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Understanding and Treating Shame: The Role of the Clinician

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Understanding and Treating Shame: The Role of the Clinician

by

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MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work

St. Catherine University and the University of St. Thomas

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In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Shame is a powerful emotion and experience that impacts how individuals interpret a situation, and often their behavior. It correlates with a number of mental health conditions that are commonly treated by psychotherapists, and yet the explicit or implicit treatment of shame directly or simultaneous to the disorder is less common. A qualitative exploratory study was conducted in an attempt to gather insight regarding the conceptualization, observation, and treatment of shame in the context of psychotherapy by both generalists and specialists (those with and without explicit training in relation to shame and its treatment). Themes that emerged from the data included: the difference between guilt and shame, observations of shame, and the treatment of shame. Social workers can utilize this information to gain a better understanding of the importance of recognizing, understanding, and naming shame in a clinical context and to have more skills in addressing it with clients.

Keywords: shame, guilt, psychotherapy, treatment, education, training

Acknowledgments

I've been told time and again that this isn't my life's work and that I should do what I can with this project without hinging my pride or ego on the final result. The process of writing this paper about shame shined a big light on my own shame experiences and even elicited many additional shame moments, yet through it all I was blessed with amazing supports: my family, my committee, and my fellow cohort members all played a significant and imperative role in the completion of this project. To my partner for life Clayton Krueger, you are the most steadfast, supportive, and loving man I've ever known. You kept me going and helped me to juggle all of our family's commitments and responsibilities, and without you I would never have accomplished this feat. To my chair, David Roseborough, you demonstrated daily that calm is contagious. I cannot emphasize enough how invaluable your support and guidance was to me. To my committee members, Shelly Richardson and Carli Kody; thank you for investing your time and energy into me, and for all of your suggestions and support. I am eternally grateful. To my daughter Ahnicka, you motivate me by your sheer beautiful existence. Thank you for being ok with the missed band concert, the fewer friend gatherings, and the longer quiet times in our home. Last, but not least, I want to thank my fellow MSW friends; your empathy and compassion will always be remembered- you were definitely born to be social workers.

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Introduction

Studies suggest that shame is connected to a variety of risk factors and is correlated with harmful outcomes (Brown, 2010). Areas identified as impacted by shame include substance abuse, mental health struggles, and eating disorders (Eisikovits & Enosh, 1997; Gutierrez & Hagedorn, 2013; Kelly, Carter, & Borairi, 2014; Wiechelt, 2007). With the vast number of unhealthy outcomes that correlate with shame it is apparent that this is an area that impacts the social work profession. Clinicians work with clients daily who experience these kinds of struggles.

Shame is a pervasive and potentially debilitating emotion and experience that is correlated with many unhealthy outcomes and risk factors. It is important to know the distinct difference between guilt and shame and the behaviors that are motivated by each of these. Studies show that shame is viewed as a reflection of self and that when shame is experienced there is a belief that the individual is defective or flawed. (Brown 2010; Chao, Yang, & Chiou 2012; Ferguson, Stegge, & Damhuis 1991; Guitierrex & Hagedom 2013; Han, Duhacheck & Nidhi 2014; Wiechelt 2007). This is very different from the emotion guilt. When guilt is experienced an individual feels poorly for their actions and behaviors rather than associating them with their identity (Han, Duhachek, & Nidhi, 2014). Guilt also encourages reparative behaviors. It sends the message to lean into someone and make amends versus isolating and withdrawing (Han, Duhachek, & Nidhi, 2014; Ferguson, Stegge, & Damhuis 1991). When individuals isolate and withdraw there are sometimes shame cycles that occur with the use of unhealthy coping skills or engaging in harmful practices that then also cause additional harmful outcomes (Gutierrez & Hagedom, 2013; Wiechelt, 2007)

Despite the plethora of research that has been done that correlates shame with unhealthy outcomes there appear to be significant gaps in how shame is treated by clinicians and the level of shame education that exists. Due to the risk of negative impacts as a result of shame it is important for social workers to have a clear understanding of the way it is interwoven in the struggles of their clients, but also to be in tune with how shame impacts the clinician themselves so as to better serve the client (Gutierrez & Hagedorn, 2013). The purpose of this research is to look at how social work clinicians are educated about shame and how they may or may not inform their practice with knowledge of shame and its impact on their clients. In addition, this researcher hoped to discover more about how clinical social workers are currently working with shame and what might improve their ability to work with it- with a focus on shame education as a way to inform clinicians and encourage intentional incorporation of approaches to treating shame versus treating the risk factors associated with shame.

Literature Review

Shame is correlated with a variety of unhealthy outcomes, and the difference between the often confused emotion “guilt” is well documented. Through the examination of current literature this writer learned that there are many societal concerns correlated with shame. Articles were found related to gay and lesbian relationships, domestic violence, gender biases, and many mental health struggles. This writer narrowed the scope of the research to focus on mental health struggles which include eating disorders, substance abuse, and suicide, but realizes that these areas are not exclusively impacted by shame.

The National Alliance on Mental Illness (NAMI) reports that “approximately 1 in 5 adults in the U.S.—43.7 million, or 18.6% -- experiences mental illness in a given year” and that “among the 20.7 million adults in the U.S. who experienced a substance use disorder, 40.7%--8.4

million adults—had a co-occurring mental illness” (National Alliance on Mental Illness, 2015). The National Association of Anorexia Nervosa and Associated Disorders (NADA) reports that “almost 50% of people with eating disorders meet the criteria for depression” and that “up to 30 million people of all ages and genders suffer from an eating disorder in the US.” In addition, NADA reports that “eating disorders have the highest mortality rate of any mental illness” (About Eating Disorders: National Association of Anorexia Nervosa and Associated Disorders, 2015). It would be debatable to venture that someone does not have a loved one who has suffered or is suffering with a mental illness. Eating disorders, substance abuse, and suicide each come with their own unique set of struggles, but there is one emotion that seems to connect them all: shame. If this is the case, then would it not be beneficial to treat (that is, understand and be able to work with) an emotion that perhaps is causing, exacerbating, or perpetuating an already significant barrier? The following literature review reflects three themes that emerged: the distinct difference between guilt and shame, shame’s impact on mental health, and the treatment of shame.

Shame and Guilt

Webster Dictionary defines shame as “a feeling of guilt, regret, or sadness that you have because you know that you have done something wrong.” It goes on to say that it is a “painful emotion caused by consciousness of guilt, shortcoming, or impropriety” (Merriam-Webster: Dictionary). This is one of the first definitions that came up when searching online, and it is commonly accepted by many that shame and guilt are used interchangeably just as this definition has done. Dearing, Stuewig and Tangney mention this in their article “On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use”:

“In everyday language, the terms “shame” and “guilt” often are used interchangeably to describe emotions that are considered to be detrimental and best avoided. However, much research has demonstrated that shame and guilt are distinct emotions with different implications for motivation and adjustment (Dearing, Stuewig, & Tangney, 2005, p. 1393).”

Dictionary.com defines shame as “the painful feeling arising from the consciousness of something dishonorable, improper, ridiculous, etc., done by oneself or another”. This definition is a closer description to shame and isn’t used synonymously with guilt, but it does leave out an important component, and that is the way that people views themselves when experiencing shame. Dr. Brene Brown defines shame as “the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging” (Brown, Daring Greatly, 2012). This definition appears to encompass what shame researchers have found regarding the two emotions.

Guilt was also explored more through this same dictionary to see how closely commonly held definitions are in line with evidence that researchers have found that distinguish this emotion from shame. Merriam Webster’s Dictionary defines guilt as “the fact of having committed a breach of conduct especially violating the law and involving a penalty” (Merriam-Webster: Dictionary). Dictionary.com defines guilt as “the fact or state of having done wrong or committed an offence”. It goes on to further define guilt as “responsibility for a criminal or moral offence and deserving of punishment or a penalty” and “remorse or self-reproach caused by feeling that one is responsible for a wrong or offence.” In this case the latter definition appears to capture the current beliefs that researchers in the field of shame work have found to be true. The emphasis on doing a wrong act or committing an offense is what separates shame and guilt (Brown 2010; Chao, Yang, & Chiou 2012; Ferguson, Stegge, & Damhuis 1991; Guitierrez & Hagedom 2013; Han, Duhacheck & Nidhi 2014; Wiechelt 2007). Agrawal, Han, and

Duhacheck (2014) write in their article “Emotions Shape the Decisions through Construal Level: The Case of Guilt and Shame”, that “in particular guilt is a negative emotion that is experienced when individuals appraise negative outcomes to their specific actions”. The authors go on to say:

“In sum, feelings of guilt result from behavior-specific appraisals limited to the behavior that caused the negative events or outcomes. In contrast, shame is a negative emotion experienced when individuals attribute negative outcomes to global shortcomings of themselves. Individuals who experience feelings of shame tend to focus on the deficiency of their entire selves and blame themselves as a whole for negative events” (P. 1049).

Guilt says “I’m sorry. I messed up, and I want to make this better.” Shame induces the fight, flight, or freeze response. Shame looks like running, hiding, avoiding, shutting down, or lashing out whereas guilt encourages reparative behavior and reconciliation (Han, Duhachek, & Nidhi, 2014; Ferguson, Stegge, & Damhuis 1991). Olatunji, Cox, & Kim (2015) describe guilt as transient, meaning that it is fleeting and brief. It does not become ingrained within someone and is not internalized as a personal defect. Dearing and Hequembourg write:

“In the case of shame, the ensuing evaluation brings forth negative, internal, global, stable attributions relating to the *self* (i.e., “I am bad”). The individual believes that the cause (i.e., the self) is something that cannot be changed. As a result, feelings of shame are acutely painful and often result in a desire to withdraw, escape, or hide. In the case of guilt, although cognitive evaluations are also negative and related to internal causality, the interpretation is that aspects of the *situation* contributed to the event or attribute. In other words, the contributing factors were specific and unstable—different circumstances could have resulted in a different outcome. Because the situation or attribute seems mutable, feelings of guilt are usually less intensely painful as compared to shameful feelings, and guilt is associated with attempts to do things differently in the future or to make amends.” (Hequembourg & Dearing, 2014, pp. 616-617)

One article that was examined discusses different types of shame. Troop and Redshaw (2012) describe general shame which consists of internal and external shame and bodily shame. In addition, Shivzi and Linehan (2005) describe what is called justifiable shame and define it

during a session in a case study as “a behavior that violated Kathy’s own moral values, and/or behavior is something that would cause others to reject her” (Rizvi & Linehan, 2005). Though these articles were the only ones that were found that differentiate types of shame, they both continue to adhere to the school of thought that shame is often harmful.

These authors continue to say the same thing. Shame is very different from guilt and it’s important that this distinction is made. Shame needs to be understood and distinguished from guilt in order to recognize the mental health implications associated with these two emotional experiences.

Mental Health Implications of Shame

Shame and eating disorders

Sanftner and Tantillo (2011), contributors to the book “Shame and the Therapy Hour” write in chapter 12 that “eating disorders affect approximately 10 million women and 1 million men in the United States” (p. 277). This startling struggle is connected with shame and it is described by the authors:

“because many women feel that they are the object of scrutiny in a culture that values appearance over other characteristics, and because most women come up short when making a comparison with an unrealistic ideal, shame is a common feeling that results from these comparisons (p. 279).”

Unrealistic expectations about body image saturate the media and bombard women every day. Men are also exposed to these messages, and are not immune to them, but it is documented that eating disorders tend to impact women in higher volumes (Sanftner & Tantillo, 2011; Troop &

Redshaw, 2012). As a result, women's experience of shame looks different from men's. Troop and Redshaw describe the emotion as "aversive", and state that:

"we modify our behaviour to reduce these feelings, for example, attempting weight loss with the intention of reducing existing bodily shame. On the other hand we may also modify our behavior in order to avoid the onset of feelings of shame in the first place" (p. 374).

The unrealistic standards that women are inundated with through multiple media sources, can induce shame that results in attempts at meeting those standards-when we cannot succeed this induces even more shame. In addition, the same culture that creates those standards judges the drastic measures women take to be thin and the eating disorder itself produces shame. It's been described in the literature as a harmful cycle. The fear of not being enough, or fitting within the standards that are set for women, the actual experience of not meeting those standards, and "the failed attempts at dieting" (Sanftner & Tantillo, 2011, p. 280) all serve to create, exacerbate, and perpetuate the experience of shame. Kelly, Carter and Borairi (2014) share that the bingeing, purging, and restricting may temporarily alleviate shame at times, but if the feeling isn't present it does not mean that it has dissipated, and is likely to resurface. The authors describe this further:

"...eating disorder symptoms are generally effective at lowering shame in the short-term, but ultimately prolong and intensify these feelings. Among individuals with BN (bulimia nervosa), binge-purge symptoms offer a momentary distraction from shame; however, these secretive behaviors ultimately perpetuate the belief that one is different, defective, and/or disgusting in some way. In AN (anorexia nervosa), symptoms such as food restriction and excessive exercise yield temporary feelings of

pride, which lower shame. However, shame tends to resurface quite quickly as the demands of the self-critical “eating disorder” voice escalates” (p. 55).

Olatunji, Cox, and Kim posit that shame is experienced as self-disgust and that this contributes uniquely to the issue of eating disorders (Olatunji, Cox, & Kim, 2015). Taftner and Santillo expand on this:

“Believing that they have the wrong body or shape or are the wrong weight, women experience shame. In a culture that values a certain slender shape, women who are larger than the perceived ideal and/or who have larger hips, thighs, or stomachs; more flab or cellulite; or less muscle can be prone to self-consciousness and emotions such as shame” (pg 280).

Fear of not being the right size is part of it, but fear of being the wrong size also contributes to shame. These are not one and the same. In the United States it has become a commonly known fact that obesity is an issue. Authors Taftner and Santillo (2011) continue to describe the many components that contribute to shame and eating disorders in a thought provoking and articulate way:

“With so much negative representation of obesity in the media, the fear of gaining weight and becoming obese is intensified for all women, and the stigma associated with being obese has been linked as a causal factor in the development of eating disorders.”

It is not this writer’s intention to argue that obesity isn’t an issue, but instead to point out that shame is also harmful and it is important to think critically about the ways that shame is connected to eating disorders. As outlined, shame at times is triggered by

messages that are received and then can be experienced as a shame cycle when afflicted with an eating disorder.

Shame and substance abuse

Substance abuse disorders are also correlated with shame. Hernandez and Mendoza write that “shame has been identified as a contributing factor in the onset and maintenance of substance use disorders (SUD) and is considered an intrapsychic and interpersonal dynamic that should be addressed during treatment” (Hernandez & Mendoza, 2011, p. 376).

Similar to eating disorders substance abuse is also correlated with shame cycles, in that shame is not only correlated with “numbing” (Brown, Daring Greatly, 2012) behaviors that seek to avoid painful experiences, but the drug and/or alcohol use illicit a lack of inhibition that creates additional shame. Wiechelt writes:

“Shame is often described in the clinical literature on addiction as a factor that is both a contributor to the development and maintenance of addiction problems and an effect of addiction problems. This notion suggests that the relationship between shame and addiction may be cyclical in nature. An individual that is shame based discovers that using a substance sedates their pain to an extent. They continue to use the substance and develop an addiction to it. In the process of developing the addiction, the individual feels increasing shame and humiliation associated with their loss of control. They again attempt to sedate their shame, thus a cycle of addiction and increasing shame emerges” (p. 403).

Shame proneness versus guilt proneness is also discussed. Potter-Efron, who is the author of chapter nine in the book *Shame in the Therapy Hour*, discusses this. He reports that substance

abuse and dependency were correlated more with shame proneness rather than frequency of use. It appeared that the behaviors and outcomes of the dependency were also more related to shame proneness and this makes sense then, when recalling the distinct difference of guilt, that “guilt proneness [vs. shame proneness] seemed to provide a protective effect against the development of alcohol or substance abuse problems in these two groups of people” (Potter-Efron, 2011, pp. 219-220). This does not mean that guilt prone individuals are immune to shame as “it is equally possible that addictive events increase the experience of shame even in non-shame prone individuals” (Potter-Efron, 2011, p. 221)

Dearing, Stuewig, and Tangney conducted a study to measure shame proneness and guilt proneness in relation to substance abuse. Published in 2005, the authors share that aside from two other studies, previous to theirs, no other research had been done to measure shame proneness and guilt proneness with accurate definitions on shame and guilt as defined earlier in this paper. The study found:

“evidence for a positive link between shame proneness and problematic alcohol and drug use in two very different groups of people—undergraduates and jail inmates. In contrast, proneness to “shame-free” guilt was generally inversely related to problems with alcohol and drugs (particularly marijuana). This investigation attempted to circumvent some of the methodological difficulties of other studies by using within-group comparisons and assessment measures designed to distinguish between shame and guilt” (2005, p. 1400).

Though it is not clear how often shame is the cause of an addiction or is the result of it as Dearing, Stuewig and Tangney state “regardless of the causal direction, shame-proneness seems to be related to substance use problems” (p. 1401). These two risk factors have been written

about by shame researchers and documented considerably over the past few years. With the growing understanding of how shame is impacting the community it is important to explore ways in which we can treat shame.

Treating Shame and the Need for Shame Education for Clinicians

At the beginning of this literature review the importance of defining shame and guilt was emphasized. This is not only necessary for identifying the risks associated with shame, but also when looking at ways clinicians can treat shame. When discussing the importance of recognizing the distinct differences between guilt and shame, Hernandez and Mendoza (2011) posit that “being able to distinguish these constructs is crucial for clinicians, as the effects of shame can thwart progress in treatment” (p. 376). Wiechelt asserts in her article “The Specter of Shame in Substance Misuse” that “the results from these studies suggest that individuals who have had substance use problems may need treatment aimed at reducing shame in order to improve their quality of life and increase the likelihood that they will be able to maintain their recovery” (Wiechelt, 2007, p. 403). In looking at the literature there did not appear to be attempted treatment of shame directly until the early 2000’s and as research has evolved it seems so has the therapy approaches available. There are still scant evidence based options, but the following ideas are highlighted from the articles that were reviewed.

Opposite Action

“The Treatment of Maladaptive Shame in Borderline Personality Disorder: A Pilot Study of “Opposite Action” describes how the DBT technique of opposite action was used to treat women with borderline personality disorder. The authors shared that to their knowledge they were the first to attempt to treat shame directly. Opposite action is defined as “when emotions do not fit

the facts, and knowing the facts does not change your emotion, then acting opposite to your emotion--all the way repeatedly-- will change your emotional reactions” (Linehan, 2015, p. 349). This skills approach encourages the individual to identify their behavior when feeling shame and then to do the exact opposite. Because shame at times drives negative and harmful behaviors the technique described is intended to combat that urge by acknowledging the behavior and then acting opposite to what one wants to do. For example, if an individual feels insecure and wants to self-injure as a result, this technique would encourage the participant to instead behave in a loving manner to themselves and does something healthy and positive versus harmful (Rizvi & Linehan, The Treatment of Maladaptive Shame in Borderline Personality Disorder: A Pilot Study of "Opposite Action", 2005)

Acceptance Commitment Therapy (ACT)

Gutierrez and Hagedorn (2013) assert that due to shame being a belief of a personal flaw it is important to treat the shame to treat the disorder or addiction. Acceptance and Commitment Therapy (ACT) is highlighted as a beneficial and effective approach for treating shame. The authors share that “its appeal and effectiveness may be ACT’s unique approach to addressing client thoughts and feelings. ACT helps clients to become fully aware of their thoughts and feelings, rather than avoiding or changing them, so they can make value-guided decisions” (p. 45). The authors go on to share that:

“CBT (cognitive behavioral therapy) often involves counteracting a thought by labeling it as irrational or faulty. This may not always be helpful. For instance, as Wilson, Follette, Hayes and Batten (1996) noted, to inform survivors of abuse that their thinking is irrational or in need of replacing will seldom be new or useful information; they may already be searching for ways to control their thinking and

feelings—often by turning to drugs or other self-destructive behaviors. Treatment based on the synthesis or aggregation of techniques that increase awareness, esteem, self-compassion, and self-acceptance (e.g., those with a mindfulness component) rather than on disputing (e.g., those based on CBT) have been found to be more effective with many clients” (Gutierrez & Hagedorn, 2013, p. 45).

This approach appears to differ from the technique of opposite action as there is more of a focus on processing through the shame and acknowledging the experiences that are causing shame.

Connections

Chapter 15 of Dearing and Tangney’s book *Shame in the Therapy Hour* is authored by Brown, Hernandez and Villarreal. The chapter is titled “Connections: A 12-Session Psychoeducational Shame Resilience Curriculum.” The components of this program are outlined by the authors:

“Brown (2007) found that men and women with high levels of shame resilience share four common characteristics that help them navigate shame and cultivate courage, compassion, and connection in their relationships with self and others: (a) understanding shame and recognizing triggers, (b) practicing critical awareness, (c) reaching out and sharing story, and (d) speaking shame. The four elements of shame resilience became the basis of the Connections curriculum and are explicated throughout the chapter as the sessions are explained (Brown, 2009).” (Brown, Hernandez, & Villarreal, *Connections: A 12-Session Psychoeducational Shame*, 2011, p. 359)

In addition, the importance of clinicians doing their own shame work is emphasized as a necessary component. (Brown, Hernandez, & Villarreal, *Connections: A 12-Session Psychoeducational Shame*, 2011)

Daring Way

The Daring Way curriculum was recently discovered by this writer through Dr. Brene Brown's personal website. Through an email correspondence with Dr. Brown's Director of Research, Ronda Dearing, this writer learned that The Daring Way is based on the Connections curriculum, but that additional components have been added with the emergence of new research. Dearing shared that "learning to use your key values as a guiding force" is an example of a "positive psychology topic" that has been incorporated into The Daring Way. She went on to explain that the curriculum is not available to the general public and only accessible to individuals that complete the training. This is due to the very sensitive nature of shame work and the belief that there could be more harm done than healing if the therapist is not trained properly (personal correspondence with Ronda Dearing, October 28, 2015).

Conceptual Framework

This study utilized the work of Brene Brown as a conceptual framework. Dr. Brene Brown is a well-known shame researcher who has written numerous journal articles and three books regarding shame, shame resilience, vulnerability, and whole heartedness. Her TedTalk on "The Power of Vulnerability" has been viewed over twenty million times and her TedTalk on "Listening to Shame", though viewed less, has an equally astounding audience with over five

and a half million viewers. Her work is relevant to the community and is known by, and resonates with, professionals and laypeople alike.

Dr. Brene Brown is a Ph.D. social worker who has an academic appointment at the University of Houston as a professor in the College of Social Work. Over the past fifteen years she has dedicated her research to understanding shame and is the leading authority on the work presently. Her educational background and current position lend to her credibility related to the application of her findings, and the use of her theory as this writer's conceptual framework.

When planning and implementing the research this writer was cognizant of the work of Dr. Brown which defines shame, emphasizes the importance of naming shame, and then discusses the ways in which people can move through shame. Dr. Brown states that "shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging" (Brown, 2012). Three key points regarding shame are shared with her readers in her book *Daring Greatly*:

- *"We all have it. Shame is universal and one of the most primitive human emotions that we experience. The only people who don't experience shame lack the capacity for empathy and human connection.*
- *We're all afraid to talk about shame.*
- *The less we talk about shame the more control it has over our lives."*

Shame causes individuals to retreat, isolate, and shut down...and unlucky for us- that is exactly what it needs to thrive: secrecy and isolation. Dr. Brown shares that it is through naming shame, being vulnerable, and sharing with trusted people, that we are able to overcome the harmful feelings and effects of the emotion. In addition, she shares that self-compassion and empathy are key components to combating shame and building shame resilience. This information on defining, avoiding, and combating shame was used to shape my interview questions.

When interviewing the participants in my study I incorporated Dr. Brown's research in three ways. I listened to the language used to determine if clinicians reported observing shame in the way that Dr. Brown has defined it. I created questions that aimed to identify ways in which individuals in a clinical context might respond to shame (for instance, disconnecting and numbing), and I attempted to gather information from clinicians to determine the extent with which they are incorporating therapeutic practices that build empathy and self-compassion.

As a licensed social worker and future clinical social worker, I sought to better understand and to apply or utilize Brene Brown's findings to research locally in my community. This is an important topic that, as Dr. Brown asserts, impacts everyone.

Methodology

My four-part research question is: How do clinicians conceptualize shame, what are the ways in which they are observing this emotion in their clients, what education have they received specific to treating shame, and what are they currently doing to address, treat and, in particular, to reduce shame in their clients.

Research Design

The purpose of this study was to explore shame specifically in regard to the ways that clinicians conceptualize and engage with it in their practice. Throughout the literature review it was clear that shame is harmful and is associated with many unhealthy outcomes, such as eating disorders and substance abuse, but it did not often highlight ways in which practitioners and clinicians can "treat" shame in mental health settings, that is, how they conceptualize and work with it. This research focused on beginning to bridge this gap.

Population and Sample

The study sample consisted of six mental health therapists who work with, or who have worked with, clients who experience shame. As indicated in the conceptual framework of this section -shame is experienced by everyone. The literature also highlights the potential negative impacts of shame. Each clinician interviewed has had a client or clients who have experienced, or are experiencing the risk factors outlined, and have grappled with the emotion. Two mental health clinicians who had completed the Daring Way curriculum that was created by Dr. Brene Brown were intentionally sought out and participated in this study. These interviews were used as a point of comparison to explore potential ways in which their training might impact their practice and how it is potentially different from the work of clinicians who have not had training in understanding and treating shame. Participants selected have a Master's degree or higher education and work in the mental health field. Participants are current therapists. These therapists included social work clinicians, psychologists, and licensed counselors. The reason for allowing all related disciplines within the field is due to the commonality of clients and the fact that The Daring Way community consists of these professionals also.

Protection of Human Participants

To ensure protection of human participants an informed consent form (see appendix A for consent form) was created and developed from a template approved by the University of St. Thomas Institutional Review Board (IBR) and was approved by the research committee before the research was conducted. The informed consent contains a summary of the study and planned procedures, information regarding the researcher, full disclosure regarding any risks and/or benefits, and assurance of confidentiality. In addition, the form emphasized the fact that there were no repercussions or negative outcomes for refusal to participate regardless of whether previous consent had been given and then retracted. This informed consent form was reviewed

and approved by the research committee that is comprised of Carli Kody, Shelly Richardson, David Roseborough, and the Institutional Review Board prior to providing the form to participants. Before the research was conducted participants reviewed the form and had the opportunity to explore and ask any questions they potentially had about the study and the process. Participants were given a copy of the informed consent form to keep for their records. This researcher did not interview current or past clients, but exclusively interviewed clinicians. Discussion about clients did occur, but this researcher took measures necessary to de-identify any personal or potentially identifying information that emerged in the interviews. Throughout the interviews I asked about and listened for themes related to shame across clients versus asking for significant details specific to individual clients.

Data Collection

This researcher used a qualitative research method which utilizes individual interviews to gather information. Interviews were conducted using a semi-structured format. Interview questions were created and approved in advance before meeting with the participants, all of whom are practicing mental health professionals in who work in outpatient settings (see appendix C for interview questions). Prompting questions were discussed with the committee and were refined after getting feedback. The questions were crafted with the intention of remaining as unbiased as possible. I asked clinicians to reflect broadly in four primary areas related to shame: *how shame is conceptualized by the clinician, how it is observed in clients, education and/or training that clinicians have received specific to understanding and treating shame, and ways in which the clinician treats or seeks to reduce shame.*

The interview questions were created with the purpose of developing a clearer understanding regarding the aforementioned four-part research question.

Data Analysis

Data analysis for this research was done by using descriptive phenomenology. This is a research method that explores and describes a phenomenon that emerges related to a topic, often in the form of themes (personal correspondence with David Roseborough, November 7, 2015). A researcher first collects data and then takes this raw data and analyzes it. Once the researcher has analyzed the data the phenomenon begins to emerge. The interviews were audio taped, transcribed, reviewed, and coded. Initially, open coding was used to discover recurring themes that emerged from the transcribed data that were most relevant to my four broader research questions. These recurring themes were grouped together and then re-examined and compared later after the second round of coding was completed.

The second round of coding was done using selective coding. Selective coding is the process of reviewing data while looking at the information through the lens of the research question. The researcher again grouped themes based on similarities and prevalence. Using selective coding, I listened for ideas relevant to the conceptual framework, that is, ideas about shame as articulated by Dr. Brene Brown. The list of themes from both rounds of coding were then compared.

A strength of this study is the sample that was interviewed. The researcher interviewed therapists who have received specific training related to treating shame and those that have not. A limitation of the study was the rural location where it was conducted, which will potentially mean that the results will not necessarily be able to be generalized to a metropolitan area.

Results

The sample for this study consisted of six participants: five females and one male. The participants were all therapists with various educational backgrounds. Two of the therapists shared that they have a Master's Degree in Social Work, one has a Master's of Science in Mental Health Counseling, and three are licensed psychologists. All participants currently provide individual therapy in their communities, and three of the providers also do group and/or family work. Each interview lasted between thirty and sixty minutes.

The method used to recruit participants was selective and purposive sampling. Padgett (2008) defines this as “a deliberate process of selecting respondents based on their ability to provide the needed information” (p. 53). The researcher called and emailed approximately 30 mental health professionals in the Brainerd Lakes area and four agreed to participate in the study. The researcher also sought out two therapists with specialized training in treating shame, specifically through a model created by Dr. Brene Brown. The two additional therapists also agreed to participate in the study. The six participants were made aware of the benefits and risks of the study and the requested commitment to take part in an audio recorded interview with the researcher for thirty to sixty minutes during a scheduled time and location of their choosing.

The therapists who agreed to participate in the study were asked questions related to how they defined, observed, what they learned about, and how they treated shame. The six interviews were audio recorded and transcribed by this researcher. The interviews took place in a location of the participant's choosing and were conducted face to face. Data were gathered through the transcribed interviews and with the use of field notes.

The data were explored and themes emerged through a process of inductive and deductive coding. The researcher began with an inductive method of open coding to identify initial themes with as little bias as possible. As themes emerged the researcher then went through the information a second time and reviewed the data using a deductive process that utilized the lens of the research questions.

The main themes that emerged through the process outlined were the definition of shame, how it is observed by the clinician, and its treatment in the therapy hour. Within the broad theme of defining shame three subthemes emerged: shame as identity, the difference between shame and guilt, and how it is both an emotion and an experience. Five subthemes emerged relating to the broad theme of observations of shame: trauma and depression, physical behaviors, relationships, client's messages to self, and client's inability to name shame. Within the final broad theme of the treatment of shame in the therapeutic context six subthemes emerged: therapists' personal shame work, self-disclosure and balancing power, normalizing and validating, self-compassion, DBT, and the importance of education and naming shame.

Themes of Understanding and Treating Shame

Theme 1: Defining Shame

At the beginning of the interview this researcher asked a broad question to the participants about their definition of shame. Additional questions were asked to the participants to gain a deeper understanding of the emotional response of shame. These questions were related to whether shame is viewed as an experience or an emotion, if it is adaptive or maladaptive, and to what extent shame is transient or fleeting. All six participants defined shame with negative components listed as part of the emotion. Defining Shame emerged as the most

significant theme during this part of the discussion with participants. Six of the six participants shared that they believe that shame is a negative emotion as experienced by the individual.

Three subthemes were also identified within this broad theme: shame as identity, the difference between guilt and shame, and shame as an emotion and an experience. These subthemes can be read or understood as ways that the respondents nuanced or described their understanding of shame, as it presents in a clinical setting, in more depth and detail.

Subtheme 1: Shame as Identity

Participants were asked to define shame and throughout this process the most significant part of the definition emerged as “shame as identity.” Four out of the six individuals interviewed referenced thoughts and statements that focus on their clients’ perceptions of their personhood or identity being flawed or bad and how the emotion is internalized as a part of the individual.

Participant number one captures this when she stated “I think of shame as somebody kind of internalizing a negative experience that they’ve had and using it to define who they are or describe who they are.” Participant number four concurred and stated that he believes that shame is “...a totalizing of self as bad, unworthy, damaged”. This idea of internalizing a behavior was echoed by participant number five when she shared the example of shame as “...attacking yourself; so I didn’t clean my room so I’m bad, or I have depression, therefore I’m bad, or I had a bad therapy session so I’m bad.”

Overall, every participant perceived shame as having negative components and experiences. Many of them explained very clearly what they believed the emotion to be and then compared it to and contrasted it with the emotion guilt.

Subtheme 2: The Difference between Shame and Guilt

While interviewing participants, additional related emotions were also brought into the discussion: fear, anger, humiliation, embarrassment, and most commonly guilt. Three of the six participants emphasized the difference between guilt and shame. They explained that guilt is a behavior and a focus on what an individual may have done that was bad versus shame being a focus on the person's identity as being bad. Participant number six explained this well stating "I think guilt is when you are feeling bad about a behavior, you don't feel bad about you as a person, you just feel bad about something that you did." Participant five agreed with participant six and stated "...so I talk about like guilt being when you do something and you feel remorse about it, but you don't attack yourself as a person. You don't think I'm bad."

Five of the six participants believe that guilt and shame are two different emotions or experiences, though two of these five described believing that though the emotions are different, they struggled with defining the difference. Participant number two stated, "I think they are two different things..." but was unable to explain how they are different. She stated "Shame can be embarrassment, hurting, can create guilt, but no...they're two different things". Much like participant number two, participant number three had difficulty differentiating between guilt and shame. In regard to the difference between the emotions she stated "I think that I struggle to find the line where it is because when you're working with somebody and they can give you an event that they feel guilty about it's a blurred line when we go into the shame of themselves..." She finished this definition by stating "So I think there's a difference, because I think one is brought on by an event and the other is brought on by that inner thought process. It's so confusing."

In addition to the subtheme related to how guilt and shame are different, participants also identified how shame is both an emotion and an experience.

Subtheme 3: An Emotion and an Experience

Five out of six of the therapists interviewed believed shame to be a negative emotion and experience, and provided feedback on the difference between the emotion and the experience.

Participant one described this:

“I think it kind of evolves through experience; by having various experiences or possible external messages, and then I think it kind of transforms into kind of an internalized emotion”.

The same therapist explained that she does not believe that it is a healthy emotion or experience and when asked if she would see it as adaptive or maladaptive she shared that she believes it is maladaptive.

Participant two went a step further and shared that “...it is an emotion, an experience, and it creates behaviors outwardly.” She was uncertain whether shame was adaptive or maladaptive and stated that “...shame affects everybody differently and you can be resilient and create positive behaviors or it can create negative behaviors.” Two of the other therapists interviewed were uncertain if shame could serve a purpose and be helpful in some way, but leaned toward the idea that it is not helpful and pointed out that perhaps guilt could be helpful, but not shame.

Though every therapist interviewed agreed that shame is a negative emotion related to how it is experienced, only one therapist clearly stated that shame is maladaptive, but another therapist strongly disagreed with this. One participant asserted that there is a positive function to shame and called it functional and adaptive. He shared “*So, adaptive shame would be, would serve a purpose of holding a social fabric together and that would be adaptive.*” He went on to offer this scenario as a supporting example:

“An example that comes to my mind is that we tend not to do things because of societal shame, so we kind of restrain ourselves. Oh, I don’t want to go off and yell and call that person a bitch and just lose my shit in the middle of the store because people would go

“oh what’s wrong with him”. So in that sense it’s very functional. That would be adaptive shame, you know?”

Participant four makes this distinction regarding shame, and though he explains that most of the shame he sees is when someone is experiencing pain from the emotion, he does believe that there is a component to shame that can be helpful for future behaviors.

Lastly, participants three and six pointed out that there can be a healthy and empowering process that occurs on the other side of shame. This idea is illustrated in participant three’s statement regarding the after effects of shame

“I think that what I’ve seen is that the other side of shame is very positive. So when someone is experiencing the shame it is so heavy and it is so negative. It is so, almost self-loathing, that when they gain insight, and process, and are able to come out on the other side it is almost as if they are better for it, but I wouldn’t wish that upon anybody.”

Both of the participants that mentioned this “other side” to shame emphasized that they don’t wish the emotion or its effects on anyone, but are pleased about the growth and discovery that can occur when shame is worked through.

Theme 2: Clinicians’ Observations of Shame

The second theme that emerged was the clinician’s observations of shame in their clients. All of the participants described behaviors that they believed to be the result of shame. Through the coding process five subthemes emerged relating to the broad theme of observations of shame: trauma and depression, physical behaviors, client’s messages to self, relationships, and client’s inability to name shame.

Subtheme 1: Trauma and Depression

A prevalent subtheme that emerged when coding the data was trauma and depression. Trauma was often described in conjunction with abuse, but was also mentioned in relation to

attachment. Five of the six participants described trauma, and half of the participants specifically mentioned depression as a struggle that they address with clients, and see connected to shame. Participant one shared about the stigma associated with mental health disorders and how shame could potentially be a result of that stigma or compounded by the stigma. She went on to describe the secrecy that she observes with abuse victims/survivors and described that to the researcher:

“Anytime when you’re working with a lot of abuse there’s a lot of secrecy, and so when I see those patterns of somebody just shutting down when we’re talking about a certain topic, to me that’s generally a sign that there’s some kind of a shame based thing happening.”

Many other participants spoke about various forms of abuse including sexual abuse and domestic violence. They described this when discussing trauma experiences that they observed in their clients and how they see shame as a component to these experiences. Participant three explained her thoughts on this, stating; “I think particularly when we talk about some pretty significant trauma I think the shame for some reason, unfortunately, is able to be easier identified in themselves.” She then explained that the diagnostic criteria for PTSD includes shame as a part of the process of diagnosing. While meeting with the participant she brought out her copy of the DSM 5 and cited it during the interview. She stated:

“it’s under the negative alterations and cognitions in mood. “persistent and exaggerated negative beliefs of expectations about oneself, others, and the world. I am bad, no one can be trusted, the world is completely dangerous.” Here it is, “persistent negative emotional state i.e. fear, anger, guilt, or shame.”

Though the other participants did not cite the Diagnostic Statistical Manual (DSM), they did often describe observations of shame when working with trauma. Participant one provided this example:

“(who) comes to mind is a young adult female who had a pattern of sexual abuse throughout her childhood and some sexual assaults as an adolescent, and in her current adult life it’s continuing to impact her in very negative relationship patterns.”

Participant six also mentioned trauma as a struggle that her clients are facing, but asserted that she sees shame impacting clients in many other areas as well. She shared:

“...definitely with eating disorders, substance abuse, any trauma, PTSD, but I actually really see it across the board. I mean we all experience shame, and I actually think it’s probably one of the most important things to address in mental health and I don’t know if it’s addressed enough because that’s the one thing that people can’t get past.”

Consistently the participants identified shame being observed in their clients in connection to their mental health and the disorders that were being treated by the clinician being interviewed.

Subtheme 2: Physical Behaviors

All six of the participants observed physical behaviors in their clients when experiencing shame. Consistently all participants described a type of shutting down, avoiding, and pulling away from the therapist as a physical experience of shame. Participant one shared her thoughts stating that “...part of shame is, I think they’ve just been programmed to be on the defensive, kind of put that wall up and get that barrier up.” Participant two was in agreement and added that “It’s easier to avoid and walk away than it is to deal with it.” Participants three, four, five and six all described the body language of their clients in a similar fashion, sharing that they often observed downcast eyes, scrunched in body or caved in chest, and covering the face with their hands. Participant six used the word “shrinking” to define her observations of the physical behaviors.

In addition to the shutting down, some participants also shared about “perfectionism” and looking very put together as a way to overcompensate for the shame that the client is feeling.

Participant three shared that she sees some clients that are “very put together” and elaborated by saying:

“you know if we make bad choices in our past, who hasn’t, and they feel shame over that, sometimes we swing to the other extreme. Where we’re always following the rules and we’re always doing what we’re told, and we’re always doing the best that we can. I think that can be shame based because they’re making sure that they don’t go back there. It’s not giving yourself the happy middle.”

Participant five concurred with these thoughts by stating “I think that shame can underlie perfectionism. That’s something that we talked about in our training...” she went on to say that “...I think perfectionism and shame can really go hand in hand because it’s kind of like not wanting people to see who you really are.” She clarified later that shame is experienced differently by everyone and that there are also internal physical feelings that some of her clients report such as feeling sick, or a “blackness in their body”.

Subtheme 3: Relationships

Four of the six participants mentioned a relational component to shame and how it is observed by the clinician. One participant discussed a variety of relationships that are reportedly impacted by shame. She described that she sees it “...in friendships, intimate relationships, family relationships...” Other participants shared about the dynamics of unhealthy relationships and how these relationships are continued in shame. Participant two reflected that “they feel they don’t know enough about anything or they won’t speak up. Socially they feel very inadequate.” Domestic violence was also specifically mentioned by participant four as a type of relationship that he has observed with shame.

Participant five captured this subtheme about how shame is seen in relationships when sharing about one of her clients that she served previously. She stated in regards to her client:

“...So I’m thinking of one client who, like, the shame proneness impacts her ability to reach out in an interpersonal way to others because she might feel shameful pretty quickly if she’s perceived as doing anything wrong or if someone doesn’t meet her in that, if someone doesn’t reach out back.”

The participants that did mention relationships all cited negative types of interaction or qualities as a dynamic that they see with shame.

Subtheme 4: Messages to Self

Another subtheme that emerged frequently was the messages that the clinician’s clients tell themselves in and out of session. The participants described the negative self-talk as a part of the shame experience. Five of the six individuals interviewed brought this up in some way to the researcher. Participant three gave examples of self-talk statements such as “gosh, what is that about me?” and “why am I feeling like this?” while participant two shared her examples of “I’m not as good as they are.” Participant four was in agreement and also added another concern about the behaviors that he sees that may stem from the way that his clients talk about themselves. He disclosed that his client would state, “I view myself as pathetic” and would continue to engage in behaviors that were not healthy. Participant two described this well when sharing her observations of a client’s view of self and how it impacts her relationships. She stated her client believes:

“I can’t get any better and that’s who they deserve and they deserve that behavior. Even crisis intervention, they will end up in crisis because, they aren’t going anywhere, but they deserve it.”

These messages to self were described as harmful and concerning by the clinicians and were often an area of focus for the therapist.

Subtheme 5: Naming Shame

As described above, the clinicians noticed that their clients had many negative thoughts and self-talk that they engaged in. When asked by the researcher about the client's self-awareness regarding the shame that was being experienced all of the clinicians interviewed reported that they did not believe their clients could name the shame or connect it to the feelings or behaviors. Participant two described this stating:

“No, I don't think I've ever met anybody that literally would just immediately would say shame. No, it shows in them maybe having a lack of support not being able to identify it or not even knowing how to identify it by what it is or why they feel inadequate or why they feel like yah know, what happens years ago or what created them to feel shame.”

Participant five elaborated stating that she believes that many of her clients confuse similar emotions and use them interchangeably. She stated;

“I often hear confusion between shame, guilt, embarrassment, humiliation...you know those four feelings. There can often be some confusion.”

This was consistently reflected on as a deficit by the clinicians. Participant three explained it as a need that the clients have, and a desire to have a name for it is something that she believes exists. She illustrated this in her statement:

“So I feel like it's more of like the people are reaching out for the, give me a name for it. Something we can call it, something we can at least identify.”

All of the clinicians agreed that their clients struggle with naming shame.

Theme 3: Treating Shame

The final theme that emerged through the coding process was the therapists' approach to treating shame. All of the therapists interviewed acknowledged that they observe shame during their therapy sessions with clients. Three of the six individuals interviewed shared that they have had specific training related to treating shame, and five of the six therapists identified that they had at least some familiarity with specific modern day shame researchers. Six subthemes

emerged during the researcher's coding process: therapists' personal shame work, self-disclosure and balancing power, normalizing and validating the emotion and experience, encouraging self-compassion, the use of DBT skills, and educating the client and the importance of naming and defining shame.

Subtheme 1: Therapists' personal shame work

Three of the six therapists interviewed spoke of the importance of doing their own shame work, before and while serving clients who are experiencing shame. Participant five and six specifically mention their shame training when asserting the need for personal work to be done. Participant five believes that it is necessary for both her effectiveness and for her professionalism. She stated:

"...say you're facilitating a group and something that somebody brings up helps you to encounter shame or they shame you and then you feel shame, like once you're kind of down, once you feel shame yourself it can be hard to be an effective facilitator or an effective therapist. So the idea of doing your own shame work, first of all it's just a good idea, but also it makes you more effective at facilitating and being an effective therapist"

Participant six also mentioned her specialized training and stated that she has a few close, trusted friends that she goes to when she has a "shame experience" and that she also speaks to her husband. She shared that "it changed" her and that she feels as though it is still changing her. Participant two is a generalist therapist who bluntly captured the need for therapists to work on themselves. She stated, "so it's almost a matter of, you can't help anybody else until you help yourself, and to me that is huge"

In addition to personal work there was another process that had the same level of intentionality, and that is found in the second sub-theme of self-disclosure and balancing power.

Subtheme 2: Self-Disclosure and balancing power

Four of the six participants discussed self-disclosure and balancing power when treating shame in the therapy session. Participants four, five, and six believe that self-disclosure is a necessary and important component to finding the balance with power. Participant four described a DBT concept of being radically genuine and how this is at times difficult, but attempted. He stated, “because we can easily move to a power paradigm, where I’m the therapist and so I have to kind of, I can’t be radically genuine, so Linehan has the six levels of validation and radically genuine is one of them so there’s always that fuzzy line of self-disclosure...” but he goes on to say:

“where it kind of fits for me is, being with somebody in shame and actually just being able to do some modeling, right, from a behavioral point of view, just some modeling of my own kind of experience, and it’s like I don’t know, I don’t know what that’s like, I don’t know the answer to that. So for me that would be exercising humility and not letting that go to shame. So it’s just like yeah I don’t know, and that being absolutely ok, because we don’t know all things and if we can kind of be, well I had this conversation with this one guy and it’s just like, it was really kind of cool, he’s a college student and we talked about this idea of the more you know the less you know, you know? So really being good with the less I know.”

In the example provided by participant four he did not share a personal life story with a client, but instead shared his feelings while in session, which he described as a form of self-disclosure.

Participants five and six described how they have specific shame stories that they intentionally share with their clients. Participant five clarified that she “wouldn’t share an active shame trigger” in herself. She stated, “I give examples, I give often an example for myself so it’s not an example from their life where it’s maybe kind of murky for them.” Participant six elaborated on her colleague’s stance and described very clearly how the self-disclosure is used as a way to show her clients that she is no better than them. She stated:

“you use yourself as a therapist too, you talk about your own shame experiences. Ones that you’re really comfortable with; they’re well-rehearsed you’ve worked them out,

which is very different from other forms of therapy. You're not going to actually reveal much of yourself in most therapy experiences. So, with this technique, especially in a group setting, you're going to share so you let them know that we've all had this and you're not above people."

Another participant agreed with the need to find a balance in power during the therapeutic process. She described:

"...so one of the things that I always do, I strive to always let my clients know that this is a treatment of equals. Ok, so that doesn't mean that I sit here and I have no issues, I have no problems, we're not going to talk about them, but that doesn't mean that I know everything and I don't have any struggles of my own."

Participant three disagreed with the use of self-disclosure and declared, "I certainly don't think it's appropriate to bring up your own stuff when a client is talking about shame...", but though she does not personally talk about her shame experiences she attempts to balance the power in other ways. She described how she works to examine the client's lack of engagement as a way to share responsibility in the therapeutic process:

"Talking about shame is just a really vulnerable experience. You know our clients come in here and they talk about anything and everything sometimes, and it's always an honor to me that I am a witness to their truth, and this isn't easy for people to walk in the front door or to drive down here, so I just think that when they do pull back there's a reason for that. So it's evaluating yourself as a clinician; why might that be..."

Self-disclosure was observed in this research process as a way to balance the power with the clients being interviewed, but it can also be a way to validate and normalize the client's experience, which is another subtheme that emerged in the coding process.

Subtheme 3: Normalizing and Validating

Normalizing and validating the client's shame experience emerged in four out of the six participant's explanations of treating shame. They discussed the need to create a safe and non-

judgmental space to allow the clients the room to share their stories. Participant one described this:

“I think I have a soap box about the strength based empowerment strategies of just really validating clients so if they’re willing to even touch on a hard topic I just praise them and positively reinforce how awesome that is that they’re willing to kind of go there, and they’re willing to share, and they’re willing to kind of unbury some of those things. And that to me has seemed very helpful.”

She went on to describe the importance of validation and the use of resources to normalize the client’s experience. Participant three agreed with this stance and stated that she will directly tell clients “of course that’s fine that you feel that way, that’s normal.” In addition, participant three shared that “90% of what I do is validate and then normalize, because listen, it’s ok. We’re all humans, like none of this is perfect”. Participant two concurred and stated that she normalizes by “just relating”.

Participant six described why she believes this to be an important part of the process. She stated, “...I think that’s really helpful to the clients. Hearing that there are other people who have struggled with this, and one person’s story isn’t worse than another person’s story.”

This subtheme reflected both the style and approach of the therapists. Normalizing and validating are not specialized techniques, but were described by the mental health professionals as a way to engage the client throughout the therapeutic process.

Subtheme 4: Self-Compassion

Another approach that was described by four of the six participants was self-compassion. Participant four and five attribute this term and teaching to researcher Kristin Neff. Participant five described self-compassion:

“so it’s just this kind of idea um, how we treat ourselves when things are difficult, so if we say to ourselves I suck, no one else would feel this way, those kinds of things, that’s just going to drive us deeper into shame, but if we can have some common humanity, that means like yeah I feel really down right now and other people struggle with this too.”

Participant four concurred. He described that “other voice”, the one that fuels shame and the message it sends, and how self-compassion can combat that. Participant four went on to say that he finds Kristin Neff’s work to be very helpful and that there are tools that she recommends to practice self-compassion:

“Exploring self-compassion through writing, this is from Kristin Neff, so writing yourself a letter from the perspective of an unconditionally loving imaginary friend.”

Participants one and three did not specifically mention the term self-compassion, but described their approach similarly to that of participant four and five. Both participants described how they have worked with their clients on writing letters to themselves and journaling. This is captured in participant one’s example:

“she was doing a lot of journaling and so she transitioned that into positive self-talk and she started writing stuff on her mirror. I remember her telling me, and she would write herself positive sticky notes to tell herself positive things about herself.”

Participant one continued and stated:

“often times that’s where the shame comes through so we really do address it I think heavily in that respect, trying to kind of change some of those self-talk patterns.”

Participant four and five described an approach that is intentional and how it relates to the shame experience. They also shared the progress that is seen and importance of using this technique. Participant four described a client he worked with:

“So she’s really made some great progress with being able to exercise that self-compassion and being like I’m criticizing and this hurts when I’m critical, so she’s gotten really good at being able to identify when shame is activated and being able to just be with it without going into any escape behavior.”

Participant five asserted that:

“[it is] so effective, I think self-compassion is really, I think that’s really very important for shame resilience.”

Subtheme 5: DBT

Half of the participants specifically identified using DBT when treating shame. The therapists mentioned the use of the “both/and” discussion as a way to assist with alleviating shame. Participant one stated:

“The other thing I would say that I use a lot, which is kind of a DBT model, is the idea of practicing with clients to say AND, so I can be sad AND I can still love myself. I can feel unhappy that a situation has happened and I’ve experienced something AND I can still be ok. So, trying to get people to understand that two things can be true at the same time.”

Participant one and four shared that they use Opposite Action to treat shame which is another DBT technique. Participant four described this and stated:

“Opposite Action is a DBT, emotion regulation skill, so acting opposite of the current emotion. So what Kelly Corner does, is she does some kind of informal in session exposure. She’s kind of a third wave behaviorist so she goes for that exposure part; so accurate expression of emotion versus avoidance of emotion. So there’s some, um I found that helpful just to be able to in session target shame.”

Participant four shared about a client who might be resistant and shutting down while experiencing shame in the therapy session. He described how he would use Opposite Action to address this situation:

“...have them maybe soften their gaze, look at me; so there’s some opposite action right there right.”

Participant three shared about the non-judgmental value of DBT and how she uses this approach when treating shame.

“I do DBT too so we always work on being non-judgmental, and being compassionate, and being equals. So that’s always in the thought of my head. Even the way that I carry myself, even the way that I’m sitting. You know, to always just be open, and even I say a lot “there’s no judgment in here” like when somebody’s like “I feel like a bad mom because I’m thinking this right now” it’s like, listen, there is no judgment ok. So we’re not even going there. No judgment. I just feel like giving them an open space is probably

the best technique that you can use and just saying; this is your space, this is your process, there's no timeline."

Subtheme 6: The importance of education and naming shame

The participants had described earlier in this research paper the client's inability to name shame. This concern is addressed by the therapists in this subtheme as they describe how their role in treating shame should include naming it. All six of the participants interviewed shared that they believe shame should be identified to the client.

Participant one stated, "that one of the most successful things that I've utilized is naming it. I talk a lot with kiddos about "name it and tame it". She shared an example of a therapeutic process that initially did not address the shame simultaneously with the disorder that was being treated. She explained that at first she did not name shame; and how later it was necessary to go back and name it. She described the experience:

"We worked through a lot of the direct trauma work without necessarily naming the shame component and so then we kind of revisited it as it came to my attention and became clear to me. We kind of revisited the same patterns in her life, but instead of really naming the abuse we named the shame that came with it and with the experiences. When we discussed it in the different way I said "ok, now the abuse happened, what was shameful about that? How did shame go with that experience? Or how did shame linger after the experience?"

Participant two and three agreed with the need to name shame, but struggled themselves to do so.

Participant two stated that identifying it is "huge", but was unable to give an example of a time she did this or how it would be done.

Participant three stated that:

"There are, there's a time and a place for challenges, but particularly with trauma I think you kinda just go with it and you just are like, well ok, I'm getting the vibe that we're not talking about that today, so we're not talking about that today."

Participant five opposed this approach and stated:

“I think shame can really shut people down so sometimes people can feel in the moment like in an individual session talking about it can kind of trigger the shame and it can kind of shut down their ability to work with it effectively, so when that comes up I work to just name it and we can notice together what that feels like and then go from there and then maybe revisit it again in a future session because I don’t think it has to, probably the worst thing to do would be for me to join with somebody in avoidance so just not doing that, not joining with people in avoidance.”

Participant three also stated that she prefers to use her clients’ language to define shame. She stated:

“I guess I try to use their language because is that’s what they’re identifying with I think a definition that I give might not carry much value. It might in the future, but whatever they walk in with, I mean that’s how they’re identifying it then that’s what it is.”

When asked about what that would look like she was unable to give an example of how a client had used their own definition to name shame. Participant four disagreed with the idea that the client should define shame and stated that:

“research indicates that actually people are less aware of shame. That’s not something they really readily identify. I think it’s so interesting, so that’s part of treatment is increasing that mindfulness or awareness of shame and doing education around that.”

He emphasized the need to educate “on the front end” and how this could assist with addressing the shame later in sessions because it would have previously been named and could more easily be worked with. Participant four went on to summarize that this way he can “target” shame after he has done that front end educating, and more importantly, his clients can then name shame for themselves. He described this:

“...when there’s in session shame, so targeting it, talking about it, describing it, kind of being with it, without escaping would be informal exposure. It’s like here we are now, oh my gosh, there’s shame, oh yeah you know, they identify it...”

He explained how he would ask for clarification to make sure he was interpreting the behavior as shame, and how he considers this to be an invaluable piece of the process. He stated:

“So identify it, so be like, it’s here right now, this is what I notice you doing, is that on track? Identifying those things, and for me that’s the best part, I think that’s huge, I’m going to say therapy traction so to speak as far as making progress, that to me is invaluable to be able to do those in session things.”

Participant five and six agreed with participant four’s opinion that there should be a pre-teaching that occurs to define shame. Participant six went a step further and described how emotions that are confused with shame should also be defined to the client so they can easily differentiate. She presented her explanation of how she defines the different emotions:

“...humiliation is where you have an experience that you don’t feel that you deserved. For instance, an example might be, like a kid getting yelled at in class for doing something and maybe they feel like they don’t deserve that. If they didn’t feel like they deserved that then they wouldn’t go into shame, they would feel humiliated because other people around them are hearing this transpire. Embarrassment might be something where you have toilet paper on your shoe and eventually those are things that you kind of laugh off; it’s not going to be enduring. And we talked about guilt and the difference between the guilt and the shame...”

Though the therapists did not agree on how they would name and define shame, or when and how that would occur, all of the participants interviewed agreed that it is an important component in treating shame.

Discussion

The purpose of this study was to explore the ways in which therapists conceptualize and treat shame. The literature review found an abundance of articles that identified the risk and correlation of shame with a number of mental health disorders. Many mental health related struggles emerged as being associated with shame, but consistently substance abuse and eating disorders were mentioned in the articles found by this researcher. Though a relationship was clearly identified in the existing literature there was difficulty finding information on how therapists are addressing this relationship. As research progressed this writer found few articles that directly addressed the ways in which therapists have worked with or treated shame. The

findings in this study reveal both similarities and differences in the ways that shame is treated. It is important to emphasize that two of the participants have been trained in Dr. Brene Brown's research, whose work is utilized in this paper as a conceptual framework. The remaining four participants are generalist providers in the Brainerd Lakes Area. The present study found many similarities and differences with existing literature. As described above, themes related to defining, observing, and treating shame emerged throughout the coding process. These themes are largely consistent with the information discovered in the literature review, with a few differences noted below.

Shame and Guilt

Participants in this research study reported a difference between the experiences of shame and guilt with four of the six participants defining this difference, and describing a need for understanding how they differ in experience and impact. The two generalist providers who did not identify any specific shame training struggled with clearly defining and differentiating guilt and shame. They believed the two emotions to be different, but were unable to explicitly define the difference. The third generalist without shame training shared that she has done a lot of self-teaching and specifically has watched videos and read books by Dr. Brene Brown. This likely accounts for her ability to differentiate the two. In addition, the three therapists with specialized training also mentioned embarrassment and humiliation as other commonly confused emotions. The one thing that the three participants with specialized training disagreed on was the outcome of a shame experience. Participants five and six, who were trained in Dr. Brene Brown's research, shared perspectives that are consistent with current literature that this writer found, which states that shame leads to behaviors that disconnect the individual from themselves and peers. However, participant four who reported participating in a training by Dr. Jason Luoma,

another shame researcher, stated that their class was taught that shame can be adaptive and lead to behaviors that promote being in line with social mores. Current research differentiates shame and guilt as the former being a focus on identity and the latter focusing on behavior, but it also distinguishes the two in outcome. Research suggests that shame can lead to harmful behaviors, while guilt holds the potential to lead to reparative behaviors (Han, Duhachek, & Nidhi, 2014; Ferguson, Stegge, & Damhuis 1991). When this writer inquired about this, participant four agreed that shame is a focus on identity, but disagreed that it solely leads to harmful behaviors and outcomes.

Observations of Shame

All six participants agreed that shame is present during the therapy hour. This was anticipated and consistent with existing research, but it differed in that while eating disorders and substance abuse were discussed in the literature, they were not discussed extensively by my respondents. Instead, participants mentioned trauma, abuse, and depression as present in clients that they observe are experiencing shame. This could be due to the fact that several of the therapists interviewed were generalists and perhaps individuals struggling with substance abuse and eating disorders are seeking treatment at facilities with specialized training for those needs.

Behaviorally, some literature described a pulling away or hiding that occurred when observing individuals that are experiencing shame (Hequembourg & Dearing, 2014). All six of the participants in the current study shared that they too noticed these physical reactions in their clients. In addition, three of the six participants describe their client's presenting with perfectionism as another way to hide or overcompensate for their shame experience. Dr. Brown solely describes perfectionism as a behavior correlated with shame in the sources that were

reviewed by this researcher. Two of the three participants who noticed these behaviors were also the participants who were trained by Dr. Brown and her team.

Specialized Training

Three of the six participants interviewed identified that they had received specialized training for treating shame. Two of these individuals were trained by Dr. Brene Brown and her team through The Daring Way Model, and were intentionally sought out for a comparison sample. This model (the Daring Way) is not available online and the information they learned is only accessible through the trained facilitators, or by attending the training as a mental health professional. Both of these participants discussed a process for treating shame that included having the therapist do their own shame work, defining shame to the client, naming it in session, reaching out to trusted individuals to shed light on shame, and being grounded in one's values as a way to make healthy decisions that do not cause or exacerbate shame experiences. It appears that this process has components from other articles and books that Dr. Brene Brown has written or co-authored. The one exception is the idea of naming one's values and rooting themselves in those values when facing a shame experience. Personal values arose as a unique theme among the two individuals who were trained through The Daring Way Model.

The third individual unexpectedly shared that he was a part of an online training group called The 100 Day Challenge to Treating Shame through Dr. Jason Luoma. He explained that Dr. Jason Luoma is a shame researcher based out of Oregon and teaches the group utilizing principles of self-compassion, DBT skills, and ACT to treat shame. He specifically mentioned Opposite Action and The Three Chair Technique as tools that he uses when treating shame.

All three individuals described the importance of educating clients about the difference between guilt and shame, naming the shame in session, and using techniques to work through the shame. Three components that were absent in the model as described by participant four, and were present in The Daring Way Model was the importance of the therapist doing their own shame work, the need for clients to talk about their shame experiences with trusted friends, and a focus on knowing one's values and being rooted in those values. Being rooted in one's values was described by these participants as knowing what you stand for and then tapping into that belief and value system to overcome an experience that may cause shame. One participant shared that a very important value to her is family, so when she makes a decision that triggers shame in her she will often focus on her family to combat the negative emotion. There was a particularly notable level of intentionality described by all three of these participants when they spoke of working with and treating shame.

Generalists and Specialists: Treating Shame

All of the participants interviewed reflected and expounded on their observations of shame in the therapy hour. Half of the individuals reported that they had received specialized training to treat and respond to clients who are experiencing shame, while the remaining participants identified themselves as generalists. The generalists without specialized training often echoed the sentiments of those who have been trained. There was an overlap in many areas of thought including: the importance of differentiating guilt from shame, the use of validation and normalizing, the need to name shame with the client, and utilization of DBT techniques. It appears as though a major difference with these two groups is the intentionality displayed when working with clients that are experiencing shame. This was illustrated by the specialists' description of how they define shame and contrast it with often confused emotions: guilt,

embarrassment, and humiliation. In addition, the specialists utilized their training to name shame when observed in the therapy hour and to work through the shame with techniques they have learned or a specific process that was taught to them.

Strengths and Limitation

The current study has both strengths and limitations regarding both the process and the participants. One strength of the study was that the participants were selected through a purposive process which identified both providers in the region that the researcher works with and also providers who are specialists in a metro area of Minnesota. Comparing and contrasting these two groups provided a lot of insight into the ways in which specialists and generalists treat shame. In addition, there were over thirty therapists notified of the study and the six who responded had various educational backgrounds. This diversity in background encourages me to not pigeonhole a particular discipline. Due to the imbalance of gender in the helping field, it was viewed as a strength that one participant was male.

The researcher attempted to connect with eight participants, and was successful in engaging with six. This may be a limitation as it is a small sample size and may be difficult to generalize across geographical areas. Another limitation that can be reflected on is the use of a single coder to analyze the data. Though the data were reviewed many times through various lenses, this was done by the same individual each time. It may have been beneficial to have a coding partner to assist with, and provide more depth to the process.

Suggestions for Future Research

The existing research for treating shame is scant and there continues to be a need for more information on this subject. There is a plethora of literature that identifies the correlation

between shame and a number of risk factors, but there is a gap in how to treat the shame directly or simultaneously. The current study revealed that there are therapists who have found trainings to treat shame, but it did not measure the effectiveness of the approaches that the specialists are using and how this may differ from the effectiveness of a generalist who is working with someone who is experiencing shame. Future research could focus on gathering this information. Another interesting and valuable path for research would be to explore the correlation between trauma and shame. This theme was present in the current study, but was missing in the existing literature.

Implications for Social Work

Social workers are called to serve a person holistically, and to look at all aspects and facets of the situation when assisting their clients. This perspective begins as a generalist social worker and continues into the work of a clinical social worker. In doing so, we must look beyond the disorder and examine what factors are contributing to, or exacerbating the individual's struggles. Though shame is mentioned as a diagnostic criterion for PTSD, it is not named or recognized widely as a reason for or influence on relapse, eating disorders, or depression as was found both in the existing literature and the current study. This study adds to the literature that emphasizes that shame is a powerful emotion and experience that impacts behavior and the success of our clients. Knowing this, it is our responsibility to work on reducing shame which has the potential to reduce the symptoms clinicians are treating.

Conclusion

Shame is an extremely powerful emotional experience that impacts how an individual experiences a situation and their behavior in response. The literature is clear in describing and

defining how shame is correlated with many conditions that are currently being treated by therapists, but there is a tremendous need for those therapists to have the tools to treat shame directly. This current study will hopefully be one of many that continue to explore how therapists are addressing this need in their communities.

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UNIVERSITY of ST. THOMAS
MINNESOTA

Appendix A
Consent Form

Understanding and Treating Shame: The Role of the Clinician

IRBNet Tracking Number: 842141-1

You are invited to participate in a research study about understanding and treating shame, and how the clinician interprets this emotion and engages with it. I invite you to participate in this research. You were selected as a possible participant because you are a mental health professional who treats individuals that experience shame. You are eligible to participate in this study because you have or currently are working with clients who have experienced shame. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Jennifer Perez and the research will be advised by David Roseborough, through the University of St. Thomas School of Social Work. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to learn about the ways in which clinicians observe and treat shame. I will be asking questions related to how shame is observed, education that was provided to clinicians related to shame, and ways in which clinicians treat shame.

Procedures

If you agree to participate in this study, I will ask you to do the following things: participate in a 45 minute to one hour interview that will be audio taped and later transcribed. The location of the study will take place where it is most convenient and comfortable for you. There will be an estimated number of eight participants that will participate in the study.

Risks and Benefits of Being in the Study

The study has no direct benefits and minimal risks. A potential risk is emotional distress brought on by discussion of the emotion shame. Though no questions will be asked to you directly related to personal shame experiences, there is the potential for the interviewee to recall or reflect on shame they may have felt in their life which could lead to feelings of discomfort. I will intentionally be asking about your professional opinions in relation to a professional topic. I will not ask, for instance, about any personal experiences in relation to shame. I will be asking for your opinion, but will not ask you to speak on behalf of, or to represent your workplace or discipline. If you decide to participate, I will audiotape the interview and then transcribe it. The digital audio recording will be deleted by September 1, 2016.

Compensation

There is no compensations for participation in this study.

Privacy

Your privacy will be protected while you participate in this study. This researcher will protect the participant's privacy through making sure your name is not attached to any documents and that the researcher will not have any highly identifiable information transcribed (such as your name or the names of specific locations or other people you might mention). The researcher will delete the audiotapes by September 1st 2016. As the interviewee, you can choose the location and time of the interview as well as the amount of information you are comfortable sharing. You are free to skip (decline to answer) any specific questions.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include recordings and transcriptions of the interview, master lists of information, and computer records. The recordings will be recorded on audiotapes that will be stored in a locked safe at the researcher's home. The transcriptions will be transcribed by an individual that the researcher has chose and the transcriptionist will sign a confidentiality form created by the University of St. Thomas Institutional Review Board. The master lists of information and computer records will also

be stored on a password-protected desktop at the researcher's home. The interview recordings will be destroyed by September 1st 2016. All information gathered will be available to the 682 research professor David Roseborough.

All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas, St. Catherine University, with the School of Social Work, or with myself. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected from you would not be used if this is what you request. You can withdraw up to two weeks after the interview. If you choose to do so, please contact me at the phone number or email below to express your request that your data not be included in the study. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Jennifer Perez. You may ask any questions you have now and any time during or after the interview. If you have questions later, you may contact me at 218-820-3445 or jennifer.perez@stthomas.edu. You may also contact the advisor David Roseborough at djroseboroug@stthomas.edu or 651-962-5804. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give my permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

Request for Establishing MSW Clinical Research Committee

STUDENT NAME: _____ **Student UST ID#** _____

I have discussed my research with and request that the following comprise my research committee

CHAIR: _____
Faculty Chair Signature Date

COMMITTEE MEMBERS:

By signing below, committee members acknowledge their responsibility to, at minimum, meet as a committee once each semester, to read and comment on student's written work, to offer support and guidance throughout the research process and to attend the public presentation of the paper in May.

1. COMMITTEE MEMBER:

PRINT) Signature Name (**PLEASE**

_____ Date

Institution/Agency

Email address to send Final Program and other communication – PLEASE PRINT clearly

2. COMMITTEE MEMBER:

 Name (PLEASE PRINT) Signature

 Date

 Institution/Agency

 Email address to send Final Program and other communication – PLEASE PRINT clearly

Appendix C

Interview Questions

1. How do you define shame?
 - a. (After the mental health professional's response) I have a definition of shame from Dr. Brene Brown I'd be interested in sharing with you. Does this offer any additional perspective or help you to think of anything additionally?
 - b. From your professional experience, is it more an emotion or an experience? Does it have components of both?
 - c. Is it ever ok for a client to experience shame? That is, do you see it as adaptive or maladaptive?
 - d. Is it enduring or more transient?

2. How do you observe shame in your work as a mental health therapist?
 - a. That is, how does it "show up" or present among clients?
 - i. Do clients tend to identify it as shame or as something else? How aware of it are they?
 - b. Are there particular presenting problems or diagnoses where you're esp. likely to encounter it? (such as eating disorders, substance abuse, body image struggles)
 - c. Some people talk about a shame culture? What do you think of this?

3. How do you think about shame and work with it? That is, are there ways you try to help clients work with and/or ultimately to reduce it?
 - a. Are there strategies or skills you use that you find particularly effective or ineffective? For example, research suggests that opposite action and acceptance based approaches (such as ACT) are helpful to clients.
 - b. What have you learned along the way about what does and doesn't work? How do you work with the sense of retreat or hiding that people sometimes write about in relation to shame? Are you seeing these dynamics?

- c. Without a lot of client-related detail, could you give me some practice examples where shame came up and how you worked with it? (This could be from one person or from trends you've observed across clients)?
4. What were you taught, if anything, about shame and working with it?
 - a. I'm thinking here of your graduate education and about any potential training since.
 - b. Can you think of any books or especially good resources?
 - c. Have you received any specific training in relation to shame?
 - i. What was it?
 - ii. Was it helpful, and if so, why or why not?
 - iii. Are there any promising areas or specialized training that you are aware of?
5. What could training or education programs do better to prepare clinicians to help in this area?

