



## Shame Uncovered: Its Psychotherapy and Transformation

A Review of

Shame in the Therapy Hour

by Ronda L. Dearing and June Price Tangney (Eds.)

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Many things make *Shame in the Therapy Hour* a welcome addition to the canon, and the first is that it was written at all! Although intermittently over the years books or book chapters have been written about shame as it relates to psychotherapy (e.g., Badenoch, 2008, pp. 105–118; Broucek, 1991; Lewis, 1971, 1987; Nathanson, 1987, 1992; Schore, 2003, pp. 151–186), few have focused on how to work with shame in psychotherapy (see Kaufman, 1992, 1996, for notable exceptions).

Not only does this new book, coedited by Ronda Dearing and June Price Tangney, describe how shame expresses itself in therapy, but also it does so from several psychotherapeutic orientations, including cognitive behavior therapy, dialectical behavior therapy, functional analysis of behavior, psychodynamic object relations therapy, relational–cultural therapy, compassion-focused therapy, emotion-focused therapy, and psychoeducational groups. In addition, the editors make sure to cover all major therapeutic modalities, including individual, couple, family, and group therapy, as well as a psychoeducational group format.

The editors did well to invite authors who address working with shame in several distinct populations, including people having borderline personality disorder, eating disorders, and posttraumatic stress disorder (PTSD); shame-ridden patients; alcohol and drug-dependent patients; and refugees. Finally, although there is a dearth of research to reference when one is discussing working with shame in therapy, authors in this collection who can cite such references do so, and all authors seem aware of the research that describes the phenomenology of shame and its development as detailed in earlier work (e.g., Gilbert & Andrews, 1998; Tangney & Fischer, 1995).

But if shame and its relationship to psychotherapy have not been discussed much over the years, why now? Has shame been unfairly overlooked, or is it simply not very relevant to our work as therapists? In the introduction and again in the final, summary chapter, the editors make a clear and forceful case for why understanding shame is, in fact, so vital to the effective practice of psychotherapy. The reasons cited include the following:

1. Research shows that shame negatively impacts psychological adjustment, including interpersonal adjustment as well as overall life functioning (p. 3).

2. People feel shame in seeking therapy, as well as when revealing intimate life details within therapy (p. 3).
3. Therapists must know how to identify and work with patients' shame. If not, the patients' problems will either persist or they will feel misunderstood and be more likely to terminate treatment prematurely (p. 3).
4. Regarding psychological functioning, shame is significantly correlated with a host of psychiatric symptoms and disorders, including low self-esteem, depression, suicidal ideation, anxiety, eating disorders, PTSD, and substance abuse (p. 6). Likewise, addiction, anger, depression, mania, and shaming others may all mask underlying shame (p. 7).
5. With respect to interpersonal functioning, shame diminishes empathy (via heightened self-focus) and increases angry, hostile, or aggressive behavior (p. 6).
6. Shame is ubiquitous in therapy, be it within the patient, the patient–therapist interaction (e.g., given therapy's intense focus on self and the patient's vulnerabilities), or the therapist (e.g., when therapists face uncertainty in the work or their inevitable limitations) (pp. 375–377).
7. Despite its importance to psychotherapy practice, shame is nonetheless easily overlooked or actively avoided because (a) therapists are usually not trained to work with it, (b) shame is so painful that it is naturally avoided by most people, and/or (c) shame remains hidden unless the therapist is taught to identify the nonverbal markers of shame, eliciting and working with it in therapy, without causing additional shaming (p. 377).

When describing the phenomenology of shame, the editors of this volume and several of the chapter authors emphasize the importance of therapists paying attention to characteristic words/cognitions/beliefs, feeling states, and neurophysiological, nonverbal, or behavioral markers of shame. The reader is taught to recognize how a patient's words indirectly refer to shame; for example, when a patient calls him- or herself a loser, ridiculous, defective, foolish, dumb, unworthy, shy, and so forth (pp. 32, 268); makes self-evaluative remarks without overt shame (p. 179); uses self-deprecating remarks or humor (pp. 97–98); expresses disgust toward him- or herself or, defensively, toward others (p. 49); or experiences his or her mind going totally blank (p. 70), becoming confused (p. 268), and unable to solve problems (p. 238).

From an object relations perspective, Michael Stadter (Chapter 2, pp. 45–68) ably delineates three common self-experiences in which shame is at play. He discusses the *bad shamed self* (e.g., "I am bad"), the *defective shamed self* (e.g., the patient feels he or she is "lacking" a valued attribute, such as intelligence), and, perhaps less expected, the *successful shamed self*, whereby the successful but shame-ridden patient still feels inadequate or grandiose, and feels shame for feeling ashamed (pp. 53–54).

Shame is often revealed not by the patient expressing it directly, but rather via his or her defensive emotional reactions. For example, shame may hide within social anxiety, self-loathing, reactive anger or hostility, despair, contempt, superiority, envy and the urge to destroy the envied (including scorn toward the therapist), shame-based depression, and suicidal thinking (pp. 28–31, 65–66, 119–120).

Likewise, shame often does not manifest in pure form but rather is intermixed with anger, disgust, and/or sadness (p. 325) and, I would add, fear. Patients more directly in touch with shame may feel small, inferior, worthless, and overexposed, or they may experience intense self-consciousness, with despair as a painful marker of inadequately treated shame. It is important to remember that shame results not only from someone being mocked or maltreated but also when excitement or spontaneous emotional displays are not responded to or are not given their due (pp. 70–72).

An often overlooked aspect of shame's phenomenology is its neurophysiology. One author, citing Trumbull (2003), astutely observes that shame is experienced as "interpersonal traumatization," with symptoms similar to those of an acute stress disorder (p. 46). That is, the shamed individual may either experience a "hyperaroused shamed self," flooded with overwhelming physical and emotional activation (commonly seen in a flushed face), or, in contrast, a "dissociated shamed self," with the patient feeling paralyzed (p. 70) and/or feeling nothing at all (p. 56).

Behaviorally, the shame-burdened patient may wish that he or she could sink into the ground or curl up, shrink, disappear, or retreat. Such individuals often avoid eye contact, look down and away (p. 70), cover their face, or, more subtly, break eye contact for an instant (pp. 98, 268). Speech may become excessively soft, rapid, mumbling, or imbued with nervous laughter (p. 268). Although most people recognize blushing as linked with shame, perhaps less well known manifestations are squirming, false smiles, biting or licking lips, or biting one's tongue (p. 268). At the extreme, overwhelming shame can induce self-injurious or suicidal behavior (p. 238).

Both the editors and several chapter authors discuss how important it is for therapists to differentiate guilt from shame, as research suggests that guilt ("I *did* something bad") fosters empathic responding and taking more responsibility for one's behavior, whereas shame ("I *am* bad") leads to heightened self-focus and withdrawal rather than reparative action. Interestingly, unlike what Freud would have predicted, research shows that shame, rather than guilt, is correlated with a host of psychological problems (pp. 8–9; including eating disorders, pp. 282–284).

Several authors (particularly Greenberg and Iwakabe, from an emotion-focused therapy perspective) differentiate adaptive from maladaptive shame, something that tends to be overlooked by most writers on shame. Adaptive shame enhances survival, whereas maladaptive shame no longer serves survival (e.g., a childhood abuse survivor fearing closeness). Adaptive shame, or what I call "well-regulated shame," helps to organize a person's thinking and action, as when an overly aggressive person gets the message to tone down his or her behavior (pp. 71–72, 398). Thus, shame helps us "detect . . . a demotion or exclusion from a social group" (p. 93) and thus may benefit our survival as social animals.

The editors, in contrast, suggest that shame evolved when there was a need to appease others in the group but argue that it no longer serves adaptive functions, preferring "guilt . . . [as] the moral emotion of choice" (p. 398). I would argue that well-regulated shame, unlike guilt, can help a person modify behavior, not only according to group norms, but also by realigning it with one's own values, that is, as a form of "self-righting."

In discussions of how to work with shame in therapy, it is important for the reader to remember that what is being treated is *maladaptive* shame, not shame that is bearable and helps individuals adjust their behavior for the better (Chapter 1, Morrison, pp. 32–33). I particularly appreciated Greenberg and Iwakabe's chapter, which outlined from an emotion-focused therapy perspective four principles for therapists to follow when working with shame (pp. 74–79).

The first principle is to create a supportive, validating, empathic, attuned therapy relationship. The next is to help the patient access, within this safe relationship, previously avoided shame by "exposing the activated maladaptive shame to new emotional experiences generated in therapy" (p. 74; see Bromberg, 2006, on why the therapist must identify shame or risk, giving it "legitimacy," p. 154).

The third principle is to assist the patient in regulating previously avoided shame in order to foster new meanings about the self. Shame is regulated both explicitly and implicitly. Explicit, "left-brain" approaches include psychoeducational (Chapter 15, Brown, Hernandez, and Villarreal, pp. 355–372) and cognitive-behavioral strategies (Chapter 7, Epstein and Falconier, pp. 167–194), such as what dialectical behavior therapy practitioners call "opposite action," that is, doing the opposite of one's natural tendencies when feeling

shamed (pp. 245–246; cf. a similar stance from a relational–cultural therapy approach, moving from disconnection to connection; pp. 285–286). Implicit regulation, or “right brain” strategies, include relational soothing, meditation, deep breathing, redirecting of attention from inner/self to outer/others, and so forth.

The final principle is something most authors discuss insufficiently, namely that therapists should assist the patient to transform shame, not merely reduce it, by mobilizing his or her strengths such as self-compassion and genuine pride, empowering legitimate anger, identifying and giving voice to underlying needs, refocusing (e.g., moving from “I *am* worthless” to “I *feel* worthless”), and accessing positive imagery and emotions—all to support the patient’s emerging self-confidence (cf. Brown et al. on developing “shame resilience,” p. 359).

*Shame in the Therapy Hour* delivers many wonderful surprises, including for me a brief transcript from a radical behavior therapy session that reads like the work of a masterful attachment- and emotion-focused therapist (pp. 105–106): the linking of trauma and dissociation with the phenomenology of pathogenic shame (p. 266) and consideration of how to help therapists with their inevitable shame, mentioned either briefly, for example, from a functional analysis of behavior (p. 109) or psychodynamic perspective, (p. 40) or discussed at greater length within the context of supervision (Chapter 13, Ladany, Klinger, and Kulp, pp. 307–322). Given the power of mirror neurons and right-brain to right-brain communication, working directly with a patient’s shame can produce a contagion effect (p. 395), so it is vital that therapists deal with their own shame (p. 144).

My major critique of this fine text is threefold. First, as mentioned above, the editors view shame as always maladaptive, whereas I agree with Greenberg and Iwakabe that well-regulated shame is adaptive and can sometimes support social cohesion as well as self-righting. I suspect that theorists from collectivist cultures might agree with me.

Second, given that pathogenic shame is often an overwhelming neurophysiological experience, typically including an initial phase of hyperarousal followed by intense down-regulation (cf. Tomkins, 1963, on shame’s braking function) and hypoarousal (including numbing and dissociation), it is disappointing that no somatic psychotherapies are included, whereas the book describes several from a cognitive-behavior therapy perspective. I have found that certain body therapy approaches to working with trauma (e.g., sensorimotor psychotherapy, Ogden, Minton, & Pain, 2006; and somatic experiencing, Levine, 2010), as well as the use of touch in therapy (e.g., Bowen’s psychophysical therapy; [www.psychophysicaltherapy.com](http://www.psychophysicaltherapy.com)), provide wonderful tools that can be applied to working with shame, particularly in its most difficult, “shutdown” phase.

Finally, and this is unavoidable, some of the therapeutic techniques described warrant a book-length exposition on working with shame rather than an abbreviated summary: My favorites include emotion-focused therapy, functional analysis of behavior, and relational–cultural therapy. But again, and most importantly, I am grateful that the editors and contributing authors prepared this valuable and long-overdue volume.

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