

Therapists' Experiences of Shame: An Heuristic Study

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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.

Using heuristic methodology five psychotherapists were interviewed to elucidate their experiences of shame. Consistent with heuristic methodology and method there was in-depth analysis of the researcher's experience of the phenomenon.

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. Four interwoven themes were identified: second hand shame, shame with colleagues, being different, and not being good enough. 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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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”



Marian Hammond (Candidate)

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Chapter One: Introduction

In the early 1990s, when I was working in a group psychotherapy unit, I lent a young male client a copy of my new book *Healing the shame that binds you*. He told me it was like I had given him a bomb and that he could read no further than page 3. He had what the author John Bradshaw (1988) called in his opening sentence a ‘life-jolting discovery’ as he came to name ‘shame’ and see how this powerful phenomenon had played out in his life (p.vii). Ultimately he discovered how shame bound him as he studied to be the doctor his parents wanted him to be, how his failure as a medical student reinforced his sense of being defective and fatally flawed, and how his depression gave him refuge from this toxic affect. His new understanding paved the way for therapeutic change.

Two and a half decades ago, just as my client had his awakening, so did I. Visiting my own experiences of shame over my life-time, I discovered how shame had been a supreme ruler in my life leading me towards restrictive solutions to life’s challenges, which were in essence ‘anti-life’. I found power in the recognition and naming of my experience of shame. My earliest memories of being shamed are located in my infant classroom where I lived in terror of the teacher and the strap she introduced me to on my first day at school. Thereafter I remember vividly wishing I could disappear into my desk; I made myself as small as I could be. At age five I had taken out a lifelong insurance policy against shame: invisibility.

Just as shame can cause ruptures in relationship, so too must the person who feels afflicted by shame be healed in relationship (Kaufman, 1992, 1993). Whilst individual psychotherapy has assisted me significantly in this transformation, my experience in psychodrama groups has been particularly potent in achieving this purpose. In 1984, in my second year of psychodrama training, I attended a week-long residential workshop. I wrote the following story from this pivotal event in the preface to my thesis for accreditation as a psychodramatist. The thesis, titled *Psychodrama: An antidote to shame* (Hammond, 2010), documented how psychodrama in both individual and group contexts offers significant reparative opportunities for the shame-bound person. I share the story and its explication as a stepping-stone from that practice-based thesis into this research-based thesis:

Yet, from the workshop's outset I was locked into myself, experiencing paralysis when it came to interacting with the group as a whole. I was well into my third day of silence when Max asked me what my family would think of the ensuing group discussion on sex. My face reddened and I was mute. Of course Max knew I was in a "void," one of which I could never find my way out of alone. Over the next couple of hours he skillfully directed me to display, what seemed like, every aspect of my life on stage, beginning with my conception. Catapulted out of hiding, I came to experience a peace and solidness within myself so unfamiliar, yet so me. Although strange, I relished this way of being, which strengthened as group members approached with warm friendliness expressing their acceptance and recognition of me. From a dark space somewhere beyond the edge of the group I had been walked over a bridge, onto the stage, right into the middle of the group where I was highly visible. Magically my debut on stage had put me on the map. At last I was one of the group.

Shortly after the session I raced off to the sea below to reflect on what had just happened. It was not until five years later though, that I learnt the accurate label for my experience: Shame. Only as I began to recognise and understand this affect, could I make meaning of my experience on the stage with Max. My shame had been triggered by 'exposure' and fear of anticipated condemnation and rejection, which in turn spiralled into my underlying sense of inadequacy. My warm up to the stage, which included speaking out in the group, was severely restricted by the resultant experience of mortification. 'Invisibility' had been my primary strategy of defense against such exposure. I soon learnt though that a psychodrama group was no hiding place. On the contrary, there is great visibility to many sets of eyes, especially 'on stage'. However, I had been warmly held in the eyes and hearts of the group, and given back to myself.

(Hammond, 2010, pp.iii-iv)

As a psychotherapist I have striven to understand shame, recognise its impact and many faces, and how effective interventions can be made in clinical practice. Increasingly I have become aware of how shame is a potentially powerful and prevalent phenomenon in the therapeutic context. My personal experience as a client has certainly born this out. Over the years I have been privileged to have clients I have worked with, in individual and group contexts, trust me with their stories and allow me to help mitigate the toxic forces of shame they have experienced. I am passionate about this work. It is not always easy though. Sometimes the shame and self-loathing experienced by my clients feels so intractable and I experience a myriad of strong countertransferential feelings that may include powerlessness, rage, despair, alienation, and shame. My wonderings on how other therapists navigate the swamp of shame in their practice have inspired me to undertake this study.

Context of My Study

Shame is a crucial issue frequently overlooked in the therapeutic context because it has many hiding places and inevitably echoes with experiences of shame in the therapist. Nathanson (1987) alerted us to the significance of psychotherapy as an arena for shame. Dearing and Tangney (2011) asserted that with the exception of psychopaths, shame is ubiquitous in the therapy room for all clients. The concealment and neglect of shame in the therapy setting is well reflected in the lack of attention on the issue in the therapeutic literature. In the context of the existing literature the spotlight is on the client's shame, with minimal light thrown on therapists' shame.

Helen Block Lewis' (1971) book *Shame and guilt in neurosis* was the first clinically oriented work on shame. Over the subsequent 40 years "surprisingly, comparatively little has been written to guide the clinician on how best to recognize, manage, treat or capitalize on shame in the therapy hour" (Dearing & Tangney, 2011, pp. 375-376). Dearing and Tangney's book *Shame in the therapy hour* is a rich resource that brings together the expertise of a range of experienced practitioners, many of whom acknowledge the dearth of literature on the therapist's shame and thus make attempts to address this situation. Brown's (2006, 2008, 2012b) grounded theory shame research has had a major influence on my writing of this thesis. An American university professor, trained as a social worker and therapist, Brown identified that she held a goal to start a national conversation on shame. Through her research, self help books, audiotapes, and internet courses she has successfully created international conversations. Much of her writing has direct relevance to the underpinnings of this study. Furthermore in her relaying of endless stories, many of which are drawn from her own life, her work seems to have a definite heuristic flavour. Psychoanalyst Morrison (2008, 2011) has written extensively on the topic. His candid authentic accounts of his experiences of shame, coupled with his analysis of these, are inspirational.

Additional layers of context of this study include discipline, location, gender, and culture. The study is located in the psychotherapists' community of Aotearoa New Zealand, of which I am a member. This is a relatively small group in the vicinity of 600 psychotherapists. The participants in the study are all female. While I recognise differences in the experience of shame exist between genders I have chosen not to pursue this focus. In terms of my cultural background as the researcher I am a fourth generation New Zealander of English, Scottish, and Irish descent.

Point of Concern

In the grip of shame both therapist and client can fail to see one another and understand what unfolds between them. Adelman (2016) summarised the potentially powerful impact of shame on therapists: “Shame is a potent affect state that binds us up in knots, with the power to obscure our thoughts and interfere with our actions” (p.126). The therapist may not even recognise the presence of shame in the client and herself. Unconsciously the therapist may enact various coping strategies to mitigate the toxic effects of the shame. These, in turn, can be problematic for herself and her client who is likely to feel misunderstood and experience a lack of empathy. Retzinger (1998) maintained 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” (p.209). Another outcome may be that the client makes a premature departure from therapy; responsibility for which Lewis (1971) asserted can often be laid at shame’s doorstep.

So how does shame become so problematic for therapists? To begin with shame is a deceptive phenomenon. As an emotional response to exposure it impels us to hide, making it hard to recognise and readily access. A desire to avoid pain generated in both the client and therapist can ensure the affect remains hidden and not addressed (Morrison, 2008, 2011). The problem is exacerbated by the contagious nature of shame; the exploration of client shame inevitably induces shame in therapists. We can feel reluctant to talk about our experiences of shame in supervision and with our colleagues. As Lewis (1987) pointed out we can feel ashamed of feeling shame. Yet the therapist is confronted by powerful major sources of shame generated from the client, the therapeutic interaction and within herself (Dearing & Tangney, 2011). Furthermore, sources of therapists’ shame extend beyond the therapy room to include contexts of training, supervision, and collegial relationships.

Therapists can react to shame with a range of responses, at best these are therapeutic and at worst, injurious to the client or colleague. A therapist’s lack of awareness of the phenomenon of shame and its various hiding places may mean she neglects to address the client’s shame which impedes the client’s wellbeing and/or she inadvertently shames her client (Stadter, 2011). Inevitably such reactions have an impact on the therapeutic alliance and therapeutic outcomes.

The magnitude of the problem can be viewed from many angles. On a broad scale the personal and social cost of neglecting and misunderstanding the central affect of shame is significant. Shame is highly correlated with many of the afflictions that bring our clients to therapy: depression, anxiety, addiction, eating disorders, dissociation, suicide, bullying, and violence (Brown, 2006; Dearing & Tangney, 2011; Lewis, 1987).

Dearing and Tangney (2011) claimed shame interferes with the building and maintaining of relationships. Their research has consistently shown that the self-focus characteristic of shame obstructs empathy for others who may have been mistreated (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007a). This has major implications for therapists for whom the relationship is central and within which empathy is considered a key component. The problem magnifies when we take into account Brown's (2008) claim that empathy is a powerful antidote to shame. Finally, there is the issue of 'therapists' wellbeing' the importance of staving off 'burnout' that may be contributed to by unresolved shame issues; this in itself creates a compelling reason for study.

The above section underscores the 'trickiness' of working with shame. In its concealment shame can be readily acted out upon meaning that therapist and the other miss one another and end up disconnected. Shame is an important issue to address on societal, interpersonal, and intrapsychic levels. The following sections aim to introduce the current study and its focus on therapists' experiences of shame.

The Question

My quest to uncover and understand others' and my own experiences of shame, in both clinical and collegial contexts, has motivated me to ask the question: *What are therapists' experiences of shame?* Through closer examination of the terms I aim to clarify the question.

"What" is a pronoun that requests specific information. "Therapist" may be defined as "A person trained in psychological methods for helping patients overcome psychological problems" (Dictionary.com). This word has been chosen to encompass a range of professionals including psychotherapists, psychoanalysts, psychologists and counsellors. The key word "experience" relates to the participant's exposure, involvement and familiarity with the subject that ensures a stream of knowledge vital in

the elucidation of shame. Moustakas' (1990, p.17) claim that "Knowledge grows out of direct human experience" is foundational to this study.

Less easy to define is the term "shame" as discussed later in the literature review. For the purpose of introducing the concept I present Brown's (2008) definition "Shame is an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p. 5). Key aspects of the shame experience are imagining the self being watched through the other's eyes and reacting by wanting to hide, escape or hit out at the person in whose eyes we feel exposed and ashamed (Lewis, 1987). DeYoung (2015) wrote about 'chronic shame' as involving the repetition of shame experiences that result in lifelong debilitating patterns of self-awareness and relational responses. The current study is primarily focused on experiences of chronic shame.

Within this research question there exists additional questions: What are the sources of shame for therapists? How do therapists react to shame experiences? What is the impact of shame on the therapeutic relationship and therapeutic process? How do therapists mitigate the effects of shame in themselves and with their clients and colleagues? These questions provide a framework on which data collected from many sources are assembled for analysis.

My Biases and Assumptions

A foundational assumption is that shame is a universal experience. Brown (2010b) assured us that everyone has it, is afraid to talk about it and the less somebody talks about it the more they have it. I hold that there are some people more sensitive to experiences of shame than others and these people will be referred to as 'shame prone' or 'chronically shamed'.

I believe as human beings we are all worthy and that shame involves a sense of threat to our worth. The uncovering and understanding of shame is integral to the shifting of one's relationship with it and the building of self worth.

I hold the assumption that addressing our shame as therapists is essential and potentially empowering. Furthermore, this 'shame work' ultimately benefits our clients, as it enables us to be more present with them and to read and understand their underlying

shame. Trained in psychodrama and psychodynamic psychotherapy I adhere to the assumption that most current experiences are influenced by past experiences.

Lastly, I believe that through speaking out our experiences of shame as therapists we can break down walls that exist between us and alleviate the isolation, pain, and internal disruption caused by the experience of shame. These biases and assumptions will be addressed within the study.

A Perfect Match

Many have made the call for therapists to address their own unresolved shame issues, first and foremost Lewis (1987); Morrison (2011); and Brown, Hernandez and Villarreal (2011). Heuristic enquiry answers this call providing the perfect vehicle for the journey. Developed by Clark Moustakas (1990), a humanistic psychologist, heuristic enquiry has involved me in relentless investigative immersion in shame with the purpose of uncovering its hidden nature and meaning.

Map of the Journey

Coupled with my own self-study I examine the experiences of shame of five psychotherapists who participated in my research. Consistent with heuristic methodology I use the term ‘co-researcher’ to refer to the participants as well as ‘the therapist(s)’.

My thesis is presented over a series of chapters beginning with this present chapter. The next chapter, the literature review, builds a platform of knowledge on which this heuristic study draws. The chapter is in four parts. The first includes: definitions of shame, shame versus guilt, and developmental origins. In a second part I present the experience of shame and strategies of defense. In the third part I refine the focus to the therapist’s shame and include a definition, sources of therapist shame and reactions, countertransference and shame resilience. The fourth part addresses two specific contexts for therapist shame: the group and supervision.

In Chapter 3 I introduce heuristic methodology and the methods employed in this study. Initially I identify aspects that create the ‘perfect match’ between the phenomenon of shame and heuristic inquiry. I share my understanding of the methodology and how it

aligns with my practice as a psychotherapist and worldview. Each step of the method is described and interlaced with examples of application.

In Chapters 4 to 7 the data are presented. In Chapter 4 the co-researchers' and my experiences of shame are portrayed in individual depictions. In the latter part of this chapter there are exemplary 'portraits' of co-researchers that are created by adding demographic and autobiographic detail to descriptions of their experiences of shame. These portraiture are intended to convey to the reader a sense of the person behind the data. In Chapter 5 a 'group composite depiction' is presented that aims to capture the common experiences of all those who have participated in the research. Chapter 6 elucidates 'core themes' delineated from data from the interviews and my own self-enquiry: second hand shame, shame with colleagues, being different and not being good enough. Verbatim passages are included throughout the data chapters. Chapter 7 tracks my heuristic process from inception to the delivery of this thesis. The entrapment of shame is described together with liberating aspects of the endeavour.

In Chapter 8 the questions I posed in this introduction are addressed. Data from the literature and all other sources are interfaced in a discussion that explicates meanings and the value of specific findings. Core themes and how they interweave are discussed. Implications are recognised and considered and related to current theory and praxis. Strengths and limitations of the study are identified and suggestions made for future research. The chapter ends with a conclusion.

Chapter 9 is the grand finale of the journey. Expressing my *Creative synthesis* of the material this exposition characterises therapists' experiences of shame in their fullness. The story *Lone puriri* is presented as an artistic rendition of the themes and meanings that have been explicated; this final scene aims to synthesise the experiences.

Chapter Two: Literature Review

When I was working in the addiction field, in the late eighties, a colleague gave me a handout titled *Shame* attributed to Sue Evans (See Appendix i). It appears to be a summary of an article she wrote in the *Alcoholism Treatment Quarterly* (Evans, 1988). This document was the first literature I read on shame and has continued to prove itself a useful account for both clients and students over the years. In just four pages it manages to provide a succinct conceptualisation of shame. It concludes by underscoring the centrality of the relationship and naming simple steps in the healing process. Although the body of literature on shame in the therapeutic context has expanded over what is now almost 30 years since I received the handout, much of the basic landscape looks the same. I have chosen to use the key areas addressed in this foundational document as scaffolding for the initial part of my literature review.

There are two parts to this literature review. Consistent with heuristic research the review includes areas that I, as the researcher, have been drawn to uncover and deepen my awareness of. The first part sets the stage for the study in the broader context of shame literature and includes: defining shame, shame versus guilt, and developmental origins. In the second part shame is, as it were, on stage and in the wings with the presentation of the experience of shame and strategies of defense. The third part puts the therapist's shame centre stage and incorporates a definition, sources of therapists' shame, therapists' reactions to shame, countertransference and shame resilience. The fourth and final part addresses shame in two stage sets – the group and supervision.

Setting the Stage

Defining shame

As a concept shame has only fully arrived in the language of psychological study over the past 40 years. Typically it has been called guilt or, sometimes, another emotion; rather than a separate affect. Theorists have made multiple attempts to define shame.

A beginning point is the linguistic origins of the term as conveyed by Wurmser (1997): "The word *shame* is derived from the Germanic root *skam/skem*.... with the meaning "sense of shame, being shamed, disgrace (*Schande*)"(p. 29). He expanded on these origins highlighting how the concept of hiding is intertwined with shame: "It is traced

back to the Indo-European root *kami/kem* ‘to cover to veil to hide’. The prefixed *s* (*skam*) adds the reflexive meaning, ‘to cover oneself’” (Wurmser, p. 29).

Locating a satisfying definition in the literature that accurately reflects the meanings and complexity of shame is no mean feat. Conceptualisations range from traditional psychoanalytic to contemporary relational theory perspectives. Traditional views appear focused on the ‘self’ and are concerned with shame as the opposite of pride, involving a loss of respect or self-esteem and failure to meet expectations. Contemporary views see shame having an intersubjective premise, being co-created in relationship. The following sampling of definitions aims to reflect the evolution of this range.

Being the first psychoanalyst to write a book on the significance of shame some 45 ago it seems fitting to begin with Helen Block Lewis’ (1987) conceptualisation of shame as an acutely painful and disorganising emotion. She contended shame impelled us to hide, escape, or strike out at the person in the eyes of whom we feel ashamed. Furthermore, left in an intensely self-conscious state the person experienced his/her self as ‘split’ in his/her imagining of his/herself in the eyes of the other. Lewis wove key processes together with impacts and behavioural reactions making this a substantive explanation of the phenomenon. In contrast Morrison (2011) provided a rather more succinct definition: “A negative feeling about the state of the whole self, a noxious conviction that the self is bad, defective, a failure” (p. 25). These few words capture something of the pernicious nature of shame, the ‘state’ of the self in shame. Kaufman’s (1993) use of metaphors created a powerful inner resonance as they reflect the painful injurious impact of shame on the self:

Shame feels like a wound made from the inside. Shame is dishonor, fallen pride, a broken spirit.... To live with shame is to feel alienated and defeated, never quite good enough to belong. And secretly the self feels to blame... Shame is without parallel a sickness of the soul. (pp. 24-25)

From her research interviews Brown (2008) created this simple definition to reflect the feeling and meaning that emerged from her data: “Shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p. 5). With the reference to “belonging” this definition drops an anchor in the social world. Judith Jordan (1997), a self-in-relation therapist, developed this relational viewpoint in her definition of the experience of shame as:

....a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how 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. (p. 147, italics in original)

De Young (2015) maintained shame is activated because our need for connection and emotional joining has not been met, rather than a failure in meeting our needs for recognition, admiration or adoration which results in a lack of self respect and self esteem, as suggested in some other definitions. In an attempt to integrate the various aspects of shame theory De Young created a definition in agreement with the previous definition that honours the impact on the ‘self’ as well as the role of the ‘relationship’ in the experience: “Shame is the experience of one’s felt sense of self disintegrating in relation to a dysregulating other” (p. 18). ‘Chronic shame’ involves the repetition of the experience creating patterns of self-perception and relating to others in ways that are in essence restrictive. This concept has been construed using other terms in the literature. Building on the work of Kaufman, Bradshaw (1988) presented an expanded definition using the term ‘toxic shame’ to describe the extent to which shame hijacks the self as:

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

Across the various meanings and definitions shame remains a painful experience involving exposure, a moment when we are flooded with feelings of defectiveness and unlovability. In this sense, shame can be seen as a normal experience that momentarily interrupts a person’s transition through life, from which recovery can be made relatively easily. However when one’s core being is infused with the intractable belief one is defective and unlovable, a profound sensitivity to everyday shame exists. Dearing and Tangney (2011) distinguished between “*in-the-moment shame* and *shame proneness*, with the latter being a dispositional tendency to experience shame across situations” (p. 5, italics in original). Shame prone individuals tend to be those with psychological symptoms presenting for therapy. De Young (2015) referred to this population as being afflicted with ‘chronic shame’. The current study is concerned primarily with the experience of shame in the shame prone, those burdened by chronic shame.

Debate exists as to whether shame belongs to a family of emotions or is a distinctive emotion. Wurmser (1997) perceived shame as inclusive of humiliation, embarrassment,

shyness, bashfulness, modesty; as well as the belittling feelings of disgrace, degradation, and dishonor. He stated:

Shame in its typical features is complex and variable, a range of closely related affects rather than a simple, clearly defined one. It shades into moods on one side, into attitudes on the other. Moreover, it is clear that anxiety is a cardinal part of it. Yet evidently shame is more than anxiety, and anxiety is more than shame. (Wurmser, p. 17)

In contrast, other theorists emphasise the importance of differentiating shame from the other self-critical emotions. In comparison to shame: embarrassment occurs more fleetingly and is experienced with less intensity; humiliation results from the actions of others and creates only a limited impact on identity (Lewis, 1971; Tangney, Miller, Flicker, & Barlow, 1996).

Shame versus guilt

It is not uncommon for the terms shame and guilt to be used interchangeably. The Merriam-Webster dictionary even calls shame a “feeling of guilt”. In the confusion guilt usually comes out on top or, as Broucek (1991) suggested, guilt ‘swallows up’ shame. Lewis (1971) proposed a simple distinction between shame and guilt to which most theorists continue to adhere:

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. In guilt, the self is negatively evaluated in connection with something but it is not the focus of the experience. (p. 30; emphasis in original)

In a nutshell guilt is “I *did* something bad” and shame is “I *am* bad”. This distinction is important for practitioners to keep in mind. With the possibility of making amends for the action that caused harm to another, guilt can be considered the more hopeful reparative emotion. Addressing a core sense of badness is another story.

Developmental origins of shame

So how does the developmental sequence that creates toxic shame, shame proneness and chronic shame unfold? Affect theorist Tompkins (1962) as cited in Nathanson (1992) argued that shame is one of nine specific innate affects: two positive, one neutral and six negative affects that feel dreadful. Hardwired into the brain each affect has its own triggering programme. Shame is seen as occurring anytime our experience of positive affects is interrupted and as such acts as an inhibitor. Nathanson built on the

work of Tompkins his mentor. He continued to view shame as connected to the self and as such not essentially relational. In the social sense he considered shame to be an interruption to the more pleasurable influences of engagement. As shown below, other theorists hold a contrasting view that shame originates in relationships when one has an affective need and the other responds or fails to respond to that need. A further difference is that these affect theorists contend the core affect of shame remains unaltered through life.

Schore (1998) cites (Schore, 1991, 1994) in which he presented “multidisciplinary developmental data which suggests that shame makes its initial appearance at 14 to 16 months.” (p. 64). From a neurobiological point of view Schore (2003) maintained that shame and the parasympathetic nervous system provide a braking system that can protect the child, to inhibit what might get them into trouble. However, he cautioned that it can only be an effective system if the parent(s) soothe and transform the state of shame. When the parent says, “No, put that vase down!” a little dose of shame is evoked in the child, letting him know he needs to pull back.

A mini rupture in the relationship results as the child experiences a moment of exposure and then the parent reunites with the child. The essential repair occurs as the parent moves towards the child, draping her arms around him, the shame is resolved and he regains his equilibrium. This is the notion of healthy shame, which Bradshaw (1988) referred to, that informs us when to pull our horns in; that is, helps us pull back in relationship and makes sure we do not forget that as human beings we are essentially limited.

In contrast, other children are stimulated to excess by repeated overdoses of shame in the form of criticism, name calling, ridicule. There is no return to the safety of the accepting parent. Such objectifications break what Kaufman (1993) termed ‘the interpersonal bridge’, the bond between two people, in this case parent and child. Kaufman’s (1992) developmental theory of shame and identity provides a useful construct to inform our understanding of the origins of shame. When expected responses to need are not provided, or seen as wrong, shame results. Feelings of exposure and a diminished sense of self are experienced. The ongoing misattunement of the primary caregiver towards the child leaves the child with shame intertwined in her identity. Shaming scenes are internalised and interpreted and become part of the

identity, thus influencing self-image and future interpretations of relationships. The shaming scenes leave the child with the belief that she is worthless and inadequate and that relationships are not safe havens. In this sense shame behaves autonomously, an occurrence that I comment on below.

After a while the child knows there is no point expressing her feelings. It is too painful to continue getting dressed up with nowhere to go. Furthermore, certain feelings become bonded with shame. For example, if she gets angry she will experience shame. Therefore shame becomes a powerful controller of inner experience. The child begins to develop a persona or ‘false self’ that pleases her caregivers and thereby ensures her survival. The ‘authentic self’ is well out of reach of herself and others (Bradshaw, 1988; Winnicott, 1960a/1987).

No study of shame is complete without mention of Erikson’s 1956 theory of human development as cited in Crain (2000). In the second stage of this theory *Autonomy vs Shame and Doubt* the child develops the ability to retain or withhold and to expel or eliminate at will. In the child’s second and third year of life his/her new-found autonomy is reflected in standing on his/her own feet and exploring together with the development of language that features the repetitive use of words like “me,” “mine” and “no”. Shame and doubt are born out of the awareness of social expectations. Shame is the feeling that we do not look good in the other’s eyes. Ideally, with sensitive parenting, the child can learn social behaviours, for example, toileting without having a crushed will. However, as described above, other forms of parenting shaming practices can be used to excess to control children. For example, ridiculing children for having a bowel accident or trying to do things on their own. When such experiences occur on an ongoing basis enduring feelings of shame and doubt persist and override impulses toward self-determination (Crain, 2000). In spite of the current focus on the neurobiology of shame, Erikson’s theory of shame still holds relevance today. In practice I often hear clients speak of ‘self-doubt’ that alerts me to the presence of shame. Like other theorists mentioned in this section Erikson’s Theory encompassed the healthy purpose of shame, whilst alerting us to the perils of its overuse in parenting.

This section has summarised how the stage is set for vulnerability to experiences of shame in early scenes involving acts of omission and intent to harm by those involved in caregiving. In speaking about the different presentations of chronically shamed

clients De Young (2015) stated: “But for all of them, whatever their protective self-organizations, their shame comes from the same basic experience: something went badly and consistently wrong with their early connection with others” (p.164).

Shame on Stage and in the Wings

In this section I build on the above definitions, first offering a descriptive account of the experience of shame and second identifying various strategies of defense. There is, of course, overlap between the two areas.

The experience of shame

The multidimensional experience of shame is captured in the fullness of Adelman’s (2016) description:

You feel shame in your bones, in the pit of your belly, where it burns, in your inflamed cheeks, in the tears that sting your eyes, in your racing, sinking heart, in the heat that courses through your body. Consumed with shame, we bow our heads and seek relief. When shame over takes us, it is a moment of total exposure, raw and naked, whether it is on display or others to view or kept tightly under wraps, known only in the most private alleyways of our minds. (p. 186)

There is a convention of reifying and animating shame as if it has agency, a life of its own. An extreme of this is found in the source document of my original handout by Evans referred to at the beginning of this chapter in its description of a “shame spiral”:

Having a shame attack is excruciating. People commonly report the experience is like having an abusive monster rise up and take over their minds. The monster replays all the terribly cruel and exposing things that they’ve heard over the years. The internal abuse feels true. This is a set up to feel vulnerable to further exposure/abuse.... The shameful feelings tend to overpower all other feelings and can be overwhelming. (Evans, 1998, p. 166)

I have found the concept of a “shame spiral” useful insofar as it encompasses the whole person’s experience of the phenomenon. Evans (1988) reported that this ‘rampage’ of shame could go on for days, weeks and even months. Initially something triggers the shame response, which may even go unnoticed. The description goes on to identify the automatically triggered affective response aimed at achieving safety, similar to that identified by Adelman (2016). Finally, in a split second, a range of defenses or secondary reactions are mobilised which may include: anxiety, denial, critical scrutiny, numbing, disowning the self, becoming rageful, denial, invisibility and perfectionism. Many of these defenses are presented below.

Not all descriptions are so animated and emotionally charged. Gilbert (2011) wrote the following introductory passage on the ‘nature of shame experiences’ in a book chapter. Encompassing all domains of impact succinctly, it proves itself a valuable categorisation of shame experiences:

Shame is typically regarded as multifaceted, with feelings of anxiety, disgust and/or sadness and at times a “heart sink” feeling; a sense of self as inadequate, bad, or defective in some way; beliefs that other people look down on the self and hold us in a negative frame of mind; behavioral dispositions and urges to run away, freeze, hide, and avoid; and unpleasant physiological arousal. (Gilbert, p. 325)

Lewis (1971, 1987) described shame as having two key variants. The first ‘overt undifferentiated or unidentified shame’ the affect is available to consciousness but the person will not or cannot identify it. The person may be in a severe state of self hatred and once he/she says “I am ashamed” the affect usually starts to diminish. Whereas ‘bypassed shame’ is largely out of consciousness and difficult to observe. Experienced only as a ‘jolt to the self’ it shows up primarily in thought processes and relationships. The latter concept is integral to understanding of therapeutic process as it can impact outcomes.

At this point it seems important to address the confusion that exists between the concepts of ‘affect, emotions and feelings’ that are regularly used interchangeably. Shouse (2005) argued that these terms should be understood and presented as distinct from one another. ‘Affect’ he said, “is the body’s way of preparing itself for action in a given circumstance by adding a quantitative dimension of intensity to the experience” (p. 1). The experience of intensity is non-conscious. Shouse claimed, “a feeling is a sensation that has been checked against previous experiences and labelled. It is personal and biographical... an emotion is the projection/display of a feeling. Unlike feelings emotions can be genuine or feigned” (p. 1). Nathanson’s (1992) statement: “Whereas affect is biology, emotion is biography” exemplifies the confusion between the feeling and emotion (p. 50). However, due to the lack of clarity in the literature I have decided to use the terms feelings and emotions interchangeably.

In considering the experience of shame, self-perceptions are a key aspect. Internal and external judgments are elicited that are about the self. These in turn impact on relationship. Lewis (1987) examined the relationship between self, the other, and shame:

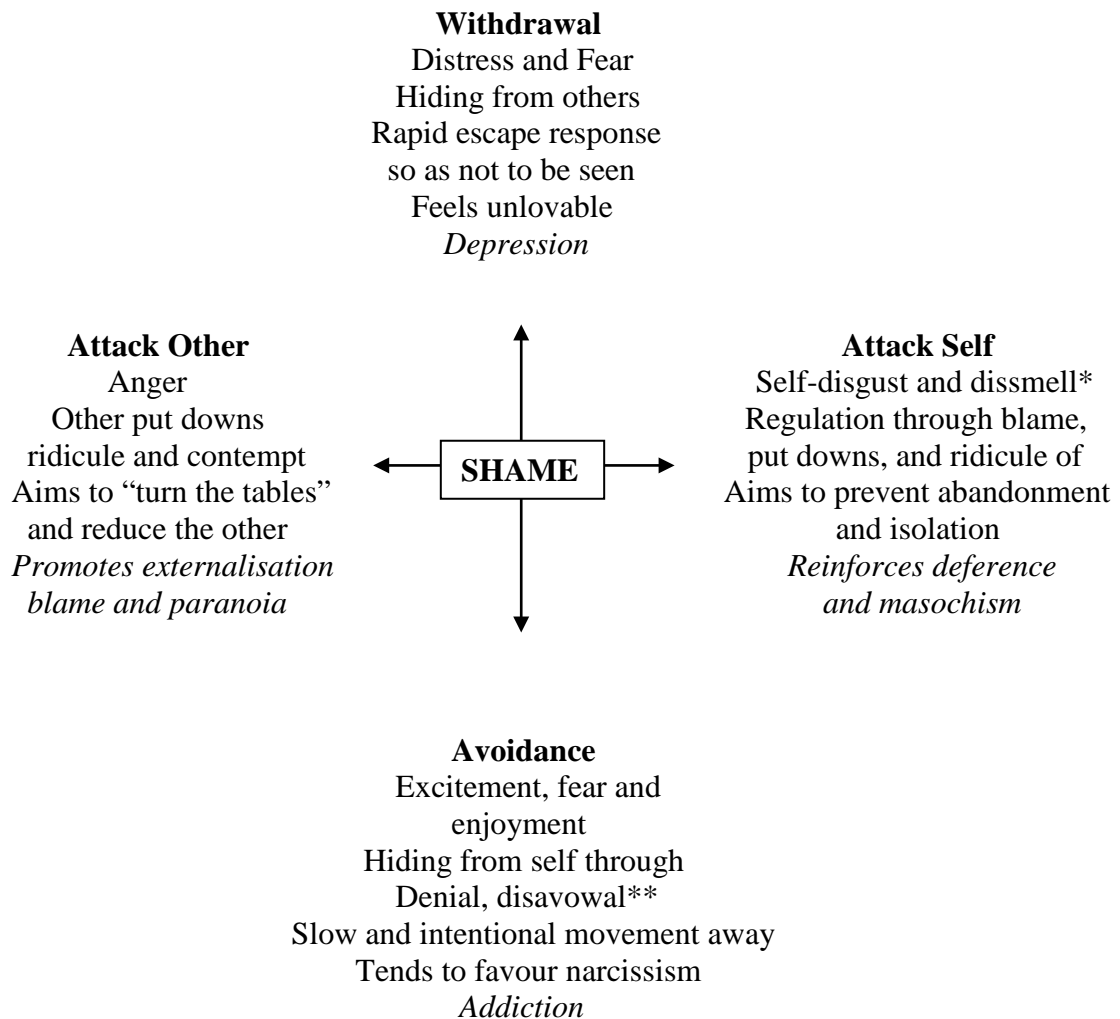
Since the self-in-the-eyes-of-the-other is the focus of awareness in shame, “identity” imagery is usually evoked. At the same time, however, this identity imagery is also registering as one’s own experience, creating a “doubleness of experience” that is characteristic of shame.... Because shame is the self’s vicarious experience of the other’s negative evaluation, in order for shame to occur there must be a relationship between the self and the other in which the self “cares” about the other’s evaluation. (pp. 15-16)

Thus, just because the experience is seen as originating outside the self it does not mean it is not an internalised experience.

Strategies of defense

As mentioned, often that which triggers the affect of shame may go unnoticed. What is visible are the individual’s strategies of defense. Relational-Cultural theorist Hartling in her article (Hartling, Rosen, Walker, & Jordan, 2000) built on the 1945 work of Karen Horney’s classification of personality types. Hartling presented three categories of ‘strategies of disconnection or survival’ used to respond to shame or humiliation. Some of us may use a ‘moving away’ strategy, for example: withdrawing, hiding, being silent, invisible, and keeping secrets. Others engage a ‘moving towards’ strategy involving appeasement and pleasing in an effort to secure the relationship. Finally, there are others who adopt a ‘moving against’ strategy in which aggression is used to gain power over and to shame the person triggering the shame. These strategies lead to greater disconnection and isolation.

Nathanson’s (1992) *Compass of shame* provides another conceptualisation which although similar has a few more dimensions. The compass has four systems of defense that are activated when we ignore the ‘spotlight of shame’, that is, what shame wants us to attend to. Each pole of the compass is a whole library of scripts or modes of responses. Aimed to make us feel different, each pole embodies an: “entire system of affect management” (Nathanson, p. 312). We may respond out of any of the polarities depending on what the shame trigger is; however consistent with Jordan’s model presented in her contribution to the article Hartling et al. (2000) we generally have a preferred position. Nathanson presented a simple diagram of the *Compass of shame* (p. 312) that I have expanded (Figure 1) to include relevant descriptions of aspects of each category from his text. These details include the ‘auxiliary affects’, defense mechanisms and possible outcomes inherent in each strategy.



* The primitive affect of dissmell is described as turning up one's nose in a rejecting way. Together with disgust dissmell motivate us to keep a distance from the event triggering shame.

** Disavowal “indicates one's inability to comprehend information that remains unwanted because it triggers unwanted affect” (Nathanson, 1992, p. 337).

Figure 1: Compass of shame

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.

Denial, repression, and projection are ways that shame is primarily defended against (Alonso & Rutan, 1988). I refer to McWilliams' (1994) text in defining these terms. 'Denial' is a way of dealing with unpleasant experiences through refusal to accept they are happening. In essence 'repression' involves “motivated forgetting or ignoring”

(McWilliams, 1994, p. 118). Ideas, emotions, or perceptions that are too upsetting or confusing are deliberately relegated to the unconscious. 'Projection' occurs in the absence of a boundary between self and world, so that "what is inside is misunderstood as coming from the outside" (McWilliams, 1994, p. 108). This is particularly relevant to Lewis' (1987) concept of the 'doubleness of experience' when the self is judged through the other's eyes. 'Projective identification' is a powerful experience for both therapist and client which features often in clinical literature on shame and therefore warrants discussion here. McWilliams (1994) cited Ogden's (1982) definition as a succinct account reflective of 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. (pp. 2-3)

Debate exists in regard to the potential misuse of the term to disown or blame the client for the therapist's experience of shame (Powell Livingston, 2006). The answer seems to lie in the therapist maintaining an awareness of her own shame vulnerabilities. This means identifying the part of the projective identification experience that does relate to her, the one that reverberates with the client's unconscious communication. Morrison (2011) proposed that 'contempt' may be seen as the projective identification of shame. The burden of shame is relieved through ascribing it to the failings of another, thereby becoming personally superior to the other. When the projector of the shame continues to interact with the recipient, this could be interpreted as evidence of a continued 'identification' with the projected aspect of self (Broucek, 1991). In comparison to the afore mentioned defenses, this latter one is complex. I have found good supervision following bewildering and painful clinical experiences involving the projective identification of shame especially effective in developing my understanding of the phenomenon.

In this section I have identified the multidimensional impactful experience of shame together with the myriad of ways in which we react to shame viewed through different lenses. The array of defense mechanisms a person engages to counter shame often appears to create secondary problems. This overview of shame is of course relevant to the therapist both to inform her clinical work and expand her understanding of the impact shame may have upon herself. What follows is a narrowing of focus onto the therapist's shame.

Centre Stage - Therapists' Shame

As the client's shame begins to move centre stage in the literature, the therapist's shame largely remains off stage. Apart from a small number of papers and the studies described below, most writing is located in pages rather than chapters of books. In my examination of the literature on therapist's shame, vignettes and case studies have spoken to me most. These accounts may be centered on one shaming event or an entire therapy and consistently seem to give an open and authentic description of the therapist's experience and actions followed by thought provoking discussion. For example in Powell Livingston's (2006) article she presented an engaging account titled *An involuntary laugh* focused on a group therapist's shame. Psychoanalyst Carr's (1990) *Wounded but still walking: One man's effort to move out of shame* is a very moving detailed case study of the experience of shame in both the therapist and her chronic shamed client. These studies underscore the complexity of what the therapist is dealing with in addressing issues of shame and the extent to which they are embedded in the relationship. Finally, on the internet I came upon a post written by psychotherapist Joe Burgo (2013) titled *Diary of a shame attack* written immediately following a couple of rejections in the context of his practice. In his choosing to share from within the experience, rather than seeking refuge in defenses, he offered hope to both clients and therapists alike as evidenced in the many validating responses he received.

Defining therapist shame

My search of the literature has revealed one definition of therapist's shame: "An intense and enduring reaction to the threat to the therapist's identity that consists of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (Ladany, Klinger, & Kulp, 2011, p. 308). The description of an "intense and enduring reaction" highlights the on-going impact of the shame trigger as no fleeting experience; rather one that may continue to haunt the therapist over time. Inherent in the definition is a link to what the therapist 'believes' shows incompetence in her practice. This definition fails to include reference to a continuum of responses and therefore the potential debilitating impact of the shame affliction. It also fails to capture the significance of shame as an intersubjective experience.

Sources of therapists' shame and reactions

In exploring areas of potential therapist shame Pope, Sonne, and Green, (2006) urged 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. In an attempt to throw light on possible impacts of therapist reactions with clients, Dorahy, Gorgas, Hanna and Wiingaard (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. 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, coupled with the need for fine-tuning of the therapist's response. Researchers Safran and Muran (2000) as cited in Gilbert (2011) claimed the therapist's recognition and response to her own shame and fear of being shamed (for example, tolerance, mindfulness, or defensive acting out) can be critical in shaping therapeutic outcomes. Numerous writers have echoed the requirement for the therapist to attend to her own shame to reduce the likelihood of enacting unhelpful reactions outside awareness.

There are multiple sources of shame for therapists, many which can be out of awareness. Different therapists experience various beliefs about what is shameful and therefore a range of reactions. There are, however, 'sources of shame' that may be shared. In their study involving 93 therapists and supervisors with clinical experience ranging from 6 months to 40 years, Klinger, Ladany, and Kulp (2012) asked their subjects to "describe an event in which they felt embarrassment or shame during a therapy session and how they reacted to the event" (p. 558). A total of 16 *Therapist embarrassing and shameful events* were identified. Key events were: "A scheduling mistake, forgetting or confusing client information, being visibly tired, falling asleep and arriving late" (p. 554).

The study matched these sources of shame with the therapist's reactions. Not surprisingly these reflect a mix of moving towards and moving away (hiding) responses by the therapist including: Apologising, use of humour, ignoring the event, processing with client, avoidance, recurring thoughts about the event.

Such a study covers a breadth of experiences and in the main pertains to therapist errors or perceived failings. The results of this study appear to reflect Morrison's (2011) proposal that shame resides in the gap between our 'ideal self' who has professionally efficacy and our 'actual self'. Klinger et al. (2012) presented a rich array of research possibilities emerging from their study aimed to address the absence of research on therapists' shame. A notable absence in the study is countertransference shame which they propose as an avenue of future research.

In his identification of various types of shame experienced by therapists Morrison (2011) presented a range of types and sources of shame, including those born out of the countertransference: In the first type, shame is triggered by the therapist's identification with the patient which leads to a 'mutual collusion to avoid' attending to the shame. The second type is activated by the therapist's fear of treatment failure, never more relevant than with challenging patients. 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, p. 40). In an earlier paper discussing *The Analyst's Shame* Morrison (2008) presented a rich array of possible sources of shame for the therapist which include: Engagement in an assessment; recognition of a want or need from a patient; evaporating referral sources; being told we are not being helpful; fears of badmouthing from patients; comparison with colleagues; being bypassed for a teaching position; and personal shame events including those that afflict our families: for example, a son's failure at college. Morrison (2008) alerted us to the fact that countertransference shame has been less studied in comparison to transference shame and that the former includes shame evoked by the asymmetrical relationship between patient and analyst with its implied superiority of the analyst. Identifying how shame can be experienced in the countertransference serves to deepen understanding of that which unfolds in the therapeutic context.

Countertransference

Gabbard (1993) described the mutual activation that can occur amid therapist and client when working with shame. First clients may project or externalise an aspect of their shameful feelings that they are unable to contain and second the therapist's internal shame experience can be activated though identification with the client's internal experience. An example of this phenomenon is when the therapist's shameful feelings

of a relationship breakup 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. This experience is very much like projective identification. In treating shame Hahn (2000) maintained that both types of countertransference identifications operate in tandem with the patient's "devalued introjects" and "devaluing introjects" (p. 12). 'Introjects' are lasting patterns of relationship established in interactions with the principal 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 or frustrated and angry with the client. For example, this may show up when the therapist uses a terse tone when making a scheduling change instigated by the client on the phone. 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.

The therapist does of course bring her own personal shame to the relationship that may have nothing to do with the client. She may be struggling with sources of therapist shame mentioned above (Morrison, 2008). Or she may be trying to make a recovery after feeling shamed by her previous client, after being told, "She wasn't as good as the client's previous therapist." How then does the therapist build her resilience to manage such moments?

Shame resilience

The therapist's level of resilience towards shame has a significant bearing on her functioning within therapeutic, supervisory, and collegial contexts. As mentioned, several authors have articulated the value of knowing one's own shame (Brown et al., 2011; Gilbert, 2011; Morrison, 2011; De Young, 2015). There are obvious reasons for this. First, being alongside a client in his/her deep self-loathing and helplessness is difficult without having addressed one's own shame. As I was told by a previous

supervisor, the late Evan Sherrard, early in my training “If you can’t stand the heat don’t stay in the kitchen.” Second, when our own shame is activated by the client’s shame strategies of defense of blame or contempt we need to be available to feel it, identify it and locate where it lives within us (De Young, 2015). To sum up, knowing one’s own shame is integral to shame resilience.

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 our authenticity and grow from our experiences” (Brown, p. 31). An increase in courage, compassion and connection in relationships with self and others are seen as positive outcomes from experiencing shame resilience. 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) practicing critical awareness (c) reaching out to others and sharing stories and (d) speaking shame. Interestingly, these are very similar to those steps towards healing in my foundational document, *Shame* by Evans.

In a grounded theory study *Shame and Resilience in Adulthood* Van Vliet (2008) interviewed 13 adults who told stories that elicited intense feelings of shame. She created a theory focused on the rebuilding of the self that occurs in the recovery from a shame event. Van Vliet postulated, “With rebuilding, individuals restore and expand their positive self concept, repair and strengthen their connections to the outside world, and increase their sense of power and control. This occurs through five primary processes: connecting, refocusing, accepting, understanding, and resisting” (p. 238). The last process involves rejecting negative judgments, also identified as a critical step in my foundational document . Connecting and understanding shame triggers are consistent across categories in both Brown’s (2008) and Van Vliet’s studies. In the next part I examine specific contexts for shame for therapists.

Sets for Therapist Shame

The group

Weber and Gans (2003) pointed out that shame in the therapy group has been given minimal attention in the literature. Even less focus has been given to the leader's shame and its impact on leader efficacy and group process, a situation that they contended does not equate with the power and prevalence of this phenomenon. So why is the experience of shame likely to be intensified in a group? In a group one is 'under the gaze' of many, thus the potential for feelings of exposure is increased. Shapiro and Powers (2011) summarised other key contributors to the stimulation of a heightened sense of shame in group therapy:

In addition to the presence of others, heightened self awareness, norms of self disclosure, social comparisons, group focus, and multiplicity of potential perceived injuries and empathic failures, there is a powerful and acute potential for object loss, both real and imagined, in group therapy. (p. 117)

They name a shame-based belief that speaks of the inner experience of toxicity as the generator of the fear of potential loss: "The belief that 'if they really knew me, they would want nothing to do with me' means that 'when they do know me they will reject and abandon me'" (Shapiro & Powers, 2011, p. 117). Defenses against shame in the group are driven by the desire to hide that impedes its detection (Gans & Weber, 2000). As referred to above, in the context of individual therapy, this cover-up is problematic for therapeutic process, particularly when the therapist's unresolved shame is activated and a mutual collusion to avoid the shame occurs (Morrison, 2011). In spite of the described exacerbation of shame and activation of its defenses, the group can prove an antidote to shame. Alonso and Rutan (1988) highlighted how group psychotherapy simultaneously stimulates shame yet paradoxically provides a powerful means of resolving shame.

Weber and Gans (2003) claimed that beyond the leader's personal vulnerabilities there are factors pertaining to leadership that stimulate shame in the leader. They cited Brightman's (1984) grandiose ego ideal as contributing to shame in the group therapist just as it does in the individual therapist. The ideal includes "(1) omnipotence (the wish to be powerful); (2) omniscience (the wish to be all knowing); and (3) total benevolence (the wish to be all loving)" (p. 399). A form of perfectionism, this relates to Morrison's (2011) concept of shame filling the gap between the 'ideal' and 'actual' self.

In making reference to shame in the context of the group my intention is to underscore the significance of shame in this arena, its impact on how we function and see ourselves whether we are leader or a participant. In the group there is a complexity of shame related dynamics to be taken into account, the description of which extends beyond the scope of this study. Supervision, however, is one resource available to support the group leader in what is a very demanding task.

Supervision

As clients can struggle with revealing weaknesses to a therapist, so too can supervisees be challenged to do the same with their supervisors. 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. Aggressive-withdrawing responses to clients are apt to feel shameful for the therapist without an opportunity to make meaning of them. 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 her supervisee, 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. Perceiving the particular vulnerability of trainees to exposure and humiliation Alonso and Rutan (1988) suggested a range of strategies for shame reduction. 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.

In summary, what has been presented is an overview of shame literature firstly, related to the phenomenon of shame in the broader sense as a basis for this study and secondly, in the specific realm of the therapist. The importance of recognition and understanding of shame and its various masquerades has been highlighted. The conveyance of a language for talking about shame is another significant outcome sought in this review. Whilst it is pleasing to note that a number of clinicians have begun to address the issue of therapist's shame there remains a gap in the literature which I hope this study will go some way to filling. Now we will transition from focus on one kind of data to another: Data generated by the co-researchers and researcher

Chapter Three: Heuristic Methodology and Method

In this chapter I discuss the methodology and research design I used in this study. I outline the theoretical underpinnings of heuristic research and how I have applied its praxis, explaining how I personally experienced each stage through the journey. Throughout I identify merits of the chosen research approach. I conclude with discussion of some of its potential limits.

The research methodology chosen needs to align with the nature of the study and the researcher's worldview. My choice of qualitative methodology was based in my desire to delineate some of the essential qualities of the complex phenomenon of shame experienced by therapists and to understand why and how shame operates in both clinical and collegial contexts. I was not interested in quantifying the phenomenon and so was not drawn towards a quantitative approach. Qualitative approaches span a continuum ranging from a focus on conceptualising to experiencing the selected topic (Braud & Anderson, 1998). My interest in research of an experiential nature saw me exploring a phenomenological approach, that is, one that was concerned with thinking about what people's life experiences are actually like. Spiegelberg (1982) as cited in Cresswell (2007) stated that phenomenology is rooted philosophically in the writings of the German mathematician Edmund Husserl (1859-1938) and those who build on his views including Heidegger, Sartre, and Merleau-Ponty. Grbich (1999) stated that Husserl believed that meaning began in individuals who were also the central point for social analysis. She elaborated "The impetus for the development of phenomenological ideas was a concern that the foundations of knowledge should be placed upon *reality* as it could be consciously experienced" (Grbich, p. 167, italics in original). The truth about reality is based in people's lived experience and how this experience is interpreted.

In the phenomenological approach to research a phenomenon from the realm of human experience is identified and data is gathered from individuals experiencing this phenomenon. The researcher aims to describe the essence of the experience towards a common understanding (Creswell, 2007). When I first conceived of doing this study 15 years ago I wrote a proposal based on Gadamerian hermeneutic methodology and van Manen's (1997) procedures for data collection and analysis. In hermeneutic phenomenology the orientation toward lived experience (phenomenology) includes the interpreting of "texts" of life (hermeneutics) (van Manen, 1990, p. 4). Gadamer saw

people as having historically influenced consciousness, and therefore he saw understanding as a historical process. Whilst valuing the relevance of Gadamerian hermeneutics in permitting the necessary depth and understanding of the phenomenon of shame, I abandoned this approach in favour of another type of phenomenology that I had since discovered: heuristic enquiry. My decision was based first, on the likelihood that Gadamerian hermeneutics, with its heavy emphasis on language as the vehicle for understanding, was potentially problematic in the study of a phenomenon that often has no words; and second, I found the active use of self and self awareness integral to heuristics attractive and appropriate for addressing shame, which for any therapist must begin with attention to the self, as has been mentioned. The latter tenet has meant that “all” of me could be present as the researcher. The development of a considerable body of knowledge and likelihood of personal transformation, through a committed and disciplined approach to the enquiry as proposed by Douglass and Moustakas (1985) proved additional deciding factors in my choice of the heuristic research process.

Heuristic enquiry thus, is an adaption of phenomenological enquiry in which the researcher’s involvement is integral, to the extent that the lived experience of the researcher becomes the main research focus (Hiles, 2001). It is this explicit involvement with the research phenomenon by the researcher that distinguishes heuristics from other research methods. As in this study, the researcher’s experiences are incorporated with those of others, who are known as ‘co-researchers’, a term used in heuristic enquiry to refer to the participants in this study. These people have direct experience of the phenomenon being studied and their involvement assists in the researcher’s discovery of its essence and meaning. I am drawn towards the term ‘co-researcher’ as it acknowledges that together we are therapists on a quest to understand shame as it impacts on us, and thus implies mutuality. Beyond the characteristics identified above that distinguish phenomenology from heuristic inquiry, Douglass and Moustakas (1985) noted other points of contrast. I consider two key ones to be first, that heuristics emphasises connectedness and relationship with the phenomenon rather than detachment from it; and second, in heuristics individuals are visible rather than lost in the analysis of data and remain portrayed as whole persons.

Derived from the Greek word *heuriskein*, heuristics means “to discover or to find” (Moustakas, 1990, p. 9). Developed by Clark Moustakas, a humanistic psychologist, this methodology aims at discovery of the nature and meaning of phenomenon through

relentless self-enquiry, exploration and elucidation of the phenomenon being studied (Douglass & Moustakas, 1985; Hiles, 2001; Moustakas, 1990). Heuristic research is suited to this project as the experience of shame is a deeply personal experience and, moreover, a shared experience impacting on both practitioner and client. Furthermore, it is “a method of research that particularly resonates with inquiry into counselling and therapy related issues” (Hiles, 2001, p. 14). Heuristic enquiry is viewed as both a methodology and a method of conducting research (Moustakas, 1990).

When I first became familiar with heuristic enquiry I was struck by its similarities with psychotherapy practice. Both are highly relational activities involving dialogue, subjective awareness and a well-tuned ability to enter into the world of the other. It was reassuring to discover that some of the skills and practices involved in heuristic research fit with regular daily practice in the consulting room, as is shown below in the description of methods. Rose and Loewenthal (2006) validated heuristics as a “relational research method that facilitates exploration of the lived experience of psychotherapy” (p. 133). They postulated that therapists undertake a type of relational research in the supervisory relationship. This made sense as in my quest to understand shame and its impact I have sought additional supervision from four different clinical supervisors. In supervision therapist and supervisor together strive to understand, gain new perspectives and knowledge about the therapeutic relationship. As with heuristic research this knowledge has the potential to inform practice. Gestalt psychotherapist Stevens (2006) reinforced the validity of heuristic inquiry for therapy process research in her contention “that it explicitly operates at third-order awareness -awareness of awareness-creating cognitive discourse that makes subjective experience of doing therapy accessible for research through self-reflection” (p. 173). The following brief account of the evolution of heuristic enquiry shows the extent to which therapeutic concepts and practices are intertwined within the approach.

Based on Moustakas’s (1961/1989) personal experience the publication of *Loneliness* launched heuristic research. Moustakas (1990) acknowledged the influence of several significant works in his development of heuristic research. Sela-Smith (2002) cited these as Bridgeman (1950), Buber (1961, 1965), Gendlin (1962), Jourard (1968, 1971), Maslow (1956, 1966, 1971), Polanyi (1964, 1966, 1969), Rogers (1985), and Moustakas’s own earlier work (1968, 1981, 1988).

Just as I was struck by the fit between heuristics and psychotherapy, so too did I see how well heuristics interfaced with the study of therapists' experiences of shame. I constructed Table 1 to illustrate what I consider 'a perfect match'.

Table 1: A perfect match

<i>Heuristic Inquiry</i>	<i>Experience of Shame</i>
Lived experience of researcher is central	Power lies in therapists' acknowledging their own shame
Emphasis on connectedness and relationship with topic (Douglass & Moustakas, 1985)	Highly subjective and deeply personal
Visibility of whole person that is the person is not lost in data (Douglass & Moustakas, 1985)	Involves "one's whole being in relationship" (Jordan, 1997, p. 2)
Well suited to study of psychotherapy	Involves self and other misattunement and disconnection
Encourages creativity and 'going with the flow'	Both are useful in uncovering shame's concealment

Key Concepts

Moustakas (1990, pp. 15-27) presented seven key concepts in heuristic research.

Identification

Involves getting inside the research question, becoming one with it, living it.

Identification is achieved through fully entering into the phenomenon; that is, in this case, actually 'being' the shame that impacts me as a therapist, getting underneath it, in behind it, merging with it. Psychodrama is a method that has enabled me to do just this: to physically embody shame and gain access to the experiences, feelings, and meanings at a deep level. Dialoguing with the shame deepens the process of identification.

Self-dialogue

Coupled with 'being one' with the phenomenon, the researcher can enter into a dialogue with the phenomenon allowing it to speak directly to one's own experience. An attuned openness, trust, and receptivity to all aspects of one's experience is required, together

with rigorous honest self disclosure. Douglass and Moustakas (1985) highlighted the importance of self disclosure: “At the heart of heuristics lies an emphasis on disclosing the self as a way of facilitating disclosure from others - a response to the tacit dimension within oneself sparks a similar call from others” (p. 50). In my interviews with the co-researchers I actively self-disclosed with this purpose in mind, I also knew that self-disclosure could help alleviate shame in the speaker.

From the meeting and examining of one’s experience over and over again numerous meanings emerge, leading to the identification of core themes and essences. It is through this process of self-dialogue that a body of knowledge emerges.

Moustakas (1990) emphasised the necessity of beginning with a focus on one’s self, developing self-awareness, gaining insights and understandings. This concept is mirrored in the requirement for therapists to attend to their own experience of shame or shame work as a starting point in enabling them to be open to recognising and making sense of the experiences of their clients (Morrison, 2011). On a larger scale my own inner knowing is that ‘my’ human experience, as both client and therapist, has held deep value and broader significance. In my practice of psychotherapy I am strongly engaged with my own tacit knowing.

Tacit knowing

Referencing Polanyi’s (1964,1969,1982) work Moustakas (1990) claimed that “Underlying all other concepts in heuristic research, at the base of all heuristic discovery is the power of revelation in tacit knowing” (p. 20); that is, we can know more than we can tell. The tacit dimension lies mostly below our levels of consciousness and becomes the foundation on which all other knowledge stands. Sela-Smith (2002) described it as the place inside us where experience, feeling and meaning come together giving us ways to look at the world and navigate it. Tacit knowledge is a constantly growing multilayered, deeply structured organisation.

Polyani (1964) (as cited in Moustakas, 1990) suggested that tacit knowledge consists of two elements: the first ‘subsidiary’ factors are those which draw our attention, are visible and able to be described, for example, the posture that folds in on itself, the eyes that avoid the gaze, the words “I’m stupid, worthless.” The second ‘focal’ factors are unseen, implicit, or subliminal facets of an experience, for example, the dark feeling,

the sense of anxiety, the passive apologetic demeanour. Together both elements create a sense of wholeness, a complete body of knowledge or essence of a phenomenon.

Channels for accessing tacit knowing include: dreams, metaphors, images, poetry and intuition. Specific skills found in heuristic methods, for example, focusing, concentrated gazing, pattern observation are designed to bring to conscious awareness our previously unseen inner knowledge. Moustakas (1990) stated “Such knowledge is possible through a tacit capacity that allows one to sense the unity or wholeness of something from an understanding of the individual qualities or parts” (pp. 20-21). Intuition has an important function in linking tacit and explicit knowledge. An example of tacit knowing lies in my writing of this thesis. Once I heard the singer KD Lang say that she preferred to read people, rather than books. Although I may often have the books I think I need to read, like Lang, I am not the keenest of readers. Yet when I have been writing I have been surprised how the words I seek seem to float up from nowhere. This is preceded by an intuitive sense of there being a particular word for what I want to convey. The words that suddenly present themselves are not words I use in conversation, or even thought I knew. I have always held the assumption ‘limited reading’ means ‘limited vocabulary’. As I write I am fortunate in being able to easily check my tacit knowing of the ‘right word’ with the tool of explicit knowledge: the thesaurus.

Intuition

Living in clues and hunches intuition bypasses logic and reasoning, making knowledge readily available to us. Moustakas (1990) described how we surmise the truth using our intuition to perceive something, observe it, and look over and over again going from clue to clue. The experience and expression of intuition is a skill claimed Polyanyi (1990), one which requires practice (as cited in Moustakas, 1990). I argue that before we can practice the skill, we need to hold a belief that intuition is of value. In my early training in my family of origin I learnt to override my intuition in favour of adhering to the family rules. As a therapist I have been given a second opportunity to respect intuition as a valued part of our humanness.

I am guided by my intuition as a heuristic researcher as it takes me down different paths, to explore additional resources, to talk to particular people, to call for me to adjust my methods and shift my understanding in the quest to discover and excavate inherent essential meanings, which in turn lead to enriched meanings and deepened and extended knowledge. Moustakas (1990) underscored the importance of intuition in his

assertion that “Every act of achieving integration, unity, or wholeness of anything requires intuition” (p. 23). The ability to access our tacit capacity is heightened by committed sustained inner searching as described in the process that follows. For example towards the end of this study I have had an intuitive sense that I needed to write another chapter centered on my whole experience of the study. This endeavour has taken me down some fruitful roads uncovering differences between ‘being seen’ and ‘being exposed’, as well as inspiring me to pull all the threads together in a creative and synchronistic way.

Indwelling

The term ‘indwelling’ is used by Moustakas (1990) to refer to “the heuristic process of turning inward to seek a deeper, more extended comprehension of the nature or meaning of a quality or theme of human experience” (p. 24). He explained, “It involves a willingness to gaze with unwavering attention and concentration into some facet of human experience in order to understand its constituent qualities and its wholeness” (Moustakas, 1990, p 24). My study of therapist shame has involved me in tuning into my thoughts, feelings, impressions, and the vague and sometimes intense awarenesses I experience as I sit with my clients and in the world beyond the therapy room. In doing so my intention is to grasp the full nature and significance of shame. I am involved in capturing the lived experience of the phenomenon including its features, triggers or sources that evoke it, which can be past or present events, contexts, and/or people. I have, at times, found the discipline and skills required in this process difficult and demanding. Indwelling has brought insight and reward as I have progressed towards the *Creative synthesis*: the full portrayal of the vital qualities and meanings of shame. The next process of focusing enhances indwelling and thereby the ability to tune into the tacit dimension.

Focusing

Gendlin (1978) (as cited in Moustakas, 1990) developed intentional ways of using centering, concentration and reflection in the therapeutic context known as focusing. In heuristic research the term refers to the creation of an inner space that permits sustained inner attention so that thoughts and feelings can be captured. Focusing is relevant to a number of steps in the inquiry including clarifying and grasping the question, reaching central themes and elucidating the themes. Douglass and Moustakas (1985) claimed

‘differentiation’ functions in tandem with focusing during acquisition in heuristics and that these add to the powers of perception. Differentiation is a process involving “sniffing out the meanings and perceptions that are generated by focusing” (Douglass & Moustakas, p. 52). In my shame study this means identifying and exploring affects that might cohabitate with shame as well as places and situations where it shows up. An example of focusing is found in Chapter 7 when I hit the wall and felt unable to write up my study. Alone at home for the weekend planning to concentrate on my writing, I focused my entire attention on what was impeding my progress. I journalled and drew sketches and eventually through permeating my layers of defense, shaming beliefs and fears I could explicate my experience and move forward. Finally, I describe the ‘internal frame of reference’ a concept that underpins all the above heuristic processes.

Internal frame of reference

The ‘internal frame of reference’ of the experiencing person is critical in the understanding of the characteristics, nature and meanings of the human experience that is explored (Moustakas, 1990). This is to say that we each have our own very individual worlds of perceptions, thoughts, feelings, and meaning making.

Rogers (1951/2003) underscored the importance of empathic understanding of the other’s internal frame of reference. Through entering the private world of the other as a companion, suspending judgments, tuning into felt meanings, communicating what is sensed, the other can be assisted towards personality change. As a heuristic researcher I actively encouraged my co-researchers to express, explore and elucidate their experiences. All but one interview was conducted in the co-researcher’s office space. I think being in their own space helped put them at ease. I kept the interviews open and invited expression of whatever aspect of experience was not being expressed; that is thoughts, feelings, and/or actions. From the outset my intention was to create an ambiance of openness, respect, sensitivity, and trust between us. Such qualities are closely aligned with the interpersonal requirements of working with shame. I aimed to create a sense of connection that warmed them up to their own spontaneity and willingness to self disclose.

This way of being in relation to the other is well grounded in me from my many years of engagement with the psychodrama method. Role reversal is integral to psychodrama and perhaps its most potent technique. Involving a change in physical place with the

other, a powerful opportunity is given to explore the other's role, see the world as they see it. "Together role reversal and encounter represent the potential ability of one individual to really experience the world from the point of view of the other" (Yaniv, 2011, p. 53). Jacob Moreno (1889-1974) an Austrian psychiatrist and founder of psychodrama wrote the following poem that expressed his philosophy of how encounter makes the world go round:

A meeting of two: eye to eye, face to face.
And when you are near I will tear your eyes out
and place them instead of mine,
and you will tear my eyes out
and will place them instead of yours,
then I will look at you with your eyes
and you will look at me with mine

(Moreno, 1914, p. 3 as cited in Yaniv, 2011, p. 53)

This description leaves us in no doubt as to the strong feelings that can be evoked by role reversal. Next I will present the phases in which the above concepts and core processes are anchored.

Phases of Heuristic Research

Moustakas (1990) outlined six basic phases involved in the heuristic approach. He emphasised the need for the researcher to surrender to each phase. The following chart (Figure 2, p. 37) highlights how the phases are not necessarily linear in their progression.

Below I will convey how I relate to each phase and identify the methods I have used in the study.

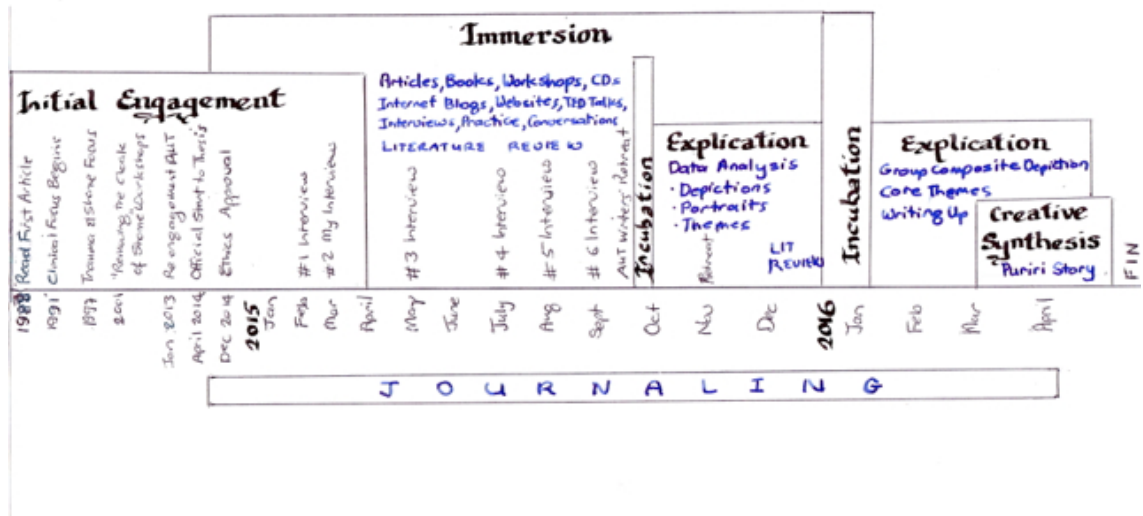


Figure 2: Non linear phases of my heuristic study

1. Initial Engagement

Within each researcher exists a topic, theme, problem or question that represents a critical interest and area of research. The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal compelling implications. (Moustakas, 1990, p. 27)

My initial engagement with the topic began well over two decades ago, since which time I have maintained a strong focus on understanding shame, recognising its many faces and discovering both its impact and how effective interventions can be made in clinical settings. I have developed an in-depth appreciation of how shame has become internalised in my identity and how the restrictive forces of shame have shaped my life. As a therapist shame is an everyday experience and one that I believe is seldom discussed amongst colleagues and is therefore worthy of study.

Defining the research focus demands a certain rigour in ascertaining the reasons for study of a particular phenomenon, what specifically the researcher wants to know more about and why, alongside the broader issues of previous research and the likely contribution of the research to the existing body of knowledge in the subject. My process of choosing the research question was convoluted and lengthy. Initially I sought to explore the experience of transforming shame through psychodrama with a client and myself as subjects. I was challenged to represent the merits of such a study within the academic system. Furthermore a clinical supervisor cautioned me of the likely perils of the inherent exposure of myself that would be required in such a study.

With escalated feelings of shame, I abandoned my initial focus and pulled back to focus on therapists' experiences of shame. Out of my long preoccupation with the topic of shame I have evolved a strong interest in that which transforms shame. However, I was to learn that focusing the study on therapists' experiences of the latter meant I was 'skewing' the research. That is I wanted to go from A to Z and avoid acknowledging 'all' aspects of the experience of shame. This response relates to Key and Kerr's (2011) claim that in an attempt to avoid personal pain the heuristic researcher can shift to a less threatening question. Ultimately, I settled on the research question: "What are therapists' experiences of shame?"

Next I set about constructing methods and processes to guide me in gathering the data. Whilst I could have conducted the investigation with myself as the sole participant, as Moustakas (1990) suggested, the engagement of co-researchers added to the richness, depth, and variety of meanings to my study. Normally in heuristic research the co-researchers are involved in the interpretation and analysis of the data in ongoing sessions. The time commitment that would have been required to meet for these sessions and work with the co-researchers as a group, was beyond the small scale size of this study.

Consistent with heuristics I aimed to uncover as many experiences and meanings as I could. I believed that my choice of co-researchers was significant in achieving this aim. Potential co-researchers were chosen with my academic supervisor in accord with two main selection criteria: they needed to be members of the New Zealand Association of Counsellors and/or The New Zealand Association of Psychotherapists. Those I interviewed all belong to the latter professional body. Additionally, co-researchers were required to have a working knowledge of the power and prevalence of shame in the therapeutic context. I began with people who had written on the subject. These therapists needed sufficient shame resilience to self-reflect with openness and honesty, as well as the ability to articulate their experience. My academic supervisor and I reviewed the suitability of potential participants in the light of the criteria; she then approached those whom we agreed upon. Through Margot making the invitation to potential participants, they were given the opportunity to decline without pressure. Her senior role in the community of psychotherapists meant that she was well placed to know of possible candidates for the research.

Adopting the open ended approach applied in heuristics I incorporated various steps noted in Moustakas's (1990) 'methods of preparation' and allowed the process to unfold. All co-researchers initially accepted the invitation to participate and they were sent a *Participant Information Sheet* (see Appendix ii) outlining the research design, its purpose, procedures, and participant expectations. A key purpose of this sheet was to give co-researchers information from which they could make an informed choice about their participation in the study. A *Consent Form* (see Appendix iii) was emailed to each participant and a hard copy was signed when we met for the interview. Initially, I proposed to conduct 10 to 12 interviews. While time constraints were certainly a factor in my decision to reduce the number of interviews, I was satisfied with the depth and breadth of the data I had collected in the five interviews I had completed. In discussing participant numbers in heuristic research Rose and Loewenthal (2006) stated "...it is the quality of the information rather than the quantity that is particularly pertinent with this research method" (p. 135).

The next step was to conduct what Patton (1980) termed a "standardized open-ended interview" (p. 198) with each co-researcher. As mentioned we met in the offices of the co-researchers in all but one occasion when we met in my office. While heuristic interviews may vary from 15 minutes to 2 hours, I chose to specify the time frame for interviews as 60 to 90 minutes, based largely on my experience of clinical sessions. Initially I asked what generated their interest in the topic, I then invited stories about their experience of shame in their practice as seen in the following excerpt from one of the interviews:

Marian (MH): Thank you very much for agreeing to be interviewed. What I'm interested in mostly is your experience of shame as a therapist, so that's not so much the theories you have about it but what you feel and what you think and what you did. So primarily I'll be interested in stories and towards the end I'll ask you some reflective questions and as I said I think it could be an hour, maybe a bit longer, we'll see how we go. So I'll start by asking you first what makes you interested in the subject of shame?

During the interview, at various points, I invited participants to expand on what they said and say more about what they may have omitted in conveying their experience. Consistent with the heuristic approach dialoguing was an integral aspect of the interview. Towards the end of the interview I asked a couple of reflective questions:

- What 'inhibits' your ability to respond to the client's shame and/or your own shame in the therapy room?

- What ‘enhances’ your ability to respond to the client’s shame and/or your own shame in the therapy room?

I did not find these questions particularly useful as in most cases the participant’s responses were embedded in the stories. I suspect the questions were too cognitive in nature, interrupting the flow of actual lived experience. Whilst my experience of each interview was different, overall I was surprised by the extent to which I felt moved and satisfied by the dialogues I had with each person. Most of those interviewed reflected similar sentiments about their experience, which has further strengthened the validity of my study. These experiences confirmed for me that I was conducting the interviews in a manner consistent with heuristics involving cooperative sharing, free expression, and spontaneity.

2. Immersion

Once the question is discovered and its terms defined and clarified, the researcher lives the question in waking, sleeping and even dream states. (Moustakas, 1990, p. 28)

The researcher must become awake to anything related to the question as raw material for immersion. Concentration and self-searching are required as the researcher becomes one with the question. Sela-Smith (2002) underscored how immersion is a natural process. She claimed:

Something amazing happens when the researcher has surrendered to the call in Phase 1. When the question has been properly formed, it appears to have a power that draws the image of the question everywhere in the researcher’s life experience (Sela-Smith, p.65).

In this phase I have used a reflexive journal to record hunches, ideas, reflections, dreams, essences in both written and art form. Consistent with a heuristic approach to research I have followed my own psychodramatic ‘warm up’ in this process, this has meant being aware of, and responding to thoughts and feelings that have emerged spontaneously from within in relation to the topic. I have been particularly mindful of my experiences of being with shame as I work with my clients. Coupled with this I have drawn material from the external world of conversations with others (including my partner, colleagues and friends), training, supervision, teaching, film and the internet. I have been delighted to discover the value of consulting with more than one supervisor with respect to particular shame evoking clinical situations.

My literature review has been integral to this phase. I have been totally surprised by the burgeoning of interest in the topic, particularly in regard to shame in the therapeutic context, from when I first proposed the study in 2001. In the original form of heuristic enquiry presented by Moustakas (1990) it is recommended that a detailed review of the literature be completed after the data analysis, so as not to skew the findings. While I delayed the review in favour of ‘indwelling’ and getting underway with the interviews, my timetable dictated the need to get on with the review. I found it important to go back and forth between the literature and my own experience, in doing so claiming validity in my own authority, rather than simply getting lost in the power of the printed word. In this sense ‘emersion’ has been as important as ‘immersion’.

The interviews were taped and transcribed and notes were made of observations and reflections immediately after they had taken place and when I chose to re-immersify myself in a particular interview. I listened to the tapes many times during the long distance I travel to and from work and found this helpful in generating intense involvement with the data presented by each person.

Analysis of data proceeded via a number of steps and involved progress through the three phases of *Incubation*, *Illumination* and *Explication* identified below. All transcripts, notes, and emails pertaining to each co-researcher were gathered and organised into a sequence that told the story of each. This required “timeless immersion” whilst in-depth understanding was reached (Moustakas, 1990, p. 51). By necessity this process was punctuated by rest periods, identified in the *Incubation* stage below, in which the data needs to be set aside to refresh the researcher and facilitate the emergence of new perspectives.

Upon further review of all the individual’s material, notes were made on the themes and qualities emerging from the data. An “individual depiction of the experience” of the phenomenon of shame for each participant was constructed (Moustakas, 1990, p. 51). The participant’s language was used and, in some, excerpts of verbatim were used. In order to ascertain whether the individual depiction of experience of each individual truly fitted with the data from which it was developed, I presented the depictions to each participant to check for accuracy. I also checked in with two

participants for whom I had constructed ‘portraits’ as described below. I was interested to know whether I had captured the essence of their experiences. Some co-researchers responded with changes they wanted to make to their verbatim and/or depictions and portraits. They chose to amend phrases and in some cases make additions. One person elected to have one particular depiction not included in the data as it felt “too identifying”. I was pleased to have discovered this, as I remain committed to preservation of the anonymity of all my co-researchers and, furthermore, I am acutely aware of the sensitivity of the topic. I valued the opportunity to link with the co-researchers again and once more felt heartened by their interest in my study.

I gathered the individual depictions together and entered further immersion with alternating incubation periods and eventually developed a group composite depiction described below in the ‘explication’ phase.

Next two individual depictions were selected as characteristic of the group as a whole. These were used together with autobiographical material, personal documents, writing, and the transcript to create ‘portraits’ of the persons. The individual depictions, group composite depiction and two portraits, together with verbatim examples and discussion of thematic structures formed the data, the soil out of which the *Creative synthesis* grew, as shown below.

3. Incubation

Incubation is the process in which the researcher retreats for the intense, concentrated focus on the question. Although the researcher is moving in a totally different path, detached involvement with the question...on another level, expansion of knowledge is taking place. (Moustakas, 1990, p. 28)

Stepping back for a while, pursuing work, play and rest, gives the inner tacit dimension and intuition an opportunity to clarify and develop understanding. With the pressure of time to complete my study I found this difficult to do as it called forth a level of discipline and trust to which I was not normally accustomed. I took two breaks – the first six months out from completion and the second, a two-week break, was three months before finishing. On my second break I attended a young relative’s wedding in the South Island. As the groom watched his bride walk towards him at the altar his tears flowed freely. As the couple’s friends gave speeches they laughed and

cried at the same time. I was truly enriched by my experiences of their expression of vulnerability in the absence of shame. I was reminded of the words of my psychodrama trainer the late Max Clayton, “The sign of a healthy person is someone who can laugh and cry at the same time.”

I consider incubation has occurred on a day-to-day basis. I have been surprised how a day in the garden could advance my study with no effort. To some extent, although I was in the phases of immersion and explication, I experienced my *Writers' Retreats* as periods of incubation. This being another example of the fluidity of the phases.

4. Illumination

The process of illumination is one that occurs naturally when the researcher is open to tacit knowledge and intuition. The illumination is a breakthrough into conscious awareness of qualities and clustering of qualities into themes inherent in the question. (Moustakas, 1990, p. 29)

Themes begin to percolate into consciousness as previous understandings are updated and new discoveries emerge. This is a spontaneous phase in which a major reorganisation of knowing occurs, involving transformation at a deep level (Sela-Smith, 2002). Illumination can of course occur at any time in the research process. I learnt that when out on cycling rides I needed to take pen and paper to capture the insights that would fly into my head as I rode along. To help stimulate illumination I used academic and clinical supervision as forums to identify the emergent themes and develop my understanding of the knowledge I had uncovered.

In this phase I constructed two charts to facilitate my analysis of the data. The first, titled a *Theme Analysis* (see Appendix v) was a list of all the themes represented by the co-researchers and myself in the interviews. After considerable focusing and indwelling, with the help of my academic supervisors I distilled my long list of themes to four core themes over a three phase process. I saw other themes not encompassed in the core themes more appropriately represented in the group composite depiction (self blame, regression, collapse, vulnerability, disconnection, anger, isolation, and no redemption). I recognised that to some extent these would also feature in the individual depictions. In discussion with my academic supervisors I decided the well represented themes of ‘good supervision’ and ‘building resilience’ belonged in the discussion section. On the second chart titled *Data Analysis* I wrote at

least two depictions for each co-researcher and recorded my responses and analysis of each (see Appendix vi). These charts became foundational documents assisting in the formation of Chapters 4, 6 and 8.

Towards the end of my study I reviewed my journal and indexed all that I wanted to consider for inclusion in my final write up. Looking through my journal I gained a fresh appreciation of how tacit knowledge had revealed itself in my dreams. Returning to my dreams was very illuminating. Nine months prior to completion I had a dream that I describe in Chapter 7. I had driven my car into a swimming pool: immersion in its fullest sense.

5. Explication

The purpose of the explication phase is to fully examine what has awakened in consciousness, in order to understand its various layers of meaning.
(Moustakas, 1990, p. 31)

This phase involves a thorough and in-depth examination of all that has been brought into consciousness from the tacit dimension and ultimately leads to a new worldview in the researcher (Moustakas, 1990). There is a need to show, disentangle, the themes and features that have emerged in the illumination phase. The complete picture of the phenomenon begins to form with new perspectives, explanations and patterns being identified (Djuraskovic & Arthur, 2010). Like tributaries in-dwelling, focusing and self-searching all flow to create a river which carries varying levels of meaning, experiences and understandings emerging from dialogues with people. Downstream the river forks into ‘focusing’ and ‘in-dwelling’ once more, as the significant components of the phenomenon are clarified and elucidated. It is in this phase that a comprehensive depiction or group composite depiction is developed of the common themes and essences inherent in the experience of all the co-researchers and the researcher (Moustakas, 1990). Narratives, illustrations, verbatim excerpts have been used to highlight the flow and life energy in the experience in the presentation and analysis of the data.

Next I set about interweaving verbatim and depictions with the four core themes. I revisited literature and extracted meanings from the data on which I was focused and wrote the chapter on the core themes.

Compiling the ‘group composite depiction’ was challenging. I reviewed the data from each interview and listed the qualities of experience in each. Then I created a framework on which they could hang. Consistent with the experience of shame I felt my account was fragmented. I decided to add personal sketches in an attempt to add to and deepen my multi-dimensional presentation of shame within the group.

Two months before finishing my thesis I wrote Chapter 7, which is a reflection on my journey of writing this study. This had a powerful integrative impact on me and released knowledge and meaning at a deep level.

6. Creative synthesis

Once the researcher has mastered knowledge of the material that illuminates and explicates the question, the researcher is challenged to put the components and core themes into a creative synthesis. (Moustakas, 1990, p. 31)

Creative synthesis of the experience can be expressed in many creative forms such as a narrative account, analogy, metaphor, a report, poem, story, or work of art (Moustakas, 1990). Characteristic of heuristics the most effective and powerful form(s) of expression were not evident until the final phase was reached. What is presented is much more than a mere account of what went on the study; rather “it is the complete depiction of human experience in all its wholeness” (Djuraskovic & Arthur, 2010, p. 1579). Moustakas (1990) described the researcher as a “scientist - artist... (who) develops an aesthetic rendition of the themes and essential meanings of the phenomenon” (p. 52).

Throughout the study I have had faith that the shape and content of my *Creative synthesis* would reveal itself. I held the seed of the idea of building a metaphor around a puriri tree for 18 months before it burgeoned into life. When I went to take the photos of the puriri I had a chance meeting with the farmer who told me the story of the tree and his bulls that inhabited the same paddock. The synchronicity of this experience reminds me of Sela-Smith’s (2002) quote in the *Immersion* phase above in regard to surrender “that draws the image of the question everywhere” (p. 65).

Potential Limits of Heuristic Research

Perceiving limits in Moustakas’ (1990) original formation ecopsychologists Key and Kerr (2006) developed an intersubjective-heuristic research method. Two areas of

inclusion have particular relevance to this study. The first the intersubjective enquiry between researchers addresses the potential limitation of the solitary process of heuristics with one researcher 'pulling it all together'. The second involves engagement with the unconscious in response to Moustakas's lack of recognition of the significance of the unconscious as a motivating force in research. The initial inclusion proposes the involvement of more than one researcher and speaks to the benefits of this collective effort in terms of reducing isolation, mitigation of fears of opening to the unknown, broadening perspectives, generating relaxation and creativity. There are other reasons why intersubjective enquiry between researchers is desirable which take us into the domain of unconscious, the second inclusion. Reason and Rowan (1981) as cited in Rose and Loewenthal (2006) cautioned that the researcher may only hear what he/she wants to hear. They advocated the importance of support during data analysis, an aspect not acknowledged by Moustakas. Rose and Loewenthal (1998) as cited in Rose and Loewenthal (2006) reinforced the case for additional support to address blind spots, which they suggested can emerge, especially in the *Immersion* phase. In their paralleling this support to the supervisory relationship, it makes sense that I have intuitively known I have needed additional clinical supervision as I have become increasingly immersed in the research.

Key and Kerr (2006) speculated that Moustakas's humanistic rather than psychodynamic orientation may be responsible for this omission of the importance of the unconscious. They cited Sela-Smith (2002) as addressing the unconscious, in part, in her reassessment of the heuristic method, where she claimed co-researcher's experiences can be:

valuable as reflectors of possible areas of resistance that may be out of conscious awareness in the form of denial, projection, or incomplete search. This sends the researcher back into self to continue the self-search into deeper or more distant tacit dimensions, thus allowing the transformation to be more expansive. (p. 78)

In one of my interviews I had a direct experience of such illumination. My co-researcher, whom I have known previously, pointed out that she, like me, tended to 'project' on to others an experience of shame in certain situations when in actual fact they may not be experiencing this at all.

Like Sela-Smith (2002), Key and Kerr (2011) believed personal pain in the researcher could distort the research process. I have found the chart developed by Key and Kerr

(2011) particularly useful (See Appendix vi). Titled *The stages of the heuristic process and the role of the unconscious* the chart highlights principles well known in psychodynamic psychotherapy and acts as a diagnostic tool when the researcher is off track. Experiencing apprehension about transformation may cause us to unwittingly resist it. Sela-Smith (2002) postulated that Moustakas' (1990) unconscious defending against his uncertainty and personal pain shifted his research focus towards his co-researchers away from himself. In examining 28 heuristic studies Sela-Smith (2002) found "the majority did not report personal, subjective experience" (p. 70). She concluded by reiterating the value of the researcher's own life experience and perspective, as a central reference point in heuristic research. Sela-Smith's article impacted strongly on me and affirmed the need to place myself central in the research. In doing so I recognised the need to address my concerns about the level of self-disclosure required believing it would most likely elicit feelings of 'exposure'.

In this chapter I have introduced heuristic research as a creative form of enquiry into the nature and meaning of phenomenon. Heuristics involves relentless self-inquiry for the researcher and participants named 'co-researchers' in the pursuit of deeply embedded tacit knowledge, not available in normal awareness. Key concepts underpinning the methodology have been described, together with the phases relating to core processes. I concluded with a brief discussion of the potential limits of heuristics and how these may be addressed. The next four chapters illustrate the application of heuristic enquiry in this study.

Chapter Four: Individual Depictions and Portraits

In this chapter ‘individual depictions’, drawings, and portraits aim to capture the essence of the experience of the therapists in an enlivening way. As representations of the co-researchers’ experiences I have constructed depictions from the interview data. The drawings I present are from my long journey with shame. The portraits have been created to impart a sense of the people behind the data and are exemplary of the group of participants. Co-researchers’ verbatim is encased in quotation marks and names have been changed to preserve anonymity.

Individual Depictions

Hung out to dry

She had been referred to me through august channels where she held a position of power. Later I could see how difficult she was and that “she was actually quite mentally ill.” We only met for 3 sessions during which she never stopped questioning me about my knowledge and experience. She was very arrogant and I was on the back foot.

“I can’t even remember what I said but I know I said something when she turned on me and said, “You are just like a bit of bloody limp wallpaper sitting there saying your stupid little words so I think this session is over!” I was filled with shock and disbelief: “Shit can this happen, you know am I this bad as a therapist and do people really do this in therapy rooms? ...that hot flush of shame came up on me. I was a million pieces on the floor”. She hauled me out to reception so I could take her payment. I never saw her again.

There was shame in the referrers knowing I had failed abysmally with her. I imagined them thinking, “Oh well she wiped the floor with her didn’t she, obviously she is not quite up to it in ways we might have imagined.” Now, although time has brought some healing through understanding, there is still a streak of shame when I am face to face with one of the referrers. I know I need to talk to him about it but I never have.

Extraordinarily good supervision helped me understand the vehemence she needed to rebuff anyone who came close or thought they could help in anyway. She was the helper, who was in control and managed everything. Conversations with my supervisor over a period of time helped me recognise the client’s recycling of second hand shame. My supervisor’s disclosure of a similar scenario she had come through really helped, as did laughing together when she joked, “She really hung you out to dry!”

I still do feel like I should have been able to do better. Maybe that’s the thing about shame the “tyranny of the should.” There is “a very little child inside me who can never quite lose that sense of not being good enough.”

Simone

The sudden turn

I recognise the performance of this client. The bombardment of “prove yourself questions” are dangerous for me as they activate a default position of “moving towards” pleasing the other. Undermined, I am apt to lose my authority.

As this story is told I can feel the shock and stabbing pain in my own body. I know what this is like from when I have felt attacked by clients. The suddenness of ‘the turn’ is stunning. In its wake icy tension saturates the atmosphere. There is nowhere to hide. I am wrong, bad in the eyes of the other. How can there be redemption? My heart races and mouth becomes dry. I feel so awkward and inadequate as I scramble to find words. I know I need to say something but what? It seems nothing will be good enough. The one coherent thought I have is that I need to buy time to make a recovery. Marian

Gift-wrapped missile

One Saturday afternoon I had been reading an article *No Place to Hide: The Group Leader’s Moments of Shame* when out of the blue I received an email from a former colleague questioning my judgment as a group leader. The timing was exquisite. What I thought had been good work in that group I’d run 3 months earlier suddenly wasn’t. The ground had been shaken I felt unsafe. I couldn’t think. Panicky feelings created a tight horizontal band around my chest. I go over and over the communication. I am confused about what is being said. Beyond the friendly opening lives uninvited critique and demands for explanation. I suspect it was a gift-wrapped missile. Not wanting to believe this I keep trying to see the good in it.

I leave the house to go on the walk I had planned. I am rattled and beside myself. Worried my house is going to burn down I return to check the fire. The panic makes me want to jump out of my skin. I feel naked and so alone. As I walk along I remember I have a co-facilitator and I desperately want to talk to her. Most of all I am concerned I haven’t done it right. What if I can’t explain myself? I feel trapped and under the microscope.

Perspective is needed. As I look over the land from high up in the hills I remind myself that this is a little thing in a vast world. I know these awful feelings will diminish in time: next week, next month I won’t feel so bad. I visualise talking to my supervisor and how she might respond to me.

I arrive home and still somewhat out of it I set the alarm off. I reach for a list: *Suggestions for Group Leaders Mitigating Shame*. It helps me to have a structure to hold on to. I am reminded it is inevitable group leaders will make mistakes and that much of the learning can be about oneself. Certainly writing my way through the whole experience helps. I desperately needed to tap into my self-compassion.

The arrival home of my children is timely. My elder son parades around with a “unicorn ponytail” protruding from his forehead. Together we watch the *Tooth Fairy* movie. Welcome distractions that bring some relief from my torment.

I am struck by how alone I feel. I badly want someone to take away the awful feelings and tell me I am okay. Marian

Missing one another

My client is mortified about his own value. He wonders whether he has anything to offer. Should he even be a therapist? He is a very poignant illustration of shame. He is the kind of person I really want to love and look after just like I did with my Dad. My own shamed self wants to make him feel okay.

One session I texted him to forewarn him I might be a little late due to traffic. I arrive at my office to find he wasn't there. He didn't answer my calls. Days went by and I went into this terrible shame feeling that I had abandoned him, because I didn't know what happened. "I knew him well enough to know I had deeply offended him or something".

Finally prompted by his partner he rang me. I learnt he hadn't received my text and had gone into a profound shame experience when I wasn't there. He ran away because he felt so ashamed of his need to see me. It was an experience of extreme rejection and vulnerability for him. Over several sessions we processed his experience of shame.

I just felt terrible and was full of self-recriminations. "I am a bad mother." I felt awful I had let him down and ashamed I hadn't been attentive enough to him. One of my deepest fears is of transferring my childhood experience of dismissive parenting into my role as a therapist.

I got a book out to try and read about this intense shame experience. I wanted to make sense of my flooding of shame. Of course I had this massive parallel experience of shame. My client "cannot experience (this is probably half out of the book) the original desire that's emerging without feeling unworthy of acknowledgement and consequently ashamed and disconnected and expecting a deserving rejection. Now that's me as well." When someone doesn't want something I have offered I feel humiliation for offering it in the first place. It is a misplaced feeling. What occurs for me is a profound unworthiness, nobody wants me. I have nothing to offer anyone. That's the feeling though it's not actually true. It leaves me sad like I am going to cry that "nobody wants to be with me". Neither are true.

"So I just don't offer because I can't bear the threat of that feeling and it still plays out in my professional life where I always sit back." I try to never put myself forward because of the danger of that feeling. Although lately I have been just risking it and saying what I think. It is usually well received which is a bit confusing. Anastasia

A parallel process

Initially I couldn't even clearly see my supervisee's shame. She was certainly not aware of it herself. To me it looked like she was being reluctant to do something. When I asked her about this she would withdraw and avoid the topic. I felt anger and frustration and noticed I was thinking very harsh condemning thoughts. I was not used to feeling this harshness, not that I showed this to her. I got curious about it. Why was I being so harsh? Looking closer at the bigger picture I saw heaps of potentially shame inducing situations around her. I saw that especially because I felt shame.

I realised my harshness related to the massive shame I felt. My shame allowed me to see my supervisee's shame. I thought Oh my God! I am really not meant to feel like this and how can I even tell my supervisor about my harshness. I imagined she would think Oh my God!

It triggered something in me that I found quite excruciating. The shame had a contagious feeling. It was so painful to watch in my supervisee. Then at other times I would be sitting with her shame so she couldn't feel it. It went back and forth like a "hot potato."

Antonia

Struggles in the Swamp of Shame

I sit across from him
 he says nothing
 The clock ticks on
 How do I forge
 a connection?
 A good therapist
 would know!
 I'm anxious
 I want to get it right
 I make a little foray out
 No response
 Oh well "I tried"
 The clock ticks on
 I feel helpless
 Have I done something?
 Not been what
 I am meant to be?
 I am drowning
 in the unknown
 I am invisible
 Yet so is he
 The clock ticks on
 Thunder races
 across my chest
 I am afraid
 Attacks can hurt
 What will happen next?
 I want to build a bridge
 Yet I am the enemy
 The road is cut off
 No way through
 Painful alienation ensues
 He's powerless
 I'm powerless
 As we both struggle
 Through a swamp of shame
 The clock ticks on

Marian

My New Supervisor

Intense relief
in his recognition
of my client of
her
my
our struggle
Held in his words
I feel soothed
and hopeful
His slowed pace
gives me time
to solidly digest
what he has said
Empowerment lies
in a new perspective

As I talk about
my client who
I dwell with in the
Swamp of shame

My shame stirs
and I let him know
I am effective
in the rest
of my practice
He confirms this
Saying “I know”

We have a platform
to go forward

Marian



Figure 3: Web of shame

The layers that entrap include memories of scenes never to be forgotten, shaming beliefs and expectations from others and self. The experience is one of isolation, like being an island.

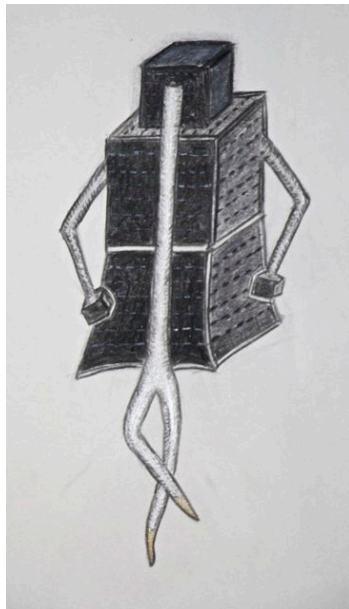


Figure 4: The authority

This is the rigid controlling one I have battled with. Obsessed with “doing the right thing” no room is left for spontaneity.

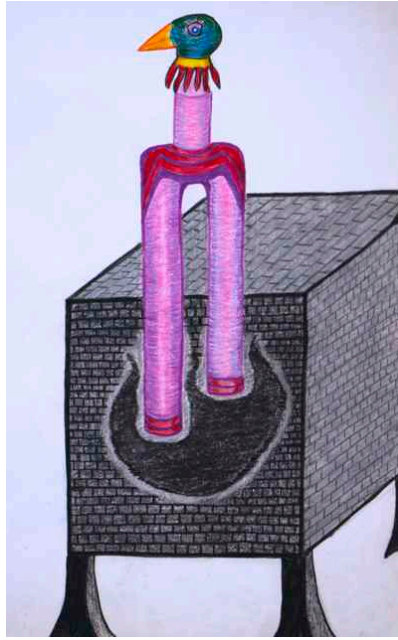


Figure 5: Stuck in shame

There is no movement with shame. There are lots of layers and stories contained within. It is hard to see what one is meant to be. A perpetual sense of heavy duty stuckness persists.



Figure 6: Broken wing

In the grip of shame it is hard to get off the ground. Injury prevents flight. It is more obvious who the bird is meant to be.

Portraits

I have chosen two co-researchers representative of the group to create exemplary portraits that convey a sense of the embodiment of the data. Some demographic data have been changed to preserve confidentiality.

Carly

A middle-aged woman Carly left a well-established career as a paediatric nurse 10 years ago to train as a therapist. Her deep compassion for others was a key motivating factor in her pursuit of this work. In a moving account she described the seeds of her interest in shame as lying in her work in a personal development group:

I remember seeing people lift their heads after telling a story they were deeply ashamed ofit was very profound for me... I would be willing them to look up.... so I could kind of love them I suppose... accepting and love them in a way like no story is so bad that you are not acceptable... all cuddled up and trying to hide within this big story.

Carly is no stranger to different forms of shame. Raised in a house with her father, a grandmother, and grandfather who had a disability and drank to excess, she described herself as born into a matrix of shame. In an effort to deflect attention away from her very different home life, she invested a lot of energy in school, where she could be 'normal' and excel. She never wanted other children to come to her home.

Carly is well aware of the insidious nature of shame as childhood scenes reverberate into the present day. With some amusement she told this story:

When I was eight years old my father had this old grey shabby Ford Prefect with faded paint. Today I went to pick up my friend from overseas. I was anxious about the state of my car and made a special point of vacuuming her side. I am still trying to ward off the shame of Dad's car. A shame attack from the inside.

Indeed many rivers of difference run through Carly's life. Being lesbian has brought sense of shame, particularly when she was younger. A separation three years ago activated enduring painful feelings of shame.

In her description of her work with her shamed clients her caring and empathic qualities resound:

...the whole image of (his childhood scene of humiliation) evoked a lot in me. I felt so caring, protective and accepting as though I was being with the little kid who is telling me the story, knowing that this is a 50 year old man.

Carly works with sensitivity with the chronically shamed:

I would be testing out the water. I would give a little bit of empathy to see that its not too much and not destroying him, then I might give a little more especially early in the relationship.

Simone

In her mid 40s Simone was born into a family in which ‘generational legacies’ of shame swamp the family. As a younger child of four she was at the bottom of the pecking order. In addition to being flooded with this “second hand shame,” as she calls it, layer upon layer of ridicule about her perceived shortcomings were directed towards her. Simone was cast as “the family joke” with her older sister being a key player in the perpetuation of persecutory scenes against her. These early scenes led Simone to perceive herself as someone who was “not good enough” and created a vulnerability to subsequent shaming attacks as an adult. An introvert, Simone’s typical coping strategy was to “withdraw, turn turtle, and disappear”. The original shaming scenes have reverberated strongly throughout Simone’s life as a psychotherapist.

Her new chosen career is given no validation within her family of origin. On the contrary, her mother, an allied health worker, has been particularly derogatory, blatantly blaming Simone for what she perceived as the consequential ruination of the family. Later Simone and her older sister moved beyond this blame and made inroads into the repair of their relationship. Simone remains sad after the possibility of further resolution of the shame that lived between them, is interrupted permanently by her sister’s sudden untimely death. In the therapy room Simone is sensitive to the activation of the “sister transference” laced with all its shame.

She knows well her experience of different types of shame: the “soft” and the “stabbing” ones. An audience of eyes makes her vulnerable to the clawing of old childhood shame. Understanding her shame and its origins has helped mitigate some of its undermining effects. Her relationship with her supervisor is a vital source of strength for Simone. As she goes on in her practice she finds power in the acceptance of her uniqueness. In her new freedom to be who she is she builds stronger bonds with her clients who feel seen and heard. However, in any professional endeavour involving an element of exposure, she knows that there will always be that “sliver” of shame.

Discussion of these experiences and their various meanings and inter-relationships and how they interface with the literature will take place in Chapter 8. Many of the stories express aspects of the essence of the multifaceted experience of shame and the core themes that feature in the next two chapters.

Chapter Five: Group Composite Depiction

“I find it has such a huge impact on so many levels”,

Antonia

Through dedicated focus, examining the data from the co-researchers and myself, the distinguishing features of the multifaceted experiences of shame became evermore apparent. Typically illusive in nature, this ‘group composite depiction’ aims to give shame more definition and make it more palpable. Exemplary narratives and verbatim excerpts are used to enliven this profile of qualities of the distinctive experiences of shame that permeate the whole group.

Through the creation of a structure an attempt is made to address the complexity of the therapist’s experience of shame and enable appreciation of its multi-dimensional nature. This structure endeavours to capture the many levels of impact aptly described by Nathanson (1987) as: *The many faces of shame*. To some extent these delineations of experience are artificial and could be seen as oversimplifying what is very much a whole person experience. Orange (2008) contended it is not possible to confine the subjective experience of shame to affect or cognition as it involves a total world of experience. The concluding section of this universal depiction aims to illustrate and emphasise the whole person experience: how shame with ‘a life of its own’ reverberates through one’s whole being and relationships with others.

Shame as an Affective Avalanche

After the triggering of shame a person is catapulted into an excruciatingly painful bodily experience that comes with an alarming lack of control. Shockingly, the world changes all of a sudden. The whole experience is very visceral and usually there are no words to apply to describe it. Capturing the essence of the experience in words in the present time is highly challenging:

Stabbing miscarriage

Well there’s an anxiety isn’t there associated with it, but it’s a sharp, it’s not like a low grade nagging oooh I don’t feel so good, what’s happening, that you can kind of do an audit and sort of, it’s more like a stabbing miscarriage or something you know it’s like aahhh shit, you know, Oh my God! Oh my God!

and then you know and then that sort of hot shock adrenalin sort of – Fuck,
 Fuck, Fuck, Have I really screwed up here? Simone

The “stabbing miscarriage” references the “heart sink feeling” that Gilbert (2011, p. 325) described in the experience of shame. The adrenalin is released and the fight/flight system is activated. The stomach functions as the ‘second brain’ independent of the head. The self-blaming thought quickly arrives on the scene scanning the self for culpability. The brain in the head remains ‘off line’ and often for quite a while, as shown in this poem:

Sudden attack

Immobilised-
 Just comes
 Like a blast
 In my body
 Time is needed
 Before thinking comes

Rattled-
 Reverberations
 Distract me
 Into the next session
 Taking me away
 From the other

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When shame strikes most often an auxiliary engine needs to be activated to achieve some semblance of functioning. Understanding the experience as one of fight/flight involving rapid activation of the right brain helps. Brené Brown reported that she “is not fit for human consumption” when in shame and usually it takes her a good 15 minutes or longer to recover (2012, CD no 2).

There is of course a continuum of shame experiences. Not all experiences are as crushing. The four other co-researchers noted their affective experiences, some of which were re-experienced in the retelling of stories in the interviews:

“I felt clumsy.”

“I feel my heart is beating.”

“My hand is a little sweaty.”

“I feel extremely uncomfortable and sometimes sick in my stomach and hot and panicky.”

The experience of exposure and vulnerability can often be profound; like a magnet it attracts bodily experiences of ‘feeling small’ and ‘overpowered,’ together with thoughts of ‘being less than’ or ‘not being good enough’ as expressed in individual depictions in the following chapter

“I felt so raw.... I felt like my vulnerability was completely exposed.” Carly

“I felt like I had suddenly been stripped naked.” Amy

In the extreme the experience of the described ‘flooding’ of shame can really rock one’s foundations.

“I was utterly, utterly a puddle on the floor just completely.” Simone

“It’s hard to trust myself... I find it hard to find the ground to stand on... I find it is something that normally has a strong feeling like melting or dissolving, so when I would normally be able to put my feet on the ground and breathe and just center myself again, I can’t.” Antonia

The experience is one of being shaken to the core. In spite of wanting to return to normal body sensations, thoughts and emotions, these are experienced as hijacked. How did shame make the therapists in the study behave?

Shame as Action

The experience of shame immediately activates a body driven urge to hide or flee from what has caused the fall into shame.

“Everyone else was milling around and talking and I thought fuck I have to get out of here.” Anastasia

With an acute shame attack it is not a time to stand around talking; the impulse felt strongly is to get away, to be alone in a bid to regain equilibrium. The head is dropped, blushing may occur, the eyes look down and the spine collapses as if one tries to hide inside themselves.

Combating shame through the body

In a psychodrama I enact a distressing shame filled moment with an agency team member. Slumped in my chair looking into the floor, Max the session director deliberately straightens my spine. At the time I have no idea what he is trying to achieve. Twenty-six years later I watch a U tube clip of psychologist Dr Janina Fisher doing exactly the same thing: *Combating Shame through the Body*.
Marian

(It makes me want to) “Just throw a blanket over myself and disappear.
‘Don’t look at me’” Amy

“I want not to be seen and not see. So it’s a wish to look away, to hide something for myself and from others.” Antonia

Like a child we engage in magical thinking: if we cannot see the other then they cannot see us. The desperation not to be seen and found wanting, drives these hiding behaviours. Avoidance or hiding, coupled with hypervigilance may be used as a longer-term protection against shame as described in two of the depictions in the next chapter.

“Anyway the thing was I was so ashamed (of my illness) I didn’t take any time off.” Carly

“I always sit back because of the danger of that feeling (shame).” Anastasia

Such attempts to ‘go under the radar’ can be viewed as a type of insurance that minimises the risk of exposure and its perceived dangers for the shame prone person. Perfectionism is another behaviour that belongs in the same policy. We believe if we keep everything ‘looking good’ our ‘not being good enough’ self will not be revealed. We will now explore the emotional aspect of the group’s experience of shame.

Shame as Emotion

Shame is one of the strongest emotions I know, I found it much bigger than anger, even despair... it excludes all other feelings, I find it so... consuming... that it takes up the entire emotional space... Antonia

Shame cuts us off from our feelings. There is no room within for experiencing a range of emotions. Shame contributes to or directly shows up as anxiety in a myriad of ways. Situations that test one’s worth can produce significant anxiety.

“...I find it hard to think, I find it hard to put words to what I feel, I get nervous, I get warm. When I get nervous I twitch, just like now (in the interview). Tick tick tick.”
 Antonia

(In my writing I fear) “...I’ve exposed something about myself and have I inadvertently opened myself up to people seeing something shameful? That fear will probably stalk me forever.”
 Simone

The first therapist identifies how anxiety takes her over. The second therapist describes the hypervigilance that accompanies anxiety about being shamed. Hypervigilance is symptomatic of a trauma reaction.

The emotional pain of shame can explode into rage that can slip into resentment. Anger is a protective emotion however sometimes the experience of anger evokes shame and even contempt:

(I felt) shamed about how angry I was in those meetings and how my feelings got really exposed... But the feeling of shame the next day was just awful and again I suppose it was the feeling that they were inflated, they didn’t get furious at all they managed their feelings, it seemed like they were a lot more composed than me.
 Carly

Sadness features often in the experience of shame.

“What I also have is if I try and talk about something I find shameful that I cry and that I can’t cry and speak in that particular moment.... the voice has gone which I find even more shameful.”
 Antonia

“I suppose that sense of shame does feel a bit different from the others I’ve mentioned. It’s softer, it’s not quite sharp and stabbing, it’s more of a sadness.”
 Simone

It seems by the time we are able to experience our sadness at a gut level that shame is no longer cutting us off from ourselves. The fullness of the expression of our sadness brings us back into connection with ourselves as shown by this therapist after she had experienced a compassionate response from another following a shame inducing event with colleagues:

Then somehow I held it together for the rest of the day then had to get it out and then I couldn’t stop crying and I cried and I cried. I walked home luckily I was by myself and I just cried and cried and cried for ages and that night I had a dream...
 Anastasia

Other words that attempt to capture the emotional pain of shame are intense “self-consciousness”, “embarrassment”, and “awkwardness.” The following section describes thought processes that accompany the experience of shame.

Shame as Cognition

The avalanche unleashes a flush of inevitable thoughts. Samplings from this ‘go to place’ are:

“I’m stupid”

“I’m wrong”

“I’m inadequate”

“I’m not good enough”

“I have nothing to offer”

“Nobody wants to be with me”

These thoughts reflect judgments of the self as being foolish, amiss, not enough, not worthy and ultimately not belonging. In one’s thoughts others are always looking and the person sees herself through the other’s eyes.

(Shame means) “being intensely self-conscious. Suddenly being aware of the probable judgment and disapproval from other people or definite disapproval I can see.”

Antonia

“It’s easy to feel like everyone thinks I am useless now when there might not be any evidence at all.”

Simone

Often there is a belief others are looking down upon the person and making a negative evaluation. Conversely experiencing shame the therapist can project shaming judgments on to her client:

I find that there is the counterpart to shame so that there is the fear to be condemned so that there is a countertransference of the harsh voice so I find the risk is also with somebody who has a very strong feeling of shame that the client elicits harsh feelings. I find it is very important to notice when I have a feeling like that that I become judgmental of them or I think oh my God! Antonia

Antonia’s excerpt highlights the importance of being aware of one’s typical responses to shame, what one might find oneself doing which one does not normally do. Whether

thoughts are focused on our self, the other, or both, our thoughts impact significantly on one's sense of self.

Shame as a Sense of Self

The experience of shame spirals into a sense of being bad, worthless, flawed, and contemptible. All pervasive these hijack the self, holding the self captive for what can be a long time.

A character flaw

It has a quality I find that is very deep, it goes down to a core feeling of been seen as though there is something wrong, so that there is something in the core that is nearly, it is like its unrepairable it's like a fact of something that is no okay feeling. It feels like I haven't learned something or have done something incorrectly its more like a character flaw like something intrinsically wrong and there is that fear of condemnation, of being shut out, cast to the side, not being wanted but it has a final feeling.

Antonia

The negative experiences of the 'self' result in fears of rejection and isolation. This is a profoundly disabling experience from which recovery is difficult. The sense of "badness" or "wrongness" permeates one's being.

Shame as an Intersubjective Experience

As a therapist or supervisor it is to be expected that one will be the recipient of countertransfereential shame as shown in the following excerpt:

In the back door

A: The dynamic is a need or wish for control and a way of addressing topics like there is a blaming aspect in it. So in this particular case the client was absolutely convinced I should have told him I was working at X agency, but in a way really like how could I not have told him? I really had this feeling of why didn't I tell him. It really took me a while to think about it and think why would I there was no problem. But there was a feeling of 'Yes I did something wrong'....

MH: (Your supervisee was) blaming you?

A: But not in a straight-forward way it comes through the back door and then I'm sitting with a feeling of shame and wondering how I got there and then when I have lots of space then I think, yes we have a topic of shame in here. I'm absolutely certain that he sits with a lot of shame and I'm getting it. That's what I meant in the beginning this depositing shame in me, I don't want to have it, you have it and I'm sitting there and I think Ohhh!

MH: That's a very clear example of how it inhibits the therapeutic process and how it impacts on the alliance relationship.

A: And what helps me is that I really then need to bring that to supervision because there's that input of not wanting to continue working. Antonia

Blame is a way to discharge the unbearable pain and discomfort of shame and the excruciating vulnerability that underpins it. The shame can bounce back between one person and another as shown in this example. In the interchange 'self-doubt' is activated in the therapist and perspective is lost, leaving her with no capacity to think clearly in the pressure of the intersubjective encounter. The supervisory relationship provides an arena for analysis of what has been communicated by the client and its impact on the therapist. Perspective taking stops the therapist enacting her immediate default position of wanting to assist the client to find another therapist.

All co-researchers presented intense experiences of shame in the context of the group. Some years ago I captured my experience of working in a psychotherapy group in this drawing:



Figure 7: Many eyes

In reflecting on this picture I can see how my experience of being 'under the gaze' impacted my sense of functioning as represented by the hands. The snakes depicted my perceived inherent danger within this high level of visibility. When being observed by a supervisor the whole situation would trigger a state of paralysis and dissociation.

This experience is echoed in a number of stories in the data pertaining to group experiences involving authorities: trainers, senior colleagues, and assessors as conveyed in the following Chapter. In her book focused on the 'eyes of shame' Ayres

(2003) described “The world of shame as a world of staring eyes” (p. 16). She proposed:

A central theme around shame, then, is about seeing and being seen when one wishes to hide, or of not being seen in the way one wants to be seen, or in a way that is congruent with what one is trying to show. Looking and self-exposure are dangerous activities for which one can be punished. (Ayres, p.18)

The next section encompasses the experience of shame as we respond to it with our total being.

Shame as a Whole Person Experience

In reality it seems a person spirals through a whole universe of experience as one experience collapses into another. This movement is captured in the following verbatim excerpt from my interview with my academic supervisor (MS):

MS: So you used the word shame. I wonder if you could describe it both as your experience and your idea of it?

MH: At the worst it is just wanting to die really, just wanting the ground to open up and swallow me up and it’s an experience in which I part company with myself, become quite disconnected, to use a clinical term, fragmented.

MS: Can you say what you mean by fragmented?

MH: Just a little scattered, unfocused and not connecting with the power within me in a coherent way. With that comes a feeling of just feeling bad and really exposed and really keen not to evoke further shame with the other or from the situation.

MS: So what you are describing is becoming really cautious?

MH: Yes, and second-guessing, yes, not flowing, not spontaneous and not resilient really. I was thinking driving here this morning how to confront shame requires courage but you have to have this certain resilience.

This account reflects the co-researcher Simone’s description in *Hung out to dry* in Chapter 4 (p. 47) of being “a million pieces on the floor.” In following drawing I depict the disconnection inherent in my experience of shame.

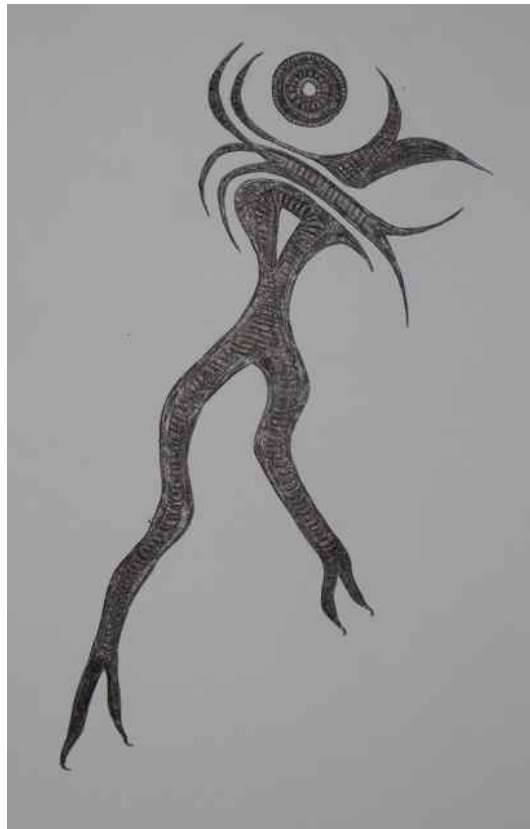


Figure 8: Disconnected

Darkened by shame the figure is on the back foot, the overall experience is one of being knocked back. Although there is movement, head and body do not connect. There is limited contact with the ground that speaks of the lack of groundedness experienced in shame.

In this group composite depiction I have presented a picture of shame having “a huge impact on so many levels” as expressed above by the co-researcher Antonia. This expression of the experiences of shame in the study participants reflects that shame is a core affect radiating from one’s center through one’s whole being impacting emotions, thoughts, actions and relationships. The depiction conveys a sense of the disruption, pain, and disconnection occurring in these experiences.

Chapter Six: Core Themes

In this study four core themes emerged from the experiences of all the participants: Second hand shame, shame with colleagues, being different, and not being good enough. Extrapolated from the data these themes represent experiences of the phenomenon that span the group as a whole. The examples are presented as quotes and depictions that illuminate the physical and sensory sensations, emotions, perception, thoughts, and judgments that imbue the themes with meaning. In some stories I have added brush strokes in text around the verbatim to create a more unified account. As with heuristic methods literature and drawings are presented as a source of data to shine further light on the themes.

Consistent with the concept of inter-relatedness of the qualities of shame portrayed in the group composite depiction, the core themes interweave with one another. As such they tend to be mutually reinforcing. For example one's experience of 'not being good enough' can be exacerbated by 'shame from colleagues,' arising from their empathic failure.

Second Hand Shame

“Is it yours or is it somebody else's and so often it is something that has been projected onto (us) that's second hand shame.” Simone

Across all the participants there is a sense of being born into a matrix of shame in one's original family systems. The co-researcher who introduced me to the term experiences “second hand shame” as having an “endlessly recycled feel to it” and believes a lot of shame is second hand. She describes her experience:

Shame piled on top

... I think especially as a child a lot of it gets piled on top of you and it's just not fair. If (my sister's) shame got piled on top of me, if Mum's shame as a child got piled on top, you know, all the various family tragedies and self doubts... But it all piled on top I was the lowest common denominator, the bottom of the feeding chain, whatever they say - yeah put it on me. And lots of family rifts and ructions over the years that have been laid at my door and it's so easy to crawl back into it and I do periodically. Simone

The following statement made by Broucek (1991) captured the projective dynamics and the shame-based role forced upon this family member:

It is not uncommon for families to use one child as the repository for shame of the parents and other family members. The child in that situation can never dare successfully compete with others because of the pressures on him to contain the projected feelings of shame and failure for the family are too intense and whatever acceptance or tolerance he enjoys is dependent on his willingness to function in that role. (p. 73)

Broucek (1991) used the terms ‘borrowed’ and ‘inherited shame’ to describe this type of shame that is felt about some aspect of one’s parent’s or child’s life and is experienced as if it were one’s own. Sweezy (2013) contested that the content of this shame is a fiction and often rooted in a shame regulation strategy adopted by the shaming other; an inaccurate communication about the worth or unique nature of the individual being shamed. The powerful transmission of second hand shame is captured in the following metaphor: “Shaming is an extraordinarily dynamic phenomenon that loops from external to internal relationships and back, gathering strength like a hurricane that can blow the message *I am flawed and alone* through generations” (Sweezy, p. 33, italics in original).

Associated with secrets, myths, poverty, childhood death, and adoption this inherited shame can be third and even fourth hand. This therapist believes firmly that shame is:

The foundation of us all

I think what happened for me as a child is that my father was deeply shamed. His father went blind in the early times when there was no hope for anyone, for his family and his mother who was a very proud woman, they lost everything as a result of the father going blind when he was 27. She was English, she’d married an Irishman and she had become Catholic to do that so that was already a shame. My father as the eldest child he watched this denigration of his father by his mother and you know I think as a child I was very close to my father. I bathed in the participation mystique, I bathed somehow in his experiences of shame even though he was a tyrant, he was a tyrant in our household.

Anastasia

This story clearly illustrates how shame involves loss. Concurrent with the loss of sight, home, income, religion, status, and religion there is a multi-generational loss of relationships that over time translates into a loss of self. Feelings of powerlessness evoke shame. It is not hard to imagine how powerless the father would have felt witnessing his mother’s disavowal of her feelings of shame upon his father in her denigration of him. What is the meaning of the term participation mystique? Jung (1921/1974) stated it is:

a term derived from Lévy-Bruhl. It denotes a peculiar kind of psychological connection with objects, and consists in the fact that the subject cannot clearly distinguish himself from the object but is bound to it by a direct relationship which amounts to partial identity... it is a transference relationship, in which the object (as a rule) obtains a sort of magical – i.e. absolute – influence over the subject. (pp. 456-7)

L. Holford (personal communication, 10 April, 2016) found that the easiest way to think about the term is as a projective identification or a merging phenomenon in psychoanalytic thinking. In the depiction it seems the father's experiences of shame are soaked up as if they are Antonia's and form a partial identity. This process speaks of the rupture of boundaries characteristic of shame-based families, one does not know where one begins and the other ends.

In her interview this co-researcher claimed her first memory of shame was when she was 3 years old. She stated:

I think shame was my constant companion when I was growing up and it has been something I have had to deal with in therapy for many years. So it's an intimate companion of mine you could say. Amy

Curious about this way of experiencing shame I invited Amy to elaborate. This is what she said:

A house I was living in internally

The intimate companion thing is that shame has been with me, I think, since I was born. I was told I roared so loud when I was born that my father heard me two floors down. I think I was accompanied by shame all through my childhood - nothing I did seemed to be ok and I was so used to the twists and turns of what went on inside me. Maybe it would be more apt to call it a house I was living in internally, than a companion. I'm not sure about anything positive - other than an acute sensitivity to the moods and feelings of others - but much of that can be projective. I guess that sensitivity has been positive in my work as a psychotherapist. Amy

It is not hard to envisage the layers of shame in this household. Amy provided a clear description of how the shame is internalised and becomes a part of her 'self'. Fisher (2014) postulated that historically shame often has a protective function. That is, submission makes sense when it is dangerous to be out in the world, shame keeps us under the radar. In this sense perhaps shame could be seen as a "companion". For Amy though she described herself as dwelling in a house of shame through her early years. This implies there was no escape from shame.

Second hand shame can be considered as the evacuation of one person's unwanted shame feelings onto another. Occurring over a lifetime it lands and takes root where the ground is fertile. Typically the person is caught unaware of the arrival of second hand shame, for it is transmitted through indirect means, often out of consciousness. Shame is perhaps most powerful when it is transmitted over generations.

Shame with Colleagues

Across the entire group of co-researchers the experience of shame in relation to colleagues was spontaneously reported. This theme embraces empathic failures of colleagues, competition, envy, and group shame.

There are times when empathic responsiveness from colleagues is very important and perhaps never more so than after the suicide of a client. Shame fills the gap between the ideal of keeping the client alive and the reality of the loss. This depiction tells of the therapist's profound experience of disconnection and isolation in her professional community. The empathic failure of a significant senior colleague appears to have intensified her experience of shame.

The shameful thing is if somebody dies

What I found most difficult were those first people I told staring at me and not responding. I knew in my head that my client could suicide, but I was a young therapist and I never actually believed she would do it. It was an awful shocking reality that rocked me to my core. "I didn't know whether to feel responsible or not." More than anything I wanted response from others yet found myself in a vacuum. I discovered there were few who could meet me and help me bear my feelings. It is like everyone ran for cover, fearful that they might catch what I had. The isolation was unbearable. I had expected empathy from my fellow therapists in my enduring of this shocking loss that I could not share with anyone else in the world. Instead shame was piled on top of my vulnerability and I was left disconnected, abandoned, and exposed.

My worst memory was of my senior colleague who proudly let me know that no such thing had ever happened to her. It was like "her comment was almost designed to elevate her". I knew then "the shameful thing was if somebody dies". I felt so raw, like it was my fault. Bewildered and shocked I was down an alleyway and nobody was there. Tense and angry, my tears are not far away as I retell this story.

In contrast some colleagues were right there and some even said "me too". There was something about just being able to tell people. As they met me I felt soothed and no longer exposed. Looking back now it wasn't enough.

I was in a group with Margot “I felt immediately heard and felt connected. I could bear my feelings more.” My therapist was great she shared that she had lost a client to suicide and that really helped me. “It was like she had her arm around me ...I felt soothed and not kind of exposed. She was the same as me. You’re no different it could happen to anybody.”

My supervisor was really fantastic. “She made herself really available and the next time I saw her I went and sat down and right next to where I was sitting she had put a container of fresh small tomatoes. It was really to do with life it was really great.

Carly

The therapist’s perceived lack of empathy in her colleagues is experienced as exposing, disconnecting, and increasing her sense of powerlessness. Brown (2008) reported this powerlessness leads to isolation and cites relational–cultural theorists Miller and Stiver (1997) as fully capturing the sense of isolation:

We believe the most terrifying and destructive experience a person can have is psychological isolation. This is not the same as being alone. It is feeling that one is locked out of the possibility of human connection and of being powerless to change the situation. In the extreme, psychological isolation can lead to a sense of hopelessness and desperation. People will do almost anything to escape this combination of condemned isolation and powerlessness. (p. 2).

Self-blame accompanies the experience as the therapist wonders to what extent was she culpable for the suicide. This could be interpreted as an attempt to gain some control, a way of putting on the brake. As Fisher (2014) claimed, shame and self-blame are best friends, meaning they create a protective system.

Upon disclosure of the suicide the therapist’s previously esteemed colleague is perceived as distancing herself. Is the colleague fearful and seeking refuge from her activated shame through superiority? Whatever, her response is the opposite of an empathetic “me too” type response that can be so helpful in bringing connection with another at such times. The perceived lack of support and empathy is a feature that runs through the stories of others.

Competition and envy can be thought of as cousins to shame. Pope et al. (2006) identified a basic myth that psychotherapists’ training and practice in organisations is not influenced by competition. They argued, “This myth is *not* about whether competition per se is helpful, hurtful, mixed, or ‘it depends’. It is about the degree to which the presence and influence of competition may have become visible, unacknowledged, unexamined, and unspoken” (p. 6, emphasis in original).

As with shame it is the hidden nature and denied reality of competition that is potentially problematic. The same could be said of envy: the wanting of something someone else has. Allphin (1982) stated, “Because it is extremely painful to see in another what is lacking in oneself, one wishes to get rid of the painful sight by destruction or spoiling” (p. 152). Born out of a sense of lack, envy causes feelings of inferiority, smallness, and wounded self-esteem, all characteristic of the experience of shame.

Typically competition and envy live under the same roof and most often it seems their presence is not openly declared. Yet competition and envy exist within the therapist’s professional community as illustrated in the following stories:

The hat

I was invited to join a small study group to make up the numbers. My training background was different from the others and I had some shame about that before I even arrived. Their patronising attitude did not help. I was angry I felt lesser and was anxious they wouldn’t value my contribution as much as theirs. When my turn came to read aloud it wasn’t exactly that they sneered but somehow amidst their responses I dissociated. I can’t remember what they said I knew I felt humiliated.

When I got home I just had to stay home and hide and worse, I had to put a hat on. “I had a full-blown shame attack.” I couldn’t understand it because I knew the work I was talking about really well. Feeling terrible I arranged an extra supervision session. I couldn’t explain it especially the hat, I never wear a hat in the house, but somehow the hat helped.

My supervisor was fantastic. Her formulation of the whole incident as an envy attack was a new idea to me. Whether it’s true or not, it was resourcing. Skilfully she asked me to consider what might have been going on in the others that they needed to attack me. We talked about the hiding and related how my mother attacked me a lot leaving me ashamed. My supervisor’s affirmation of my skill in the work I had shared in the group further aided my recovery.

Anastasia

In this therapist’s warm up to the group she has already been triggered into feelings of shame. As, in the previous story, condescension exacerbates these feelings catapulting her into dissociation, a means of avoiding the disturbing inner experience. Feelings of humiliation result from the actions of others and this experience is often confused with shame (Brown, 2008). Humiliation differs insofar as there is a belief it is not deserved, whereas with shame a person believes it is deserved. As in this story humiliation lapses

into shame, as can easily happen, especially when others are perceived as being more powerful and shame is carried around inside oneself.

The home provides an additional shield from the world of perceived critical others. *The hat* provides a protective skin, an attempt to counter the excruciating sense of exposure. Contact with the supervisor is successful in intervening in the spiral of shame. It is interesting how even though the therapist may not believe the theory about envy this new perspective helps her regain her equilibrium. Identification of original shaming scenes from childhood provided an additional viewpoint from which meaning is made of the experience.

The group leader may be especially vulnerable to experiencing shame for there are ‘many eyes’ upon her. This vulnerability is heightened when the group leader is not on top of her game. The depiction that follows concludes with an experience of shame with another member for the community of colleagues: the supervisor.

A gift to the group

In the lead up to the group I had endured a number of stressful events that cast me into a state of vulnerability. The most recent was the withholding of my pay by a new boss who had completely changed the face of the organisation I taught in. I disclosed my stressors and wobbliness to my co-facilitator before our three-day group began. In doing so I felt exposed, I think mainly because we were so new to one another, this being only our second time working together.

The more I tried to arrive in the group the more ungrounded and disconnected I felt. It was like the stage had been knocked from under me. I work hard to come back to myself both in and out of the group. I cannot make it happen. The events preceding the group had left me shocked to my core and exposed.

It is hardly surprising that in the fourth session I am chosen to be a role that embraces doubt. A group member takes on the role of shame and drapes herself all over me. We explore a scene which features an oppressive boss. Oh my god it is all too much for me! Overheated I spill over, catapulted out of hiding. My co-facilitator stands with me in the outpouring of my grief. It’s like a boil has burst. My vulnerability is met with loving acceptance. I am told I have given a gift to the group that has moved us all on. At last I arrive in the group. I belong. I can function as a leader. To my surprise I feel no shame.

Two weeks later in reviewing our work in the group together with our new supervisor the shame attack happens. I feel overlooked and my professional integrity and possible alternative interventions become the focus. The judgment extends to my co-facilitator but I do not even notice this. My experience of

being met with compassionate acceptance in my extreme vulnerability in the group is now contaminated by shame. Marian

In this story I illustrate differing relationships with my vulnerability. My initial relationship is fear based, undoubtedly born out of the popular cultural perception of vulnerability as weakness, a most undesirable quality for a group leader. Furthermore in new relationship with my co-facilitator a lack of familiarity meant greater vulnerability. Brown (2008) highlighted how responses to broken expectations can slide beyond disappointment into shame. I had built up a valued picture of how I thought the group would unfold, how each person would be involved, and how I would feel in relation to the group. In my 'actual' experience I cascade through fear, failure, into a pool of shame and struggle to avoid drowning. My relationship with my vulnerability shifts dramatically when I am met with compassion, empathy, and acceptance from others. These antidotes to shame allow me to embrace my vulnerability and function once more with the level of spontaneity that featured in my initial picture.

My sense of vulnerability is corrupted by shame once more in the supervision session. Talbot (1995) identified one key source of shame in the supervisory relationship as "Shame that arises from the therapist's fears of, or actual experience of, not being approved of or admired by an idealised supervisor" (p. 339). My inner judge formed an alliance with the supervisor's judge in the activation of my shame. The 'get it right police' in my head had a field day.

Sometimes the experience of shame in a group of colleagues is triggered internally within a person, other times from within the group and most often by a combination of both sources. Groups involving evaluation and/or large numbers appear to evoke shame related performance anxiety in the presenter. The size of the group appears not to correlate with the extent of debilitation from humiliation and shame in these contexts.

Going blank

I thought I would apply for NZAC soon after I graduated and it was during the interview process that somebody asked me a question and I went blank. Is that shame I don't know but I had that burning kind of oh my... they are going to see that I can't do this, so it's the shame of somehow being caught and seen in that. But I was actually able on this occasion to say "I've just gone really blank, give me a minute and I'll..." and they were good with it. It's that sensation, bringing the memories through now, that hot flooding horror. Simone

The metaphor of the ‘possum caught in the headlights’ fits with the above story. In naming her experience to her assessors the therapist is freed to regain her equilibrium. The following story shows how one comment triggers a sense of shame in the therapist and how an audience of colleagues is perceived as magnifying its impact.

An idiot therapist

S: Another time it happened is with a clinical group presenting a case and there was a particular member of that group who I found difficult and when he would say something he was very analytic in his orientation and I find that can be quite a shaming discipline, the analytic you know like I find it hard to come and go from. I like a lot of stuff about the analytic frame.

MH: But what’s shaming for you?

S: Well because somebody like this person, they hold it so tightly that any variation is the wrong way to do it. I was presenting a client and talking more in psychodynamic or maybe I said I lent a book to this client- and “Oh we don’t do that”...I’m aware in the moment that I’m being shamed rather than this is my shame but nevertheless the little girl is right there joining in. And there’s that collision inside and then it’s because everybody-there’s a group.

MH: Many eyes.

S: Seeing it. Then it’s easy to feel like – see everybody thinks I’m useless now when there might not be any evidence for that at all.

MH: It gets transferred around everyone.

S: Yeah so they all think I’m an idiot therapist because I lent a book to a client and you don’t do that in analytics. Simone

Three participants identified moments of debilitating shame in situations in which they were facilitating or presenting to an audience of colleagues. This story is a poignant account of how a shame filled therapist’s sense of disconnection and private agony was powerfully transformed by a simple caring ‘intervention’ made by a colleague.

Being noticed

I have no idea why I offered to facilitate that discussion. “Of course I just dissociated so badly... it was so embarrassing... it’s like I go deaf, a little bit blind, everything is fuzzy, I can’t think of any words. It’s the most horrible feeling, it’s so terrible and I’m sitting with a whole huge, I don’t know 80, 60 or 70 therapists all watching me”. I asked my co-facilitator who was sitting next to me to take over and he just did. After it was over wanting to hide “I thought fuck I have to get out of here!” I bolted from the room. A senior colleague came and found me and stood very close to me. He said “You did good” and I said “Did

you think so?” “I didn’t think so. And it was just such an intervention. It was huge... then I tried to make a conversation about nothing and he went with it” Then I had to get OUT of the venue “...only then could I cry in the safety of being alone in response to his unexpected empathic kindness... that he saw my shame and tried to help me. I wasn’t crying because I stuffed up, it was because he noticed how awful I felt and cared.”
Anastasia

This depiction tells of an instance of ‘being seen’ that deeply moves the therapist. The exquisite attunement of the senior colleague contrasts markedly with the misattunement of the senior colleague in the depiction *The shameful thing is if somebody dies*.

Whether the therapist is the leader or a participant, the group has the ability to evoke excruciating experiences of shame that can reverberate well beyond the life of the group. The sense of getting it wrong in front of the group mirrors an earlier classroom scene in both situations the person is reprimanded and the impact is profoundly deep and disturbing.

I felt like I had been killed almost

There was one session when I was trying to help someone in our group therapists training group and I got it horribly wrong and made a mess. I had totally over thought it all. I felt intense exposure and I couldn’t stop crying. I can’t blame the person who reprimanded me they were right. It was so shaming at the time though. “I felt like I had suddenly been stripped naked.” Every time I see that person again I get that feeling “Oh my God!”

I have gone over and over it in my mind since. In therapy I related a memory of that same feeling when I was 4 or 5 years old and I called the teacher ‘mummy’. Her contemptuous witch like face bore down on me as she poked me in the stomach with her big stick reminding me that she wasn’t my mummy. I felt I had been killed almost.
Amy

Amy described what Kaufman (1993) defined as a ‘governing scene’: “The scene is an event as it is lived, experienced; affect fuses with and amplifies the scene... These scenes are the building blocks of personality” (p. 60). Kaufman cited Tomkins (1987) who postulated that these scenes can fuse together and therefore magnify one another; as appears to have happened in the story. Interpersonal needs and relationships and the expression of affect are key domains around which these scenes are centered (Kaufman, 1993). I am reminded of my own story in the introductory chapter about being strapped by the infant mistress at the same age. The world changed that day.

Shame with colleagues encompasses a range of contexts. This theme shows how our relationships with colleagues can help us alleviate the pain of shame when our needs are recognised. Conversely, it shows how pain and a sense of isolation increase when our colleagues fail to respond to our needs in the moment of shame. Unacknowledged competition and envy have been identified as potentially limiting relationships in the community of therapists.

Being Different

Shame can fill the perceived space that opens up when we feel dissimilar to others. 'Being different' showed up in two main areas: physical illness and culture. Other differences that emerged included: relationship status (separation) and sexual orientation.

Physical illness can cause significant vulnerability for therapists and some illnesses appear more infused with shame than others. This first account exposes the extent to which the therapist is debilitated by the shame she experiences related to her illness. She invests enormous energy in hiding. She identifies a whole network of value-laden judgments held by others that speak of poor boundaries and inadequate self-care. As a consequence she retreats into self-blame. In her eyes she has fallen short of her expectation of how a 'good therapist' is meant to be. Shame inhabits the gap between this ideal and her afflicted self:

Self-inflicted illness

It was an illness that everyone knew could be attributed to working too hard, a lack of self-care: self-inflicted. It would have been different if I had an accident. Clearly, I was to blame for my illness.

I was terrified of anyone knowing I had the illness. Those that did know were sworn to secrecy. I was deeply ashamed believing my vulnerability as a therapist was completely exposed. I would never have felt that had I been in my previous profession. It was as if good therapists or the best therapists would have such good self-care they would never get exhausted and be susceptible to such a thing. This was another layer to deal with on top of the vulnerability of the illness itself. I kept working concealing how incredibly difficult it all was, inevitably prolonging my recovery.

Carly

The second account that the participant names as her "main area of shame," highlights the intersubjective challenge of dealing with an obvious health problem in the therapy

room. There is an unwanted exposure over which the therapist has no control and therefore, as could be expected, creates an extreme vulnerability in the therapist. It is interesting to note how the affliction ‘lives’ within the relationship almost as if it is a third presence that each person works around. The account highlights the delicate interplay between the body and psyche and sets up a wondering about the extent to which the body acts as a resonator of the intersubjective dynamic between therapist and client. The shame appears to bounce from one person to another:

Holding onto my shit

I had several years of this awful need to run out of sessions due to a lot of intestinal bowel problems. For years I didn’t know if it was a psychological problem or the physical problem it turned out to be. I worked out that there were certain people who I would get very nervous with. With one particular woman it happened every time, maybe twice in a session. She would notice me shifting around and said, “Do you need to go to the toilet?” And I’d say, “Oh yes I have to go the toilet” and then I felt it almost got so that I couldn’t not want to because there was this dynamic between us that was just agonising.

Another man I saw had this “odd sort of sexual dynamic going on and I think he was highly uncomfortable about and then I was absorbing his discomfort which was then manifesting in my usual you know... I would find half an hour into the session I would get intensely uncomfortable and would need to go to the toilet.... I remember that man saying ‘I hope I don’t make you want to shit yourself’ ... of course I didn’t say well actually you do. He wasn’t the kind of client you could go there with.

So if I made it clear that that’s what might have to happen then it felt okay, but it was the thought of you know, oh my God what is this person going to think of me, that I am a therapist who can’t hold on to her shit literally!

...very often the other person would be embarrassed too so it would be very difficult.

Amy

It seems the more Amy has addressed shame related issues in therapy, including potty training, the more she has been able to relax and reduce her level of embarrassment. This creates a further wondering of the extent to which the reverberation of early shaming scenes exacerbates the described health problem.

When we feel exposed we can exhibit obvious signs of shame: for example, struggling to find words, blushing, awkwardly shifting in my chair, and avoiding eye contact. Adelman (2016) reminded us that while shame is a profound inner experience it is easily observed by others, unlike other emotions we feel towards people. There is a

powerlessness related to not being able to do anything about what is there for all to see, as shown in the following description.

This therapist speaks of her recent awareness of her deep sadness and shame associated with her different culture, an inherited shame. The accompanying paralysis and sense of burden were palpable in the interview:

Being German

I noticed that with European white people I didn't address the topic of culture as I did with people from other cultures. One part of this was shame about being German.... if I work as a white woman with a white woman or white man still to address the topic of culture I find it difficult for me because the topic that is in the foreground is my ancestors and the second world war and Nazi Germany and millions of dead Jews. So that is very, very difficult for me there is a lot of shame attached to it.... I can't do anything against it... or anything for it... I am completely powerless I have to bear it.

Antonia

In this story Antonia conveys her absolute powerlessness. She illuminated how clients can use symbolic language alluding to Nazi Germany and after reflection in supervision she decides whether to bring this into the session. The last thing she wants to do is to bring the issue up herself and make it centre stage, when it is not an issue for the client. A great deal of fine-tuning is required. This is another whole level of shame for this therapist to have to deal with. This story illustrates the power of projection, coupled with the burdensome nature of the inescapable legacy of inherited shame.

In spite of our best efforts we may be seen as failing to honour cultural differences and this is experienced as mortifying for the therapist:

Oh my God what did I just say??

Upon hearing about my client's horrendously traumatic childhood I made a comment, "It's a bit like a tree with no roots". He said "Oh I do, I do have roots, I have very strong roots." He acted as if I had accused him of being rootless and you know I felt clumsy and I thought of course he's got roots he's Māori and so I felt very wobbly there thinking what did I mean? I often think of that image with clients who have been abused, it's like a little plant that has never been nurtured, and had nothing to help it grow. He responded to me as if to say you don't know anything about roots.

It got worse. He was telling me about his mother and the sorts of things she did which were really shocking. "I thought how could this woman, and I said ... "It's like a tuatara cannibalising her children" and he like pulled back and I could see the absolute look of shock on his face and I thought what on earth did I use the

word ‘cannibalises’ for – to a Māori? So anyway he didn’t come back, I tried to redeem myself.

I wrote to him in Te Reo offering an apology together with an invitation to return to talk. He sent a very nice response in which he assured me he was fine and that he didn’t need me anymore. I didn’t buy this for I knew “I had offended him deeply in a cultural way.”

I tried to make sense out of what happened. I had seen a documentary on the Poor Knights tuatara eating their young. Just as I had been shocked that the revered animal did that I was shock at how this Māori woman could do what she did to this “incredibly sensitive feeling boy.” Somehow my outrage with his mother was misconstrued as a lack of understanding of his culture on my part. I think maybe he had shame about his mother. I must have sounded judgmental or prejudiced and this made him pull back. Yet I had felt very drawn to connect with this man with his strong cultural identity. Amy

Left with a pervasive inner torment and, no doubt, guilt Amy worked hard to repair the broken interpersonal bridge between her and her client and sent him a carefully constructed letter in his language. It seems there is no redress for her perceived ‘inappropriate’ comments. A feeling of ‘being without redemption’ can often accompany shame. The therapist engages in rigorous self-examination in an effort to understand and make meaning of her experience. Sweezy’s (2013) chapter heading: *Emotional cannibalism: Shame in action* seems to encapsulate what the therapist is grappling with. Without an established therapeutic alliance working through such powerful shame dynamics is a huge challenge. There is no doubt the therapist had enormous compassion for the client in what we can imagine is his burden of shame emerging from the severe prolonged early traumas he endured.

The following difference relates to the shame of separation. One therapist reported the breakup of her relationship as significant in sparking her interest in the study of shame. Her statement implies a sense of self-blame and failure characteristic of shame:

Amongst all the grief and all of that I felt shame that I couldn’t stay in relationship. Carly

She elucidates the implications of how she has fallen short of her ‘ideal’ of what a therapist ‘should be’ and how difficult that is to tolerate:

The perfect therapist doesn't have broken relationships. I just realised that they are in relationship that's solid, no divorce... Somewhere there is that perfect image really- like a divorcing therapist!

Carly

Two therapists identified sexual orientation as a difference that can recruit shame.

Homophobia refers to the manifestation of shame lying within a person whether they are in the dominant culture or a minority culture of lesbian and gay people. The following excerpts give insight into thought paths and emotional experiences emerging out of the participant's own homophobia:

I'm thinking that it would also mean that the most ideal therapists- are they heterosexual? I dread to think that but I wonder if that old homophobia that is instilled in me even though I've worked pretty hard to get it out, I wonder if that's also what I think that those top of the pile therapists are heterosexual...

Carly

With every new client the issue presents over again:

Sometimes it's relevant to come out, especially with someone who is also lesbian or gay. The implicit knowing and acceptance of them and their world is vitally important to them. Other times I think what would the client think if they knew? Mostly I think they probably know and are more interested in their own issues. There is always a little wondering that it might matter to them.

Marian

What I show here is the interplay of the need for relational authenticity, therapeutic value, and personal privacy for the therapist. There is a necessity for flexibility and courage in facing into this difference, which may be brought into the relationship by the client. When difference is not accepted it is likely to be shame inducing as captured in this excerpt:

... when I was years younger the shame of being a lesbian and people not wanting to know I was a lesbian. "Look you're the same as us" or "it doesn't make any difference," actually it does, it did, I live very differently, but somehow the shame they conveyed to me they didn't want to know about it and it made it to me more shameful.

Carly

This is an example of a distorted mirroring from others which is very much part of the shame picture. There is an invitation to deny oneself through denial of difference; perhaps in an attempt to make the other more comfortable. It is, however, a threat to Carly's sense of self.

This theme shows there is a significant range of ways in which therapists experience 'being different' and how these experiences create a sense of vulnerability. Dissonance created by the failure to acknowledge difference has also been noted. Conflicts of

belonging versus not belonging and worthiness versus not being good enough underpin this theme.

Not Being Good Enough

The default position of ‘not being good enough’ was expressed across the group of participants in its various forms. In the first example the participant described her reaction to a new client’s harsh criticism and unexpected premature departure from the therapy room. The therapist’s understanding of this theme as rooted in her earlier relationships is clearly conveyed in this incident in which the client had shamed the therapist:

MH: Yes although you have been able to make some sense of it through supervision and self reflection, it still lingered, the shock of it?

S: Well I think it goes all the way back down to the very little child inside that can never quite lose that sense of not being good enough, up to it, old enough, can’t even know more than my brother or my sister, everybody knows more than me. Simone

Others in the group of participants spoke of this theme as carried through from early life. When others perceive or even express that we are ‘not being good enough’ holding onto belief in our own worthiness seems to go beyond being challenging. Other manifestations of this theme show up in the ideal of the “perfect therapist,” that is there are certain ways a therapist should behave and falling short of these means one is not good enough.

For one participant being good enough was tested when she saw famous clients:

It’s harder for me to process exactly what’s going through my mind because the nervousness can over shadow it. I used to get like that with famous clients, I don’t so much now. Well I’d get a bit like oh I’ve got to be really, really, really, good. I’ve got to show how clever I am. Amy

There are many ways in which the spotlight can be put on the worthiness of the therapist. For example the client may tell the therapist that the therapy is not helping and/or that the therapist she is not as good as the previous therapist. When another therapist is involved in the assessment of one’s client, one can feel vulnerable and under scrutiny: fertile ground for the activation of this theme that in turn links to shame with colleagues:

It is also the shame of (the assessor) thinking I'm not a good therapist.

Carly

When there is a breakdown of relationship with the assessor, as reported by this therapist, there is the potential for shame to bounce between assessor, therapist, and client. Shame can of course go the other way too, with the assessing therapist concerned her report will be criticised and that she may not be perceived as 'good enough.'

As to be expected the propensity for experiencing shame in the 'assessment context' is significantly high and especially so amid trainee therapists as reported by two therapists. As trainee, teacher and therapist I have experienced the rigorous demands of this situation in which under the gaze one must maintain a relationship with self and other, whilst being evaluated: a strong trigger for a shame prone person. In these situations it can be easy to spiral into self doubt and fear one will be discovered to be a fraud and not good enough. The ground is fertile for 'envy' among those who are being compared and must compete with one another. Pope et al. (2006) highlighted how in a context of a system fostering competition, opening up, allowing vulnerability, engaging in genuine exploration and discovery is potentially "a handicap, ready for skilled exploitation by others who see taking down others as a way to advance in the competition" (p. 6).

In the next example I show how the inner critic or judge is readily activated in a supervision session with a new supervisor:

The moral high ground

The judge was already active in me after that session. When I found the judge in my supervisor I was sunk. Down I went. My professional competence crushed in one blow. Not good enough. I felt judged. Shamed. In her 'one size fits all' approach I got lost. "This is the rule..." Of course I know the rule! Her taking the 'moral high ground' fuelled my shame. With this new supervisor I have no money in the bank, we have met but once before. I needed her to find me, the person behind the experience. It's good she wants to have a go at resolving things. Scary though.

Marian

After the moment of shame I spent the remainder of the session in hiding. I felt too vulnerable to reveal more of my 'self' and have that 'self' found further wanting. Like the depiction *The shameful thing if somebody dies* earlier in this chapter, 'superiority' appears to represent itself as a defense against the countertransferential shame that was activated in the supervisor.

When we experience ourselves as ‘not being good enough’ most often we enact this in our relationships.

When I’m really shamed I go compliant and beige in a group where I feel not good enough. As I go inferior they become superior because I make them and let them.
Carly

Again this speaks of the superiority versus inferiority dynamic. In this case the therapist is aware of her role in creating the dynamic.

In this chapter I have presented four themes from the data that, as discussed in Chapter 8, interweave with one another. Initially the power of second hand shame to impact subsequent generations was identified. Over the following three themes of shame with colleagues, being different, and not being good enough, a range of contexts were presented and reflected upon. Both subjective and intersubjective impacts and challenges were acknowledged within the varying contexts. The following chapter is an account of my experiences of shame in writing this thesis within which all four core themes can be identified.

Chapter Seven: Righting the Effects of Shame through Writing

I am driving along the road passing a big bus with “Honeymoon” written on its side. As I make my way back to the left side of the road in my small car an oncoming car comes straight for me. I have a narrow escape.

Dream 3 June, 2015

In reflecting upon this dream the bus is the life I am leaving behind to study. It is clear the oncoming car is my master’s thesis with shame embodied in each passenger and undoubtedly sitting in the boot as well. Only now 10 months later do I gain a sense of why I might have taken on such an arduous journey as I begin to free myself from shame’s entrapment. What follows is an account of significant moments and the meaning I have made of them in this heuristic process. In many respects it has been a journey towards ‘a birthing’ of myself that mirrors the psychodrama experience described in my introduction.

Three days later still on the road:

I drive my car into a swimming pool. I am embarrassed about making such a silly mistake. I am used to running and jumping into the pool.

Dream 6 June, 2015

My master’s thesis is a pool filled with the waters of shame. I do not engage in a normal dipping into the pool, instead I have a full ‘immersion’. Immersion in the interviews and their data is enjoyable and satisfying. Immersion in the literature review is not enjoyable and proves frustrating. In attempting to write my literature review my shame is fuelled as I struggle to find a way through the words of others, to hear my own voice.

Lost
Paralysed
They want my thoughts
But nobody is interested
In my thoughts
How can I even access them?
Know what they are?
My false compliant
Second guessing self is no use
They want to know what I think
Pulled into territory
I have never been in
Claiming the one who knows
Verses the shamed one
Who looks to they

Who know more than she
 The dependent learner
 Hits a brick wall
 She can go no further
 She doesn't belong
 In the chapters
 The authentic self
 Must do the talking
 It is a risk though
 Exposing to the readers
 What I think the one
 Who knows
 Knows

28 August 2015

I attended a *Writers' Retreat* for postgraduate students. As I settled into the first session focused on the thesis as a whole I was engulfed by a tidal wave of panic. Immediately I knew I needed to find somebody amid this group of strangers to help step me through the days ahead. My approach to the lecturer Patria was met with warm welcoming responsiveness. Together we made a plan. That night I became a sculptor as I chipped away at a 'depiction' bringing out the essence of a co-researcher's experience encasing it in a story. I had plugged into a powerhouse of creative expression. I began to believe "I can do it!" Back at base Margot received my depiction and made an affirming comment "Gorgeous!" The acceptance and validation given by Patria and Margot helped squeeze out my shame.

At home again my struggle to keep engaged with shame and produce writing persisted. At the end of September I attended an academic supervision session with both Margot and Keith. Early on in my study I had made a pact with myself to avoid going into my shame as best I could in supervision. This session was a challenge though. I felt way behind the eight ball and what I had produced had a couple shortcomings of which I had not even been aware. It had been 14 years since I had last done academic study and I was stuck. I felt as if I was from another culture, not really understanding the language. It was like something had broken in me. The territory looked vast:

My partner and I are up high in a little viewing room on the edge of the Coromandel Ranges and we look out. I say "Man its rugged!" Lots of places to get lost. Heaps of work to get through.

Dream 26 September, 2015

I become increasingly more anxious about my study and begin to feel like a failure because I am not doing it. I wake in the night with my shameful thoughts. I dare to look down the road in which I give it all away. I tell myself I have good reasons to do so: I work fulltime, parent two children, and so on. I realise though as I study 'shame' I am living a life of 'shame'. I do not have a full life to buffer the shame. Caught in the eye of shame I am where I am meant to be in my heuristic study.

Last night when I couldn't sleep I went into my mind: a darkened room in which I struggled to grab ahold of something to calm and comfort me beyond the emptiness I felt. A voice resounded loud and clear: "You need to take charge of your thoughts!" No longer could I afford to keep going there. Defaulting to shame is an addiction.

Journal 4 October 2015

I had been influenced by the master's thesis I had just read: *Addiction to shame: An exploration of shame as a defense* (Ricter, 2013). In this heuristic study shame was identified as a major obstacle prohibiting the writer from expressing herself on paper. For Ricter writing "... had been and excruciatingly painful, nearly impossible experience" (p. 3). Data in the study was drawn from a series of personal therapy sessions addressing her shamed writer. I resonated with Ricter's recognition of the dynamic of feeling both controlled by shame and using it to give a sense of control. The latter idea was not new to me as I have an enduring memory of being a protagonist in a psychodrama and finding myself keeping ahold of shame. There was a part of me not wanting it give it up. I decided though it was better for me to give it up than give up the master's thesis. With no classmates my journey of study had been an isolated one, so Emily Ricter became a companion. I hoped that just as she had inspired me I could inspire others to keep going.

Then I had a couple of dreams that spoke of transformation and held the promise of something new:

There is a hole in the ground with dark muddy gunk in its bottom in the center. This transforms into a very small rectangular swimming pool in a shed. I cannot see because I have gunk in my eyes. A man from the neighbourhood helps take it out. This is very scary. I go towards the water.

Dream 1

I am high up in the hills and my little army hat flies off. I got that hat when I was in Israel some 35 years ago. I keep my eye on where it's goes. I run down the hill after it. A bird swoops down and takes it away. I have to let my little green hat go.

Dream 2

11 October 2015

In this first dream the pool could be understood as the thesis: a container in which to examine the dark muddy gunk (shame). The dream speaks of the kind of blindness that accompanies shame. Ashamed I cannot see myself accurately, nor the other. An auxiliary is needed to help regain my vision.

‘Letting go’ is an obvious theme of the second dream. I am desperate to retrieve the hat I have held onto for a long time: yet nature demands I must let it go. The hat a military one can be seen as armour a protection against shame. This linked with the story of *The hat* in the previous core themes chapter.

I began to think about my study in a different way and found the following metaphor useful in shifting my relationship with it.

I thought about how when I start out on a cycle ride my cycle and I are separate. As I ride on and climb a few hills my cycle and I get into a rhythm. I experience us as one.

Journal 11 October, 2015

Nine days later I completed Chapter 3. My writing flowed as I wrote into the night. I experienced such relief and feelings of satisfaction as I realised I had recovered my writing ability. Next I engaged in the creative task of writing depictions that to my surprise I found I enjoyed.

My energy was boosted by a two-day workshop: *Removing the cloak of shame* that I led with a group of health professionals. I was reminded of the power of imparting a language to talk about shame. Once given a ‘stage’ the stories came tumbling out. I was reminded of the interviews I had conducted. The importance of my study had been underscored.

I created my own little *Writer’s Retreat* over four days. I revelled in unlimited space to follow what I was currently warmed up to in my study: self-reflection, reading, and data analysis. It was a grand opportunity for ‘immersion’ interspersed with times of ‘emersion’ walking the beach. I was beginning to carve out ‘my way’ with the project, as I aligned with my own inner authority. I consider this time alone was both necessary and strengthening.

I continue to craft depictions into sculptures that embody all of my co-researchers' experience. In-depth immersion has brought me confidence. I have decided to stop fighting.

Journal 19 December, 2016

A short period of *Incubation* follows thanks to the holiday period. The journey resumes back at the university:

Sitting at the round table Margot and Keith are on either side of me. Suddenly, I notice myself flowing freely with my ideas, being open to their comments and gentle suggestions in a non-dependent and non-defended way. Keith's voice is soft and intertwined with the threads of excitement about all sorts of creative possibilities. Margot is empathetic and endlessly encouraging. At last I can see myself through the teachers' eyes as a valued learner. It is only now that I can see that there is no shame in Keith's office on that hot January afternoon.

Reflecting at home later I had an image of my "good enough self" having been stuck down a deep well surrounded by dirty water. Like a coil I had been bound in 'not good enough' experiences that ensured I stayed trapped in the dark.

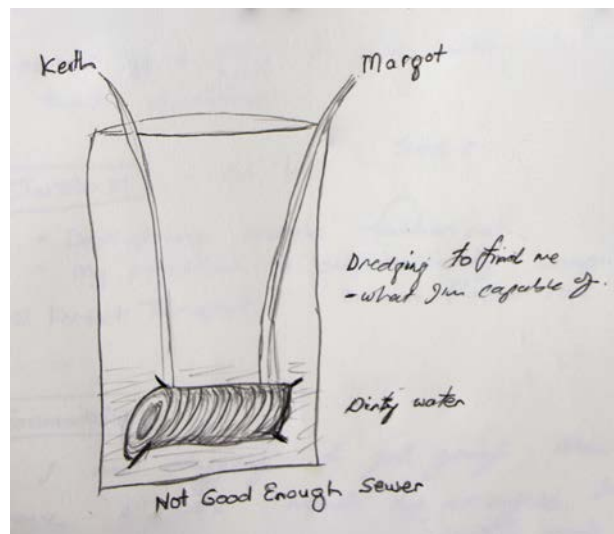


Figure 9: Not good enough

Journal 22 January 2016

Next came the presentation to the postgraduate students and lecturers. Somehow I had managed to fly under the radar and ended up presenting my study at the opposite end to that which I was meant to that is, the beginning. As I waited my turn to present I became acutely aware of how 'different' I was from the other students who shared classes together and were obviously much closer to academia than I was. I experienced myself as an 'outsider' from another 'culture.' I did not belong. As my turn approached shame had begun to take root. I attempted to counter my vulnerability by seeking refuge

in the familiar role of teacher. Armed with what I thought was a great powerpoint I launched into the presentation. I modelled heuristic inquiry in my sharing of personal reflections and stories. I was not sure how to read the audience and felt increasingly more exposed. Then the questions and comments came mostly from a line of lecturers. I had titled my presentation *The therapist's experience of shame* and it was pointed out to me that I did not have a question. I remember thinking well surely I just need to say "What is." The words were jammed down my throat as I stood paralysed filling up with shame. I slid into doubt as my 'second guessing self' believed there might be something more complex required. It was best to say nothing. I made a hasty exit.

I awake the following morning with a clear image of myself still 'in bondage to the shaming authority' I wrote:

I will be my own authority - do my own thing. Some tie to the old authority to who I have been subservient has been broken. It doesn't matter how my presentation was received. I took my work. I took myself. I am still okay. I need to remind myself (and the group) that when I present the topic will evoke the unconscious. Shame can land anywhere.

Journal 19 February 2016

I take the message from heuristics that my own knowing is my authority. Yet, as is shown in the story above, shame clouds my knowing. It is more complex than that though, for sometimes I set myself up for shame, as I discovered in my post presentation academic supervision session. Still feeling in a vacuum I invited feedback from my supervisors on the session. In focussing on the issue of the missing research question Keith highlighted that I made several references to the "research question" without ever framing it as a question. Unconsciously I had created the confusion and drawn the shame to myself. It seemed likely that towards the end of my study the research question had in fact become the title. I learned of the limits of my personal perspective on the experience of the presentation. Margot alerted me to the bigger picture of students who possibly envied me for the depth of study I was able to pursue. Another example of how shame feels so personal and yet, perhaps, inevitably other factors are at play.

I create another writing space of three days and I am sucked into a major shame spiral. A prolonged labour ensues as I attempt to midwife my way through using my writing:

Paralysed. I feel like I know nothing, certainly nothing new. I am totally bogged down in the lit review. The perfectionist and distractor are full time on the scene. I am alone. I feel enormous pressure and I'm not up to it. Everyone is going to see I know nothing. Perhaps I should go back to the data. All I know is I am miles off finishing. I am in shame. I have nothing and everything to say. It's like I can't move. I am squirming to get away. I want people to know this anguish so they can be sensitive, understand, and creatively work to find ways to walk over the bridge to meet the shamed person. But also I want them to understand themselves and not burnout.

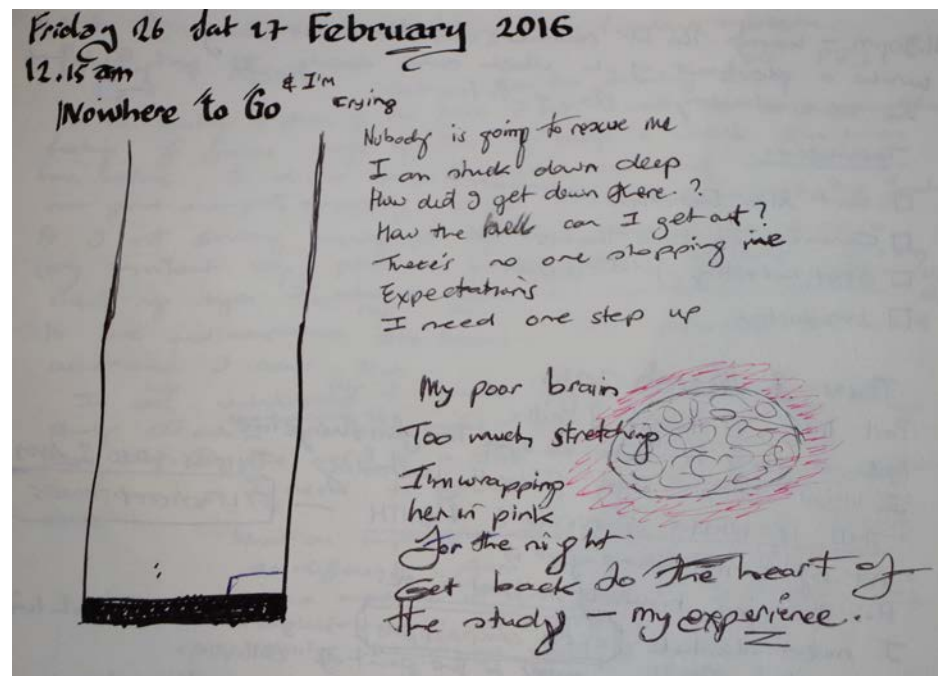


Figure 10: Nowhere to go

Journal 26 February, 2016

Thrown up against myself

Often I have talked of being “beside myself” in shame. This is different. I am up against myself: fight/flight. I need to fight - to get out - to get up. To draw from myself all I already know. Get back to the “heart” of the study. “I can do it!” A midwife is needed. Step by step I need to go on.

Journal 27 February, 2016

In an academic supervision session I am unsettled because after 18 months of travelling together Margot is about to leave on sabbatical just before I reach the final destination. Keith pledges to get me over the finishing line. There is wholeness in this because he took me to the start line. I like that I am able to tell him who I am and what I need. No shame. I make a pact with myself to travel with absolute self-compassion as I attempt to arrive within the time limit.

I attempt the final write up:

I hit a wall. The most powerful feelings of failure surge up through my body. I've been here before: I don't know enough, still have nothing new to say, not good enough, exposing myself and what's more exposing these facts. Paralysed once more. As I sit sobbing my son's cat snuggles into me in a very insistent way making sure I know she is there. She pushes her head into my body and looks into my eyes. I'm sure she understands shame. Muffy embodies the love and acceptance I need within.

In my vulnerability I remind myself I am doing an heuristic study of the therapists' experiences of shame. My experience is meant to be the centerpiece. Why wouldn't I get in my own way at the end? It is in the nature of the territory. I need to be with my difference, embrace it. I need to honour my own knowing and find my own voice.

Journal 4 March, 2016

I was interested in my upsurge of feelings of 'failure' just before I am about to make it. I remembered a book written by the late Petrūska Clarkson (1998) *The Archillies syndrome: Overcoming the secret fear of failure* that described this very same dynamic. I could identify with the underlying fear of being found a 'fraud,' as reflected in a number of the shaming voices in the stories in the data. In the bottom of the well once more I hear the voice "She's a failure," from when I gave up primary teaching. It was time to let go of this shaming belief. In making reference to it in this thesis I could be assured the belief would end up in the library of the campus that 42 years ago was the Teachers' College I attended. There it could rest.

One of my clients commented that she envied the time I had taken off to write my thesis. It turns out she was my 'teacher' in that moment. In response I asked myself "Why did my writing have to feel like such a form of enslavement for me?" "Why couldn't I be joyful about writing like her?" I envied her! In truth it was the voices of shame that have tripped me up all the way. I became angry and asked "Why shouldn't I be able to write freely as I know I can?" The answer came two days later when I finally finished my draft of my literature review. I could write freely. I was aided by two comments Margot had made. The first was to "Put the perfectionist in the cupboard and get on with it." The second was "Remember your literature review is a heuristic one." It was with great relief that I sent my work to my supervisors exclaiming that at last "I could see the head!"

The little shame niggles never quite give up though. I am reminded of this fact in a couple of dreams over the following weekend of writing. In the first dream my cellphone is stolen, my means of communication had gone. In the second dream I let friends come over for the afternoon and in doing so I sabotaged my writing. Nevertheless the transformation ensued and miraculously six chapters were good to go a few days later. However, there remained one unresolved matter.

Throughout my writing I have wrestled with the issue of ‘exposure’. I have reflected upon why I, a shame prone person, have made certain choices. First why would I choose psychodrama, one most of the most exposing forms of psychotherapy? Second, as a researcher, why choose heuristics a highly personal and revealing form of enquiry? Integral to each is a requirement to be with one’s vulnerability in a sustained way. Brené Brown (2012a) claimed vulnerability is the birthplace of creativity. Each has a methodology and methods that enable me freedom whilst feeling held. Their structures provide a frame from within which spontaneity and creativity can be expressed. Their emphasis on connection aligns with that which I value in my world.

So how did I resolve the issue of exposure in my writing? I reflected on a discussion with Simone one of the co-researchers at the end of her interview. I had expressed my mixed feelings about the study to which she responded:

S: Everybody will see it and they will see my inner shame!

MH: Exactly! Especially when I’ve chosen my own methodology and I go into my own process but I believe it is about how we are with ourselves.

S: Well its authentic, how can it be authentic otherwise really?

This little interchange went some way to validate my choice to share my inner experiences in the public arena. Like the co-researcher I will still no doubt experience that “sliver” of shame in the final submission. In taking the matter to supervision I ended up reflecting upon the difference between ‘being seen’ and ‘exposure.’ There is a choice in the former that is usually absent in the latter. It seemed it really is a matter of “What is trapping?” and “What is freeing?” Ultimately, my experience of writing has been one of freedom.

In part my journey has been a quest to heal the ‘schoolgirl’ within. I needed to find a final chapter for a story that began in my early school years. The main characters were the infant mistress and her husband, the headmaster. Scenes similar to the one told in my introductory chapter continued through my first six years at school. I prided myself on being a ‘good girl’ so I was always too ashamed to tell my parents I had been given the strap at school. Since leaving school I have been fortunate in having many excellent trainers and teachers. However, I had not been able to alleviate the toxic effects of those early ‘governing scenes’ from my little country school. Serious remediation was required back within the education system. Intuitively, I knew I needed a male academic supervisor who I could relate to without fear or shame to counter the internalised bullying headmaster. Keith began patiently travelling with me over three years ago. As the journey progressed I was glad Margot could join me, she has provided the alongside experience the infant mistress failed at so dismally. I am fortunate in finding a final chapter that has a satisfying ending.

The beauty of heuristic inquiry is the permission for the researcher to change their mind and the direction of the study (Moustakas, 1990). My decision to include this chapter has been made towards the end of the study. In part it was motivated by my desire to honour the key tenet of the centrality of the researcher’s experience in this form of inquiry. Intuitively I knew this decision was the right one. As I conclude I experience a strong sense of consolidation of my journey and its many gains. As one of my clinical supervisors predicted the writing has given me something outside of myself by which to feel validated. An invaluable form of mirroring it has proved a ‘right’ way for me. This chapter serves an integrative function linking my data with that of the co-researchers’ in the previous three chapters. In the chapter that follows I will discuss and make further meaning of the data that has been shared, interfacing it with the literature.

Chapter Eight: Discussion

In the previous four chapters I have presented my co-researchers' experiences of shame together with my own experiences. I have made links between the various experiences, extrapolated possible meanings and analysed these. In this chapter I begin by discussing the interface of the literature with the findings. Following, I will respond to the questions raised in the introduction that ask what are therapists' experiences of shame, sources of shame and reactions and how therapists mitigate of effects of shame? Next, I identify and discuss implications for practice, followed with comments on the limitations and strengths of the study, together with suggestions for future research.

Interface between Findings and Literature

In this section I address key aspects of the literature presented in the review and show their relationship with the findings or in some cases their absence of relationship. I begin by reviewing how the findings are reflected in the definitions offered in the literature review.

The findings largely confirm 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" (p. 5). A couple of co-researchers even used the term "flawed" and a sense of "unworthiness" was expressed by all who participated in the research. Although the words "acceptance" and "belonging" were not always used, the absence of these experiences appeared to underlie many of the stories. There is certainly evidence from the data supporting Morrison's (2011) definition of "a negative feeling about the state of the whole self, the self is bad, defective, a failure" (p. 25).

Surprisingly the self was not actually referred to as "bad" except by one participant. The sense 'defective' or 'imperfect' and a 'failure' was referred to with more frequency.

Jordan's (1997) definition emphasised the breakdown of relationship that occurs in the shame experience including the "loss of the sense of *empathic possibility*, others are not experienced as empathic, and the capacity for self empathy is lost" (p. 147). All the therapists communicated the loss of relationship and accompanying yearning for relationship as significant impacts in their shame experience. As would be expected, the feelings of 'unlovability' that Jordan referred to were not discussed with reference to the clinical context. However, these feelings were named, or at least alluded to, by three

participants who spoke of their earlier family life in some depth. The experience of the loss of empathy for other and self shows up in the data as well and is discussed later in this chapter.

Lastly, I consider De Young's (2015) definition "the experience of one's felt sense of self disintegrating in relation to a dysregulating other" (p. 18). I see the first part of this definition as a descriptive encapsulation of the 'collapse' occurring in the shame experience described several times by each therapist. The latter term 'dysregulating other' emerges from affect regulation theory and describes "a person who fails to provide emotional connection, responsiveness, and understanding that another person needs in order to be well and whole" (De Young, p. 20). Ongoing experiences of dysregulating others appeared to feature strongly in the early histories of the co-researchers and certainly this is true for myself. These experiences have prompted all of us to undertake considerable personal work to heal their impact. I question how well the latter part of this definition fits for 'experiences of therapists' shame'. While the therapist at times may unintentionally be the dysregulating other, expectation in the therapeutic endeavour does not revolve around the client's attunement to the therapist's needs for connection, receptiveness, and understanding. The therapist can experience the client as the dysregulating other in the relationship, which may well trigger the therapist into her own shame. However for nearly all the therapists in the study experiences of dysregulating others tended to feature strongly in the core theme of *Shame with colleagues*.

The definition of therapist's shame offered by Ladany et al. (2011) does not appear to capture the full essence of the therapists' experiences of shame in this study, although it does name exposure of 'physical' limitations as a trigger for shame and this was described by two of the therapists. Major shortcomings of this definition lie in its failure to recognise the intersubjective experience and limiting of therapists' shame to the context of practice, thus omitting the collegial setting. The concept of what the therapist 'believes' shows incompetence in her practice is important. As evidenced in the discussion below, regarding sources of shame, these beliefs vary between individuals and perhaps even across disciplines.

In summary, with the exception of the last definition, most aspects of the definitions presented in Chapter 2 align well with the findings. It can be said that all therapists in

the study are in varying degrees afflicted by chronic shame. Aspects that have not been mentioned above will be discussed in therapists' reactions.

In Chapter 2 I named that confusion between guilt and shame can often occur. This was not my experience of the co-researchers in the interviews. The assumptions can be made that through their previous study of the topic they are informed of the difference and they were intent on keeping a focus on shame as the topic of the interview. Similarly, there was limited use of other words in the shame family, 'embarrassment' and 'humiliation' being the words most used.

In the literature review I posed the question how does the developmental sequence that creates toxic shame, shame proneness and chronic shame unfold? I cited various theorists' views in response to this question. The findings of my study point to a perpetuation of empathic failures throughout childhood as described by all but one of the co-researchers who did not speak of her earlier life. 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 chronic shame (Bradshaw, 1988; De Young, 2015; Kaufman, 1992, 1993). Four of the co-researchers volunteered poignant stories of how repeated shaming scenes in childhood set the stage for sensitivity to shame triggers as an adult. Regressive experiences are described in which the person is catapulted back into the early experience of shame. For these therapists reverberations of childhood shame show up in a myriad of forms in practice. For example: fears of transferring experience of "dismissive parenting" onto clients; not being good enough to take opportunities to advance oneself professionally; fears of making a mess; being rejected by clients; and failing in therapeutic endeavours.

It is interesting to note that no reference was made by the co-researchers to the experience of 'healthy shame' or to the value of shame as a monitor for their own behaviour in relation to others as suggested by many theorists (Bradshaw, 1988; Lewis, 1987; Retzinger, 1998). This may be a reflection of what Witt (2007) in his book *The gift of shame* described as the vilifying of shame in our culture. In part he attributes this to the generally critical attitude towards shame emotions in the literature. However Witt did acknowledge that 'unregulated shame' is damaging in many ways.

I have chosen to interface subsequent material contained in the literature review with the data in the remaining sections of this chapter that address questions raised in the introductory chapter.

Therapists' Experiences of Shame

There is no shortage of data confirming the multidimensional experience of shame described by Gilbert (2011) and Adelman (2016) in the literature review. The concepts of 'shame attack' and 'shame spiral' are well mirrored in the findings. A striking aspect has been the reported extended periods of time required to make a recovery from these experiences. I have been well aware of this requirement with my own experiences and many a time I have expressed resentment for the way a shame attack steals my time. For all therapists, supervision and sometimes therapy was reported as integral to recovery from particularly shameful events occurring in their work.

There was a range of intensity of experience described by therapists. Typically the stories with the most charge were told at the outset of the interview. However this was not always the case as therapists warmed up to other stories stored deep in the recesses of their minds, a process which usually caused them to express surprise. This phenomenon confirms my experience of the power of simply creating a 'space' or 'stage' for people to talk about their experience of shame, in this case therapists.

Amid the co-researchers 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. Only two of the co-researchers correlated 'anger' with their experience of shame. Thoughts expressed by co-researchers experiencing shame reflected the "doubleness of experience" inherent in shame identified by Lewis (1987) involving self in one's own eyes and self in the other's eyes. Shame is made possible because the internal judge is devaluating the self. How therapists 'react' when experiencing shame is discussed further below. Next I will identify various sources of shame reported by the group of therapists.

Sources of Shame

Initially, when preparing my literature review, I began to compile a list of possible sources of shame for therapists. The list seemed never ending and as mentioned somewhat individually determined, consequently I abandoned it. I considered that

sources of shame located in my research data could be readily identified in the data chapters, particularly in Chapters 4 and 6.

First I compare the findings in the study conducted by Klinger et al. (2012) with the findings of my study. None of the six key *Therapist embarrassing and shameful events* were reported in my study. Of the remaining events there were only four individual reports of each in my study: 'Misspoke'; 'bodily function'; 'client challenge' and client terminated abruptly in the category 'other'. The discrepancies between findings can perhaps best be interpreted as the differences in the subject groups. Unlike my research group of psychotherapists, the subjects in the comparison study comprised 89% counselling psychologists and clinical psychologists. The majority of the 16 events involved omissions and/or inappropriate actions on the therapist's part. Other events involved concerns about the client's perception of the therapist in areas of imperfection and one event concerned 'sexual references' made by the client. Working from intersubjective perspectives the assumption can be made that the psychotherapists in my study recognised the influence of the unconscious, coupled with their embeddedness in the therapeutic relationship. Integral to 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 therapists in the study conducted by Klinger 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 from: the therapist's feelings about herself; the therapeutic dyad, supervisory relationship and group; and her professional community.

The findings in my study align more closely with the sources of therapist's shame reported by Morrison (2008, 2011). In a sense Morrison used himself as a 'case study' for the elicitation of his findings. Unlike the aforementioned study he uncovered sources of shame beyond the therapy room, reflective of those revealed in my study. For example: therapists' illness, evaluation, competitiveness, envy, vulnerabilities, perceived superiority, and lack of empathy amongst colleagues. I discuss the four sources of shame identified by Morrison (2011) in Chapter 2 (p. 22) with reference to the findings.

The first source concerns the 'activation of shame through identification with the client'. In the depiction titled *Missing each other* in Chapter 4 (p. 49) we see this

dynamic played out on many levels. The experience is excruciatingly painful for both therapist and client. It is easy to visualise how initially the therapist would have struggled to make any sense of such an all-consuming experience. The therapist is active in her attempts to unpack the reverberations that exist between them, recognising what belongs to her and what rests with her client. Had she not done so it is easy to imagine how the shame dynamic could continue to be enacted and potentially wreak havoc in the therapeutic relationship. I am well aware of the similar vulnerabilities around shame that my client and I share as conveyed in my poem *Struggles in the swampland of shame* (p. 50). It is as if my thundering heart is the echo of the infusion of these sensitivities.

The second source of therapist shame relates to ‘treatment failure’. The depiction *Hung out to dry* in Chapter 4 (p. 47) sees the therapist questioning herself “Am I this bad a therapist?” upon the sudden termination of the relationship by the client. The fear of failure in our therapeutic endeavours is perhaps never far away for all of us. It is intensified when a client does not appear to be progressing at the rate we anticipated they might have been. I have had the experience of a client reporting that in her family’s eyes I was the “bad one” responsible for her lack of progress. Whilst I can understand how they might need to blame someone external to the family, the accusation still created an inner disturbance. It took up residence in an early governing shame scene in which I am blamed and punished by the headmaster for something that clearly was not my fault.

The most challenging fear of failure we therapists live with is that of suicide. The depiction *The shameful thing is if somebody dies* in Chapter 6 (p. 70) shows us how the suicide of the therapist’s client feeds directly into the therapist’s ‘self doubt’ and creates uncertainty in regards to her culpability. It seems that both anticipation and experience of actual treatment failure can readily activate shame scripts of ‘not being good enough’ or ‘not being enough’.

Located within collegial relationships the third source recognises ‘competition and comparison’ with others as key potential inducers of shame for the therapist.

The section *Shame with colleagues* (Chapter 6, p. 70) highlights these issues that appear to typically reside underground in our professional community. The depiction

The hat (p. 72) offers a nuanced description of both competition and comparison. The story exemplifies ‘anticipated shame’ fuelled by a sense of ‘being different’ and somehow ‘inferior’ on account of the therapist’s perceived less esteemed training background. From the outset the therapist had tapped into a well of shame born out of her comparison of herself with others. Her shame was exacerbated by her experience of ‘judgment’ and being held in ‘contempt’ by the other group members. What if the group leader had recognised the therapist’s inherent vulnerability in joining an already established group and worked hard with the group to establish norms of inclusivity and acceptance? Perhaps the therapist could have mitigated, at least in some way, the effects of the shame as it began to grip her. This has implications for leaders and supervisors of groups. On the other side Morrison (2008) pointed out that holding onto the value of our endeavours can serve to counter professional shame. The interesting thing is that in my experience competition is made little reference to in our community. It does not even occur to the therapist in the story that ‘envy’ on the part of her colleagues could be in the picture. Of course, this is characteristic of the self-focus of the shame experience, in which perspective taking is limited. In silence the fallout from unacknowledged competition and persistent comparison with others builds.

The fourth source of shame for therapists identified by Morrison (2011) concerns ‘illness and aging’. The data in my study supports this assertion in respect to illness via two stories. The first story refers to an illness perceived as so shameful by the therapist that she needed to ensure it remained hidden. The therapist in the second story had ‘no choice’ in regard to disclosure as her affliction announced itself in various client sessions. In both situations I imagine the illnesses were experienced almost like another ‘presence’ in the room, like magnets that could easily attract shame. Aging was not acknowledged as a source of shame by the co-researchers. The assumption could perhaps be made that, like me, they have a touch of ‘denial’ in regard to their aging process. However, like Morrison, I grieve the loss of a memory that can be relied upon for the recall of vivid detail in my practice. I anticipate the issue of aging and its accompanying incapacities will continue to gather shame as long as it remains unacknowledged and not talked about. Morrison (2008) claimed “wisdom” was a gift of aging, however even he stated it was “Small recompense, sometimes, for the vigor of the past” (p. 78).

Central in Morrison’s (2008) recognition of therapists’ sources of shame is the concept of the wide gap between the “ideal (wished for) and the actual (experienced)” selves,

between which he reminds us, there is always an unsettled tension (p. 80). Reference is made in the data to “the perfect therapist”. 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. Certainly there are expected ways of behaving ethically and professionally that are necessary. However, I am aware of referencing the “get it right police” in my head to ascertain how a ‘proper therapist’ is expected to respond or behave. Recently it was with great relief that I learned from my supervisor that there are some clinical responses that neither I, nor any other therapist, could be expected to know. In addition the thought that one should know things I can’t possibly know is self persecutory. There are other sorts of ‘ideals’ that concern our professional goals and aspirations. In falling short of these we must face ourselves and find a way to live with our failures. Now I discuss what therapists “do” when experiencing shame.

Therapists’ Reactions to Shame

Beyond our affective response our experience of shame includes our reactions to shame. These of course vary between individuals; however as Hartling in her contribution to the article Hartling et al. (2000) showed reactions to shame or humiliation can be delineated into three categories. I consider them all to be different forms of hiding. For the purposes of this discussion I have completed a brief analysis of the data and classified the number of therapists’ reactions in clinical and collegial contexts into these categories (see Table 2, p.103).

Clearly the preferred response for therapists in this study is to move away from the other when experiencing shame. This result is consistent with my observation of other therapists’ reactions that I have worked with in my shame workshops. In inviting them to locate themselves in a similar classification the *Compass of Shame* their preferred response to shame becomes apparent.

Table 2: Therapists' reactions to shame

Therapists' Reactions to Shame	Data
Moving Towards -appeasing, pleasing	5
Moving Away -withdrawing, hiding, being silent, invisible, keeping secrets	11
Moving Against - being aggressive	2

Looking at the table we can see the 'moving against' response is least favoured and usually experienced as the most shameful. We are not meant to show aggression towards our clients. The popular 'moving away' reaction may be perceived as 'going under the radar' and 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. 'Moving towards' is rated as a less favoured reaction by the therapists in my study. I see a need for a 'moving towards' category that involves progressive relational responses, rather than adaptive 'people pleasing' reactions.

Some of these more functional relational reactions were identified in the study conducted by Klinger et al. (2012) and included: Apologising, using humour and processing with client. I have examined the 13 *Reactions to Therapist Embarrassing and Shameful Events* identified in this study using Hartling's categories and found: three reactions involved therapists' personal reactions: Internal emotional reactions, body reactions and recurring thoughts; five involved 'moving towards'; four involved 'moving away' and one 'moving against' (Hartling, et al., 2000). As with the *Therapist Embarrassing and Shameful Events* there is some discrepancy in preferred responses between the findings of the two studies that in part appear to represent the varying praxis in the different disciplines.

Recognition of our own typical strategies of defense against shame is what remains important. As pointed out earlier most often we may not be aware of what activates our shame. 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? In the next section I will discuss the core themes that emerged from the data and how they are interrelated. Whilst implications for practice are addressed in the section that follows it is inevitable that some of these will be interwoven in the next section.

The Weave of Core Themes

Second hand shame experiences form the stage for building a shame based identity. It is very hard to get out from under shame when we feel we have been born into it. It seems that shame is most powerful when it is transmitted across generations. The story *A foundation of us all* in Chapter 6 (p. 68) reveals the extent to which shame arises from the broader social milieu. A loss of social status through disability and poverty, together with a change of religion, all contribute to the burden of shame in the described family. The family's sense of 'being different' is reinforced when they move to a remote part of the country. We can imagine how this sense gives way to an underlying sense of 'not being good enough.'

Typically shame projected upon a child has nothing or little to do with the true nature of the child (Sweezy, 2013). For example a child may in fact be 'competent and capable' yet told by significant others that she is 'useless and lazy.' Yet without significant intervention she continues to believe the devaluing messages. Throughout the stories in this study it is shown how readily the past collapses into the present in shame experiences. Shaming beliefs held from childhood that one is 'not good enough' are instantaneously brought 'on stage' once activated in today's shame scenes. This is another illustration of how the core themes interweave.

The data shows there are specific contexts in which therapists are especially vulnerable to experiences of shame with colleagues. The first context is when the therapist is in obvious 'need' as conveyed in the story concerning the client suicide. The usual equation for the chronically shamed person is that needs equal shame. One's vulnerability can easily be contaminated by shame. The second context is when leading a group, giving a presentation or being a member of a training group. In this scenario many eyes are upon the therapist that can easily tip the shame scales. The third context is an evaluative one that may involve a group. Such situations generate enormous anxiety and, if not managed well, can become a nightmarish experience. The fourth is illness; especially when the illness is perceived to be shameful. Out of the second two

contexts unacknowledged ‘competition’ and feelings of ‘envy’ amongst colleagues have been identified as creating difficulties by four of the therapists in the study.

In these contexts the therapist who experiences chronic shame is likely to be exquisitely attuned to the responses of others. The question becomes to what extent is the therapist’s experience a projective one verses an accurate reflection of the state of affairs in relationship with the other(s)? Does it even matter? The colleague’s experience is one of feeling in pain, isolated, not good enough, and vulnerable. Should that not be enough to mobilise others towards being empathic and caring? The challenge for the colleague experiencing shame is to tolerate being vulnerable enough so as not to retreat into hiding and thus allow her colleagues to find her.

Experiences of ‘being different’ permeate both collegial and client relationships as do feelings of ‘not being good enough.’ Both are born out of comparison with others. A sense of being different can often be tracked back to early life as reported by co-researchers; as such it can even relate to second hand shame experiences. The story of being different through culture shows how culturally inherited shame can evoke an intensity experience of the phenomenon.

Differences typically create feelings of ‘exposure’, some differences being more visible than others. In my study the differences of illness and culture are more visible than those of sexual orientation and relationship separation. There are choices for the therapist to make in talking about being different whether or not her difference is visible.

Brown (2012b) claimed that shame drives two ‘tapes’ that can be described as core beliefs, one of which relates to ‘not being good enough.’ The other comes into play if somehow one manages to function as if they are ‘good enough’ and inquires as to who one thinks one is. 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 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 client. Alternatively, as Morrison (2011) suggested, 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. It is interesting to note that this category that appears to underpin all the others is the smallest of the core themes. One possible reason for this is that it is difficult to own 'not being good enough' and discuss the experience in detail as this involves further shame. In questioning its validity as a core theme I revisited the data and affirmed the theme was dispersed throughout and expressed in the group composite and individual depictions.

In summary it appears almost every core theme interweaves with the other. I visualise them as a basket surrounded by colleagues and those with whom we work: a container for shame. These themes speak to shame as a whole person experience occurring in relationship with others.

Implications for Practice

In this section I address the two of the additional questions I raised in my introduction: What is the impact of therapist's shame on the therapeutic relationship and therapeutic process? and How do therapists' mitigate the effects of shame in themselves and with their clients and colleagues? Whilst responses to these questions have, to some extent, been given in the earlier part of this chapter, the explication and discussion below gives particular focus to the building of the therapist's shame resilience. That is, uncovering what helps therapists in dealing with shame in both themselves and their practice. Active 'noticing' by therapists is encouraged so that shame can be detected and used in understanding the countertransference and therapy failures (Retzinger, 1988). I begin with a focus on '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).

The power of the auxiliary

One afternoon my 11 year old son and I went out cycling. At the top of a hill Matt spontaneously said, "In every person a confidence can grow and Mum you are my confidence!" In researcher mode I enquired "Does everyone have that confidence?" He replied, "Yes but you need someone to help you grow it!" I had believed that he could ride with me up what was a very long and steep hill. A month later on the same hill we were no longer neck and neck.

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Emerging from my psychodrama background I understand the term ‘auxiliary’ as meaning a person who facilitates the growth of another. Thus the therapist is an important auxiliary to her client, as the supervisor is to her supervisee, as the group leader is to the group member, and as the therapist is to her fellow colleague. In the story *Lone puriri* in the last chapter I talk about the differences auxiliaries can make in a metaphorical way.

Sometimes it may take some time to find a therapist who can untangle our deeper layers of shame as conveyed in Morrison’s (2008) personal story in which he finally found the right analyst. He shared, “My analytic work with this woman was, for me, foremost in my exploring and facing my particular pain—an example of attaining efficacy, in the presence of another, in an effort to master shame” (Morrison, p. 79). Being an auxiliary works both ways; that is, the client can be a very good auxiliary to the therapist for example, informing her of shame ‘blind spots.’ In the absence of another’s belief in oneself, in our shame proneness we are apt to remain caught in a web of shame and at best “Go through life with the hand-brake on,” to use the words of co-researcher Anastasia. In Chapter 7 I described how auxiliaries have had an integral role in my writing of this thesis. Monica Lewinsky (2015) described the “mistake” she made 17 years ago as near fatal and claimed she would not have recovered without significant others walking with her.

Meeting a person in their shame is challenging and creates a sense of vulnerability. There is risk of ‘rejection’ that in itself being a trigger for shame. It can be easy to go to ‘self-doubt’ when there is not much feedback forthcoming from the client as shown in the poem *Struggles in the swampland of shame* in Chapter 4 (p. 50). Being an auxiliary to a client, group leader or supervisee who is actively ‘judging’ are tests of one’s shame resilience. Recently in a client session, in which my shame was activated, I recognised I had that ‘shield’ that my supervisor had, for a long time, wanted me to develop. Somehow we need to keep in mind our potential ‘power’ as auxiliaries in simply ‘being with’ and giving of ‘our best efforts’ to the other, be they client or colleague.

Shame and supervision

Outstanding in the data is the consistent experience of the supervisor as an invaluable ally in dealing with shame evoked in both therapeutic and collegial contexts.

Subsequent to being triggered by a shame event the therapist can view supervision as a

haven to which to retreat, where she can anticipate soothing through empathic connection, validation and the gleaning of new perspectives. Supervision also provides indemnity cover for the therapist as she faces into subsequent shame evoking encounters with particular clients or colleagues.

Across the group of co-researchers there was deep appreciation expressed for their supervisors and the benefits gained from examining material involving shame. There is a need to recognise however that not all supervisory experiences are positive. As mentioned above Talbot (1995) claimed such experiences are rarely focused upon. In *The moral high ground* in Chapter 6 (p. 83) I shared an experience that activated shame I had striven to keep at bay following a group session. With my own shades of ‘doubt’ about functioning as a leader and the absence of ‘runs on the board’ with my new supervisor, I was especially vulnerable to her criticism. Our lack of history reduced the resources within the relationship that I could draw upon.

So what are the qualities of the supervisor that facilitate mitigation of the effects of shame in therapists? From the data and rigorous heuristic examination of my own supervisory experiences I have composed a list of these qualities. The supervisor needs to be experienced as:

1. An ally, an alongside human being
2. Empathetically responsive
3. Genuinely interested
4. Compassionate and patient
5. Accepting of shame experiences
6. Collaborative, knowing together there exists a “we”
7. Able to be vulnerable and can say “me too”
8. Available in times of need
9. Holding a map of shame scenes, triggers and defenses, coupled with strengths and an overarching belief in the supervisee
10. Offering new perspectives

These qualities will be found in trusted others, be they colleagues, friends, or partners who are available to accompany a person through recovery from a shame event.

The effectiveness of supervision is of course dependent on the supervisee informing the supervisor of her experiences of shame and being courageous enough to enter into the exploration of these. The supervisor most likely experiences her ‘vulnerability’ as stories are told that resonate with her own clinical or collegial shame experiences. However it tends to be easier for the supervisor to offer perspectives because they are not caught up in the experience of shame that compromises the cognitive functioning of the supervisee. In essence, good supervision for the therapist experiencing shame involves a sense of being ‘held’ whilst together the waters of shame are navigated.

Shame and the group

Leading a group is a challenging task and, as reported in the data, typically opens us to intense sense of ‘exposure’, particularly when we fail to meet others and our own expectations. If we adopt Brightman’s (1984) grandiose ego ideal as cited in Weber and Gans (2003) in attempting to be an all powerful, all knowing and all loving leader, we set ourselves up as ‘God’. It is not uncommon for those in the group to want us to have these attributes. I contend there is a need to apply the concept of ‘healthy shame’ to the endeavour of group leadership and remind ourselves as humans we are not God and essentially limited.

Conversely, the data speaks to a need for leaders to be mindful of the vulnerability of client, supervisee or trainee group members, and the potential for the triggering of shame in these contexts. This has particular implications for the training of new therapists who lack the buffering to shame that usually comes with clinical experience.

Whether the therapist is a leader or participant the following sections on vulnerability, authenticity, empathy, compassion, laughter and shame resilience all have direct relevance to the building of effective functioning, as they do for the individual therapist and/or supervisor.

Vulnerability

Vulnerability is not weakness, and the uncertainty, risk, and emotional exposure we face everyday 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, p. 2)

Brown's claims are relevant to the therapist who works in the relationship where I contend being vulnerable is essential. It is not possible for us to work from a 'comfortable' position when 'engagement in relationship' is integral to our practice. It seems when we put in our best efforts to be open and available, we are most vulnerable. 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? What is conflictual for me? What makes me want to move away? Toward? Against? What am I doing at the moment? I believe to be therapists we need to be connected to the 'human' condition and open to all that comes our way in the relationship. I am aware that all therapists do not hold this foundational tenet that effective therapeutic praxis must include vulnerability in both chairs.

In the grip of shame the challenge for the therapist is to find words to keep connected with her client. If I am agonising within myself and cannot speak, I am no use to my client. To some extent 'experience' can assist us to build this capability. 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" (Kaufman, p. 233). Kaufman maintained that self-disclosure is fraught with shame for therapists, in part because there is no clear 'rule' about how much and when to disclose. Yet Brown (2008) and others have advocated that "me too" are two of the most powerful words in the English language, when it comes to meeting others in shame. Being mindful of the therapeutic purpose of any disclosure, together with the need for follow up on how therapist disclosures have been received, are generally both important. This said, it maybe that the therapist chooses self-disclosure on occasions as a means of mitigating shame in the other.

I contend therapists have a valuable role in 'modelling' the human condition and indeed the value of vulnerability. The problem remains that shame can infuse or contaminate our vulnerability. When this happens I believe we become a beacon attracting any shame the other may wish to disown. My current supervisor has helped me to understand the importance of finding words to come out from under the shame. This process has particular relevance to working with the defense mechanism of projective identification. For example in one particular situation involving this defense I could

have said, “It feels like I ought to be ashamed of myself” in an attempt to create movement in the relationship.

Early in my practice, my then supervisor Dale Herron said to me, “Nobody can shame you less you let them.” This was a revelation to me and subsequently, I spent years puzzling as to how I could shut the ‘gates of shame’. As shown in the depictions and core themes, shame triggers activate responses in a flash without our consent. I do not know that it is possible to be the gatekeeper that I would want to be. However I find inspiration in this quote:

Between stimulus and response there is a space.
In that space is our power to choose our response.
In our response lies our growth and our freedom.

Victor E. Frankl

As with any aspect of personal development self- awareness, coupled with awareness of others, is critical. Knowing our shame triggers, default positions and ‘what we might need’ in the moment of shame all help give us more choice in the interface of the stimulus and response.

I have found relief in De Young’s (2015) claim that there was ‘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 or role actually helped in ensuring survival, for example, being seen and not heard makes sense as a response to certain early traumatising family environments. In accepting shame as ‘part of who I am’ I was liberated from feeling inadequate because “I couldn’t get over it.” This study shows that for the shame prone therapist there is a need to learn to live alongside the shame and has exemplified how therapists have done so. This process is captured in the *Creative synthesis* in a story that shows how one can triumph over adversity. Vulnerability is expressed through authentic communication.

Authenticity

I begin by defining authenticity and then discuss its relevance to the study. Brown (2010a) created 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” (p. 50). This

definition challenges the idea of the “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. It is difficult, if not impossible, to function with authenticity without some level of resilience to shame. Shame often stops us from presenting our real selves. This brings us to Winnicott’s (1987) conceptualisation of the ‘false self’ which functions to hide and protect the ‘true self’ that is based on spontaneous authentic experience. Bradshaw (1998) 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 the shame prone person 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” (p. 1). As Relational/Cultural therapists they underscored the importance of considering the context of each relationship. The distinction between ‘reactivity’ and ‘responsiveness’ is pertinent 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 is one way we can be brought back into connection.

Empathy

In her contribution to the article 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 he/she has an impact on the therapist through observation and experiencing those responses of the therapist that tell him/her he/she matters. Such

relational responsiveness contrasts with traditional modes of psychotherapy in which neutrality and non-disclosure are advocated. Based on my own experience as both client and therapist I suggest limited responsiveness in a therapist is problematic and, at worst, triggering for the shame prone person. This view is supported by Nathanson (1992) in his contention: “*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*” (p. 325, italics in original). What Miller et al. (1999) have advocated is a reparative experience of relationship, one featuring an accurate mirror that can assuage the impact of the past inaccurate mirrors, characteristic of shame based family systems.

As described in the methodology chapter empathy involves an ability to see the world of another from their perspective. It can be considered an antidote to 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). As mentioned in the introduction shame’s self-focus has been shown to obstruct empathy for others who may have been mistreated (Tangney & Dearing, 2002; Tangney et al., 2007a). This has major implications for therapists, most of whom consider empathy as one of their tools of trade. What else is required for a therapist to build her resilience to shame so that she can remain open and empathic?

Compassion

Beyond empathy lies compassion in its complexity and depth. Gilbert (2011) cited his earlier work Gilbert (2010) when he advocated “Compassion, with its focus on acceptance, understanding, and affiliation, can be a powerful antidote to the alienating experiences of shame” (p. 339). Citing Rogers (1957), Gilbert (2010) noted core aspects of the therapeutic relationship: positive regard, genuineness, and empathy as constituting compassion. The depth of compassion expressed by the co-researchers for their clients and supervisees was noteworthy. This makes sense in the light of backdrops of early shaming scenes.

Gilbert (2011) believed self-compassion needs to be taught to people with high shame. De Young (2015) maintained, “If we practice from a developmental/relational perspective we believe our clients internalize the capacities for emotional regulation, mentalization, and compassion that are embedded in how we relate to them” (p. 173).

There is of course as a therapist a need to actively practice self-compassion, particularly in the moment of shame. In the following section I discuss further ways in which therapists can build resilience to shame.

Laughter

Lewis (1987) claimed, “Most important for the discharge of the shame state is that shame can be discharged in good humored laughter at the self and its relation to the other” (p. 20). However, Lewis cautioned that laughter needed to be shared otherwise it would result in renewed shame. Retzinger (1987) postulated laughter restores severed ties and as such breaks the shame-rage spiral. Laughter is bonding and provides release of physical tension, together with feelings of well-being. Humour expressed in funny stories can prove an effective way of ‘getting in the back door,’ addressing shame in therapy without setting off the alarm.

Therapists’ shame resilience

“When therapists work with shame, they are subject to facing more of their own shame, a reminder we are never completely “finished” as human beings” (Fossum & Mason, 1986, p. 162). The need for clinicians to pursue ongoing shame work is strongly advocated by Brown et al. (2011) who maintained it is ethical practice to do so. In the following section I present a weave of elements of shame resilience from the theories of Brown (2006) and Van Vliet (2008) and my findings, and I apply this to therapists.

a. Understanding shame, identifying triggers and reactions

Knowledge and understanding of the affect of shame, its varying masquerades, and impacts is critical to shame resilience. Integral to our comprehension of shame’s impact in the present, is the completion of a ‘shame inventory’ of our personal history. This knowledge and understanding does not prevent us from experiencing shame but does, I believe, help reduce its impact and enable us to process shame more quickly. As identified in my foundational document ‘recognition’ is paramount. Involving identification of triggers and reactions, these can be common to the group and/or unique to the individual. Signals for therapists recognising feelings of shame have been identified by Harper and Hoopes (1990) as including: discomfort towards client, emotional withdraw, therapeutic impasse, inappropriate caretaking, self doubt and self blame regarding lack of progress, outward shaming of clients, dreading sessions with

certain clients. This study illustrates a range of other activators for therapist shame and reactions. The key issue is the therapist's awareness of these signals.

b. Connection with others

The importance of finding allies, both within and outside professional field, has been discussed extensively above. Having a language to speak about shame together with a willingness to use that language to tell stories and express feelings are key aspects of shame resilience. Supervision with an empathic caring supervisor who facilitates 'perspective taking', can significantly impact the toxic effects of shame in the therapist. Again courage is required in each person to face what each may rather avoid. Authenticity, empathy, and compassion have already been named as key features of relationships that facilitate the building of shame resilience.

Amongst colleagues 'connection' is a significant shame resilience strategy. Sometimes this entails 'asserting oneself' and 'challenging others' (Van Vliet, 2008). The study findings point to a need to sensitively 'move towards' colleagues who we believe may be experiencing shame. It may also involve challenging cultural stereotypes and prejudices contributing to shame.

c. Rejecting shaming beliefs and judgments

Fisher (2016) identified how shame prone people get caught in a vicious cycle in which sensitivity to triggers to shame and beliefs about 'self' trigger physical responses. The physiological shame that is experienced appears to reinforce the beliefs. She maintained that it is crucial to disrupt the automatic pattern of thought by challenging whether thoughts are 'resourcing' or 'de-resourcing'. In a repetitive way we must work both with our clients and ourselves to increase resourcing thoughts and decrease de-resourcing thoughts. I am reminded of an anonymous quote I once saw on a café wall: "Don't believe everything you think." The shifting of thought patterns is, I assert, integral to the building of shame resilience.

d. Accepting shaming events and facing feelings

My account of my journey writing this thesis in Chapter 7 is a testimony to the power of facing into and addressing the situation evoking shame. Co-researchers demonstrated this process in their stories and in their experience of the interview in which, as mentioned, some experienced relief and gained new perspectives in being willing to 'go

there.’ When faced with an attack of shame I believe this saying applies, “Life is not about waiting for the storm to pass but learning to dance in the rain.”

e. Perspective taking

This can take time. Certainly in the moment of shame the ability to do this is usually severely compromised. In part perspective taking involves exploration of the needs, feelings and motivations behind our actions in any given situation (Van Vliet, 2008). Others can be enormously helpful in this process.

f. Divorcing shame

Ten months ago I announced I was in a bad marriage with shame and I was getting a divorce. My drawing *Stuck in shame* in Chapter 4 (p. 53) depicts the relationship. What did I mean though? Van Vliet (2008) proposed that in rebuilding the self increased externalisation and separation from shame occurs. As such it is the reverse of the initial internalisation process in which shame is taken into the self. Van Vliet claimed this enables reclamation of personal power and control.

g. Building strength

This comes through being all of who we are. Through my heuristic process in this study I have build a new authority within that dwarfs my ‘shaming’ authority. The validation of my own knowing, integral to heuristic methodology, has been highly instrumental in this transformation. While they still live alongside one another, the new authority has a vigour and power that cannot be denied.

h. Making meaning

A client reported to me that her Body Therapist had asked her “What are the ‘treasures’ in the trauma?” Experiences of shame may be perceived as having a positive meaning and value (Van Vliet, 2008). In the data the co-researchers reported their engagement in quests to make meaning of their experiences through individual reflection and supervision. Gains from the trauma of chronic shame may be seen in terms of strength, compassion, and self-awareness. De Young (2008) posed the question, “Why might excellent therapists also be shame-prone therapists?” (p. 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. As the co-researcher Amy said the “sensitivity to moods and

feelings of others” she developed in the house she grew up in, “has been positive in her work as a therapist.”

Over this last section suggestions have been made with the purpose of identifying ways that therapists can mitigate effects of shame. 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. These qualities have direct relevance and serve to crystallise the essence of shame resilience described above.

Limitations and Strengths of my Study and Future Research

One of the possible limitations of the study is the small sample size. 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 co-researchers ‘in-depth’, both dictated a small sample size. Furthermore the methodology demands immersion in the data over many months (Moustakas, 1990) and logistically this prohibits a larger sample size.

The requirement to complete the study within a specified time frame and in accord with procedural rules may be considered a limitation in terms of limiting “free-fall surrender to the process” required in heuristic research (Sela-Smith, 2002, p. 70). It is of course not possible to say when the study would have come to a natural end.

All of the participants were women and European, two being immigrants. Thus the group is not truly representative of the field of psychotherapy in terms of gender and cultural diversity. Brown (2008) acknowledged that while the core experience of shame is similar for men and women there are some significant differences. She identified a clear expectation for men not to be perceived as weak. Women, on the other hand, Brown maintained, “often experience shame as a web of layered, conflicting and competing social-community expectations” (pp. 17-18).

In terms of a traditional view of research validity the question could be asked: “Were the co-researchers 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 responses. Although acknowledged by some co-researchers as difficult to describe in words, the question “What are your experiences of shame?” did elicit clear responses and illustrations; thus providing a more qualitative assessment of shame. Shame was illustrated to have certain common qualities and core themes. These were consistently verified across the group and matched my own experiences.

Another potential limitation of heuristic enquiry is the emphasis placed on the subjective experience of the phenomenon. The responsibility for the creation of a synthesis of meaning and essences rests solely with the researcher. This could be seen as increasing the likelihood of researcher ‘bias’. It is possible that blind spots occur and also countertransference issues that impact on how we hear and interpret the co-researchers’ stories (Rose & Loewenthal, 2006). To this end I have used my clinical and academic supervision extensively for the purpose of addressing possible blind spots, parallel process, and countertransference.

In contrast with the concern about researcher bias Rose and Loewenthal (2006) cited that Sword (1999) claimed declaring the direct interest of the researcher in the phenomenon increased the legitimacy of the findings. This transparency is considered to enhance the study.

In heuristic enquiry verification occurs firstly, through the researcher’s constant checking and assessing of data together with an evaluation of its significance and secondly, through returning to the research participants to ensure accuracy (Moustakas, 1990). Participants were given copies of their transcripts, the depictions, and quotes that were used in the study. 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.

The study involves participants who have a working knowledge and understanding of shame who were interested in exploring the topic in more depth. Furthermore the group of co-researchers comprised therapists with experience ranging from 15 to 25 years. This meant they were able to share a range and depth of experiences accrued over time, as well as offer reflection on their differing responses to shame events in the varying stages of their careers. As a participant researcher my experience as a therapist spans 36

years. For 25 of these years I have engaged in the study of shame reading literature, observing clients and myself in relation to the phenomenon of shame.

I was familiar with two of the co-researchers and had worked with them both previously. To a lesser extent I was familiar with a third. It could be argued that this familiarity ensured a deeper level of disclosure or that it held the possibility of skewing the findings. My experience of the interviews together with their comments naming the safety they experienced in the familiarity of myself as a 'known' person confirms the former. It is not possible to discern how knowing the participants previously may have limited the research because the 'knowness' is already an established context between us. That is, we tend to meet in the context of what is known. Surprisingly, I experienced the other two co-researchers who I did not know as very forthcoming in their willingness to self disclose. In part their responses may have been due to the trusted link that they had with my academic supervisor, who had invited them to participate in my research. Disclosure included experiences of being shamed and in some instances shaming others.

Professional opportunities for disclosing shame related experiences amongst colleagues are limited. The provision of this opportunity can be viewed as a strength. Subsequent to the interviews three co-researchers have reported that the interviews were a springboard for further self-reflection and insights. 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 include additional exploration of how the therapist's shame impacts on the therapeutic relationship and/or therapeutic outcomes. A focus on 'countertransference shame' could help elucidate the therapist's feelings of shame and distinguish them from the client's feelings in order to deepen understanding of the experience of the client. A second study could include a broader cross section of therapists including males and therapists from different cultures. A third study could involve therapists who practice from different modalities in the exploration of experiences of shame.

Studies focused on therapists' experiences of shame in any of the specific contexts of Group Leadership, Couples Therapy, Supervision, Therapists' Training could add significantly to the thin bodies of literature in these domains.

Conclusion

The elusive nature and complexity of shame pose significant challenges for therapists in practice. The mention of the word 'shame' most often feels painful to therapist and client alike and makes us want to move away. 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, known as 'strategies of defense', make it a truly elusive phenomenon. These factors appear to have contributed to a lack of attention in the literature on 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.

As therapists, shame is an experience common to us all in varying degrees. This heuristic study has focused on therapists who are shame prone and experience chronic shame. Chronic shame has been reported as originating in repeated experiences in early life of failures where self and other might connect. An unsafe myth exists in our community of therapists that says therapists should have done all their work and should not experience shame. This study shows that therapists' personal shame work is never complete. In reality we go on encountering 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 experience of shame as an attack on the self, as reported by all participants, is reflected in the literature. In an attempt to 'expose' shame and go to the heart of the experience I invited stories from five therapists, while entering into a heuristic process of examination of my own shame. Individual depictions, portraits and a group composite depiction compiled from the data have offered rich accounts of these 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. The 'self' looking at the 'self' through the other's

eyes was consistently reported in the data, as a behaviour characteristic of shame experiences (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 default position 'not being good enough' presents itself as an automatic reaction in these experiences.

Implications for practice 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, some universal and others unique to individual therapists, have been revealed. Similarly, the many ways both therapists and clients defend against shame have been described, for example projection, denial, repression, self-blame and contempt. 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. There is merit in the idea of each therapist completing her own heuristic study of her experience of shame and in doing so building her own 'shame profile', a process that Kaufman (1993) advocated was essential for therapists. I argue that in equipping oneself for shame work with clients the therapist needs to be willing to go there first. In my experience shame prone clients are expert in gauging their therapist's ability to engage with them effectively in addressing their shame issues.

The data revealed four interrelated core themes. The first 'second hand shame' referred to intergenerational projected shame and had relevance for all study participants. Poignant stories were told of the legacies of shame inherited by co-researchers. The largest theme 'shame with colleagues' mostly revealed experiences in which therapists had felt shamed by their fellow therapists. 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 colleagues cast us into our own fears, anxieties and sometimes shame. The resultant experiences of empathic failures amid colleagues were experienced as excruciatingly painful. Under the gaze of many sets of eyes, groups were found to be arenas that evoked intense shame experiences for the therapist whether leader or participant. This theme highlighted shame as a relational affect that leads to disconnection and isolation. The third core theme 'being different' captured shame experiences activated by illness, culture, separation, and sexual orientation. The fourth core theme 'not being good enough' underpins all the other themes.

Shame has been presented as constructed in relationship. Therapeutic work demands an ability to tolerate this often dark and disruptive affect. 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. If we can embrace our shame experiences and view them as something positive to address within ourselves, and our clients, we can help transform these experiences and build resilience to shame in both. Conversely I maintain a certain level of resilience is required to work with shame in the therapeutic relationship, as there is an inherent vulnerability for both parties in this process. Courage and self-compassion, as well as compassion for the others, have been identified as significant requirements for the therapist in addressing shame be that with clients, supervisees or colleagues.

Supervision with a trusted attuned and responsive supervisor was identified by all study participants as critical in the building of shame resilience. For colleagues experiencing vulnerability in certain situations, for example, a client suicide, illness, a presentation of a case study, sensitivity and empathic attunement needs to be extended. The value of talking of vulnerabilities and shame experiences has been born out in the study.

I contend that we still have much to learn about working with shame. Nevertheless attending to our shame sensitivities is a responsibility we carry as therapists. In learning to live alongside our shame, our resilience is built through self-acceptance, self-compassion and connectivity with others. Our experiences with shame and its transformation serve to create new depth, enrichment, and expansiveness in our relationships with self and others.

The following concluding chapter, *Creative synthesis*, is an expression of the essence of therapists' experiences of shame that includes the themes and meanings that have been elucidated. Throughout my study I was often drawn to the tree that features in the story. *Lone puriri* reflects therapists' shame experiences of intergenerational trauma, profound aloneness, exposure, being different, not being good enough and a rocking of one's foundations. The neglect, attacks and isolation the tree endures mirror the myriad of sources of shame therapists face. As reflected by the stunting of the tree, shame inhibits the flourishing of the self.

Chapter Nine: Creative Synthesis

Lone Puriri



Figure 11: Lone puriri

I can be a magnificent tree with my lush green foliage and large canopy. My flowers and berries provide an endless source of food for wildlife. Historically I have had so many uses. I am the mahogany of Aotearoa. The strongest wood of all the native trees; I am heavy, dense and resist rot. My ancestors were used by Māori to make long lasting tools, paddles, and weapons. There is a legend that buckshot would ricochet off my palisades (Keene, 1988). My timber is usually greenish dark brown, although sometimes it is black streaked with yellow. I am a healer. Māori used my leaves to make infusions for sprains, backaches, and ulcers (Brooker, Cambie, & Cooper, 1981). As well, my potions were used for preserving the dead and my leaves would be used for coronets or carried at ‘tangis’ (funerals) (Dijkgraaf, 1994). I have a deep association with death; some of us lived in Māori burial sites where we were considered ‘tapu’ (sacred) (Burstal & Sale, 1984).

An iconic sight in paddocks in the northern half of the North Island is one gnarled puriri left behind after all the other straight trunked trees were taken away for timber a long time ago. This is the story of one such puriri, which echoes the lives of many who have endured a similar fate.

I was left on my own in a paddock high on the side of a hill, exposed to the harsh salty winds that blow across the Tasman Sea up along the west coast. Nobody really knows what caused my collapse. I was struck by lightning once. Without the protection of my fellow trees, those winds just eroded my strength, until one day I could take it no more. I fell to the ground. With my roots still lodged deep in the ground, I lay on my side. My beautiful canopy of green was cut away to make way for the grass beneath. What remained of my severed trunk lay stretched out for all to see. Naked.



Figure 12: My old trunk

Some months later high electrified fences were put up all around my paddock. It was not long before a herd of deer arrived. Any signs of new life on my trunk rapidly disappeared. The deer thought my shoots were such tasty little morsels. Those salty winds of the Tasman continued to batter my greying carcass. The farmer and his neighbours all thought I was dead. Yet I struggled on, settling for little expressions of life in the odd shoot here and there. I resented the way my life had become so limited. Then to my surprise one day, after 40 long years, the deer moved on. Slowly, one shoot after another, I began to grow my branches up towards the sky, clothing them in lush green foliage. I enjoyed a sense of pride that I had not felt for half a century.

A year later seven sturdy bulls arrived to share my paddock. Fortunately I had sent up branches that were mostly beyond their reach. Although they could feed off my lower leaves they could never steal life my completely. I had renewed vigour and a resilience that mirrored my former self. My trunk that looked dead all those years had shown itself to be a conduit for life. However, while the bulls were not the voracious attackers the deer were, they were dangerous. In a moment when the farmer turned his back, one particularly angry bull attacked him and sent him to hospital. One could never take their eyes off them.



Figure 13: My new shoots

As I grew up I opened up and began to feel free. Yet I remained vulnerable to attacks that could injure me. Thistles grew up around me and wasps made their nests in me but nothing outdid the wounding inflicted by Aotearoa's largest moth. The size of a finger, the caterpillar of the 'puriri moth' would bore deep into my trunk and suck my sap (Martin, 2010). Sometimes it lived in me for an astounding five years before hatching into the moth that survived a mere 48 hours. Long enough to start another generation of parasites that could harm me.



Figure 14: My guests

Although I am always on the watch for danger I have gone on building my strength. Throughout the year I produce the most beautiful little flowers. Fluorescent pink and sometimes red, I flower mostly over winter. My orange and red berries ooze nectar for the birds throughout the summer. I love the way the kereru flies onto my branches, eats my berries, and spreads my seeds through the forest.



Figure 15: My flowers

Imagine if, like the Māori, the farmer held respect for me, together with a belief in my worth. I dream that one day he might be inspired to take on a revegetation project. He would replant the grove providing me with the shelter and companionship I have longed for. We would all live within the safety of a stock proof fence dressed in shelter cloth. On a diet of fertiliser tablets, none of us would go hungry. Even though I am misshapen and bear the scars of my injuries I could still become the tree I was destined to be.



Figure 16: My berries

Cowan (1929) told of how the Bay of Islands Māori believed the puriri to be a symbol of the joy of being alive. Their special proverb, “Ka kata nga puriri o taiamai” is used to greet, congratulate and honour others. An English translation of this is “the puriri trees of the bay are laughing with joy.” The saying acknowledges a sense of delight and gladness that comes with pleasing news. “It signifies the smiling face of Nature on a summer day, when all seems to go well with the world” (Cowan, p. 23).

I have lived on in defiance of my attacks and brushes with death. In being simply myself: I laugh with joy.



Figure 17: Being myself

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Appendices

Appendix i: Handout on Shame (Sue Evans)

Shame is an emotional state experienced as “feeling exposed”, a “wound from the inside”, the process of “turning the eyes inward and watching oneself critically”, feelings of “being little”, “humiliated”, “defective”, “alienated”, and feeling as though “you have been diseased all of your life”. Shame often has a binding effect and feels as if you are frozen, immobilized or “going blank”. The outward expression of shame can be non-verbal such as hanging the head, blushing, hiding or a frozen face and dropping of the eyes. Shame calls attention to the self and there is a natural tendency to lessen exposure/vulnerability.

On the other hand, many people don’t even recognize that they are experiencing shame. They’ve learned to call it something else (guilt, embarrassment, shyness, inferiority complex or feeling self-conscious) or they’ve developed defenses to protect themselves from the experience because it’s such a powerful affect (feeling). These **defenses or secondary reactions** are often split second responses developed as survival skills to help deal with the pain. One common secondary response is **anxiety** due to the fear of further exposure. Another response is **rage** used to insulate and protect the self as in “keep away from me/don’t come any closer”. Another response is the impossible attempt to **be perfect**/in control of everything so as to not feel “bad”. Another response is **disassociation**, the experience of “going numb” or having your awareness separate from your feelings/body. An accompanying experience to dissociation is “**disowning the self**” whereby the part of yourself which is perceived as unacceptable is ignored and/or denied. These survival skills can, however, ultimately become dysfunctional in themselves when left untreated.

Many people experience a **shame spiral**, which often follows the same course.

1. Something triggers shame response,
2. this automatically triggers the secondary defenses,
3. which then triggers the internal verbal process (the tapes in their head of all the mean things they’ve heard about themselves as children), “You’re so dumb... how could you have ever done that... you are the most stupid person on the face of the earth... and besides that you are so fat and clumsy you’ll never amount to anything and nobody likes you anyway”. This can become an obsessive and compulsive reaction and because isolation is such a common way to protect oneself in this situation there is no way to get a reality check. They go away obsessing about how awful they are.

This **rampage** sets them up for more shame inducing situations because they believe their shame. Shame, of course, is a valid feeling but the tapes are a lie even though in the midst of it all it feels to be the truth. The shame spiral can continue for days, weeks, even months at a time with no relief in sight as each shame experience spirals even deeper.

There are a variety of ways shame can be induced in a person but shame in itself is not bad. It’s a feeling just like any other and shouldn’t be avoided. A child needs to learn to cope with it and won’t learn this tool if insulated from it. It does, however, become damaging **when shame becomes internalised** into one’s identity.

Interpersonal relationships become the model for how we relate to ourselves. We learn to treat ourselves the way we were treated as a child, partly because the child tries to be like the much loved/needed parent (sibling, other relative-anyone the child holds important) through the process of identification. Identification is the experience of children imitating their elders to enhance their power and to merge with another person for a sense of belonging and rootedness. Children internalise (take into themselves) what they see and experience as core affect/beliefs that help shape their identity. First they identify (this is how I am the same) then they differentiate (this is how I am different/separate) to form their own identity. If, however, what they experience is critical, shaming, and mean their identity is based on these feelings of worthlessness and shamefulness.

The difference between **shame and guilt** needs to be addressed because they are often confused. Guilt can be used as a positive tool to socialize our children (needed because a person without guilt is in trouble, as is society). If the child does some behaviour that is inappropriate the parent can call their attention to it and say, “This behaviour is inappropriate, I don’t like that you did that. You need to change it/fix it.” (The child has the power to make it better and come back into the caring/love).

Shaming, however, in the same situation would go something like this. The child does something inappropriate and the parent says, “This behaviour is bad and you’re bad for having done it and there is nothing you can do to change it, you’ll always be bad” (No way for the child to come back into the caring/love). A blame-oriented family focuses on who is to blame – fault finding rather than how to repair the damage. “I feel shame” becomes “I am shameful, unlovable and defective”.

Children have a critical need for a relationship(s) (i.e. the need to be wanted, to be loved for themselves and not for what they do and the need for mutuality). Simply having children doesn’t build a relationship and we can’t assume that every parent and child had one. A child might not have been wanted at all or born the wrong sex or trust might have been broken too many times by the parent. The parent looks bigger, stronger, wiser and the child is left with feeling of “What’s wrong with me? It must be my fault”. Particularly if the parent feels shameful themselves, insecure or inadequate. They need to the child to be perfect (always clean, polite, adorable and never naughty) for the parent to feel o.k. This is of course impossibility so it’s a set up for the child to fail. They have an over investment in the child’s accomplishments, often putting a lot of pressure on the child to succeed. The child’s job from the beginning is to take care of the parent (a role reversal). But if the child is a regular kid, with natural mishaps, the parent must transfer the blame with “you’re embarrassing me” and “you’re such a disappointment to me” in order to feel adequate. It’s almost impossible for the child to come out with any self-respect and the interpersonal bridge between the parent and the child is broken. Trust is broken and the child learns the world is unsafe and not to be trusted.

When a child experiences a need to receive parenting (to be held, nurtured, respected, paid attention to or receive guidance) and the need is not attended to, the child’s expectations are exposed as wrong and it induces shame. In these situations the child is taught that their own needs are unimportant, that to be needy is shameful and their job is to take care of others.

Language, imagery and affect help shape **identity** in the following ways. Children often internalise, directly word for word, what they hear. If a parent continuously calls the child dumb and stupid they will not only believe it but will also act dumb and stupid. They stifle their creativity, spontaneous learning and natural information-seeking abilities and tend to give up easily saying, “I can’t learn this, I’m too stupid”.

Another powerful evoker of shame is **imagery**. Visual imagery is a more basic experience of shame even than language because it is often experienced before the child has words (pre-verbal) to describe what’s happening. A look of contempt from a parent can be devastating and remembered for years.

Affect shapes identity in that some families are more accepting of certain feelings than others (such as anger being more acceptable than being vulnerable or hurt being more acceptable than self-satisfaction/pride). Soon certain feelings get associated with shame/disgust/alienation and even experiencing that certain feeling alone is enough to trigger shame. Soon that certain feeling is denied/disowned. Some families are so uncomfortable with feelings in general the expression of any feeling can trigger shame.

Soon the **shame is bound** to the child’s identity and becomes autonomous. It doesn’t require inappropriate behaviour to trigger shame. A person can experience shame from any number of triggers but because it feels like they’ve been bad they look around the world to see how they’ve messed up. Of course, being human, there is always something they can find that they should have done differently and so they feel perfectly justified in chastising themselves. The shame spiral begins again.

Therapeutic Intervention – A Model of Healing

Relationship

Recognition

Stop the Inner Abuse

Neutralise

Relationship: The main element in healing a shame-based identity is in developing a caring relationship with someone who is trustable, someone who is capable of having a respectful and caring relationship. Trust is the main issue that needs to be addressed and developed in the therapeutic relationship, so it is vital that this trust be guarded by both parties. Within this relationship it is helpful to explore where you learned your shame; who shamed you, what did they shame you for, how did they shame you, how did you deal with it, what effect does it have on you now?

Recognition: This process can be done in stages. For most people it is quite enough to simply be able to recognise and label shame. They have used so many defences in order to not have the feelings of shame, that to finally acknowledge it is often excruciating. At this stage it most likely will feel worse before it feels better.

Stop the Inner Abuse: The next step is to stop the mental (sometimes physical too) self abuse. This is a very critical but difficult step. The playing of the tape is so automatic that you might need to stop yourself literally hundreds of times a day, over and over, before you break this pattern. It's often helpful to say to yourself, "This is shame, this is what it felt like to grow up in my family. I'm not going to listen to all the abusive things that are coming in to my head because they're lies".

Neutralise: Each time you are able to recognise that you're feeling shameful and stop the self abuse, you need to find some way to neutralise the toxic effects. One way to do this is to say something nice about or to yourself (even if you don't believe it) over and over each time you recognise the shame.

Another tactic is to do a relaxation exercise whereby you visualise your shame (in whatever form it takes and in whatever part of the body you see it) and slowly move it out of your body, leaving it fresh and clean.

It is very critical to reconnect the interpersonal bridge in whatever manner you are able. If possible, change the focus of your attention from internal criticising to outside yourself – such as lifting up your head and making eye contact with someone. Another helpful thing to do is to check out with someone that you trust, and who cares about you, the validity of the words coming from your tapes. Often getting reassurance that how they see you is very different from what the tapes are saying is helpful (let yourself believe them!).

There is also something very healing about making a physical connection with another person. Many people will find this too threatening, but eventually find it very soothing. It seems like there is a visceral message to the soul that says you are touchable/lovable/all right.

Although it takes hard work and diligence, and healing a shame-based identity is a difficult task, this model provides a helpful way of looking at and understanding shame. With such a model, there is hope for breaking the shame spiral and building/rebuilding interpersonal bridges.

Participant Information Sheet



30 June, 2015

Project Title

The Therapist's Experience of Shame.

An Invitation

Thank you for your interest in my research project exploring the experience of shame in the therapeutic context. I am a psychotherapist who is completing a thesis for a Masters in Health Science Degree. I am looking for counsellors and psychotherapists to participate in my study. Your participation is entirely voluntary and should you decide to withdraw, you can do so at any stage prior to the completion of collection of the data.

What is the purpose of this research?

The purpose of the research is to explore the experience of shame from the therapist's perspective. Focus will be given to how the experience of shame impacts on the therapeutic process and efficacy. Raising the therapist's awareness of the significance of the phenomenon of shame and the sharing of ideas for best practice are key outcomes sought from the research. On completion I plan to present the study at a Conference for the New Zealand Association of Psychotherapists (NZAP) and in an article in "Ata: Journal of Psychotherapy Aotearoa New Zealand".

How was I identified and why am I being invited to participate in this research?

Participants have been invited through my academic supervisor on account of their interest in the topic that may include having written on the topic. Selection of participants will be made on the basis of membership of the New Zealand Association of Psychotherapists (NZAP) and the New Zealand Association of Counsellors (NZAC). Participants need to be willing to be self reflective and engage in an open discussion of the topic of shame in their practice.

What will happen in this research?

Individual participants will be involved in an interview anticipated to last approximately 90 minutes. The interview will take place in a mutually agreed venue. The research methodology I am using is heuristic methodology, a form of qualitative research in which I am seeking to create comprehensive descriptions of each participant's experience. This means you will be asked to talk in detail about specific events or episodes in your practice and life in which you experienced both your own and your client's shame. Identification of your thoughts, feelings and behaviours associated with these situations will be integral to this process. After the interview you will be given an opportunity to review and correct the interview transcript. My focus will be on understanding the essence of the phenomenon as it reveals itself in your experience. My hope is to illuminate answers to my question: What are therapists' experiences of shame? I plan to audio record the interview so that I can transcribe the session. I intend to use the material from the interview as data for my thesis.

What are the discomforts and risks?

I do not believe that there are any major negative consequences from participation in this study. However, shame does evoke discomfort and pain, which makes us want to avoid focusing on it. It is by no accident that minimal focus is given to the issue in the therapy room and related therapeutic literature. The neglect and concealment of shame pertains particularly to the therapist's experience of his/her own shame. In the context of the interview it is likely that the experience of shame may well be triggered.

How will these discomforts and risks be alleviated?

I envisage that participants will take any discomfort or issues emerging from the interview to their own clinical supervision and/or therapy as required. The AUT Counselling Service is available to participants who may require additional support post interview at no cost (see attached letter). It is important for participants to know that what they share is strictly confidential.

What are the benefits?

This research is a partial requirement for my Masters in Health Science qualification. The potential benefit to you as a participant is that you will have the opportunity to gain insight into and reflect critically on the impact of shame on you as a practitioner. Your involvement is likely to be professionally and personally transformative.

Within the community of psychotherapists and counsellors potential benefits lie in increased awareness in the practitioner of the importance of acknowledging, understanding and working actively and effectively with not only the client's shame, but also their own shame.

In the wider community the best possible outcomes would be a significant reduction in shaming practices and the building of shame resilience in individuals, particularly in those who are shame prone.

How will my privacy be protected?

Your identity will remain confidential with a pseudonym used in the write up of the study.

What are the costs of participating in this research?

Your commitment will involve attendance of a 90 minute interview. You may choose to share reflections subsequent to the interview.

What opportunity do I have to consider this invitation?

I would appreciate it if you could advise me if you are willing to participate in the study within the next three weeks.

How do I agree to participate in this research?

Upon this advice you will receive a Consent Form by email. Following this I will contact you to arrange a time and place to meet. Interviews can not occur in private homes.

Will I receive feedback on the results of this research?

You will receive a sheet summarising the results of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Margot Solomon, margot.solomon@aut.ac.nz (09) 921 9999 x 7191

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTECH, Kate O'Connor, ethics@aut.ac.nz (09) 921 9999 ext 6038.

Whom do I contact for further information about this research?**Researcher Contact Details:**

Marian Hammond

Phone: 021 167 6020 Email: marian.min2@gmail.com

Project Supervisor Contact Details:

Margot Solomon

Senior Lecturer, Department of Counselling and Psychotherapy,
Auckland University of Technology

Physical Address: AUT (Room AR 232), North Shore Campus, 90 Akoranga Drive, Northcote,
Auckland.

Postal Address: Private Bag 92006, Auckland 1142.

Phone (09) 921 9999 ext 7191

**Approved by the Auckland University of Technology Ethics Committee on
19 December 2016 AUTEK Reference No 14/361**

Appendix iii: Consent Form

Consent Form



Project title: ***The Therapist's Experience of Shame***

Project Supervisor: ***Margot Solomon***

Researcher: ***Marian Hammond***

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated:
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio recorded and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including audio recording and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one):
Yes ☐ No ☐

Participant's Signature:

Participant's Name:

Participant's Contact Details (if appropriate):

.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on
 19 December 2014
 AUTEK Reference number 14/361***

Appendix iv: Interview Questions

What makes you interested in shame?

Can you remember a story where you as a therapist felt shame?

- What did you think?
- What did you feel?
- What did you do?

How do you experience shame as shaping the therapeutic process and impacting on your therapeutic alliances with clients?

What *inhibits* your ability to respond to the client's shame and /or your own shame in the therapy room?

What *enhances* your ability to respond to the client's shame and /or your own shame in the therapy room?

Appendix v: Theme Analysis

Themes	1	2	3	4	5	6
Disconnection and Isolation - empathic failures amid colleagues	+	+		+	+	+
Physical Health - exposure of vulnerability	+		+			
Bad Therapist vs Good Therapist - the “Perfect Therapist” judgment	+	+		+		+
Vulnerability as a Therapist -exposure of vulnerability	+	+	+	+	+	+
Under Scrutiny - peer assessment (3 rd party)	+	+		+	+	
Anger	+					+
Being Different – in the margins, an outsider	+	+		+	+	+
Power of Good Supervision - empowerment	+	+	+	+	+	+
Colleague Shame	+	+	+	+	+	
Cultural Shame		+				+
Making Mistakes - Beyond conscious control		+		+	+	
No Redemption	+		+			+
Group Shame	+	+	+	+	+	
Intergenerational Legacy - second hand shame	+	+	+	+	+	+
Competition - Envy	+	+		+	+	
Transformation over time - Building resilience		+	+	+		+
Regression	+	+	+	+	+	
Not Good Enough -unworthy	+	+	+	+	+	+
Rejection	+	+	+	+	+	+
Self Blame	+	+	+	+	+	+
Collapse	+	+	+	+	+	+
Parallel Process		+			+	+
Refined Themes						
Intergenerational Legacy	+	+	+	+	+	+
Colleague shame - Competition – Envy – empathic failures amid colleagues	+	+	+	+	+	
In the Margins- being different- an outsider- gay- cultural shame	+	+	+	+	+	+
Worthiness – bad therapist vs good therapist –	+	+	+	+	+	+
Supervision	+	+	+	+	+	+
Vulnerability – physical health	+		+			
Group Shame – Under scrutiny – self presentation	+	+	+	+	+	

Core Themes

- Second Hand Shame (Intergenerational)
- Shame with Colleagues
- Being Different (Physical Health, Culture, Separation, Sexual Orientation)
- Not Being Good Enough

Appendix vi: Data Analysis

Depictions	Reflections	Synthesis
<p><i>“The shameful thing is if somebody dies”</i></p> <p>What I found most difficult were those first people I told staring at me and not responding. I knew in my head that my client could suicide, but I was a young therapist and I never actually believed she would do it. It was an awful shocking reality that rocked me to my core. More than anything I wanted response from others yet found myself in a vacuum. I discovered there were few who could meet me and help me bear my feelings. It is like everyone ran for cover fearful that they might catch what I had. The isolation was unbearable. I had expected empathy from my fellow therapists as I endured this shocking loss that could not be shared out in the world. Instead shame was piled on top of my vulnerability I was left feeling disconnected, abandoned and exposed.</p> <p>My worst memory was of my senior colleague who proudly let me know no such thing had ever happened to her. Trampling over my vulnerability she elevated herself into a superior stance. I felt so raw, like it was my fault. Bewildered and shocked I was down an alleyway and nobody</p>	<p>First Response:</p> <p>I too experienced the whole scenario as shocking as I heard the story. In her shoes I would have felt betrayed. As a therapist having a client suicide is my worst fear.</p> <p>Second Response:</p> <p>I was catapulted back to a memory of a client I really enjoyed working with in the public mental health system. For my own health reasons I couldn't take her on privately as she requested. Four months later she was dead. I often wonder “what if?” I guess I feel a shade of shame that I said “no” on account of my needs. It was unusual for me to say “no” and I didn't like saying it for I was well aware of the client's level of need. There is loneliness in this place and I realise, I too, need to talk.</p> <p>I am struck by the multi-layered reverberations of shock in the story. It bounces around inside the storyteller as well as between her and others. I think shame does the same. I know sometimes I may not engage for fear of not saying ‘the right thing’ - an old shame driver. The isolation that results for this therapist following the suicide appears to create one big chamber in which</p>	<p>Isolation is a strong feature of this story</p> <p>Empathic failures between colleagues is a theme</p> <p>Why are some colleagues able to respond and others not? How do we make sense out of her colleagues' responses?</p> <p>What is the dynamic of “superiority” in relation to shame? An expression of contempt? A form of projective identification?</p> <p>The challenge of self-blame needs exploration.</p>

<p>was there. Tense and angry, my tears are not far away as I tell this story.</p> <p>In contrast some therapists were right there with their arm around me, saying “me too”. As they met me I felt soothed and no longer exposed. Looking back now it wasn’t enough.</p> <p><i>Illness: When vulnerability is completely exposed</i></p> <p>It was an illness that everyone knew could be attributed to working too hard, a lack of self-care: self-inflicted. It would have been different if I had an accident. Clearly with this illness: I was to blame.</p> <p>I was terrified of anyone knowing I had it. Those that did know were sworn to secrecy. I was deeply ashamed believing my vulnerability as a therapist was exposed. I would never have felt that had I been on my previous profession. It was as if good therapists would have such good self-care they would never get exhausted and be susceptible to this illness.</p>	<p>shame and self-doubt thrive.</p> <p>There is something about the concept of “limit “ which connects all my responses. I am unclear about this at present. Perhaps the word is “constriction.” Suicide catapults us into our own reactive fears and we struggle to reach beyond ourselves with empathy towards the colleague in need. Perhaps having experienced a suicide reduces this fear and makes reaching out to a colleague dealing with a suicide more possible.</p> <p>First Response:</p> <p>I thought about when I had a knee injury and how yes, I felt vulnerable but it was accompanied by a legitimacy that allowed (self) acceptance. I see the co-researcher feels suddenly opened up for scrutiny, it is excruciating for her. The judgments are not fair and this makes me angry. I wonder what the threat is in getting with her? Or is it that she is too hard to find? It takes courage to front up to the vulnerable other.</p> <p>Second Response:</p> <p>I am reminded of an experience I had as a therapist when I needed to take time off for burnout. The only option I could see</p>	<p>The vulnerability of illness is a theme.</p> <p>Morrison (2008) writes of this and aging.</p> <p>Relates to Interview No 3</p> <p>When control is vital</p> <p>The myth of the “Perfect Therapist”</p> <ul style="list-style-type: none"> - limits therapists - being perfect = insurance against shame <p>To what extent are the colleagues’ responses projections of the therapist’s self judgments? Examples given of comments made by colleagues appear clear judgments from the other. However is that how it is in</p>
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<p>This was another layer to deal with on top of the vulnerability of the illness itself. I kept working concealing how incredibly difficult it all was and inevitably prolonging my recovery.</p>	<p>was to drive myself on covering up my failing functioning. I could have died a thousand deaths when a colleague unexpectedly exposed me in a meeting, naming my struggle. I felt so affronted and injured. Angry I sought refuge in isolation and soon after left the job. Like the co-researcher I had two layers to deal with: my declining health and its related shame.</p>	<p>the broader therapists' community? Or is it merely the shame speaking? Or both? How would we know?</p>
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Appendix vii: Stages of the Heuristic Process and the Role of the Unconscious

Key & Kerr

The Ouroboros (Part 2)

Stage / Description	Unconscious – hindrance	Unconscious – help
1. Initial engagement Discovery of a research question which has intense personal interest for the researcher.	Personal pain linked to the research project may shift the focus to something less threatening. An unconscious drive to resolve the painful question may persist, and split the focus.	Unfinished business or wounds in the researcher's personal life or culture may draw the researcher into passionate engagement with the research question
2. Immersion Intense focus on, and “living inside” the question.	If the research is not central to the researcher's concerns, and has been undertaken, for example to fulfil institutional or organisational requirements, immersion will not be possible, as the unconscious conflict between personal and organisational needs will sabotage the process. The researcher's own past experience may create unconscious distortions in the direction of focus. If the question is central to the researcher's concerns, its pull may be so strong that the researcher becomes submerged in the process.	Opening to the research question as a vocation – a call from the depths of the unconscious can provide powerful energy to deepen the immersion process. This requires a supportive and nurturing institutional and personal environment, and a sense that it is safe to surrender to this process.
3. Incubation Retreat from the question	Researchers may fear that if they retreat from the question, they will lose motivation and fail to complete their research. The sense of meaning, completeness and life given by engagement with the question may make it hard to pull away. There may be a painful sense of loss on withdrawing from this depth of engagement.	The unconscious may make it obvious that a time of rest and letting go is needed. For example, ideas may dry up for a while. There may be a sense of flatness or closing down.
4. Illumination Naturally occurring intuitive insight and spontaneous elucidation of the phenomenon.	If previous stages are incomplete or not wholehearted, illumination will not occur.	Knowledge of the dynamic of the unconscious, and a willingness to open to mystery can allow new understandings to emerge.
5. Explication Full examination of what has emerged into consciousness in the previous stage.	If the major source of data is not personal, but is focused outside on the experience of others, the phenomenon cannot be felt from the inside, and therefore cannot be authentically explored in the researcher's own subjectivity. The researcher's own past experience may act as a “chaotic attractor” for particular interpretations.	If the unconscious is allowed to move freely through the researcher into the explication, the researcher may experience a sense of “a resonance so harmonious that it would be.... hard to say who is writing and who is being written” (Romanynshyn, 2007: 17).
6. Creative synthesis Holistic expression of conclusions	If the researcher is lacking in self confidence, or has previous trauma surrounding creative expression, the full unfolding of the final phase may be choked.	Opening to the unconscious can allow free flow of creative expression.