professional standards with a direct impact on therapy outcomes.

4.3d) Self Care – supervision and supportive systems

Here participants pay attention to the person of the therapist and they identify self-awareness, self-care, and supportive systems as the basic necessary ingredients for engaging in clinical work around shame. The analysis unveiled the following shared underlying view: a therapist's capacity to embrace their vulnerability usually leads to clinical maturity, which in turn is linked to effectively working with shame. Self-awareness was discussed in terms of personal insight and personal care where therapists were encouraged to remain alert to issues of intersubjectivity and to pay attention on how they impact and get impacted by the dynamics of shame work because:

'…therapists can't do therapy without really thinking about ourselves and what we bring to that… we can all become contaminated by shame and I definitely see that in the work where it feels sometimes as though its quite paralysing for everybody in a room to talk about it…trying not to act on my own shame in I guess trying to get closer to the things that are difficult rather than moving away from it…' (Kim).

I am noting the use of powerful language like 'contamination' and 'paralysing' and 'moving away' that capture Kim's experiences of shame in the therapy hour. Shame is viewed as a form of sickness and therapists are not immune to it; such experiences cause immense levels of vulnerability and according to the data part of a therapist's job is to accept *'…being vulnerable, you've got to be vulnerable in the space for it to be human…'* (Jane). Therefore, it is not surprising that participants talked about the essential need for self-care within the context of shame work as it involves:

'…meet[ing] the client but you obviously then need to hold yourself afterwards, and how does one do that?...' (Gill).

Jane said that the answer to this question is:

'…incredibly good supervision…in order to practice in this way you need to have supervision where you can let it all out…'.

Kim adds another layer to this when she states that:

'…even talking about it in supervision or with peers creates a feeling of shame often…so that's part of the beast of shame…(pause)…'

Overall, most participants shared the view that good supervision not only assists them to become aware of their blind spots but also helps them to conceptualise how relationality gets interrupted when tackling their issues of shame:

'…and really work out where your stuff comes in that might interrupt that relational process…(Julia).

Similarly, Jane shared:

'…it goes without saying but having incredibly good supervision and in order to practice in this way you need to have supervision where you can let it all out. And really experience what it is to share shame yourself and for it to be safe. And really work out where your stuff comes in that might interrupt that relational process. And remain curious, you cannot do that if you are watching your own back and all of that. So think that good clinical supervision is very important…'

The data also showed that as clients can struggle with revealing weaknesses to a therapist, so too can supervisees be challenged to do the same with their supervisors. Participants shared that this usually is related to their fears of disapproval. For example, Amanda stated:

'…I don't know that I bring the shame to supervision, I bring the incongruence and the challenge of engaging with the client rather than my sense of shame…'.

Amanda appeared puzzled by this insight and with prompting she came to realise that partly she did not feel that the supervisor was attentive enough to issues of shame. This sentiment, albeit covertly, was shared by most participants as the data underlined that working with shame in the therapeutic interaction involves:

'…the importance of us as therapists for having processed and continuing to work on processing our own shame…' (Kim).

The need for supportive systems was also noted when participants talked about the significance of peer supervision and feeling safe amongst colleagues. For example, Jane stated*:*

'…Feeling safe in an environment allows healthy curiosity to emerge and that enhances therapeutic effectiveness. Working in an environment where I'm far more able to enjoy being curious about the models I'm using, about the work I'm doing and ultimately about the patient…'

Similarly, Amanda argued the importance of:

'…working amongst colleagues who share same values…a culture and a team where people do reveal of the self in a way that's held very safely by others. So its who is in your team? How is it led? What do we model? What do we care about as a team, what are our values as a team? And the safety to be all of yourself in that way…'.

Kim shared her story of being part of a system that she experienced as unsupportive, punitive, and shaming:

'…I worked in that service because I really believe in supporting [clients]…and parents would tell me on many occasions that I was discriminating against their child by not referring them on… telling you that you are a bigot…that was shaming…and within the service there's a sense of from colleagues as well of kind of grouping us "you gay clinicians, you have an agenda in working here…'

Kim stated that unsurprisingly that service was plagued with records of high levels of sickness and high turnover of staff. The data also showed that therapists' shame can also result from comparing oneself with colleagues as described by Julia:

'…I often feel I am not helping this person; I am not making a difference for this person and that brings up experiences of shame. Maybe they'd better if they saw someone else, that kind of experience of shame…'.

It has also been argued that shame can result from competing with fellow trainees during professional training. The lack of attention to shame processes in professional training was highlighted by several participants. For example, Jane shared:

'…the competitive environment in my training evoked so much shame…I don't know that we talked about it enough in our training…yet its fundamental to enabling ourselves to seek help…'.

Likewise, Linda stated:

'…*And it can be quite shaming, the training itself. This is my assumption it's like we're supposed to be super humans. Yeah, I mean it's not a surprise that I got in touch with that shame during the training because I felt like I was put on the spot…*'.

Participants argued that shame is an unnamed part of professional trainings where academic achievement and excellence becomes the core aim for students and where academic failures magnify one's exposure as unfit to become a therapist. This was nicely captured by Linda when she recalled an event from her training days where she felt singled out by fellow trainees for being silent during group reflections:

'… I remember a very shaming moment in the first year… there were this kind of really dominant people talking openly about the things and issues and problems …and then at some point these people really started pointing at us like those of us who were more withdrawn and quiet. And I started crying, I felt really like yeah put on the spot and ashamed and I hated it, it was so bad…'.

To summarise, the findings suggest that most participants felt pressure to adhere to the image of the 'super-human' therapist, and as a result they reported feeling compromised to discuss shaming issues in supervision . Moreover, participants shared their experiences of shame during training, and they highlighted that training organisations rarely promote an open and honest dialogue about shame. Participants acknowledged that to work effectively with shame trainees need to be encouraged to embrace their own shame issues inside and outside the consulting room.

4.4 Shame and Issues of Power

This superordinate Theme captures my participants observations about shame and issues of power. Two subordinate themes were identified 4.4a) Power dynamics in the therapeutic interaction and 4.4b) Culture and Shame. Table 4.4a gives a snapshot of the most prevalent experiences shared within this domain. See Table 4.4b for the subordinate themes and the prevalence of these across participants.

Table 4.4a): Types of shame experiences

Types of experience	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
Seeking help can be shameful	√		√	√		√	√	√
Therapy can be shaming	√		√	√		√	√	
Shame navigates our morals/societal regulator		√	√	√			√	
Shame and cultural influences		√	√	√	√		√	

Table 4.4b) : Subordinate Themes Relating to Superordinate Theme 4 (Shame and Issues of Power)

Subordinate Theme	Jane	Kim	Gavin	Linda	Charlotte	Gill	Amanda	Julia
4.4a) Power dynamics in the therapeutic interaction	√		√	√		√	√	√
4.4b) Culture and Shame		√	√	√	√		√	

4.4a) Power dynamics in the therapeutic interaction

Participants shared their reflections about the inherent power imbalance in the therapeutic relationship and shame. Therapists highlighted the notion that seeking help can be a shaming experience and shared the sentiment that:

'…therapy itself can be a shameful experience due to the stigma associated with mental health issues…' (Linda),

And that patients often view themselves *'…as deficient and in need of fixing…*' (Gavin) and as a result:

'…[they] believe that by coming to therapy, the people around them will see them as weak and flawed…' (Julia).

Participants highlighted that self-inflicted stigma and public stigma about seeking help for mental health issues *'…might prevent them (clients) from even accessing support or help…*' (Jane). There was agreement that a client's determination and readiness to allow a therapist to help them *'……I think it depends on their history of help seeking…*' (Jane). The data showed that is important that the therapist establishes a secure attachment with the client and for that to be achieved they need to come across as a reliable person that can be confided in. In previous superordinate themes, for example The Impact of Shame on the Self and Therapeutic Reactions to Shame, we looked at intrapersonal and interpersonal difficulties entailed in shame work as outlined by

participants, here we will mainly examine what was noted about shame imposed by the therapeutic process. It was proposed that in many ways shame lies at the heart of the psychotherapeutic process as therapists:

'…encourage clients to reach a deeper psychological understanding about who are they really and what they are made of…' (Gill).

Consequently, the nature of therapy can evoke shame and shameful experiences because we encourage clients: *'…to discuss issues that make them feel the most uncomfortable...*' (Amanda). There was consensus amongst participants that in order to establish a relationship of trust, where clients feel safe to come to know their own minds in their own emotional and relational selves with a clearer sense of agency and acceptance, therapists should abstain from:

'…imposing our own values and must try to balance issues of power and refuse the role of the expert…instead we must affirm the clients' strengths…'. (Amanda)

These are often issues that clients may feel unable to speak with anyone else about and it was noted that as therapists we facilitate a private, confidential, one-to-one relationship, which protects our clients from potential humiliation if their shame were made public. However, although therapists encourage people to strive for openness at the same time they strive to maintain:

'…certain boundaries and we try to conceal our own shame about our own shortcomings…and…how they [patients] feel being with someone who appears to have their shit together when they don't…(Jane).

Participants highlighted that the therapeutic process itself can be shame inducing as the power imbalance between therapist and client gets exacerbated by the restricted social and personal cues offered by the former. To summarise, what has been argued in this section is that seeking therapy and therapy itself can be a source of shame for clients.

4.4b) Culture and Shame

Participants also argued that shame significantly influences how people live their daily lives when it comes to making ethical decisions. For example, Gavin argued that:

'…shame is mediating, it sort of teaches us not to amorally just go around and hurting people… …so I've internalised external world, so I've said because again that's the connection between shame and power, if there was nobody else in the world, there wouldn't be anybody else to wield the power over so where's the shame? In the absence of there being an actual sort of jury or audience or ethics panel in front of me, I integrated that into my I guess perception at the time and what would an ethics panel say here...'

Similarly, Linda shared that:

'…there's a moral aspect I guess of shame, which I guess has to do with your values…'.

Participants were in agreement that shame is instrumental in the development of conscience because by alerting us to misconduct or wrongdoing it motivates necessary self-correction. Gavin expands further on this point when he shared:

'…a really cultural example to hand…in Harvey Weinstein…now he will only be known for opening the door to actress in bathrobes and things…I was about to say rightly should be ashamed of. And that is a sort of cultural judgement…'.

Gavin highlights that shame navigates our morals, it helps to distinguish what is culturally and societally viewed as right from wrong implying that Weinstein's capacity, or lack of, to experience shame for his actions may have important social benefits. Kim stated that shame is almost always associated with:

'…societal ideas about how you should be…that then gets into our internal world I think…'.

This sentiment was shared by others and was mainly discussed in the context of gender, language, religion, and intergenerational transmissions of shame. For example, Linda shared that:

'…my mind leans towards thinking about gender and shame and…about masculinity and I see that in a lot of my work…men feel as though they are not meeting expectations if they have any emotion, show any vulnerability and that causes so many problems…'.

Kim argued that equally women are often subjected to ideas about femininity:

'…ideas about how women should look, how they should be, how they should be taking care of others and not themselves…so it's very linked with societal ideas about how you should be and family ideas about how you should be. Then get into our internal world I think…'

This was also echoed by Linda: *'…In (name of her country of origin) it's really shaming for women in particular…*'. Linda shared that in her experience anxiety about shame creates societal systems that value strength over vulnerability, encouraging men specially to embrace a rigid self-ideal of independence and invulnerability and women to embrace humility and submissiveness. Linda also noted that in her native language:

'…we use the same word as for embarrassment, but it means something so different…I don't know what came first to be honest. The experience of shame? Or the word shame? But I found them together in a different language, in a different country, in a different culture…I don't know whether I was carrying shame before and I was not aware of it, probably I did, yeah…Its almost castrating if that makes sense. It is such a shaming culture for women but then in a way its almost like we're not even allowed by language to experience that shame…we are made to feel ashamed but there's no way to communicate that, other than embodied or yeah…'

Linda's experience highlights that in the everyday life of different cultures the word shame potentially describes a range of affective phenomena. Participants stressed that religious beliefs about punishment can exacerbate shame in the context of a diagnosis of cancer:

'…So whether they are cultural or religious beliefs about being punished…a sense that they have done something to contribute to this diagnosis…' (Kim).

Similarly, Linda shared that:

'…especially in some cultures like X (name of country) or Y (name of country) cultures where cancer is seen as a punishment, so it means that you have done something wrong…and this fucks you up…'.

Catholicism and Christianity, according to the data, promote shame because of:

'…the whole premise of original sin that we're all born bad to begin with…'

(Amanda).

Additionally, it was argued that shame gets passed down from generation to generation until someone decides to face it and live in a different way. Kim shared that:

'…coming from a different background where people wouldn't talk about how they felt and then knowing that that really influenced me and then at the same time choosing a job that's all about…to do the opposite or do something very different…'.

Similarly, Charlotte shared that her parents' union was not approved by their culturally and socioeconomically divisive country of origin and as a result *'…there is so much shame that disseminates down families…*'. To summarise, what has been argued in this section is that shame at times acts as a societal regulator in the form of conscience, where cultural and societal influences can shape one's capacity to recognise, share and resolve shame.

5.0 Reflections about the data analysis

The clinicians involved in my study argued that the impact of shame on the self, noticing shame, therapeutic reactions to shame, and working with issues of power and shame are usually multifaceted experiences, where intra- and inter-subjective understandings about its impact on therapists, clients, and on the therapeutic relationship is of paramount importance. The implications of these findings will be discussed in the Discussion chapter. What follows is a summary of my reflections about the process of analysing the data and the writing up of this Chapter.

I would like to start by sharing my experiences during the analysis of the data. Each interview was typed in the way suggested by Smith and Osborn (2003, p.64) with a wide enough margin on both sides of the text for my notes. During transcription I kept a record of initial thoughts, comments, and points of significance in my research journal, as I believed that these might be useful to consult and check against later interpretations during the analysis. I listened to each interview and read each transcript several times and I made notes of anything that appeared significant and of interest in the left-hand margin. This process helped me to feel more immersed in the data, to prepare myself to be able to engage with the double hermeneutic and to become more responsive to what was said. In this stage I paid attention to my initial meaning making of the narratives and to convergences and contradictions in the text. Once I felt satisfied that I had addressed and noted all points of interest I would then turn to the next stage, which involved using the right-hand margin to transform initial ideas and thoughts into specific themes, by trying to capture the implicit psychological quality of participants' accounts and my initial notes. The next and final stage involved further

reducing the data by establishing connections between the initial themes and clustering them appropriately together. Smith stated that at this stage of the analysis you can 'imagine a magnet with some of the themes pulling others in and helping make sense of them' (Smith, 2004:71).

For the analysis of the first interview, I initially created a word document where I colour-coded and listed each theme as it occurred chronologically, also noting, how many times they had appeared in the transcript. This worked well and I proceeded with applying it to the next transcript. However, as the analysis of the second interview progressed it became apparent that my system did not quite give me the visual access that I needed to track the flow between cases and emergent themes. Consequently, I switched to a more traditional model of organising the data and made use of flipcharts and sticky notes. Each theme was written on a post-it, stuck on flipchart papers that were then stuck on the wall. This process was repeated for all interviews and by the end of it the walls and the floor in my study room were covered by flipchart papers. But as messy as this process was it really enabled me to have a full view of each participants' account and also of the data as a whole. I used different colour pens to acknowledge similar themes across the cases, which in turn helped me to identify subordinate themes, and I then separated the subordinate themes together into super-ordinate clusters. However, this process was full of difficulties and I got stuck almost in every step of the analysis process. I noted, with the help of my research buddies and my research supervisor, that during the early steps of the analysis I tended to jump into interpretations too quickly and did not always remain faithful to the actual texts. It was challenging to stay with the participants' words as I felt the need to make conceptual and abstract interpretations. Furthermore, even though the analysis of the pilot study gave me an idea about the complexities involved, I think I was still unprepared for how time-consuming and all-encompassing it would be.

Distilling the final themes so they could reflect and 'carry' as much of the meaning of participants' accounts as possible, was a challenging task that involved several attempts of 'getting it right'. As the analysis process progressed, I slowly gained experience in starting with describing participants' statements at face value before considering conceptual questions. I was also reminded to refrain myself, as much as this was possible, from considering theoretical links during the textual analysis as per

Smith et al's (2009) recommendation. I tried to preserve an orientation towards openness and ensure that my interpretations were grounded in the data rather than imported onto it. I found that repeated listening of the audio-recordings, repeated reading of the transcripts and leaving time between analysing different transcripts supported with this. While I attempted to be systematic about the analysis process, it soon became a difficult and time-consuming part of the study, that caused intense feelings of overwhelm and panic when I realised the density of the data I had collected. I found the process both enjoyable and interesting, but I was also concerned about losing the depth of *the experiences, particularly when moving from exploratory commenting to developing emergent themes. Such feelings would often get amplified by my strong sense of dissatisfaction with the table of themes, which I organised and re-organised several times.*

Throughout the interviews my participants explicitly and implicitly conveyed their experiences about the challenges entailed in noticing and managing shame as it unfolds in the intersubjective space. This made me think deeper about my own underlying difficulties to meaningfully engage with the research process and the subject matter. On reflection I became aware that I struggled to strike the right balance between observing from a distance and immersing myself in the transcripts during the analysis stage. It felt easier and safer to remain descriptive, albeit the dissatisfaction and disappointment that came with it, than to throw myself in the data and to attempt to name underlying processes and themes. This of course caused a lot of frustration and delay in producing a text that felt like a good enough and accurate reflection of my interactions, both at interview and analysis stages, with each participant. But by building a narrative to describe and name this parallel process I felt less anxious and less restrained within myself, which invigorated my passion for this study and helped me to feel more grounded in my research.

My previous training and the psychological theories that inform my clinical practice, namely integrative and psychodynamic, unavoidably had an impact on my analysis of participants' narratives. Smith et al (2009) viewed IPA and psychodynamic interpretations as stemming from different epistemological perspectives, but they asserted that the differences between the two are not always so clear and that it is, in fact, possible to make use of psychodynamically informed interpretations and to also maintain the participants' actual narratives strongly in the foreground. In line with this,

I tried to listen carefully to what my participants were saying and always selecting themes which were displayed in the data. Ricoeur's (1970) theory about hermeneutics of empathy and hermeneutics of suspicion, which he believed are two-interconnected levels of the interpretative analysis, helped me to re-align myself and to feel more embedded within qualitative phenomenological research principles during this process.

My sense of responsibility and duty to 'do justice' to the interview material was markedly intensified during the analysis and the writing up of this chapter. For example, when Gavin used the word 'bastardise', to describe his fear of being misunderstood by the other, this echoed the part of me that felt out of her depth and totally overwhelmed at the face of identifying themes and analysing vast amounts of data. The portrait of shame as an insidious monster that eats you little by little and the discussions about discrepancy of power in therapeutic settings made me aware of direct unconscious communications to myself, the researcher, about my duty to tread carefully and compassionately throughout the different stages of this study. In addition, I found myself thinking that the experience of shame, as well as how one (patient, therapist) copes with and regulates this emotion, has important implications for self-concept and interpersonal relationships. Also, I noted the underlying shame of holding the power in the consulting room, or indeed in the researcher-interviewee interaction, and how even when we use it out of benevolent authority to achieve the aim we seek, even when we believe it to be in our patient's best interest, in some cases we experience the shame of exercising, and secretly relishing, such powers. Acknowledging my underlying feelings of shame about my lack of research proficiency and revisiting the structure offered by the proposed IPA guidelines helped me to hold the tension between therapy and research, bastardising and analysing.

As a final point I would like to share Josselson's (1996b) comments on the dread, guilt, and shame that go with writing about others, as it encapsulates my process precisely: 'My guilt, I think, comes from my knowing that I have taken myself out of the relationship with my participants (with whom, during the interview, I was in intimate relationship) to be in relationship with my readers. I have, in a sense, been talking about them behind their backs and doing so publicly. Where in the interview I had been responsive to them, now I am using their lives in the service of something else, for my

own purposes, to show something to others. I am guilty about being an intruder and then, to some extent, a betrayer…And my shame is the hardest to analyze and the most painful of my responses. I suspect this shame is about my exhibitionism, shame that I am using these people's lives to exhibit myself, my analytic prowess, my cleverness. I am using them as extensions of my own narcissism and fear being caught, seen in this process' (1996b: 70).

Chapter 5: Discussion

5.1 Overview of discussion

In this chapter, the key findings developed from the analysis will be discussed in relation to the research question. This qualitative study explored how therapists experience shame, how it presents in their practices and how they work with shame issues. Four superordinate themes that captured the key experiences of shame for therapists were identified: *The Impact of Shame on the Self, Noticing Shame, Therapeutic Reactions to Shame, Shame and Issues of Power.* Each of these superordinate themes contains a mix of idiosyncratic but related experiences and meanings. As described in chapter 4, the themes were developed through an intensive process involving deliberate interpretation. These interpretations of the participants' life worlds, in accordance with the framework suggested by IPA (Smith et al., 2009), should be placed in the wider context of the existing literature and research presented in Chapter one and Chapter two. Therefore, through this discussion, the findings will be contextualised within existing psychological concepts of shame and relevant previous research literature in my attempt to illuminate the participants' perspectives. Ensuring consistency with the notion of the double hermeneutic (Smith et al., 2009), I will further interpret my participants' experiences and I will present my reflexive process at suitable points in the chapter to critically evaluate my interpretations. The limitations of the study and implications of the findings for future research and practice will also be identified.

5.2.1 Interface between Findings and Literature – The Impact of Shame on the Self

This superordinate theme depicts participants' conceptualisations of shame as an interpersonal phenomenon that usually involves the internalisation of early shaming experiences at the hands of caregivers. Therapists offered a glimpse of their personal histories and demonstrated that early shame incidents shaped their perceptions of themselves in personal and professional life. It also portrays participants' recollection of the challenges and complexities involved in shame work as they share reflections about the impact of shame on the self and the inherent tendency to avoid its emotional impact.

5.2.1a Early experiences of Shame

Participants shared the view that shame happens between people, and they conceptualised shame as a phenomenon that arises in the intersubjective space of our interpersonal worlds. The findings also highlighted the interplay between intrasubjective and intersubjective dynamics as there was consensus amongst therapists that the self is the harshest judge (this will be addressed in the next section). Gavin shared a Sartrean tale to emphasise the dynamic between internal and external shame, whereas Amanda proceeded to offer a distinction between indigenous and contextual shame. Morrison used the terms '…primary shame…[and]…reactive, secondary shame' (2011:41) to emphasise that a person's early life and development played a crucial role in shaping one's ability to effectively cope with shame throughout the lifespan. Gilbert (2007) proposes a similar theory where external/secondary shame is viewed as a response to the external environment where there is the threat or actual experience of the self being seen as bad or inadequate, and internal/primary shame as the experience of internally evaluating the self with fear of exposure to an imagined audience. Research conducted by Gilbert and Procter (2006) showed that self-criticism is significantly associated with shame proneness in adulthood and that a shaming experience can merge the two emotional states together causing fragmentation and dissociation. Likewise, Amanda reported that '…you can have both I think in the room…'.

Participants shared personal memories of shame in their encounters with significant others, parents, siblings, relatives, and teachers. Such memories were shared without prompting, as if their recollections were an integral part of the participants process, and none of them appeared to suffer emotional distress having done so. These encounters were regarded agonizing and haunting experiences with a long-lasting impact on one's self-esteem, and they were also considered to be central to one's understanding of the impact that shame has had and continues to have on one's life. This assertion resembles the position of the theories discussed in chapter two. For example, Tomkins (1963, 1979) proposed that shaming events persevere in a person's memory and develop into Scripts. Such Scripts are mainly concerned to control rewarding or unrewarding experiences of affect and therefore, the fear of re-enactment of these scenes, leads to the operation of 'marker' or cautionary shame and it ends up determining the scene. Likewise, Kaufman (1992) argued that images

of shame become internalised and lead to internalised representations of the self as shameful, defective, and unworthy, and when one is in a shame state, they become activated with damaging consequences for one's entire identity or sense of self. Research on self-defining memories, drawing on Tomkin's work (1963) was conducted by Singer and Singer (1992) and Singer and Salovey (1993). Their findings showed that self-defining memories, namely vivid memories that induce acute affect and are frequently thought of or spoken about by the individual, are also connected to other memories and usually revolve around the person's unresolved issues as the focus is on "affective responses that link the past and the future to the here and now" (Singer and Salovey, 1993, p.160). (as cited in Kissaun, 2017).

My data are in line with the study conducted by Kissaun (2017) as my participants' affective responses also elicited painful memories that were shared vividly in the here and now highlighting painful exchanges with significant others. Their accounts echoed the contributions of authors like Lewis (1971), who described shame as an interpersonal emotion, a discrepancy between a child's emotional needs and the capacity of the caregivers to respond to them, where judgements of loved ones are internalised as part of the private audience in subsequent shame experiences. Likewise, Bowlby (1973) wrote about the relationship between attachment and shame, and he posited that powerful emotions, like shame, are products of attachment relationships, most particularly within the context of threatened or real loss. Kaufman captures this nicely when he suggests that "…shame is a wound made from the inside, dividing us from both ourselves and others. Shame reveals the inner self…That exposure can be of the self to the self alone, or it can be of the self to others. Central to an understanding of the alienating affect is that shame can be an entirely internal experience. No one else need be present for shame to be felt, but when others are present shame is an impediment to further communication…" (Kaufman, 2004:17).

Many theorists, like Kohut (1971), Morrison (1989), Ayers (2003) to name a few, emphasized the relevance of early experiences and their enduring impact on self-image and relational patterns, which this theme demonstrates and confirms. My participants' memories of early failures by caregivers highlighted the lack of loving support after such events, which according to psychodynamic theory, is essential in order to achieve a cohesive sense of self (Kohut, 1986). Kim and Charlotte revealed growing up in families where unspoken shame featured prominently; both reported

that as a result they experienced overt-undifferentiated shame (Lewis, 1971) where even though they were conscious of their emotional distress their emotional experiences were denied by others. They shared that personal therapy and studying to become a psychological therapist assisted them to create external and internal safe spaces where shame related issues started to unfold and further explored. Their stories resonate with mine; I was also brought up in an environment where experiences of shame were never discussed. On the contrary my brother and I were always encouraged to 'hold our heads up', the Greek version of 'stiff upper lip'. Emotional experiences of shame were always shut down in my family and it is not surprising that it has taken me a long time to turn my attention to my shame. As I explained in Chapter one, my curiosity about shame stemmed from my clinical work, and my decision to pursue it as my research topic was cemented by my realisation that since shame branched out in so many different areas of the human condition researching it would be an academically enriching experience. I have since realised that my own shame also branched out in so many different areas and aspects of my life and that part of my motivation to engage with this research has also been my need to identify, name, connect and meaningfully address 'my stuff'. Perhaps that desire of mine has at times influenced my positioning during the collection and analysis of the data and for that reason I will remain as transparent as possible to enhance the trustworthiness of my interpretations and overall contribution.

Gill and Jane shared memories of being told that they were lacking '…why can you not be like your older brother...'(Jane) and being '…needy and bad…' (Gill). They reported that personal therapy helped them to address their difficult relationships with their mothers and as a result they felt less insecure in their relational bonds as adults. With the exception of individuals who have felt insuperably secure in the love and validation of early care givers, "…the threat of the blank look on non-recognition is ever-present-or the look that sees not who we wish to be but who the other wishes us to be…" (Mollon, 2002:xii). Developmental research and in particular the work of Beebe and Lachmann (2002) showed that a child's insecure attachment behaviour is a 'regulatory strategy' developed to manage intolerable experiences of affective overwhelm and underwhelm, in times of unrepaired parental missattunement. Similarly, Schore (1994;1996) described the continual experience of misattunement and/or rejection by a caregiver as repeated experiences of unregulated shame and he

highlighted the major role that caregivers play in regulating a child's emotional state. My findings expand on previous research and conceptualisations as what gets highlighted throughout my study is that in adulthood, shame involves an overwhelming feeling of unworthiness and a sense of condemnation: the self is experienced (in reality and/or fantasy) as inadequate and inferior in the eyes of a condemning audience.

Attachment researchers have shown that negative maternal attitudes led to an experience of shame in toddlerhood (Kelley, Brownell and Campbell, 2000). Moreover, Claesson and Sohlberg (2002) investigated memories of childhood interactions and they revealed an association between memories of a blaming, attacking, and ignoring mother, and the experience of internalised shame in adulthood. Similarly, Amanda, Linda and Julia made explicit associations between caregiver failures in earlier life and internalised shame in later life. Andrews' research (1995, 1998, 2002) indicated that shame-proneness stems from experiences of enduring abuse in childhood and the findings showed a direct association between trauma and shame experiences. The premise that early shame experiences may have properties of traumatic memories was explored by Matos and Pinto-Gouveia (2010) and they revealed an association between such memories and the development of shame-proneness and psychopathology. The impact of early shaming experiences on the self's emotional wellbeing has been a core shared belief amongst interviewees.

5.2.1b Being-as-you-are is not acceptable

Most participants agreed that shame gives rise to a pervasive sense of inadequacy where the self is viewed to be not good enough, not meeting internal and external expectations, to being bad and unlovable. In the context of discussing clients' experiences therapists focused on understanding shame in the idiosyncratic narratives of their clients as their main clinical focus is to gain insights into the relationship that the client has to him/herself, a relationship that was conceptualised as predating the therapeutic interaction in which the shame has surfaced. Participants described shame as an intensely painful feeling with cognitive, emotional, and behavioural elements. The data showed that those elements include self-attacking thoughts and emotional pain, which echoes Blum's (2008) assertion that shame is an intense negative emotion with feelings of helplessness, incompetence, inferiority, and powerlessness.

It is noticeable that my participants stayed away from applying terms from psychopathology, like anxiety disorders – personality disorders – substance misuse and addictions, when they described their insights about their clients' presentations. Instead they heavily relied on descriptive terms, like '…fear of rejection…' (Jane), '…fear of failing…' (Kim),'…relational difficulties…' (Gill), '…due to his complex interpersonal patterns…' (Charlotte), '…his ideas about his flaws and badness were linked to his alcohol use…' (Gavin). I became aware of this trend during the analysis of the data, and I believe that it is indicative of the compassionate and empathic stance that clinicians felt to be an important relational skill in shame work, where clients need not be ashamed about feeling ashamed, so that shame can be looked at together. We will examine this further when we discuss the Super-ordinate theme Therapeutic Reactions to Shame.

There was consensus amongst participants that the main cause of shame for clients are thoughts about not meeting other people's expectations. This is also echoed by Cozolino (2014) when he stated that shame is about bonds and relationships and how we imagine we exist in the minds of others. The findings also reverberated Brown's (2008) description of shame as an '…intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging…' (2008:5). There is consensus amongst participants that clients who view themselves as '…something [is] lacking in them…' (Charlotte) experience palpable loneliness and profuse sadness. Amanda and Linda highlighted that clients experience shame about unacceptable feelings and thoughts. The data showed that therapists must learn about the '…shoulds and should nots…' (Amanda) that clients had internalised about the things that they wanted to do or think that they should not do. Participants shared the belief that it is particularly important to listen for shame in histories of trauma. Gill, Jane, Gavin and Amanda described clinical vignettes where the sense of despair or inadequacy became too overwhelming and lead *to* clients' dissociating. Gill stated that at those moments it is often difficult to strike the right balance between proximity and distance as transferential and countertransferential feelings are at play. And it is during such moments when therapists feel that they have not been helpful and/or successful with their interventions that evokes shame in clinicians.

Participants described experiences of shame borne out of thoughts about professional inadequacy and performance anxiety that led to a deeper core feeling of shame related

to their sense of self and professional identity. Kissaun (2017) and Miller & Draghi-Lorenz (2005) reported similar findings identifying themes like 'The self is the harshest judge' and 'Shame lapses in the experience of oneself as a good-enough therapist' accordingly. Theriault and Gazzola (2005) studied feelings of incompetency in experienced therapists, and they concluded that inadequacy linked to distressing preoccupation with identity is '…narcissistic, profound and damaging…' (ibid:15). In a similar way my participants shared distressing concerns about their professional identity and a sense of unworthiness was expressed by them in the context of clinical failures. My findings appear to validate Theriault and Gazzola's conclusion regarding the deep narcissistic injuries suffered by the self during such experiences. The data also appear to support Morrison's (2011) definition of shame as '…a negative feeling about the state of the whole self, the self is bad, defective, a failure…' (2011:25). The self was referred to as 'bad' by Gill and Gavin whereas the sense 'defective' or 'imperfect' and a 'failure' was referred to with more frequency.

The findings highlighted that participants often questioned themselves about their efficacy and ability. This makes me think that the fear of failure in our therapeutic endeavours is perhaps never far away from all of us. It is intensified when a client does not appear to be progressing at the rate we anticipated they might have been, as described by Jane, Gavin, Julia, and Gill. Lanksy and Morrison (1997) in line with Lewis's (1987a) contributions about resistance claimed that resistance in clients can stem from a disavowal shame affect and it can evoke shame in the therapist who may begin to feel incompetent if the client does not show signs of improvement. The most challenging fear of failure my participants reported is the fear of being 'found out'. Most therapists implied feeling like a fraud, and Amanda and Julia described themselves as an impostor . Their accounts made me think about their strong self-denigrating beliefs: they are not the competent, intelligent professionals everyone thinks they are. The impostor syndrome manifested their shame as each of their descriptions embodied a wound made by shame.

Interviewees shared the belief that the self is the harshest judge, and my findings are in agreement with Tangney, Miller, Flicker, and Barlow's (1996) who showed that the undergraduate students who participated in their research were their own harshest critics and they evaluated themselves more negatively than they thought others did (cited in Kissaun, 2017). The sense of inadequacy for my participants was often

generated in their clinical work typically causing feelings of incompetence linking poor therapy outcomes to their own clinical failures. Such experiences would typically get heightened when working with demanding and difficult clients as described by Amanda, Julia, Linda, Gavin and Gill, where lapses in the experience of oneself as a good-enough therapist occurred. The findings supported Morrison's (2008) notion that central in the recognition of therapists' sources of shame is the concept of the wide gap between the '…ideal (wishes for) and the actual (experienced)…' selves between which he reminds us, there is always an unsettled tension (2008:80).

There is some empirical evidence to suggest that self-discrepancies are related to psychological problems. For example, Higgins, Bond, Klein and Strauman (1986) found that differences between actual and ideal representations were associated to dejection-related feelings like depression and differences between actual and ought self-representations were linked with agitation-related emotions such as anxiety. However, Tangney, Niedenthal, Covert and Barlow (1998) tested Higgins's theory and questioned its credibility. In their research they asked participants to complete the Selves Questionnaire that measures self-discrepancy and the Test of Self-Conscious Affect (TOSCA), which measures shame and guilt proneness. Their findings suggested that all discrepancies, and not only actual/own and ideal/other, were related to shame-proneness, which casts doubt on the validity of the Selves Questionnaire and Higgins's theory but also it further confirms that discrepancies between actual-self representations and ideal-self representations generate shame-proneness.

A different study by Lindsay-Hartz (1984) examined the personal accounts of ashamed individuals and concluded that failing to achieve an ideal image is not essential for experiencing shame. Lindsay-Hartz proposed that shame experiences were more strongly associated to the recognition of a negative ideal: who we would not like to be, rather than to the discrepancy between the actual self and the ideal self. Lindsay-Hartz stated that 'what we realise about ourselves when ashamed is that we are who we do not want to be' (ibid:697). For example, participants talked about things like 'I am fat and ugly' rather than 'I failed to be pretty', and I 'I am bad and evil' rather than 'I am not as good as I want to be' (Lindsay-Hertz, de Rivera & Mascolo, 1995:227). Gilbert (1998) stated that this difference is not merely semantic as participants argued that the difference was crucial for understanding their feelings. The findings, in my view, highlight the emotional intensity that accompanies shame experiences as described

by many authors like Lewis (1971) and Kaufman (1992), namely the powerful global impact shame can have on the self and how during such moments of intense vulnerability and emotional nakedness, in the presence of an actual or internal audience, we get reduced to being the person failing, the person that we do not want to be. Clearly, more research is needed to further investigate the intricate dynamics between competing self-representations of the actual self and ideal self.

Rustomjee (2009) differentiated between bearable shame and unbearable shame and argued that people with adequate self-esteem can tolerate shame and can even benefit from exposure to it by gaining self-awareness and experience. Most of my participants described themselves as shame-prone individuals implying low levels of self-confidence in dealing with shame issues in their professional and personal lives. However, despite claiming that, they were skilled at reflecting on their own shame and appeared keen to talk about it. They displayed high levels of self-awareness and were able to demonstrate their experiences in a detailed manner, which makes me think that albeit their difficulties with shame they appear to have sustained a cohesive sense of self and to have been able to transmute suffering into a resource. The data are in line with Morrison's (1989) proposal that the sense of self may remain unharmed despite suffering narcissistic injuries, but even if a self has not suffered lasting structural damage may still experience a less archaic, although painful, sense of inadequacy and shame. My participants were overly critical of themselves for not meeting their expectations, their ideals, but they also appear to function relatively well in their professional and personal lives.

5.2.1c Running away from it

This theme is mainly concerned with the notion that beyond our affective response our experiences of shame include our reaction to shame. Participants stated that these reactions usually vary between individuals but there was consensus that the self typically wants to run away from such experiences. Participants argued that the intensity of shame can be intolerable and staying with shame is not just unbearable to clients but also to therapists. Kim, Linda, and Gavin talked about the difficulty to bear the unbearable and their contribution is in par with Morrison's view that '…because of its noxious and agonising qualities, shame frequently stays hidden or unspoken in a patient's lexicon…the pain of shame threatens therapists too, often reminding us of

faults or weaknesses…This shared pain regarding shame can often lead to a collusion between therapist and patient to avoid acknowledging or identifying shame…' (2011:28).

Participants also shared that 'staying with shame' and 'not hiding from it' typically involved feeling 'emotional pain'(Gavin), 'feeling devastated'(Gill), 'moved'(Kim), 'humbled'(Linda), 'shattered' (Amanda), 'discomforted'(Julia) and 'vulnerable'(Jane). Staying with shame, therefore, remains a struggle as clinicians are feeling overwhelmed by the depth and intensity of despair and at risk of disengaging from the moment. The data also revealed that it may also feel intrusive on behalf of the clinician to stay with the feeling, for example Amanda stated that she avoids using the word shame in sessions, as she worries that she may induce it by introducing the concept of shame. My findings add a valuable set of data to Gabbard's (1993) conceptualisation of the mutual activation that can occur amongst therapist and client when working with shame, where patients may project aspects of their shameful feelings that they are unable to contain and in some instances the therapist's internal shame experience can be activated through identification with the client's internal experience. The unconscious process of projective identification provides a tentative understanding of participants' struggles to stay with shame.

Projective identification, a powerful experience for both therapist and client, it often features in clinical literature on shame. Ogden (1982) offers a definition that captures the projective and introjective processes involved: '…In projective identification, not only does the patient view the therapist in a distorted way that is determined by the patient's past object relations; in addition, pressure is exerted on the therapist to experience himself in a way that is congruent with the patient's unconscious fantasy…' (ibid: 2-3). Some authors have written about the potential misuse of the term to disown or blame the client for the therapist's experience of shame (Ayers, 2003; Powell Livingston, 2006). Thus, therapists are encouraged to maintain an awareness of their own shame vulnerabilities, by identifying the part of the projective identification that does relate to them, the one that reverberates with the client's unconscious communication. The projective identification of shame is a complex phenomenon and my participants argued that the use of supervision is paramount in disentangling such experiences by engaging in a what belongs to whom reflective dialogues. We will

discuss this further when we address the Superordinate Theme Therapeutic Reactions to Shame and in particular when we look at Self-Care and Supportive systems.

Participants highlighted that feelings about exposure and fears about being harshly judged by others, including their clients, generate unbearable levels of vulnerability and in turn it leads to greater disconnection and isolation. Meeting a person in their shame is challenging and creates a sense of vulnerability as advocated by Brown et al (2011). My data are in line with the findings of Miller and Draghi-Lorenz (2005) who also found that their participants described retreating into a more superficial and distanced type of relating when feelings are too hot to touch. My findings echo *Steiner's* (2011) theory about psychic retreats and even though his contribution is aimed to describe clients' needs to create hiding spaces, it appears that in shame work therapists also take refuge by implementing avoidance strategies, as attempts are made to distract, dissociate, or disconnect the self and others from the feeling of shame by minimising awareness of the shame or dismissing its importance (Nathanson, 1992). Such actions, according to Elison et al (2006b) are usually designed to prevent the conscious experience of shame and are believed to operate outside of a person's awareness (Elison et al, 2006b).

Theorists argue that often that which triggers the feeling of shame may go unnoticed, what is visible are the individual's strategies of defense. Hartling (Hartling et al, 2000) a relational-cultural theorist built on the work of Karen Horney's (1945) classification of personality types and proposed three categories of strategies of disconnection or survival used to respond to shame or humiliation. In her article Hartling argues that some of us may use a 'moving away' strategy, others engage a 'moving towards' strategy, and there are others who adopt a 'moving against' strategy. A brief examination of the data showed that the preferred response for therapists in this study is to move away from the other when experiencing shame. The moving away reaction as Morrison (2008, 2011) alerted us to, runs the risk of collusion with the client's shame issues, not to mention avoidance of one's own shame sensitivities. Therapists identified the need for a moving towards category that involves progressive relational responses, rather than people pleasing reactions, and this will be further explored when we discuss Therapeutic Reactions to Shame.

Nathanson (1992) proposed the Compass of Shame, a model of shame coping styles that was developed based on clinical observations, and he introduces four systems of defence, four coping styles that people are typically engaged in: Withdrawal, Attack Self, Avoidance, and Attack Other. These systems get activated when we ignore 'the spotlight of shame', that is, what shame wants us to attend to. Aimed to make us feel different, each pole embodies an 'entire system of affect management' (ibid, p. 312). According to this model constructive shame management occurs when a person attends to the source of shame and decides to address the source; this echoes the writings of Rodogno (2008) and Elison, Pulos and Lennon (2006b) when they argue that the experience of shame is not necessarily problematic but instead it is how one copes with or defends against shame that may lead to negative outcomes. Kaufman (1992) presented defending strategies for protecting the self against shame and dealing with it once activated: rage, contempt, striving for power, striving for perfectionism, transfer of blame and internal withdrawal. These strategies are seen as originating in interpersonal relationships and typically several function together.

My participants described withdrawal, attack self, and avoidance as their preferred coping styles. What is noticeable is that the moving against response as described by Hartling et al (2000), the Attack Other coping style (Nathanson, 1992), and rage and contempt (Kaufman, 1992) were the least favoured amongst participants. I suspect that this is the case because they are usually regarded as the most shameful as we are not meant to show aggression towards our clients.

5.2.2 Noticing Shame

The second superordinate theme describes the process of how shame is detected by the clinician and it appears to be in agreement with what is referred to in most theories about the phenomenology of shame and its elusive nature. What is most interesting however, is that in this sample, the detection of shame in the context of clinical work with physically ill clients is a dominant theme. Perhaps this should not come as a surprise since most of my participants work in physical health care. However, what is important to note is the lack of consideration about the sick body in most theories about shame experiences. This will be further explored below.

5.2.2a Physiological Responses to Shame

In the context of discussing different ways in which participants first notice the presence of shame entering the therapeutic space, references were made to the relational difficulty that arises in shame work, namely as Gilbert (1998) stated, the client fears what is in the mind of the other and may distance herself, and the relational rupture that arises can be observed. Participants also described that they mostly sense shame in the body, and they shared that often the detection of shame is much more intuitive, embodied or in the arena of felt sense. The data showed that therapists' personal physiological responses to shame, as described by Jane, Julia, Linda, Amanda, Charlotte and Kim, are in line with the contribution of Tomkins (1963) and Mills (2005) who stipulated that non-verbal signs of shame include hanging the head down, eyes cast downward, and facial blush.

Participants noticed shame in clients by paying attention to physical indicators, making references to phenomena that can be physically observed or physically felt in one instance. Here, the data showed that shame in clients can be intuitively sensed or picked upon, often described by participants mostly by a)observable changes in the client's body, '…rigid posture…stammering…' (Kim) '…tensed voice…' (Charlotte), b) by sensing intense levels of despair '…she disconnects and goes into a sort of isolated nothingness space…' (Gill) '…I think she goes to a very alone place separate from me… (Kim), c) further shame is indicated by a sudden relational rupture, meaning the clinician suddenly notices the client being avoidant of eye-contact, '… she would spend a lot of the session with her eyes shut…' (Gill) and d) by clinicians sensing '…an atmosphere or feeling in the room…' (Gavin).

The most common non-verbal expressions of shame include gaze aversion, bowed head, and collapsed posture according to the data; these body movements are considered important indicators in the recognition of shame because shame does not have unique or exclusive facial movements (Ferguson & Stegge, 1995). Keltner and Buswell (1996) found that the level of accuracy for identifying anger or disgust is above 80%, whereas the level of accuracy for identifying shame is 50-60%. Crozier (2014) argued that gaze aversion, a downward head and blushing can also occur when someone is feeling embarrassed, hence, identifying and recognising shame-based body language might be complex and challenging.

Shame is a biologically stressful experience and the bodily responses associated with shame include blushing, increased body temperature and sweating (Crozier, 2014). Neurobiological research reveals that shame originates from the activation of the parasympathetic nervous system. More specifically, Schore (1998) argued that the shame system originates in the dorsal medial nucleus of the hypothalamus. According to his research, activation of this area causes changes in mood, endocrine function and involuntary muscle activity. In a meta-analysis of 208 laboratory studies, Dickerson, Gruenwald and Kemeny (2004), demonstrated that socially embarrassing test conditions (for example, public speaking) reliably produced an increase in cytokine activity and cortisol. These researchers argued that 'events that threaten the social self-elicit activation of the hypothalamic-pituitary-adrenal (HPA) and proinflammatory immune systems, leading to the release of the HPA hormone cortisol and inflammatory cytokines (Gruenewald et al, 2007:74). A study conducted by Dickerson, Kemeny, Aziz, Kim and Fahey (2004), where participants were induced to experience self-blame and threats to their social self by writing about their experiences, confirmed a link between shame and increased levels of cortisol and proinflammatory cytokine activity.

The findings of my study showed that indicators of shame are understood by my participants to be both inter-subjective and intrasubjective, meaning shame is relational and occurs between therapist and client, as well as within clients, within the relationship the client has to themselves and to their body. Intuitively sensing shame is an exciting finding that requires further research as the data shows that in clinical work shame can penetrate the clinician, the client, and the space between them. The participants were remarkably consistent in describing a set of verbal and nonverbal cues that may signal underlying experiences of shame. According to the findings shame causes physiological responses and this echoes Fisher's (2016) argument that the physiological shame that is experienced by people appears to reinforce their self-deprecating beliefs, trapping them in a vicious cycle.

5.2.2b Shame and the sick body

Most of my participants reported detecting shame in their work with clients with a diagnosis of serious physical illness. This theme draws attention to an arena where even though shame prevails it has been neglected by theorists and researchers. Even

though I was not set out to explore and identify shame dynamics within the context of physical health, my interviewees by relaying experiences from their NHS work, shared powerful observations, and reflections about their clients' shame. A quick look at the APA PsychInfo database revealed 4,659 results for a search on 'physical health and shame', 936 results when narrowed by SubjectMajor:Shame, and 115 results when narrowed by qualitative methodology. A search about 'shame and cancer' revealed 168 results and 19 results when narrowed by SubjectMajor:Shame. The small number of empirical data further supports participants' contributions that despite the recognition that shame is a powerful force in the clinical encounter, it is under-acknowledged, under-researched and undertheorised in the contexts of health and medicine.

The findings confirm the widely accepted notion that, in the context of the body, shame has the potential to be a devastatingly painful experience. The specific emotion of body-related shame is defined by participants as a negative feeling about oneself or global self-blame, (e.g. '…was apologising about the state of their body and the fact that s/he had to walk slowly…' Jane), and it echoes the contributions by Sabiston & Castonguay (2014) and Tracy & Robins (2004) who argued that individuals suffer body-related shame when they fail to meet internalized social standards in relation to the body. Although, shame has been identified as a powerful force in the clinical encounter and the experience of illness (Lazare, 1987; Tomlinson 2012), curiously it remains both undertheorised and commonly unacknowledged in the contexts of health and medicine (Davidoff, 2002). As Darby et al (2014) note, despite shame's frequent occurrence within healthcare settings, there is a surprising lack of research examining the effect of shame and other negative self-conscious emotions. Commenting on this apparent mismatch of clinical importance and medical disinterest, Davidoff (2002) dubbed shame the 'elephant in the room' in healthcare contexts.

The findings highlighted that patients often regard their illnesses as personal shortcomings, or as arising from personal inadequacies, a notion acknowledged by researchers (Lazare, 1987). This is not surprising, as many illnesses continue to carry significant stigma (Weiss et al, 2006), and flaws in the physical body can often be construed as a mark of disgrace, disqualifying, as Goffman (1990) puts it, '…an individual … from full social acceptance…'. Contributions by Kim, Amanda, Linda, and

Jane emphasised their clients' experiences of self-blame and their difficulties to fully engage with their social networks, as the self becomes immersed in a crisis, where feelings of shame get amplified by a new psychological reality and the sense of self as an ill person, a person with cancer. The findings confirm the notion that the experience of health-related stigma is crucially bound up in experiences of shame (Rose et al, 2017), where threats to one's identity and one's social/relational bonds through carrying a stigma mean that, as Goffman (1990) notes, '…shame becomes a central possibility…'. The data also suggested that people usually have powerful beliefs that they had brought the disease upon themselves and that they should be excluded from the community. This is in line with Susan Sontag's (1978) theory, who argued in her book 'Illness as a Metaphor', that TB captured the romantic idea of the 19th century, suffering for love, while cancer, the metaphoric disease of our time, expressed the psychological idea that character causes illness, that the ill person's inhibited passions, their repressed feelings were destroying them.

Empirical findings have shown that shame is highly correlated with feelings of inferiority/submissiveness (Birchwood et al, 2006) and significantly associated with perceptions of low social rank and expressions of submissive actions (Gilbert, 2000). Dickerson et al (2004), found that HIV patients who felt stigmatised and rejected because of their sexual orientation died on average two years before those who did not feel stigmatised. But HIV patients who experienced other negative emotions like anger, anxiety or sadness did not experience a CD4 T-Cell decline over seven years. In other words, the findings of this study imply that shame is the only negative emotion that can forecast health problems and decline in people who have been shunned and rejected. Dolezal and Lyons (2017) aimed to further the claim that shame can have an impact on health, illness, and health-related behaviours. They outlined a few mechanisms through which shame may act on the health of individuals: a) acute shame avoidance behaviour, b) chronic shame health-related behaviours, c) stigma and social status threat and d) biological mechanisms. They also postulated that there is a case to be made for shame to be viewed as a determinant of health because shame '…is so pervasive, so corrosive of the self and so potentially detrimental to health, that there is considerable utility in considering it an affective determinant of health…' (Dolezal & Lyons, 2017:257).

The authors claimed that acute shame occurs in clinical settings because patients often experience their bodily afflictions or diseases as personal defects, a notion that was also highlighted by my findings. Empirical research has shown that threats of acute shame regarding one's health and physical body can have a significant impact on the process of the clinical encounter. For example, Darby at al (2014) showed that most of their participants recalled one or more interactions with their doctors that left them feeling ashamed that led to concealment and avoidance and lying to the medical professionals. As a result shame or the anticipation of it, '…can act as an invisible barrier to the adequate delivery of healthcare…' (Dolezal & Lyons, 2017:259). Chronic shame is distinguished from acute shame by the authors because it involves recurring and persistent shame that influences all aspects of one's life. Childhood relational trauma, social identity stigma (including race, socioeconomic status, health status, weight, sexuality), and certain psychopathologies (like PTSD, BDD), are viewed as the roots of chronic shame. Research has associated chronic shame with risk behaviours like alcoholism and eating disorders and as such it has a direct negative impact on health (Potter-Efron & Carruth, 1989; Swan & Andrews, 2003).

Dolezal & Lyons (2017) also make a case that chronic shame stems from cultural politics of inclusion and exclusion in the context of stigma and social status threat. Wilkinson (2005) showed that there is a clear empirical correlation between status anxiety (where shame is chronically experienced or anticipated), and harmful behaviours such as addiction, self-harm, violence, and criminal inclinations, which directly affect health and life expectancy. Kiecolt-Glaser et al (2002) argued that negative emotions can intensify a variety of health threats though a number of immune and endocrine responses. Similarly, Wilkinson and Pickett (2010) showed that threats to self-esteem or social status directly correlate with increased anxiety and heightened biological stress responses (cortisol and pro-inflammatory cytokines) to the bloodstream, and the chronic or maladaptive elevations of these agents, which can result in immunological or endocrine dysregulation, can be harmful to health. Lewis & Ramsay (2002), and Dickerson & Kemeny (2004) have demonstrated empirically that shame releases cortisol and PIC providing further evidence for Dolezal & Lyons (2017) that shame both directly and indirectly impacts on health through the four mechanisms.

As a final point I would like to note that none of my participants made references to personal experiences of physical illness, even though Morrison (2008) identified

concerns about illness and aging as one of the main sources of shame for therapists. I understand this to be reflective of the potential challenges that my participants are repeatedly confronted with in their clinical work, where illness vs health, life vs death, and mental health vs physical health, create fragmentation and distance and the subsequent lack of engaging with experiences of shame in the context of their physical health status.

5.2.2c The elusiveness of Shame

This section is mainly concerned with participants' reflections and observations about the difficulties involved in detecting shame in clinical work. They conceptualised shame as a powerful and pervasive phenomenon, which is '*elusive'* (Jane), *'unspoken'* (Kim), *'alienating'* (Linda),*'like a heaviness'* (Charlotte), *'shame is large'* (Gill), '*difficult'* (Amanda) and noted that 'capturing' shame is impeded by a number of barriers and challenges. The data showed that it is rather impossible to come up with a satisfactory definition about the phenomenon of shame. Jane pointed out that is vital to pay attention to a person's idiosyncrasy because shame '…means so many things to different people…'. Ayers (2003) and Nathanson (1987) have highlighted how individual differences in the perception of shame make it hard to confidently capture the essence of the experience. Likewise, Kaufman argued that '...the neglect of shame concerns the lack of an adequate language with which to accurately perceive, describe and so bring into meaningful relationship this most elusive of human affects…' (1989:4).

My findings showed that another obstacle in identifying shame in clinical work is its *'…insidious…' (Kim)* and obscure nature *'…that can go undetected…'* (Kim) as it '…*Eats you up little by little without you actually realising it…'* (Linda), an inner torment that remains hidden because it is *'…extremely difficult to be with, like a monster…'* (Gill). The use of powerful language that created the vivid image of an '*insidious' 'monster'* '*that eats you up little by little'* emphasised the underlying intense levels of vulnerability involved in shame work, which signified the need for caution and sensitivity. The findings reverberated Brown's (2008) definition of shame as an '…intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging…' (2008:5). Likewise, Morrison posited that '…because of its noxious and agonising qualities, shame frequently stays hidden or

unspoken in a patient's lexicon…the pain of shame threatens therapists too, often reminding us of faults or weaknesses…This shared pain regarding shame can often lead to a collusion between therapist and patient to avoid acknowledging or identifying shame…' (2011:28) The findings also highlighted that what contributes to the elusiveness of shame is the devastating impact it has on our connectedness with one's sense of self and with others. The breakdown of relationship that occurs in the shame experience was captured by Jordan's definition: '…loss of the sense of empathic possibility, others are not experienced as empathic, and the capacity for self empathy is lost…' (1997:147).

Jane stated that in her rush to help she has *'…play[ed] down shame…'* colluding with clients' wishes to avoid painful emotional states. This resembles Lewis's (1971) theory about overt-undifferentiated shame where there is conscious awareness of emotional distress, typically accompanied by unwanted physical responses like blushing, rapid heartbeat, or sweating, but the emotional experience is denied. An additional barrier in detecting shame, according to the data, is its clinical resemblance to guilt, and the findings largely echo Lewis's writings '…that the experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation but rather the thing done or undone is the focus…' (1971:30). The data showed that in shame individuals felt their entire self being scrutinised, which led to feelings of worthlessness and intense psychic pain. Tangney et al (1992) have provided empirical evidence that shame is more emotionally painful than guilt and showed that feelings associated with guilt and shame result in different behavioural motivations. For shame, a desire to hide or escape is typically present, which is what my data has also shown, whereas feelings of guilt tend to motivate people to want to apologise and repair (Tangney et al, 1992). To summarise, capturing a satisfactory conceptualisation of shame, according to the data, is impeded by a number of barriers and challenges. Participants described shame as a wordless state that is easier to describe than define because it causes dysregulation and alienation.

5.2.3 Therapeutic Reactions to Shame

The third theme, Therapeutic Reactions to Shame, depicts the main interventions that clinicians consider therapeutic in shame work, and identifies the need for self-care.

5.2.3a Striking a strong alliance

The findings showed that even the most mature clinicians may struggle to effectively work with shame if the wider contextual frame imposes limitations on the therapeutic frame in terms of length of therapy, frequency of sessions, type of therapy and peer supportive systems. Participants argued that such limitations can hinder the formation of the therapeutic alliance, which is vital for the course of effective psychotherapy. Robert Langs (1992) argues that the fundamental component of the therapeutic alliance is the therapist's management of the frame. My participants echoed that concept, but they also highlighted that they often feel constrained by externally imposed rules and expectations and they emphasised that such limitations repeatedly hinder their clinical effectiveness, which usually leads to intense experiences of shame for having failed their clients. In a similar tone DeYoung argued that '…if we have doubt about our…protocols…our chronically shamed clients will sense our doubts and our shame. Since shame stirs up counter-shame we will have created a shame-loaded interpersonal situation from the very opening moments of therapy…' (2015:79). The findings underlined the need for a relational frame where therapists feel empowered to reach clinical decisions led by individual client's needs and not by external factors, i.e., meeting key performance indicators in terms of 'numbers'.

Participants also emphasised that facilitating a safe environment, where a sense of overall emotional holding features permanently, is paramount in shame work. Similar findings were also reported by Kissaun (2017) and Miller & Draghi-Lorenz (2005). Winnicott (1971), underscored the importance of early interactions between mother and infant; the nature of maternal care shapes the infant's psychological development, and he states that the mother and her face play an essential mirroring role from the moment of birth. He describes the initial stage of emotional development as the 'holding phase' during which the infant has no knowledge of the existence of anything other than the self. During that phase, the infant is in 'a facilitating environment' in a merged state with the mother (ibid, 1992b:283). He likened the therapist's holding function to this form of maternal availability which protects the infant from being overwhelmed by negative affect. My participants highlighted the need to facilitate environments of trust as a prerequisite to shame work.

Demonstrating compassion about clients' stories and demonstrating being attuned to clients' emotional states were highlighted as effective interventions. Following clients' lead in terms of pace, readiness, and emotional investment to engage with shame related issues are viewed as the foundations of the facilitating environment. Winnicott proposed that the mother through attentive and consistent caring holds her infant's inherited potentials, which consist of the infant's true self and elements that create a sense of a differentiated self. According to Winnicott (1971) the potential for the development of an independent secure self can only occur within the context of good maternal care. The data showed the need on intervening on a much more subtle and relational or embodied level in order to build a suitably safe platform in which shame can be worked in. Developing relational interventions were emphasised in the context of normalising clients' needs to *'…hide…' (Charlotte), '…to slow down…' (Jane),* as therapists are sensitively avoiding causing distress and ruptures by unintentionally aggravating shame. There was consensus amongst participants that effective therapeutic interventions in shame work can only occur within the context of strong therapeutic bonds.

5.2.3b Holding my own & Being emotionally available and transparent

Participants emphasised that the key to a good therapeutic outcome is the ability to acknowledge shame as soon as it becomes present, to recognise it in the patient and to be skilled at identifying it in themselves. The ability to recognise shame in the encounter is crucial to managing the ensuing emotional turmoil that follows when shame enters the therapeutic space. Several authors have articulated the value of knowing one's shame (Brown et al., 2011; Gilbert, 2011; Morrison, 2011; DeYoung, 2015) and researchers Safran and Muran (2000) showed that the therapists' recognition of their own shame can be critical in shaping therapeutic outcomes. There are obvious reasons for this, and I think that the following quotation by DeYoung accurately captures my participants' points: '…we need to have faced and worked through our own…shame…because we need to be able to remain connected and gently fearless in the face of a client's intense self- loathing. We will have to tolerate our client's helpless, hopeless thoughts and resist the impulse to talk to him out of his negative feelings…' (ibid: 77). Amongst the participants there was unanimous claiming of the affective experience of shame. It was seen as a very visceral experience over which one has little or most often no control and typically anxiety and

sadness featured. One therapist (Jane) correlated anger as part of her subjective countertransferential feelings and another (Linda) identified aggression as a form of retaliation having felt bruised by a client's attacking attitude.

There was consensus that clinicians needed to be emotionally available and transparent, as there is no gain in the avoidance of painful emotions in shame work. For clinicians to ask clients to open up the emotion, they must also be emotionally available themselves to fully embrace the experience, to embody it, so that the experience becomes a helpful one for the client. Transparency was also thought of as a prerequisite, so that the patient knows the reasons for interventions, and does not see them as punitive or persecutory. According to the data, meeting a person in their shame is challenging and creates a sense of vulnerability confirming Brown et al (2011) claims that being vulnerable is essential in shame work. It is not possible for us to work from a comfortable position when engagement in relationship is integral to our practice and when we put in our best efforts to be open and available, we are most vulnerable. Participants shared that there is a need for us to be mindful of and understand our countertransference responses: *'…Who am I when I am working with this person?...' (Gavin) '…What is contradictory for me?...' (Amanda) '…What makes me want to move away?...' (Jane) '…What makes me want to move closer to the client?...' (Gill), '…What am I feeling and doing at the moment?...' (Kim).* The data revealed that effective therapeutic praxis usually includes vulnerability in both chairs.

Thoughts expressed by participants reflected the doubleness of experience inherent in shame, as identified by Lewis (1987), involving self in one's own eyes and self in the other's eyes. This was further evidenced by Kim, Amanda, Linda, and Julia when they shared that by participating in the interviews their feelings of vulnerability were evoked, and at times their anxiety about their shame being roused got heightened. Their experiences echo the concept that hearing of shame evokes shame even if only subtly and slightly and that there is a '…significant degree of shame about shame…' (Kaufman, 1989:4). Similarly, Ayers (2003) pointed out that shame is a very provocative and contagious affect that may incite the therapist to overreact as '…the nature of the very early material contained in shame creates a strange relationship between the unconscious and of the patient and that of the therapist…' (ibid:207). Or

indeed in this case between the unconscious of the researcher and that of the interviewee.

The data showed that clinicians' shame often got entangled with clients' material and that therapists failed to empathise with their clients' shame, which resembles Dunn's (1986,1987) findings. Participants also demonstrated that they are not immune to unacknowledged shame, in line with Scheff's (1987, 1998) and Retzinger's (1998) studies that showed the threat of shame occurring outside the therapist's awareness. Ayers (2003) argued that therapists must understand clients' shame but must also understand the unbearable tension which may be triggered when shame dynamics get re-enacted in the therapeutic relationship. She urges therapists to be vigilant and to resist acting out, as clients will pick up signs of unavailability in the therapist with potential adverse consequences for therapy outcomes. The therapist's presence and empathy, according to the data is the first step, and it leads the way to the second step which requires the therapist to introject the clients' projections, to metabolise them, that is to interpret and detoxify them, so they can be returned to clients in manageable doses at the right time.

Reference is made in the data to lapses in therapeutic integrity with a strong undertone of failing to meet the standards of the ideal self. It is easy to get the impression there exists some sort of checklist of qualities we must have in order to be acceptable as a therapist. On the one hand this could be disputed as a myth, on the other hand I contend that there is truth in this expectation within our community. My findings supported the notion that there are expected ways of behaving ethically and professionally that are necessary. Participants also agreed that in the process of failing our ideals we must face ourselves and find a way to live with our failures. *Participants stated that* they have worked on their shame and reported being in touch with it most of the time. Awareness of their shame is fundamental as it allows them to sustain themselves therapeutically and focus on countertransferential feelings as they get elicited in the process of therapy, which then could be applied in building an understanding about clients' issues.

But they also shared clinical vignettes where they failed to '…hold my own…' (Jane) and countertransferential enactments were inevitable, emphasising that holding the

client in mind and resisting the urge to act out punitively in the face of shame may not always be successfully accomplished. Lewis argued that shame affects the countertransference and that therapists may avoid addressing shame directly because of their own discomfort. Retzinger (1988) argued that active noticing of shame experiences by therapists is essential so that shame can be detected and used in understanding the countertransference and therapy failures. Similar themes were also reported by Kissaun (2017) and Miller & Draghi-Lorenz (2005), where therapists' acting out functions as a defence against their feelings of shame, a position that was shared by many authors (e.g.. Harper & Hoopes, 1990; Jacoby, 1996; Gilbert, 1998). My participants viewed their experiences of shame both as an important indicator about the current state of the therapeutic relationship, and at times, as associated to the client's issues and process, not just the therapist's. To summarise, what my findings add to the above contributions is the notion that the core elements of therapeutic interventions in shame work consist of trust, safety, embodiment, transparency, compassion, being connected and attuned, and the capacity to contain the client.

5.2.3c Self Care and Supportive Systems

Participants argued that therapists' self-awareness / insight and self-care are prerequisites for establishing and maintaining a relational frame in working with shame. According to the results insightful clinicians who feel well supported are more likely to build resilience in working with shame. The findings suggested that the therapist's level of resilience towards shame has a significant bearing on their functioning within therapeutic, supervisory, and collegial contexts. Brown (2008) claimed the development of resilience to shame is within reach of us all. She defined shame resilience as '…the ability to recognise shame when we experience it and move through it in a constructive way that allows us to maintain authenticity and grow from our experiences…' (ibid:31). Brown's research revealed common characteristics shared by those with high shame resilience that help them deal with shame and build courage, compassion, and connection. These characteristics translate into key elements: a) understanding shame and identifying triggers b) practising critical awareness c) reaching out to others and sharing stories and d) speaking shame. Brown's findings are remarkably similar to the views offered by the participants within the context of self-awareness, self-care and supportive systems.

The findings revealed that in order to attain and maintain shame resilience therapists should have access to self-care systems, like regular supervision and peer support, that encourage reflection and exploration in a safe and containing manner. Many authors (i.e., DeYoung, 2015; Morrison, 2011) note the importance of good supervision in shame work because shame can be profoundly unsettling and at the same time hidden. Most participants noted that supervision is an ideal setting to further reflect and explore clinical material related to shame work, where they anticipate soothing through empathic connection, validation, and the gleaning of new perspectives. Amanda highlighted that not all supervisory experiences are positive, and that the effectiveness of supervision is partly dependent on the supervisee informing the supervisor of her/his experiences of shame and being courageous enough to enter into the exploration of these. Hence, addressing shame in supervision is not always an easy task as some clinicians struggle to reveal their weakness to their supervisor. This echoes the contributions of Alonso and Rutan (1988) and Talbot (1995) when they argued that in spite of the value of increased awareness and skill development in the supervisor it seems inevitable that the supervisee is likely to experience some shame in the context of supervision. Implications for the practice of supervision will be further discussed at a later point.

Located within collegial relationships competition and comparison with others were identified as key potential inducers of shame for the therapist. The findings highlight these issues that appear to typically reside underground in our professional community. Linda's story offers a description of both competition and comparison. The story exemplifies an acute sense of shame fuelled by a sense of being made to feel different and somehow inferior on account of her choice to remain quiet in a reflective group session. Her shame appears to have been exacerbated by her experience of judgement and being held in contempt by other group members. What if the group facilitator had recognised Linda's inherent vulnerability and worked hard with the group to establish norms of inclusivity and acceptance? Perhaps Linda could have mitigated, at least in some ways, the effects of her shame as it began to grip her. This has implications for facilitators and supervisors of group work, and it will be further addressed later.

Not being good enough or feelings of inadequacy always underpin chronic or toxic shame (Bradshaw, 1988). If our perception is, we are not being good enough amid

colleagues, we will most likely experience ourselves as being different and run the risk of exacerbating our sense of shame. Conducting therapy or attending supervision from a place of not being good enough is challenging. The therapist may be tempted to engage in placatory behaviour in the hope she will be valued by the supervisor. Alternatively, as Morrison (2011) suggested, in therapy she may look the other way when presented with the clients and/or her own shame unconsciously ensuring her not being good enough pot is not stirred.

For all therapists, supervision, peer support and personal therapy were reported as integral to recovery from particularly shameful events occurring in their work. The findings showed that working within the context of a supportive and flexible frame that encourages self-awareness and self-care provides a platform for therapists to tackle the challenges involved in the recognition of shame. Recognition of our own typical strategies of defense against shame during supervision is an essential part of the work according to the findings. As pointed out earlier most often we may not be aware of what activates our shame but familiarity with one's own shame triggers can enable quicker recognition of shame. The challenge remains though how to stay in relationship with oneself and the other? As Gill stated: '*…meet[ing] the client [in their shame] but you obviously then need to hold yourself afterwards, and how does one do that...*'. This will be further examined in the Implications for Practice section.

5.2.4 Shame and Issues of Power

The fourth theme, Shame and Issues of Power, captures therapists' reflections around issues of power in the therapeutic interaction and their thoughts about cultural and societal influences on shame experiences.

5.2.4a Power dynamics in the therapeutic interaction

The literature review revealed that in clinical settings shame can arise from three sources: the client, the therapeutic interaction, and the therapist herself or himself. We have already discussed what the findings have shown about clients' and therapists' shame, here we focus on participants' views about therapeutic process and shame. The data showed that shame lies at the heart of the psychotherapeutic process as therapists '…encourage clients to reach a deeper psychological understanding about who are they really and what they are made of…' (Gill). The therapeutic process itself

can be shame inducing for clients '…therapy itself can be a shameful experience due to the stigma associated with mental health issues…' (Linda). Greenberg and Iwakabe (2011) support this notion when they argue that '…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 therapy begins…seeking help from professionals about personal matters thus can evoke a sense of humiliation…' (2011:74). Participants contended that clients bring into our rooms shame arising from their psychological and behavioural troubles, (that are often a source of social stigma), and their shame of having been unsuccessful to resolve such issues. It has been suggested, therefore, that clients entering therapy are likely to be prone to shame from the start, a position that is also shared by authors like Kaufman (2004), Mollon (2002), and Morrison (2011).

Participants argued that in our work we encourage a focus on feared and problematic aspects of our clients' self, and we expect them to reveal a great deal of extremely personal and perhaps inherently shame-related information without reciprocity. Similarly, Mollon (2002) comments that the shame threats perceived, consciously or unconsciously, in the psychotherapeutic situation, are various ranging from feeling shame about one's own neediness to feeling shame about the fear of not being understood or of being ridiculed and of not being a competent patient. Herman (2011) appears to be in agreement, and she emphasises that the therapeutic relationship is to some degree inherently shaming because of the power imbalance between client and therapist. Likewise, Morrison (2008: 68) alerted us to '…the intersubjective reverberation of shame between analyst and analysand…', referring to the unequal balance of power inherent in the therapeutic relationship, the implied superiority of the therapist, and the potential for a shaming effect on the client due to therapist interpretations. In a similar manner, the BPS Code of Ethics and Conduct mentions that '…not all clients are powerless, but many are disadvantaged by lack of knowledge and certainty compared to the psychologist whose judgment they require" (BPS, 2018, p. 5).

Therapists commented on the paradox between encouraging their clients *'…to discuss issues that make them feel the most uncomfortable...' (Amanda),* whilst striving to

maintain *'…certain boundaries and we try to conceal our own shame about our own shortcomings…and…how they [patients] feel being with someone who appears to have their shit together when they don't…' (Jane).* The restricted social and personal cues offered by therapists, in combination with patients' assumptions that clinicians are paragons of psychological health, according to the data, exacerbate the power imbalance between the two parties and can trigger shaming responses that shape the relationships one establishes with clients. This notion has also been supported by Herman (1992) and Steiner (2011). Steiner (2011) stated that the analytic space is bursting with shame that can be easily evoked by some features of the frame, such as time limit, fixing dates, lying on the couch. Participants acknowledged that in some cases, clients' attempts to shame them, might be an attempt on the part of the client to rectify the power imbalance. A phenomenological study conducted by Emiliuseen and Wagoner (2013) on ethical dilemmas about setting goals in therapy found that the four psychologists who participated in the study were not fully aware of the power inherent in their position as therapists. This was not supported by my research. My findings are supported by Kissaun's (2017) study clearly stipulating that in shame work the power imbalance in the therapeutic setting cannot be denied. Similarly, Ayers (2003) asserted that denial of the power imbalance between therapist and client automatically overlooks the first layer of shame inherent to the therapeutic setting.

5.2.4b The Power of Shame

Researchers have referred to shame as a silent epidemic because it affects everyone but has largely remained invisible in modern societies due to cultural taboo (Brown, 2008; Scheff, 2003). My findings supported Kaufman's (2004) and Bradshaw's (1988) claims that shame plays a vital role in the development of conscience because by alerting us to misconduct or wrongdoing shame motivates necessary self-correction. According to Tomkins (1963) and Lewis (1971) shame is the master emotion in all societies and Piers and Singer (1953) argued that shame is an important part of an internal structure of forces that control the instinctual drives to facilitate the process of socialization.

Ayers (2003) stated that '…shame is an intimate feeling of self-conception as well as a social conception of facing others…' (2003:10). Shame and its impact on the individual and the societal have intrigued the interest of modern and classic

philosophers. Protagoras, a pre-Socratic Greek philosopher in his myth about the origins of shame (Stone, 1989) states that when Zeus feared that ‘our race was in danger of utter destruction’ because the inhabitants of cities ‘did wrong to one another’ and men ‘began to be scattered again and to perish’ sent Hermes down to earth with two gifts, which would enable man at last to practice the ‘art of politics’ successfully and establish cities where they could live together in safety and in peace. The two gifts were Aidos and Dike. Aidos is the sense of shame, a concern of the good opinion of others. Dike here means the respect for the rights of others. In acquiring Aidos and Dike men would at last be able to ensure their survival according to the myth. Likewise, Kaufman (2004) and Bradshaw (1988) argued that shame plays a vital role in the development of conscience because by alerting us to misconduct or wrongdoing shame motivates necessary self-correction. After all, it is usually no compliment to be called ‘shameless’. But Nussbaum (2004) takes a different stance when she argues that although the capacity to feel shame may have important social benefits the harm generated by shaming makes it immoral to use it for punishment. She believes that anxiety about shame creates societal systems that value strength over vulnerability, encouraging men especially to embrace a rigid self-ideal of independence and invulnerability. This echoes my participants observations.

Empirical research conducted by Wallbott and Scherer (1995) showed that shame is experienced differently in collectivist cultures with shorter duration and a less negative impact on self-esteem when compared to individualistic cultures. Similarly, my participants posited that cultural imposed expectations can evoke shame and can affect how people respond to it. Participants also claimed that religion is a powerful cultural force mainly advocating that shame is a fear of disgrace by portraying the theme of original defectiveness and the need for atonement. They argued that cultural and societal influences not only shape perceptions of the self and other but also emotional experiences and as evidenced by Linda in those instances language functions as a veil over the reality of the culture in which is used, involving an agreement of its users about what there is to be seen and how it should be seen.

Participants portrayed the shame culture as being strongly associated with oppression and proceeded with describing how it may be experienced differently by people of certain genders. This echoes Bartky's contributions (1990) when she addresses

shame for women as a feminist issue, whereby shame is the expression of women's oppression. In agreement with existential philosophy, Bartky maintains that affective states have a cognitive dimension: '…if knowing cannot be described in ways that are gender-neutral, neither can feelings. Shame is the feeling disclosive of women's being-in-the- world…' (Bartky 1990: 84). She went on to say that "…The shame of some of these women was not a discrete occurrence, but a perpetual attunement, the pervasive affective taste of a life…" (Bartky 1990: 96). Bartky's argument centres on few basic assumptions: firstly, that women are situated differently than men within the ensemble of social relations; secondly, that women are more shame-prone than men and further, that the feeling itself has a different meaning in relation to women's total psychic situation and general social location than has a similar emotion when experienced by men. Similarly, my participants noted that men and women experience shame differently and they commented on how societally imposed power inequalities shape emotional experiences.

The troubling implications of shame being experienced differently by people of certain genders is its relation to power and this was confirmed in the findings. There is empirical evidence that women report more shame than men (M. Lewis, 1992; Orth et al., 2010), and as I write about this what comes to mind is the rise of the #Me Too movement in social media, mainly led by women, as a current example where victims of sexual abuse and sexual harassment met each other in their shame, and publicized allegations of sex crime, and by shedding light on a much larger systematic issue perpetrators are held accountable. We have seen that shame plays a role in our moral development, but given its often readily acknowledged harmful effects, shame is frequently put to politically problematic and morally questionable ends. In patriarchal societies, as reported by Linda, the outgrowths of this regularly entail gendered consequences, as gendered shame may form a disciplining device operating through structures of oppression, such as gender, but also class, race, ethnicity, sexuality, and nationality.

The question of a politics of shame, therefore, arises in the context of a consideration of the social and political deployment and manipulation of shame, and the reported divergence in the shame experience itself, which feminists have attributed to its manifestation through, among others, gender (Fischer, 2018). Fischer (2018) argues

that there is a politics of shame which involves gendered subordination and insubordination and she went on to highlight the relation between gender, power and shame, a notion supported by the findings. So called honour killings are inflicted on people, mainly women, who bring shame to their families, often for nothing more than loving the wrong person. What becomes highlighted here is that shame can serve as a social mechanism, a tool of bullying, a psychological form of mob violence.

If we are to use shame positively, however, we must be mindful of how easy it is to abuse it. Interestingly, the findings showed that in other contexts, as reported by Gavin in his comments about Weinstein, we are rather conflicted about the cry of shame. You can protest against honour killings one day, and then name and shame tax-evading millionaires or celebrities who commit adultery. When politicians are called shameless there is no doubt that this is a very bad thing. There is an underlying thread in my participants' accounts that shame is a bit like rain, whether it's good or bad depends on where and how heavily it falls. And yet there should be no question that we need shame. Morality is in essence the means by which we control the way we treat each other to maintain as much peace, fairness, and social harmony as is possible and shame appears to be central to this.

5.3 Implications for Practice

In this section I aim to uncover what helps therapists in dealing with shame in both themselves and their practice. The findings support Retzinger's (1988) notion that active noticing by therapists is essential so that shame can be detected and used in understanding the countertransference and therapy failures. The therapists highlighted the importance of connection, which involves coming out of hiding and isolation, in order to build and maintain strength in facing experiences of shame (Brown, 2006; Van Vliet, 2008). Participants' shared DeYoung's (2015) position that '…if we practice from a developmental/relational perspective we believe our clients internalise the capacities for emotional regulation, mentalisation, and compassion that are embedded in how we relate to them…' (2015:173).

Most participants described their difficulties with remaining clinically available in the grip of shame. For example, Gill, Amanda, Kim, Jane, and Linda reported that maintaining a connection with clients, even when they were trying to be transparent

and accessible triggered intense levels of vulnerability in them and subsequently compromised their ability to sustain an attuned therapeutic stance. Participants shared the belief that to some extent experience can assist us to build this capability. In a similar manner to the findings, Kaufman (1993) advocated for transparency on the therapist's part; for example, after making a mistake, by taking responsibility and sharing feelings authentically therapists directly facilitate healing. He claimed '…through permitting clients to know their therapists on the inside, clients are enabled to identify with them, to feel one with them…' (ibid: 233). Kaufman maintained that self-disclosure is fraught with shame for therapists, and this echoes Amanda's experience, in part because there is no clear rule about how much and when to disclose. Yet Brown (2010a) and others have advocated that 'me too' are two of the most powerful words when it comes to meeting others in shame. Participants asserted that being aware of our shame triggers, default positions and what we might need in the moment of shame are paramount aspects of effective shame work. In a similar tone De Young (2015) claims that there is no cure for chronic shame and that the work involves working with the triggers. She noted the importance of befriending the shamed part, rather than thinking we can get rid of it. Fisher (2016) highlighted the importance of uncovering how the shamed part helped in ensuring survival, for example, being seen and not heard makes sense as a response to early traumatising family environments.

According to my participants vulnerability is expressed through authentic communication and Brown (2010a) offers the following definition '…Authenticity is the daily practice of letting go of who we think we're supposed to be and embracing who we are…' (2010a:50). This definition challenges the idea of the ideal/perfect therapist identified in the data, in favour of self-acceptance. A person spontaneously and genuinely sharing who they are creates a picture of authenticity in action. Brown (2008) highlighted the impossibility of sharing ourselves though, when we perceive ourselves as flawed and not worthy of connection, a notion shared in the findings. Therapists revealed that shame often stops us from presenting our real selves; this brings to mind Winnicott's (1960) conceptualisation of the false self, which functions to hide and protect the true self, that is based on spontaneous authentic experiences. Bradshaw (1988) contended that the escape from the self, via the creation of a false self, is triggered by toxic shame. The therapeutic relationship is one place where both

therapist and client are challenged to practice authenticity. In my experience on both sides of the couch there is a deep longing in shame work for authentic communication.

According to Miller, Jordan, Stiver, Walker, Surrey and Eldridge (1999) '…therapist authenticity does not mean that the therapist is reactive or totally disclosing. Instead, it means the therapist is present, responsive and real…' (ibid:1). The distinction between reactivity and responsiveness was highlighted in my findings as pertinent aspects to the therapist's experience of shame. As discussed, the affective nature of shame may result in the therapist's engagement in reactive behaviours that preclude her ability to be with the thoughts and feelings occurring in the relationship. This in turn impacts in a restrictive way on the therapeutic relationship and process. Miller et al. (1999) named movement as a key feature of a therapeutic relationship featuring authenticity. Involving moment to moment relational responsiveness, it encompasses the movement towards connection, the associated fears, and the strategies of disconnection. Shame plays a key role in propelling movement away from connection. However, empathy, according to the findings, is one way we can be brought back into connection.

Jordan (1997) claimed that mutual empathy is a vital part of authenticity that creates a sense of connection and as such is a core relational dynamic leading to growth through therapy. Mutual empathy involves the client knowing she has an impact on the therapist as she observes those responses of the therapist that tell her she matters. Such relational responsiveness contrasts with traditional modes of psychotherapy in which neutrality and non-disclosure are advocated. Nathanson argues that '…therapeutic passivity – the decision to remain silent in the face of a humiliated, withdrawn patient – will always magnify shame because it confirms the patient's affect-driven belief that isolation is justified…'(1992:325). What Miller et al. (1999) have advocated is a reparative experience of relationship, one featuring an accurate mirror that can lessen the impact of the past inaccurate mirrors, characteristic of shame based family systems, and this was also demonstrated in the data. Empathy involves an ability to see the world of another from their perspective. It can be considered an antidote for shame; however, this is not such an easy remedy as it may first appear. The protective nature of shame makes it difficult to give or receive empathy (Brown, 2008) because shame's self-focus has been shown to obstruct empathy for others

who may have been mistreated (Tangney and Dearing, 2002; Tangney et al., 2007a). This has major implications for therapists, most of whom consider empathy as one of their tools of trade. The findings suggested that therapists suffer intense distress when shame experiences compromise their therapeutic integrity, namely their abilities to remain empathic and compassionate, with direct harmful bearings on the therapeutic relationship and process. This echoes Gilbert's argument that '…compassion with its focus on acceptance, understanding, and affiliation, can be a powerful antidote to the alienating experiences of shame…' (2010:339).

The findings are in agreement with Harper and Hoopes (1990) contributions about signals for therapists recognising feelings of shame as including: discomfort toward client, emotional withdrawal, therapeutic impasse, inappropriate caretaking, self-doubt and self-blame regarding lack of progress, outwards shaming of clients, dreading sessions with certain clients. Participants revealed an implicit shared view that engagement in quests to make meaning of shame experiences through individual reflection and supervision led to strength, compassion, and self-awareness. This is also echoed in DeYoung's question '…Why might excellent therapists also be shame-prone therapists...' (2015:78). Her answer is that early experiences of emotional disruption and shame build attunement skills, coupled with a deep desire to alleviate emotional hurts and relational brokenness, all of which equip us well for our careers. Likewise, in the context of discussing early memories of experiencing shame in the hands of others, my participants also highlighted the correlation between past experiences of shame and their adult choices to become psychological therapists.

Here we looked at my participants' contributions about identifying ways to mitigate effects of shame in clinical settings. Whilst it is difficult to gauge the impact of therapist shame on the therapeutic alliance and process, some possible impacts have been named. According to Brown (2010a) the cultivation of worthiness in our selves lies in our practice of courage, compassion, and connection, which is a sentiment shared by my interviewees.

5.3.1 Implications for Supervision and Training

Participants highlighted that internal and external pressures to fit in with the image of the super competent therapist have a significant bearing on their functioning within

therapeutic, supervisory, and collegial contexts. Most participants reported that the pressures to meet unattainable professional expectations influence their ability to openly discuss issues of shame in supervision and during training. I identify with my participants' accounts as my personal academic experiences have been such to support the notion that academic institutions may inadvertently engage in potential shaming behaviours towards students.

For example, a common practice during my studies has been the return of marked academic work in a rather public manner in front of the whole class. Many times, after such incidents, I noticed fellow students avoiding eye contact and rushing out at the end of class. Not producing academic work that meets the 'standards' is enough to throw any new trainee to a deep state of shame and panic, but to also be subjected to such feedback in front of the whole class, amplifies shame to unbearable levels for some of us. Psychotherapy courses often facilitate reflective spaces, where the whole class gets together and students are encouraged to share, reflect, and comment on their personal processes in the context of academic and clinical work. Such spaces are meant to help students bridge the gap between the personal and the professional. These groups are always facilitated by a faculty member of staff. Even though I always tried to make use of such groups I could never quite clearly determine their purpose. They are not a therapy group, or a peer supervision group but a reflective space; as helpful as the term 'reflective space' sounds what complicated matters for me was the mere fact that the role of the facilitator was also to assess students' skills and capacity to reflect in the group setting. Inadvertently, such a setup is potentially laden with shame, in similar ways to how the therapeutic process itself can be shaming for some clients. Also, as a trainee psychotherapist/psychologist you are expected to participate in role-plays assuming the role of the therapist whilst the class and the tutor observe. Again, such encounters could cause intense shame not only to novice students but also to seasoned trainees.

I am not advocating that students should not receive marked work in a group setting, or that reflective groups and fishbowl exercises should stop existing. On the contrary, I have valued these experiences as I believe helped me to develop as a clinician. Instead, what I am suggesting, is that academic trainings adjust their curricula in a way that helps trainees to find the link between their shamed identity and their choice of

career in psychological therapy as this may assist them to reduce their need to appear competent students all the time. The notion of the 'wounded healer' as introduced by Jung (1944) has encouraged myriads of therapists to embrace their own internal wounds and to recognise their longing for personal healing through the practice of psychotherapy. Perhaps we should start introducing the notion of the 'shamed healer' and/or highlight the determining role of shame in one's experiences of trauma and emotional injuries. Of course, as my findings suggest, shame also gets fuelled by cultural dynamics and there is a clear need to help trainees, as Brown (2006) recommends, to deconstruct and normalise the shaming experience by linking personal experiences, to social, cultural issues and to one's need to strive for perfection and unrealistic standards. Such a process may help trainees to externalise their views about what professional attributes they are expected to conform to and to identify their unrealistic expectations of themselves and their clinical work.

If the above recommendations could be introduced into professional trainings, it would inevitably increase the likelihood of establishing less defensive professional attitudes towards shame experiences and subsequently qualified and trainee therapists will feel less cautious to address and explore shame issues in supervision. Although most of my participants stated that they felt safe to discuss shame with their supervisors, they underlined their resistance to do so, when the supervisory environment failed to supply them with confidence. Amanda pointed out that she often kept things from supervision in fear of being perceived incompetent. She realised that this has a lot to do with her own unresolved shame issues, but she also highlighted her supervisor's lack of sensitivity about such issues. It is therefore paramount that supervisors encourage supervisees to share their feedback and critique about the supervisory relationship, a notion also demonstrated in Yourman (2003). In addition, supervisors must share an empathic understanding and a compassionate attitude acknowledging the difficulties involved in disclosing self-perceived thoughts about inadequacy in supervision. I would also like to note that another factor that affects a supervisee's openness is the power imbalance between supervisor and supervisee, particularly in the context of supervision during training, where supervisors are often asked to produce reports about the student's therapeutic skills and efficacy.

In Chapter 2 I looked at theories about the development of a cohesive self (Kohut, 1971). I concur with Kissaun (2017) that theories about the development of a healthy self can potentially be applied onto academic trainings to enhance the formation of the cohesive self-as-therapist. If tutors introduce facilitative training environments, that resemble Winnicott's (1965) notion of the 'holding phase', and from very early on care and attention is given on trainees' unrealistic expectations about super competent therapists, trainees would most likely feel empowered to address and face their limitations and flaws, and one hopes that as qualified therapists they would demonstrate a more realistic sense of self-worth and subsequently would feel better equipped to address shame dynamics in the clinical encounter.

5.4 Limitations and Strengths of my Study and Future research

The picture of therapists' experiences of shame as depicted by my study is by no means complete. It is likely that the small sample size is one of the possible limitations of this research. Even though I met the IPA criteria in terms of number of participants one can argue that a larger sample size would have provided a greater range of experiences to draw from. It could be argued that this range would have enriched the study. However, the time restraints inherent in a small-scale study such as this, coupled with my aim to capture the subjective experiences of the participants in depth, and the immersion in the data over a period of time (Smith, 2004) prohibited the use of a larger sample.

Another possible limitation stems from the characteristics of the sample in terms of gender, culture, and workplace. Only one male therapist volunteered to participate in my study. Theory and empirical research have shown that shame can be a painful topic to discuss as it can evoke intense vulnerability. Also, research has revealed that there are significant differences in how men and women experience shame. Brown (2012) identified a clear expectation for men to not be perceived as weak; perhaps this can explain why only one male therapist put himself forward for my study. However, the lack of a balanced gender representation amongst participants has inevitably affected the type of data generated. Also, the group of participants is not truly representative of the field of psychotherapy and psychology in terms of cultural diversity. From the eight participants three identified as White Other, one as British of Mixed Parentage and three as White British. The white majority of my sample has

inevitably shaped the data in certain ways since there is strong empirical evidence that shame is experienced differently in different cultures. In addition, most of the clinicians involved in my project worked in an acute physical health setting and unavoidably some of their narratives were about clients' distress about ill physical health. I wonder what my results would have looked like if I had a better representation from clinicians from a black and ethnic minority backgrounds, if more male therapists participated and if interviewees had a more diverse NHS experience, i.e., a balance between physical health settings and acute mental health settings. Therefore, an implication for further research includes additional exploration of shame experiences in a broader cross section of therapists including males, therapists from different cultures and diverse clinical experience.

In terms of research trustworthiness, one could ask the question: 'were the participants describing shame or some other experience?' This question is impossible to give a definitive answer to insofar as many variables exist in humans and our response. As I mentioned earlier, I approached the interviewing process with the utmost respect, and I tried to create an honest and open relationship with my participants. However, if we consider the intrinsic tendency to hide the most shaming experiences, and the context of the inevitably social nature of an interview, then one can perhaps speculate that in this study only the less threatening end of shame experiences were explored. Andrews (1998) suggested that one-to-one interviews could be shame inducing and hence decreasing the likelihood that aspects of shame will be shared. It is noticeable that certain topics were not discussed by participants, such as, sexual feelings about clients, client's suicide, and their own shame in relation to their physical ill health.

Furthermore, because the findings are based on self-reports any aspects of the phenomenon that remained outside of their awareness would not have been accessed, allowing only a partial view of the phenomenon under investigation. Participants acknowledged their difficulties in describing shame, but when they were asked the question 'what are your experiences of shame?' they managed to elicit clear responses and illustrations, thus providing a more qualitative assessment of shame. Also, it must be highlighted that the findings are based on participants' retrospective recollections of shame experiences and therefore cannot be taken as literal accounts of what actually happened. However, this in no way negates their value in offering a

glance into the meaning such experiences can have for the therapist, and the challenges encountered in processing them. Shame was illustrated to have certain common qualities, and these were consistently verified across the group and matched my own experiences.

Another potential limitation of the results is the subjective nature of language and the subsequent analysis. Additionally, qualitative research has been criticised for placing emphasis on the subjective experience of the phenomenon. Subjective interpretations are part of the IPA framework so it is inevitable that questions of credibility will arise primarily because there are, perhaps, an infinite number of possible interpretations of the data. For example, it is possible that blind spots and countertransferential issues can impact on how we hear and interpret the participants' stories (Rose and Loewenthal, 2006), and even though I have produced a trail of how my results came about and I have aimed to remain as transparent as I possibly can in every stage of the data collection and analysis, I am sure there exist alternative descriptions and interpretations of some of the findings. In an attempt to enhance credibility, I have used my clinical and academic supervision extensively for the purposes of addressing possible researcher bias, blind spots, parallel process, and countertransference.

A limitation also stems from my decision to introduce certain steps in order to preserve my participants' rights to anonymity and confidentiality, and even though my choices adhere to guidelines about research ethics, they bear consequences and limitations. For example, I am not able to introduce my participants as fully as I would have liked; I am not presenting a pen portrait for each one of them, and subsequently I am risking not enabling my readers to see the uniqueness of each participant and how they present themselves in their lived world. As a result, I have taken extra care in ensuring that the salient interview extracts I present in this chapter not only illustrate each theme but also, as much as possible, I sought to capture the essence of the individual. To assist my readers to get a more intimate understanding of my interviewees I also include, for each superordinate theme, tables that provide a visual representation of the most prevalent types of experiences recounted by them.

At this point I would like to consider the implications of my decision to prioritise the wellbeing of the participant over the collection of a more detailed account. I, as the researcher, would have at times liked to delve deeper into the narratives of the

therapists, but there was a clear boundary on my behalf as to how intimate one can be in exploring the experiences of participants. In some cases, I wanted to unpack the defensive reactions some therapists reported experiencing when seeing shame in the patient or when they reported experiencing shame in the process of the interview. However, I was aware that I would be potentially delving into psychological explorations with each participant risking rattling unconscious unresolved problems with potential distressing bearings on them, and the encounter could potentially turn into a psychotherapeutic examination and therefore raise ethical implications. So, the limitation here is that with many of the experiences described by participants many other meanings may lie underneath that were not revealed and identified in my study due to the above. Of course, in hindsight, I also wonder whether my personal fears about potentially being perceived as aggressive, intrusive, and insensitive were the catalysts in not pursuing the unpacking of defensive narratives.

I agree with Sword (1999) that by declaring my direct interest (as the researcher) in the phenomenon, increased the legitimacy of the findings, and this is one of the strengths of my study, as transparency is considered to enhance the trustworthiness of my work. Participants were given copies of their transcripts and this follow up process gave the opportunity for sharing of subsequent thoughts and feelings after the interviews as well as ensuring accuracy of the data. IPA studies tend to focus only on small samples so there is no generalisability claimed. However, it is intended that, by close examination and metaphorically shining a light on a small area, this may lead to the illumination of the whole. Professional opportunities for disclosing shame related experiences amongst colleagues are limited. The provision of this opportunity can be viewed as a strength. In a sense the whole study models processes in which therapists may choose to engage. For example, talking and/or writing about shame, taking shame laden material to supervision and sensitivity to colleagues who may be experiencing shame.

Implications for further research could involve therapists who practice from different modalities in the exploration of experiences of shame. The need for a study that includes a broader cross section of therapists including males and therapists from different cultures was already mentioned earlier on. Studies focused on therapists' experiences of shame in any of the specific contexts of supervision and therapists'

training could add significantly to the thin bodies of empirical research in these domains. Also, another research project could further research the role of intuition and embodiment in clinical work with shame. Additionally, a phenomenological study to investigate experiences of shame in physical health settings, in particular cancer, could shed light to the 'elephant in the room'. Furthermore, a research on therapists' body shame may be especially pertinent to the areas of physical health, eating disorders, Body Dysmorphic Disorder, where body shame is a central feature and clinicians' unresolved body issues may negatively impact therapeutic efficacy.

As a final comment about strengths, I would like to share that my findings underscored the delicate nature of the shame experience, which probably illustrates why so little direct research on this phenomenon has been conducted so far. The results highlighted that therapists are constantly paying awareness to three critical relational dimensions in shame work, that is their intrasubjective world (their relationships with themselves), the intersubjective world (the relationship between therapists and clients), and then again, the intrasubjective world of the client. Undeniably this three-dimensional phenomenon represents the nature of all clinical work, but it has been argued by my participants that there is something unique to this when it comes to shame, because as the review of the literature and research revealed, shame has the capacity to strongly hinder all of these causing ruptures that may interrupt or threaten the therapeutic process.

5.5 Personal Reflexivity

As I mentioned previously at the early stages of my study, I felt embarrassed and reticent about the choice of my topic, which I can now understand as a demonstration of my own shame about shame. My main motivation to investigate shame was to find out how other therapists manage their experiences, secretly hoping to uncover therapeutic strategies that would help me to sustain myself at the grip of my shame. As my study approaches its completion, I find myself having mixed feelings as this project has been a significant part of my life for the good part of the last ten years. I have spoken about my initial difficulties to embrace constructive criticism from my research buddies and supervisor and my struggles to fully immerse myself in the literature and my data. I vividly recall the feelings of mortification during my mock PAP presentation in front of my classmates some six years ago. My ambivalent feelings

about my topic were intensified as I observed my audience signalling boredom and lack of interest. To my surprise during their feedback, they appeared enthusiastic about the topic but unimpressed with the theory-heavy content of my slides and my somewhat apathetic presenting style. I was told that 'I was nowhere to be seen' and that I was 'hiding behind theory and research', to the extent that my audience felt disengaged from my topic and from myself.

Making myself seen has been the most challenging task for me throughout the implementation of the whole study, such is the power that my shame holds on me. This equated to having to amend my writings a number of times in my attempts to show that I as the researcher strived to remain aware of my personal positioning in the research process, including my awareness of my personal perceptions of shame and shame work, as well as my personal investment to understand working with it in more detail. Unavoidably, I drew upon my own experiences as a trainee, client, supervisee, therapist, supervisor, and my past clinical experiences, as well as the exposure to the shame literature and research in pursuing to understand and interpret the narratives of my participants. My belief that Counselling Psychology and Psychotherapy are paradigms of intersubjectivity, and that therapists must reflect on the way they generate meaning intersubjectively, has potentially influenced the analysis of the data.

My journey in completing this study has enhanced my belief that shame is neither maladaptive nor adaptative, but instead it exists on a spectrum. It is a human given that can tie us in knots, and this has led me to pay attention to many different reactions and responses to the phenomenon as experienced and relayed by my participants.

5.6 Concluding remarks

The findings of my study point to a perpetuation of empathic failures throughout childhood as described by all participants who spoke about their earlier life. The data showed that such shaming experiences become internalised and become part of one's identity, thus influencing self-image and future interpretations of relationships. The idea that shame emerges in relationship is well supported in the data. As noted in the literature review these failures of attunement, when repeated over time, set up a predisposition to shame (Bradshaw, 1988; DeYoung, 2015; Kaufman, 1992, 1993). De Young (2015) asserted that '…shame is the experience of self-in-relation when 'in-relation' is ruptured or disconnected…the experience of one's felt sense of self

disintegrating in relation to a dysregulating other…' (2015:18). Ongoing experiences of dysregulating others appeared to feature strongly in the early histories of the participants and certainly this is true of myself. These experiences have prompted all of us to undertake considerable personal work to heal their impact and yet we often find ourselves, as shown by the findings, catapulted back into the early experience of shame. Hence, shame does not happen in a vacuum. This wound occurs in interpersonal contexts and the findings showed that clients reveal intense levels of shame when discussing their underlying interpersonal needs to belong, to feel accepted, to feel loved and cared for. We all need to feel connected to others, and therefore, healing needs to occur not only within the self but also within a relational context, which is a notion supported by Kaufman (1992).

A brief comparison between my results and the findings in the study conducted by Klinger et al (2012) showed that none of the five key Therapist embarrassing and shameful events (Scheduling mistake, Forgetting or confusing client information, Visibly tired and unfocused, Late for appointment, Fell asleep) as reported by Klinger were identified in my study. Of the remaining events there were only four individual reports of each in my study: 'Misspoke' (in the context of making a comment showing incompetence), 'internal challenge' (internal self-critique due to inappropriate approach/intervention), 'client challenge' (client verbally challenges/critiques therapist in reference to incompetence), and client terminated abruptly in the category 'other'. The discrepancies between the two studies can perhaps best be interpreted as the differences in the sample groups. My research group comprised of clinicians who practiced within intersubjective process based psychological approaches. The majority of the 16 events as reported by Klinger at al. mainly involved concerns about the client's perception of the therapist in areas of imperfection. Working from process based intersubjective perspectives the assumption can be made that the participants in my study recognised the influence of the unconscious, coupled with their embeddedness in the therapeutic relationship. Integral to relational psychotherapy is a requirement for rigorous self-examination and awareness of one's issues, which includes recognition and ownership of shame. I contend that these views and practices differ from those of the therapist in the study conducted by Linger et al. and perhaps explain why the findings are skewed towards the performance or actions of the therapist. My study has elicited sources of shame generated for the therapist's feelings

about themselves, therapeutic dyad, supervisory relationship and one's professional community / peers.

My findings align more closely with the sources of therapists' shame reported by Kissaun (2017), Miller & Draghi-Lorenz (2005), and Morrison (2008, 2011). Kissaun (2017) and Miller & Draghi-Lorenz (2005) reported similar empirical findings to mine, encapsulating the psychological collapse occurring in the shame experiences, whilst also highlighting that clinicians must maintain emotional connection, responsiveness, and understanding in order to assist clients in the grip of their shame. Morrison, on the other hand, used himself as a case study for the elicitation of his findings. He uncovered sources of shame arising from the intersubjective meeting of the therapeutic duo, and he also spoke about shame beyond the therapy room, reflective of those revealed in my study (i.e., training, competitiveness). Morrison stated that in clinical work the activation of shame rises through identification with the client. We see this dynamic played out in Charlotte's work (opting to not extend the therapy of a demanding client) and its impact on both herself and client. It is easy to visualise the pain that Charlotte endured for not attempting to actively unpack the reverberations that existed between her and the client, which could have led to a recognition of what belonged to her and what rested with the client. It is easy to see that in the absence of that the shame dynamic continued to be enacted and wreaked havoc in the therapeutic relationship. It was only in retrospect that Charlotte became aware of the complex dynamic, an experience awfully familiar to me as I have found myself involved in similar enactments, and I am too well aware of similar vulnerabilities in clinical work.

To summarise, my study in line with previous explorations of therapists' shame experiences has reiterated that they can be a potent dynamic in the therapeutic encounter, strongly indicating that such experiences must be attended to and further explored, if we as clinicians are to develop our capacity to recognise, tolerate, contain, and make use of our shame in the service of our clients. The findings have various implications for the practice and training of Counselling Psychology and Psychotherapy and also it has expanded our understanding on how cultural forces serve to enhance the potency of shame.

Chapter 6: Conclusion

In this chapter I envisage to conclude by briefly bringing together key theoretical aspects about my topic. I also endeavour to share my own learning, how it has changed my views about shame, the ways it has influenced my practice and highlight any surprises as a result of the overall work. As a final point I will focus on the contribution that my research is making to the field, in terms of conceptual knowledge and the understanding of practice.

Psychotherapeutic literature has shown an increasing interest in shame over the last forty years approaching it from various epistemological stances. Most empirical studies come from a positivist perspective and have focussed on the links between shame and the maintenance of psychological disturbance. In previous studies, shame has been related to several difficulties, including eating disorders (Swan & Andrews, 2003), depression (Cheung, Gilbert, & Irons, 2004; Hook & Andrews, 2005), anxiety (Gilbert, 2000) and posttraumatic stress disorder (Black, Curran, & Dyer, 2013). It has also been suggested that shame related behaviours, such as withdrawal or non-disclosure can have a negative impact on the therapeutic relationship and interfere with positive therapeutic outcomes, as they are understood in most forms of therapy (Black, Curran & Dyer, 2013; McDonald & Morley, 2001). Indeed, it could be argued that if one believes that their 'self' is intractably defective and has a desire to hide from others, as described above, they will possibly refrain from 'being open' and developing an intimate therapeutic bond, which is seen as a therapeutic ideal in most therapeutic approaches (Gergen, 1995).

As we have already seen shame has been defined in multidimensional ways. It is described as a self-conscious emotion, a social emotion, a psychological construct with cognitive, emotional, and behavioural components, an aspect of identity, a characterological trait, a disruption in the attachment bond and an inhibitory response that shifts activation from the sympathetic to parasympathetic nervous system. In addition, shame is a common word used frequently in popular culture and has cultural context. It is universally felt to be distressing and painful to experience and has been described to be both adaptive and maladaptive. This all makes the dialogue about shame complex.

Different researchers have different opinions on whether shame can be adaptive based on how they conceptualize shame. Adaptive shame is theorized to be an acute short-lived emotion that facilitates relationships. Maladaptive shame is associated with negative core-identity issues, maladaptive defenses against shame and increased risk of mental illness. Whether shame is adaptive or maladaptive depends on an extensive constellation of factors including one's culture, background, family experiences, personality, and the immediate context. The importance of good-enough parenting, and the importance of good-enough peer relationships need to be emphasized. The repair of shame may be the most important factor in how shame is managed. It is in the rapid return from the distress of shame that an infant learns to tolerate distressing emotions, learns to manage shame, and creates an expectation that challenging social interactions will have a positive outcome. Attachment is intimately connected with shame issues (Schore, 1996).

De Young (2015) puts forward a relational theory that stresses the attuned, nurturing relationships a self must have to feel whole and well; she argues that if having a coherent sense of self is psychologically necessary for human beings, then the disintegration of the self threatens psychological annihilation. She argues that the word disintegrating-self captures the acute shame experiences of feeling humiliated, incoherent, shattered, and vaporised with the threat of psychological annihilation being captured in people's wishing to sink through the floor or to disappear. She argues that in a good enough parenting scenario when a child misbehaves a parent's disapproval may cause shame and the danger of the child's self-shattering. In good enough parenting the disciplinary comments are followed by a return to relational connection, which enables the child to internalise a sense of small break and repair, an essential ingredient for future social connection and negotiation with others. What leads to unresolved experiences of shame, or chronic shame as she calls it, is unrepaired disconnection between parent and child. In such encounters the child's sense of a coherent-self disintegrates as they can no longer feel relationally connected with a person who holds her in emotional being.

Hence, shame can threaten one's flings of belonging and acceptance within interpersonal contexts and as a result, is an alienating and isolating experience that is far from trivial, often deeply disturbing and a cause of significant distress. While shame

signals a significant social threat, it also creates a bind for the person experiencing it, as revealing that one is experiencing shame is itself shameful. As a result, shame symptoms provoke a shame spiral or 'loop', in which, when shame arises it incites more shame (Scheff, 2000). Shame, thus, is an iterated emotion; its occurrence leads to an intensification or multiplication of itself (Lewis, 1971; Kaufmam,1993; Stern, 1985).

The self looking at the self through the other's eyes were consistently reported in the data (Lewis, 1987); a trauma to the self, shame has been shown to be deeply distressing, destabilising, and pervading the core of who we are. The findings largely confirmed authors' assertion that individuals go out of their way to avoid shame (or even mention past instances of shame), even when this avoidance means harming or hurting the self. Although the experience remains available to consciousness, the person experiencing it is not able to, or perhaps simply will not, identify it as shame, and there is an intrinsic connection between shame and the mechanism of denial. In these cases, shame is 'by-passed' and other affects, such as anger, guilt, depression, doubt or excessive displays of pride through narcissism, take over (DeYoung, 2015). Shame also creates a sense of heightened visibility and, as a result, has a tendency to provoke concealment—to hide one's shame and to obscure that of which one is ashamed. In short, shame (or even just the threat of shame) induces a panic state where the 'necessity' (to hide or conceal) overrides rational thought and moral reasoning (Williams, 1993).

Subsequently, the elusive nature and complexity of shame pose significant challenges for therapists in practice. It is not uncommon for us to fail to recognise the experience of shame and its triggers and to find ourselves acting in ways we do not intend, or like. Shame's concealment behind various masquerades makes it a truly elusive phenomenon. These factors appear to have contributed to a lack of attention in the literature of shame in the therapeutic context. An even larger gap in the existing body of knowledge is that of therapists' experiences of shame, a situation which I have sought to address in this thesis.

The data showed that therapists' personal shame work is never complete. We encounter shame in our practices and daily lives and reverberations continue to impact our whole self, to a greater and lesser extent, depending on our level of shame

resilience. I consider this study has relevance to all therapists whether they consider themselves shame prone or not. The data offered rich accounts of therapists' experiences and highlighted layers of physiological, behavioural, emotional, cognitive, and intersubjective impacts. The tendrils of shame are seen as reaching right into the past where earlier scenes are located.

According to the findings therapists' shame gets activated through identification with the client, competition and comparison with colleagues and treatment failures. An overall underlying thread that underpinned all the other themes has been the notion of 'not being good enough' and failing to meet the standards of our ideal self. The human response of looking the other way automatically evoked by shame seems to have been enacted in several of the stories. It appears our ashamed clients cast us into our own fears, anxieties and sometimes shame. Similarly, experiences of empathic failures amid colleagues were experienced as excruciatingly painful. What has been highlighted by therapists' sources of shame is the relational aspect of their experiences that often leads to disconnection and isolation.

This partly reflects my personal process as the deeply disturbing notion of exposing my flawed self and my inept researcher skills to my interviewees, my supervisor and my assessors has marked every stage of this project. It has taken me many years to complete this study and I believe that part of my resistance has been my avoidance to face, confront and process my own complex issues around shame. Retrospectively thinking, I can see that as my shame permeated every stage of my research, I employed my default position of avoidance by removing myself from competing the task. Reaching out to my external resources (supervisor, personal therapist, research buddies) helped me to gradually re-align myself and to meaningfully engage with my thesis.

Although massively challenging at times, engaging with my research has been personally rewarding as I feel that my knowledge and research skills have increased immensely. I feel fortunate and privileged to have gained in-depth insight into my participants' experiences of shame and I was touched by their eagerness to share deeply personal and painful material. The research journey has enriched and deepened my academic and clinical work as I've become more aware of my own shame triggers and my defensive coping strategies. Reading and researching shame,

interviewing, transcribing, and analysing the data has inevitably forced me to look at my own intrapersonal and interpersonal difficulties. The most noticeable change, the most unexpected precious outcome of this journey, has been my attitude towards my flawed – not good enough – inadequate self. I am less harsh, less punitive, less dismissive, and less judgemental; it is like my 'inner critic', my internalised shaming other, my super-ego, the aspect of me that has always been rather unforgiving of my failures and imperfections has mellowed down, has become more accepting and less resistant to entertain a more balanced view of myself. Of course, as previously mentioned our personal work processing shame perhaps never stops, but what I can confidently say is that this research has helped me to feel more integrated within myself both in my personal and professional life, as I feel more relaxed, more present, and available in my relationships with loved ones and with clients.

So, the implications for practice, stemming from my study, involve the importance of understanding shame, recognising our triggers and reactions as therapists. The study underscores the significance of personal awareness of one's triggers as the therapist. A range of sources of shame for clients and therapists have been revealed. Similarly, the many ways both therapists and clients defend against shame have been described, for example denial, self-blame, contempt, and avoidance. Familiarity with these mechanisms and our typical strategies of defense gives us insight into our inner experience of shame. These reactions inform the countertransference and stand to be enormously valuable.

Shame has been presented as constructed in relationship. Therapeutic work demands an ability to tolerate this often dark and disruptive affect. Shame arises in the process of doing therapy itself. Therapists discussed how to handle the inherent power differential in therapy by being collaborative and transparent, pacing carefully and being compassionate. Failure to attend to shame in the therapeutic context in both oneself and one's clients has been identified as impacting the relationship and outcomes of therapy. The data showed that there is an inherent vulnerability for both parties in shame work and therefore a prerequisite for clinical effectiveness is therapists' readiness and ability to embrace their shame. Courage and self-compassion, as well as compassion for the others, have been identified as significant requirements for the therapist addressing shame be that with clients, supervisees or

colleagues. Supervision with a trusted attuned and responsive supervisor was identified by the data as critical in the building of shame resilience.

So far, we have looked at the contribution that my research is making to the field in terms of conceptual knowledge. To summarise, a key strength of the study is the empirical support it can offer to the substantial body of theoretical literature on the topic of enquiry. It is hoped that this will encourage further research in this area. As far as the contribution to clinical practice is concerned the findings showed that shame work is less about technique and more about nurturing and maintaining trust, relational responsiveness, mutual empathy and establishing genuine connection so the person feels cared for. The damage from the shaming experiences can be gently unravelled for each individual in a personally meaningful way. This, in my opinion, is a rather important outcome when we examine it within the context of psychological therapies in the National Health Service.

The National Institute for Health and Clinical Excellence (In UK) recommends Cognitive Behavioural Therapy (CBT) as the treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder (PTSD) (including shame as an occurrence in PTSD), and clinical depression. CBT aims to solve problems concerning dysfunctional emotions, behaviours, and cognitions through a goal-oriented, systematic procedure where the here-and-now is the main focus. CBT focuses on the here and now and on alleviating the symptoms by questioning and testing cognition, assumptions, evaluations, and beliefs and trying to find new ways of behaviour (Rachman, 1997). So, although CBT does not care for intrapersonal and/or interpersonal issues, which as we have seen are key aspects of shame work, thousands of clients with a diagnosis of social anxiety and low self-esteem (where issues of shame usually prevail) are being offered CBT sessions that mainly deal with symptom reduction.

Considering the findings of my research one can argue that shame work within the framework of a psychotherapeutic modality that does not promote process-based intersubjectively focused interventions can be potentially very damaging for both clients and therapists. Hence, It is not surprising that the New Savoy Partnership (NSP), which was initially set up in 2007 as an advocacy group to persuade and ensure that UK governments recognised the value of psychological therapies and

increased their provision on the NHS, has now shifted away from advocating for therapies and moved towards ensuring the wellbeing of staff within NHS services, after observing the impact the weight of demand for counselling has had on therapists and supporting staff.

This study has shown that shame is ultimately about relationship. Shame is about our connection with others. As intensely social beings who evolutionarily equate the question, “Am I loveable?” with the question, “Am I safe?” shame highlights the essential nature of belonging and relationship (Cozolino, 2014, p. 285). The results of this study showed that relationship in its many forms was the most important aspect in working with shame. This included the relationship with the therapist, the relationship with family and others, the relationship through group work, the relationship with self, the relationship with the supervisor, and the relationship with the professional community. The experiential antidote to shame seems to be establishing healthy relationship connections in many different forms. For an individualistic culture such as ours, with as many difficulties as we have with shame, this dependence on relationship may require a shift in our perspective.

Finally, are we looking at the trees when we should be looking at the forest? Do we focus on shame in the individual without looking at the bigger system in which shame functions? Can we create a learning setting that can have the effect of normalising human vulnerability and the need at times to hide? Such a revised culture of learning could potentially bypass the issue of falling into shame and gradually move away from previous experiences and create a more curiosity and research-based set of explorations. In describing the state of research on shame, Gergen and Gergen (1988) note, ‘It is as if we have at our disposal a rich language for characterizing rooks, pawns, and bishops but have yet to discover the game of chess’. Future research could explore the game of chess and look at shame with a more systematic lens.

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APPENDIX 1: Participant (Research) Information Sheet

Metanoia Institute
13 North Common Road
Ealing
London
W5 2QB
Company no. 2918520
Charity no. 1050175

Sophia Kaimaklioti
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)

'Therapists' experiences of shame in the therapeutic encounter'

A psychological research study, which aims to investigate and explore experiences of shame in the therapeutic interaction.

You are being invited to take part in a research study. Before you decide it's important for you to understand why the research is being done and what it will involve. Please take time to consider the following information carefully and discuss it with others if you wish. Please ask if anything is not clear or where you would like more information. Take time to decide whether you wish to take part.

What is the purpose of the study?

My research question is as follows: 'How do psychologists / psychotherapists experience shame in the therapeutic interaction?'. The aim of this study is to develop a detailed interpretation of participants' accounts in an effort to understand the way in which therapists make sense of their own experiences of shame in the clinical encounter.

As part of the DCPsych at Middlesex University in conjunction with the Metanoia Institute, it is hoped that the attempt to familiarise ourselves with therapists' experiences of shame might enable the profession to maintain a dialogue and to enter into sensitive areas that might never be entered into otherwise. Moreover, a clearer understanding of the nature of therapists' shame and how it influences the therapeutic work may help clinicians to reach meaningful insights and better manage countertransference identifications. By volunteering to take part you will help to guide and improve knowledge about the dynamics of shame in clinical work.

Why have I been chosen?

You have been invited to take part because you responded to my recruiting advert and you meet the following inclusion criteria:

a) all participants are UKCP, BPS, or BCP registered psychotherapists
b) they are practicing within a process based psychological approach
c) they have experience of process based supervision and process based personal psychotherapy
d) they are currently receiving regular supervision
e) they are willing to take necessary steps to attend to matters arising during and/or after the interviews (for example, attendance of debriefing interviews, attendance of supervision and/or personal therapy)

I aim to recruit eight participants and each participant will be interviewed using open-ended semi-structured interviews.

Do I have to take part?

It's up to you to decide whether you are willing to take part. If you do decide to participate you will be given this information sheet to keep and be asked to sign a consent form, and given a copy. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I decide to take part?

If you decide to take part you will be invited to attend a semi structured interview. The interview will be scheduled at a suitable time and convenient place for you. You will be asked questions about your experiences of shame in your clinical work. The interview will be audio-recorded, transcribed verbatim and then subjected to detailed analysis to elicit key themes in what has been disclosed.

What are the possible disadvantages and risks of taking part?

Shame has been described in literature as being contagious: hearing of shame it can evoke painful memories of shame even if only subtly and slightly. A debriefing session will be offered to you and should you experience feelings that you wish to explore following the interview, the researcher will help you to consider appropriate avenues that will assist you to further address any unsettling material evoked by the interview process.

What are the possible benefits of taking part?

We hope that participating in this study will help you to increase your awareness about dynamics of shame in your clinical work. However, this cannot be guaranteed. The findings of this study may help therapists to effectively manage their countertransference and to engage in an open and honest dialogue with clients and colleagues about the complexity and subtlety of shame.

Will my taking part in this study be kept confidential?

All information that is collected about you during the research will be kept strictly confidential. Any information from you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be treated with full confidentiality, collected, stored and analysed in accordance with the Data Protection Act 1998. If excerpts from your interview were to be published, this would be done in such a way that you could not be identified.

What will happen to the results of the research study?

It is intended that this research be published as part of a doctoral thesis, with copies held at Metanoia Institute and Middlesex University. If you would like to obtain a copy of the published material I will keep you updated about the progress of the work and I will forward the published results to you following the successful submission of the research.

Who has reviewed the study?

This study has been reviewed by the Metanoia Research Ethics Committee.

Contact for further information

Researcher: Sophia Kaimaklioti, Metanoia Institute
sophiakaimaklioti@yahoo.com , 07879068816

Research Supervisor: Dr Vanja Orlans, *AFBPsS, Registered Counselling* Psychologist (HCPC) Registered Psychotherapist (UKCP) Registered Occupational Psychologist (HCPC) Tel (direct): +44(0)20 8208 1235
Email: vanja@psychologymatters.co.uk

Thank you for taking part in this study

A copy of this information sheet and the consent form are yours to keep.

Appendix 2. Written Consent Form

Participant Identification Number:

Title of Project: '**Therapists' Experiences of shame in the therapeutic encounter'**

Name of Researcher: Sophia Kaimaklioti

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

3. I understand that my interview will be taped and subsequently transcribed ☐

4. I agree to take part in the above study. ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix 3: Interview Schedule

Interview schedule

1. What makes you interested in shame?

2. What is your understanding, how to you define/conceptualise shame, in clinical work?

3. How do you see shame present in your practice?

4. What are the sources of shame in your work? What are the sources of shame for you?

5. What do you consider shameful in those circumstances?

6. What is the impact of shame on the therapeutic relationship and therapeutic process? (probe: how do you manage your own shame in the clinical room? How do you experience your shame as impacting on the therapeutic process? What do you make of that?)

7. What inhibits your ability to respond to the client's shame and/or your own shame in the clinical room?

8. What enhances your ability to respond to client's shame and/or your own shame in the clinical room?

9. What do you think are the implications for clinical practice?

10. Do you have any additional thoughts about shame? Any questions I have not asked?

Appendix 4: Example of an Initial Analysis: Emergent Themes and exploratory commenting

Line	Transcript Kim	Coding: Descriptive, Linguistic, Conceptual	Themes
1			
2	I: So, Kim firstly I want to ask you what		
3	makes you interested in the topic of shame?	Laughing covering emotion? (sounded like	Personal and
4		nervous laughter): Apprehension to engage in	professional
5	P: (laughing) I think shame is something that	a dialogue about shame?	investment in
6	I've thought a lot about and has spanned	Spanned: pause – indicating difficulty	participating (5-8)
7	(pause) my professional and personal life in	describing professional and interpersonal life	
8	the interface and it's often been something	in the interface: interesting use of word	Shame impacts all
9	that I've been I suppose grappling with,	'spanned' and 'interface' indicating the	aspects of the self
10	thinking about. So your study really	prevalence of shame in all aspects of her life,	(7)
11	interested me.	shame brings together/bridges personal and	
12		professional self. Grappling: manifests the	Shame preoccupies
13	I: Am I right to think that shame has touched	emotional distress that shame can cause:	the mind (9-10)
14	you professionally and personally and is an	shame causes internal struggles.	
15	issue that you're still trying to come to terms		
16	with?		Shame impacts
17			relational
18	P: Yeah.		connections. (22-
19			23)
20	I: Could you say a bit more about that?		
21			Shame
22	P: Yeah. (pause). I think particularly		compromises our
23	because in my mind shame is something	Pause, indicative of her difficulty to verbalise	ability to mentalise
24	that shuts down conversation, even thought	her experiences: Difficult to build a narrative	(24-26)
25	and tends to prevent us as human beings	about her shame: use of words like 'shuts	
26	kind of putting words on our experiences.	down' 'prevent' suggestive of internal	Shame work an
27	And so I think it's very interesting that our	resistance: shame compromises our thinking	essential aspect of
28	jobs are all about eliciting thoughts and	process. Her job is about eliciting thoughts	

29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	conversation and thinking and so I don't think we cannot think about shame. I: So shame affects your work as a therapist. P: I think so yeah. I: Can you tell me a bit more about that? P: So I very much believe that we as therapists can't do therapy without really thinking about ourselves and what we bring to that. And I think with it being something that happens between two people, shame is often very present in that. And so if we're not thinking about it and reflecting on it then I suppose we're acting out of a context of shame and then often our patients that come in from a context of shame. At the same time it feels like something that's very difficult, it can feel quite intangible and hard to get a sense of. I: So you're implying that there is complexity in dealing with shame? P:I think so yeah very much. And I also think I'm often very influenced by having come from a family where there is a lot of shame and where no one would talk about anything and certainly they wouldn't come along to therapy. So I think I have that as a lens as	and conversation: use of word 'eliciting' highlights professional pressure to tame her shame: internal pressures. Therapist's self- awareness essential in shame work Shame happens between two people: Shame is an interpersonal phenomenon: 'If we are not thinking about it': implies resistance and avoidance, interesting choice of words 'acting out': an unconscious communication of defences? How therapists' shame avoidance can impact the therapeutic work. 'difficult' 'intangible', suggestive of difficulty to grasp shame. Shame is elusive, hard to pin down. The interface between personal life and professional life: Personal – developmental history impacts her clinical stance. Her family history has shaped her clinical lens. 'being really aware', indicative of her own internal pressures and personal need to do the right thing for her clients: Working hard to stop the cycle of intergenerational unhelpful patterns regarding shame issues.	psychotherapy (27-30) Therapists' openness to their shame and self-awareness a prerequisite in shame work (38-41) Relational and intersubjective aspects of shame (41-43) Shame can cause avoidance and resistance (43-44) Defending against shame can affect the therapeutic process (46-47) Its hard to define / conceptualise shame (47-50) Developmental elements of shame (55-57)

61 62 63 64 65 66 67 68	well of being really aware. I think especially in the physical health context we do get the chance to meet people who otherwise wouldn't come along to therapy perhaps because of reasons of shame around speaking about emotion or other things. So I think that guides me thinking that it's very important as well.	Context of physical health motivates shame prone clients to seek help. 'speaking about emotion or other things' suggestive of how past developmental and attachment histories impact clients' help seeking behaviours. Shame shapes one's care seeking behaviours.	Source of shame – family's defensive attitude towards shame (58-60) Our personal history of shame shapes our professional stance (60-61) Shame forces us to suffer in silence (63-66)

Appendix 5: An example of Superordinate Themes and related Subordinate Themes (Transcript Linda)

1. The impact of shame on the self	a) *Early experiences and shame*	'I have two older brothers and in general we all did get on, but when I started having my period my brothers would call me names and I felt very alone in my shame, I used to retaliate and taunt them about their hairy arms and legs, but my mum failed to give me the support that I was longing for' (220-224)
	b) Being-as-you-are is not acceptable	'also, the shame of not being loved, I've seen that…. Of being single' (343 & 352) 'The shame of being better off without the person they lost if it was something there that a part of them wanting that person to just go when they're in pain. The shame of letting go, of moving on. That's in bereavement…you negotiate with a paradox. You love but you let go, how can you love and let go? Fears about not honouring the deceased, not grieving long enough and what does

		that say about you? …Yeah, I guess in that sense it's just very difficult to get out of that paradox. And obviously shame is what makes it paradoxical…The shame of letting go, of moving on…making you a bad person' (153-164) 'Not wanting to work sometimes. Being happy when you have a cancelation' (170-171) 'I guess sometimes not feeling genuine could be a source of shame for me at least' (172-173) 'The thing of being found out. Of being put on the spot. It's a very little thing that a client has mentioned a name of a medication she was taking and I said, 'Which one?' I asked for clarification and she said 'What you don't know that one?' kind of in a very judgemental way and I felt some form of shame for not knowing.' (206-211)
	c) Running away from it	'I think it's very difficult to talk about shame without feeling exposed because by accepting your shame you have to accept that you are at fault in a way.' (472-474)

2. *<u>Noticing Shame</u>*	*a) Physiological Responses*	'in my experience shame is such a threatening emotion that yeah I would act in a very defensive way, it would be about me and it's my fear of retraumatising and as a result causing more pain to patients…I think that for me that is the catalyst really' (266-270)
		'and I feel it in my cheeks and my heart is racing' (476)
	b) Shame and the 'sick body'	'The shame of cancer. The shame of being ill. In the eyes of the others.' (156-157)
		'with the cancer in particular I've been thinking a lot about the hair loss for example that's when cancer becomes real, visible and in the eyes of the others' (160-162)

	c) The elusiveness of shame	‘And the shame of the cancer as well. Especially in some cultures like xx. Or even x cultures. Where cancer is almost like a punishment, so it means that you've done something to deserve it. So yeah again it's tapping into that idea of being a sinner or having done something bad.’ (328-333) ‘and we are made to feel ashamed but there is not a way to communicate that, it’s very alienating’ (94-95) ‘From a personal but also from a therapist’s point of view I feel like it's something…it wears you out. Eats you up little by little without you actually realising it, I think it is just like these little is it eroding? And it’s not really openly talked about amongst colleagues, it’s just an underlying experience that sometimes you need to bring it up and name it. (135-140)

3. *<u>Therapeutic Reactions to Shame</u>*		‘Shame has an element of self-loathing which is different to guilt’ (53)
	a) Striking a strong alliance	‘And I wonder in short term therapy how much can we do about that? And I think there's an element of shame in all of us and it's such an obstacle in our[professional] lives, really how much can we work with that in such short period of time’ (456-458)
		‘it is so important to follow the client’s pace, to make them feel understood and safe’ (462-464)
		‘I helped her to tell her story, to express something that before it felt kind of something that didn't even exist.’ (144-146)
	b) Holding your own	‘shame is more something about your relationship with yourself and how you imagine yourself being looked by others’ (line number 42-44)

		‘it goes to self-loathing, it's kind of I'm ashamed that I've done something wrong’ (211-212) ‘it's like Adam and Eve, it's that of feeling completely naked completely exposed and vulnerable. And alone because you're expelled, you're punished.’ (280-283) ‘I don't know whether, this might sound really farfetched but there's something very almost narcissistic as well with the shame… In a way of not being able to accept your imperfections.’ (407-408 & 411) ‘I banished the session in a way that I look more assertive instead of being me or more genuine probably just to prove myself and maybe out of anger.’ (253-255) ‘I feel vulnerable now talking to you but that’s ok. I think that it is very difficult to talk about shame without feeling exposed because by accepting your shame you have to accept that you are at fault in a way. So, I think it is a good exercise to do this and learn something about the way that this is heard. Like by you and your empathy’ (471-476)

		‘it [shame] makes you feel bad in a world of good people and bad people, and black and white it makes you feel bad and it affects my connection with clients’ (311-312) ‘[shame] is just so silent and I don't know how much I'm aware of it in my clinical work’. (376-377) ‘I guess when you're not being a human being in front of clients because you'd rather be a professional or a therapist.’ (177-178) ‘Yeah but it fucks you up. Because most of the shame you feel, I don' t think you feel so much shame about the act or the other but more about the thought and the internal kind of observer.’ (304-306)
	c) Being emotionally available and transparent	‘I become more defensive…that I need to prove something else to compensate my failure.’ (238-243) ‘I pay attention to my countertransference and try to make use of it’ (290-291)

	d) Self Care and Supportive Systems	‘It is hard to remain focused in a meaningful way when shame kicks in, and I often take a step back in order to take stock of my experience’ (384-386) ‘It’s so important to be able to hold and tolerate not only your shame but also clients’ shame’ (388-390) ‘I think that's [in supervision and in therapy] when shame opens up. I mean that's when I discovered the word. I think there's also a lesson of becoming more humble.’ (405-407) **‘**And it can be quite shaming, the training itself. This is my assumption it's like we're supposed to be super humans’. (424-426) ‘I got in touch with that shame during the training because I felt like I was put on the spot. I remember a very shaming moment in the first year during the Foundation and these PPD groups. And then I felt kind of there were these kind of really dominant people talking openly about the things and issues and problems and then at some point these

4) Shame and Issues of Power	a) Power dynamics in the therapeutic interaction	people really started pointing at us like those of us who were more withdrawn and quiet. And I started crying, I felt really like yeah put on the spot and ashamed and I hated it, it was so bad. I wish I could go back to that day and just exercise my right to be quiet and silent if I wanted to.' (426-436) 'because I felt like something inside me has been kind of expressed there without me wanting it and something that was showing to everyone that I wasn't good material to become a therapist. So I felt really ashamed.' (443-447) 'and therapy itself can be a shameful experience due to the stigma associated with mental health issues' (350-352) 'And the shame of mental illness of course which is that ugly label we're given and then... Yeah or having to go to their GP and take medication, or ask

	b) Culture and Shame	for therapy, there's a lot of shame in that as well. (352-353 & 358-359) ‘there's a moral aspect I guess of shame which I guess has to do with your values… and I would feel ashamed if I lied or I felt like I'm manipulating or something I would feel like morals are being kind of betrayed.’ (184-188) ‘my mind leans towards thinking about gender and shame and about masculinity and I see that in a lot of my work, men feel as though they are not meeting expectations if they have any emotion, show any vulnerability and that causes so many problems’. (78-82) ‘it's a word that I came across in this language in English which it can't really be translated into [my language]’. (10-11) ‘I was quite amazed. It's almost having the privilege to have the word to express something that before it felt kind of something that didn't even exist’. (58-60)

		‘I don’t know what came first to be honest. The experience of shame? Or the word shame? But I found them together in a different language, in a different country, in a different culture’ (64-68) ‘It's almost castrating if that makes sense’ (84) ‘my culture its shaming for women…not allowed to express shame and talk about it’ (90-91) ‘We're made to feel ashamed but there's not a way to communicate that’ (94-95) ‘Catholic upbringing... I wonder how that had an impact at least on me and being brought up as a sinner because this is the message that we got that we are sinners for something that I have no idea what my sin is although I am a sinner and then the sin is not just the action but the thought and I think this fucks you up.’ (292-296)