

INTRODUCTION: PUTTING SHAME IN CONTEXT

RONDA L. DEARING AND JUNE PRICE TANGNEY

Shame is a common emotion that contributes to many problems that bring clients into therapy, such as poor psychological adjustment, interpersonal difficulties, and overall poor life functioning (see Tangney & Dearing, 2002). Not only is shame a factor underlying many of the reasons that clients seek psychotherapeutic help, but clients may feel shame as a result of needing help with their emotional concerns. Once in therapy, clients may further experience shame while discussing intimate details about themselves. Shame is therefore likely to be elicited frequently in therapy, though signals of client shame may be subtle.

If a therapist fails to recognize client shame, the client's shame-related problems will likely continue. Furthermore, clients who experience unacknowledged shame in the context of therapy may feel misunderstood, resulting in an empathic failure on the part of the therapist. Such empathic failure may result in premature termination of therapy. Therefore, therapists must recognize, acknowledge, and address client experiences of shame—to both build a therapeutic alliance and resolve the shame.

The intent of this book is to provide clinicians with guidance for dealing with client shame. All aspects of shame are covered, including how shame develops, how it relates to psychological difficulties, how to recognize shame,

and how to help clients resolve shame-related problems. The chapters bring together wisdom and insight gained from years of clinical experience, shared by master clinicians who have struggled to manage and positively transform shame in the therapy hour. In particular, the chapter authors provide specific strategies that they use to help their clients resolve shame-related issues, and they illustrate these techniques using detailed examples and clinical dialogue. We are delighted with the resulting volume of chapters by gifted authors who provide outstanding insights into the clinical presentation, management, and resolution of shame in the therapy hour.

The intended audience for this book includes clinical and counseling psychologists, psychiatrists, social workers, marital and family therapists, addictions counselors, and other mental health providers. The book should be of interest to clinicians in training as well as seasoned professionals, the majority of whom are unlikely to have had any specific training in shame-related issues but who almost certainly encounter clients' shame experiences on a daily basis. We expect that readers will benefit from the material on different levels; new therapists are most likely to benefit from the notion of being attuned to client shame as an important aspect of therapy, whereas experienced therapists are more likely to see the book as a much-needed set of tools for addressing the longstanding challenge of helping clients work through shame in a way that will prevent future negative consequences.

In the remainder of this introduction, we present a general overview of shame, including the many potential negative consequences associated with it. We begin by providing an empirically supported definition of shame and describing research evidence that demonstrates the relevance of shame to psychological symptoms and overall functioning. Next, we distinguish between shame and guilt, as originally conceptualized by H. B. Lewis (1971). Finally, we explain how the book is organized.

WHAT IS SHAME, AND WHY IS IT A PROBLEM?

Shame is a prevalent and painful emotion that arises frequently in everyday life and that can contribute to the psychological difficulties that cause people to seek treatment. Feelings of shame arise in situations in which an individual recognizes that he or she has committed an offense or violated a standard that is held to be important. Experiences of shame tend to be intense and overpowering because they evoke a sense of being bad, worthless, or contemptible. Shame is frequently associated with a sense of powerlessness, as well as sensations of shrinking, feeling small, being exposed, and wanting to disappear. People experiencing shame evaluate the eliciting mistake or transgression as being indicative of a self that is fundamentally flawed. For

example, a client may feel shame after being rebuked by her boss, extrapolating that she is a terrible employee or even a failure at life.

Because shame tends to arise in conjunction with cognitive appraisals of the self, it falls into the category of self-conscious emotions (e.g., Fischer & Tangney, 1995; Tracy, Robins, & Tangney, 2007). This type of cognitive processing requires a certain level of developmental maturity, which explains why the propensity to experience shame is developed over time during early childhood rather than present from birth (M. Lewis, 1992). Although everyone experiences shame from time to time, some people have a greater tendency to experience shame than others. Thus, we distinguish between *in-the-moment* shame and *shame proneness*, with the latter being a dispositional tendency to experience shame across situations.

Feelings of shame in-the-moment are associated with a variety of characteristic behavioral indicators, such as having a slumped posture, lowering the head, covering the face, and blushing. It is believed that these outward expressions of shame are linked to a submissive stance that once served an evolutionary function to preserve basic safety and social standing (see Chapter 14, this volume; Gilbert & McGuire, 1998). As is seen throughout this book, therapists can benefit from becoming attuned to visible indicators of shame because these behaviors may serve as the only hint that a client is experiencing this painful yet clinically relevant emotion.

In addition to being a self-conscious emotion, shame is categorized as a moral emotion on the basis of the presumption that it limits or averts socially undesirable acts. However, although shame certainly influences one's actions, this influence may not always be in the direction of a higher level of moral behavior. The immediate action tendency when faced with shame is to hide or escape from the trigger that elicited the painful emotion. Subsequent action tendencies may include desperate attempts to eradicate the discomfort associated with shame by denying culpability, lashing out in anger, or blaming others. For example, a student feeling shame after failing an exam might think, "I've always hated this teacher—she's so unfair." Painful feelings of shame and the related action tendencies seem to result in a short circuit of the moral compass, which often causes things to go awry in the interpersonal realm.

Shame may interfere with establishing and maintaining healthy interpersonal relationships for a number of reasons. Among these are problems with empathy and anger. Empathy seems to be differentially related to both in-the-moment shame and dispositional shame proneness. Research consistently shows that the self-focus inherent in shame does not facilitate and may at times thwart a consideration for others who may have been wronged (for reviews, see Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007a). Instead, when in the midst of a shame experience, the focus of cognitive and emotional energy is directed inward. At the dispositional level,

being shame prone is negatively or negligibly related to perspective taking and empathic concern, both of which are essential to interpersonal connection. Moreover, when faced with the distress of another person, shame-prone individuals are likely to respond with self-focused personal distress, which tends to inhibit the ability to respond empathically to others.

Equally important, shame proneness is empirically linked to problems with hostility, anger, aggression, and a propensity to externalize blame (Ahmed & Braithwaite, 2004; Andrews, Brewin, Rose, & Kirk, 2000; Bennett, Sullivan, & Lewis, 2005; Harper & Arias, 2004; Harper, Austin, Cercone, & Arias, 2005; Paulhus, Robins, Trzesniewski, & Tracy, 2004; Tangney & Dearing, 2002). Specific types of negative anger management related to shame include direct physical aggression, verbal and symbolic aggression, displaced aggression, self-directed aggression, and ruminative unexpressed anger. Recent research has demonstrated that externalization of blame seems to mediate the relation of shame with verbal and physical aggression (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). In other words, shame leads to blaming, which leads to aggressive behavior. This multitude of problems with anger can result in impaired social relationships with friends, coworkers, and loved ones.

Also of fundamental relevance to clients in therapy is the consistent association between a shame-prone dispositional tendency and psychological symptoms across diverse age groups and populations. Research findings using a variety of methods have shown a relationship between shame proneness and a multitude of symptoms ranging from low self-esteem (Yelsma, Brown, & Elison, 2002) to suicidal ideation (Hastings, Northman, & Tangney, 2000). These associations encompass the spectrum of symptoms commonly seen among clients in psychotherapy, such as depression, anxiety, eating disorder symptoms, posttraumatic stress disorder (PTSD), and substance abuse (Andrews et al., 2000; Ashby, Rice, & Martin, 2006; Crossley & Rockett, 2005; Dearing, Stuewig, & Tangney, 2005; Feiring & Taska, 2005; Ferguson, Stegge, Eyre, Vollmer, & Ashbaker, 2000; Harper & Arias, 2004; Leskela, Dieperink, & Thuras, 2002; Meehan et al., 1996; Murray, Waller, & Legg, 2000; Sanftner, Barlow, Marschall, & Tangney, 1995; Stuewig & McCloskey, 2005; for reviews, see Tangney & Dearing, 2002; and Tangney et al., 2007a). Thus, empirical findings confirm the long-standing clinical literature indicating that frequent experiences of shame contribute to individual vulnerability to psychological distress.

Although shame is associated with a host of potentially problematic action tendencies, interpersonal shortcomings, and psychosocial outcomes, it has seldom been the focus of attention in psychological interventions. We can only speculate as to why this is the case, but three reasons are likely to have contributed to this lack of consideration. First of all, the word *shame* is often avoided in everyday language. Second, shame is inherently linked to a

desire to hide and conceal; thus, feelings of shame are frequently hidden and avoided, rather than brought up as the focus of attention during therapy. Third, as discussed throughout this book, it seems that therapists inadvertently avoid discussing shame-related issues with their clients. Therefore, despite its prevalence within the context of therapy, shame has rarely been a direct focus of intervention research or applied clinical writing.

Although shame can lead individuals into therapy, it is notoriously difficult to admit, discuss, and treat (H. B. Lewis, 1971; Lindsay-Hartz, 1984; Tangney & Dearing, 2002). The acute emotional pain associated with shame makes it likely that clients will avoid talking about shame-eliciting issues, yet shame experiences often have rich clinical relevance. Clinicians need to become adept at evaluating clients' tendencies toward shame and at recognizing subtle indicators of shame. Not only do clients seek therapy for shame-related issues, but the very process of entering and participating in therapy can be intensely shame inducing for the client. This is eloquently summarized by Greenberg and Iwakabe (Chapter 3, this volume) in the following statement: "The mere act of acknowledging that life is too difficult and the idea of laying bare one's deepest secrets to a relative stranger are fraught with shame."

Furthermore, shame isn't limited to clients—therapists experience shame, too. The notion of therapist shame runs throughout the book, with most of the authors acknowledging the ways in which therapist shame may influence the therapeutic encounter and providing insights into how best to manage and occasionally capitalize on therapist shame.

In summary, shame is a key factor that brings clients into therapy, can be elicited by the process of therapy, and can arise among therapists providing therapy. Thus, therapists need guidance to help them better understand shame and work with clients' and their own experiences of shame.

SHAME AND GUILT: WHAT IS THE DIFFERENCE?

In everyday parlance, the words *shame* and *guilt* are often used interchangeably (with *guilt* being used much more frequently). Clinicians, too, often use these terms interchangeably. However, shame and guilt differ in numerous ways. Therefore, we feel it is important to offer a specific, empirically based differentiation of the two. Helen Block Lewis (1971) proposed an elegant, yet subtle, distinction between shame and guilt that has withstood the test of time on the basis of evidence from abundant research using a variety of approaches (for reviews, see Tangney & Dearing, 2002; Tangney et al., 2007a). H. B. Lewis proposed that the key difference between shame and guilt hinges on whether the focus of attention is on the triggering behavior or attribute (guilt) or more generally on the self (shame). If, when faced with a

misdeed or shortcoming, the focus of attention is on the event or behavior ("I did something bad"), guilt is the likely emotional outcome, whereas if the focus is on the self ("I am bad"), shame is the likely result.

Attribution theory supports this distinction and can provide for a more nuanced understanding of the differences between shame and guilt (e.g., Tangney, Wagner, & Gramzow, 1992; Tracy & Robins, 2006). Specifically, shame is the probable result when self-appraisals for negative events are attributed to internal, stable, uncontrollable, and global causes (e.g., "I am stupid"). Alternatively, guilt is to be expected when cognitive appraisals for negative events are attributed to internal, unstable, controllable, and specific causes ("I should have worked harder on that project").

Although H. B. Lewis's definition of shame (and its distinction from guilt) has been the conceptualization guiding our own work, we explicitly instructed chapter authors to feel free to use their own definitions of shame in addressing shame-related clinical issues. As it happens, most authors adopted the self versus behavior distinction that has been confirmed by much empirical research. But a number of authors expanded on this definition and further differentiated between different subtypes of shame, adding richness to clinical conceptualizations of this powerful and ubiquitous emotion. Where chapter authors opted to use slightly different or expanded definitions of shame, these differences are clarified within the applicable chapters.

Where Does Guilt Fit in?

Guilt tends to be less acutely painful than shame (because a specific behavior rather than the overall self is brought into question); nonetheless, guilt is associated with uncomfortable feelings of remorse and regret. As a result, the action tendencies associated with guilt typically involve wanting to make things better, for example, by apologizing, confessing, or making amends. This is in sharp contrast to the action tendencies associated with shame—to escape or to lash out. Thus, although shame and guilt are both linked to moral behavior, it seems that in the case of guilt, this connection is in a beneficial direction. In contrast to shame, guilt does not seem to be characterized by visible outward signs, but the action tendencies associated with guilt (e.g., confessions, apologies) make it more likely that guilt feelings will be brought up and discussed by clients within the context of therapy.

Research has shown that both the states of shame and guilt and the propensities toward shame proneness and guilt proneness differ greatly in terms of outcome. These differences occur in a variety of contexts, including psychological symptoms, interpersonal relations, and moral behavior. In most cases, the outcomes associated with guilt are more adaptive than those we have discussed as related to shame. For example, guilt, in contrast to shame,

seems to be intricately and positively linked to empathic connection. People who are guilt prone are readily able to take the perspective of another person and to demonstrate other-oriented empathic concern in relation to others' feelings of distress (Joireman, 2004; Leith & Baumeister, 1998; Tangney, 1991; Tangney & Dearing, 2002). Furthermore, when feeling guilt about a specific behavior, the individual's focus of attention is often on the harm done (i.e., to another person) and on how to repair the situation. This urge to rectify matters leads to actions that facilitate strengthened interpersonal relationships.

People who are guilt prone are just as prone to experience anger as anyone else; however, when angered, guilt-prone individuals are less likely than their non-guilt-prone peers to engage in all types of aggression, and they are more likely to manage anger in constructive ways, such as nonhostile discussion and direct reparative actions (Ahmed & Braithwaite, 2004; Lutwak, Panish, Ferrari, & Razzino, 2001; Paulhus et al., 2004; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). These healthier reactions to anger among guilt-prone persons seem to be attributable to the link between guilt and empathy (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). Specifically, among guilt-prone individuals, anger seems to activate other-oriented empathy and a tendency to take responsibility, resulting in less aggressive behaviors. It seems that guilt-prone people manage anger by acknowledging and taking responsibility for their wrongdoings, resulting in healthier interpersonal outcomes.

Although the common clinical assumption is that guilt is a root cause of "neuroses" and other psychological problems, research has demonstrated that a predisposition to "shame-free" guilt is largely unrelated to psychological symptoms (for reviews, see Tangney & Dearing, 2002; Tangney et al., 2007a). Empirical studies that do suggest a link between guilt and psychological symptoms have typically failed to make H. B. Lewis's (1971) crucial self versus behavior distinction or have not used measurement instruments that differentiate shame from guilt. When using H. B. Lewis's operational definition, research findings have not shown a positive association between guilt proneness and psychological symptoms, including depression, anxiety, or symptoms of posttraumatic distress.

How Is the Shame-Guilt Distinction Relevant to Psychotherapy?

Clients and therapists alike are often unclear about the distinction between shame and guilt. Yet as the research evidence shows, shame brings with it vulnerability to a host of intrapersonal and interpersonal problems, whereas guilt appears to serve more adaptive functions. Thus, we believe therapists (and their clients) would benefit from recognizing the distinction between shame and guilt, rather than making the assumption that shame and

guilt are both similarly problematic. Relative to guilt, shame (and especially dispositional shame proneness) is more likely to be detrimental to the therapeutic process, and it is also more likely to represent a significant part of the clinical picture presented by clients seeking help. By being aware of the risks and consequences associated with shame, as distinct from guilt, therapists can be better equipped to help their clients work through the difficult process of identifying, acknowledging, managing, and transforming problematic shame experiences.

We have found it useful to recognize shame and guilt at multiple levels (e.g., states, generalized dispositions, domain-specific propensities) occurring at different points vis-à-vis emotion-eliciting behavior (e.g., in anticipation or as a consequence of failures and transgressions). For example, like all emotions, shame and guilt can be conceptualized as states (i.e., feelings in the moment) and as affective traits (i.e., dispositional tendencies). Although everyone has the capacity to experience both shame and guilt (perhaps with the exception of the rare psychopath; see Tangney & Stuewig, 2004), people vary in their susceptibility to experience shame versus guilt in response to failure or wrongdoing. Some people are more likely to experience shame, others are more likely to experience guilt, and still others are inclined to experience a mix of the two—an experience we call *shame-fused guilt*. People aren't exclusively shame prone or guilt prone; rather, they fall somewhere on a continuum for each dimension, and these continua are moderately positively correlated. We refer to these dispositional tendencies as shame proneness and guilt proneness. These differing outcomes associated with shame- and guilt-prone dispositions make it particularly relevant for clinicians to evaluate clients' individual levels of shame proneness and guilt proneness (for reviews of different options for assessing shame- and guilt-prone dispositions, see Robins, Nofle, & Tracy, 2007; Tangney & Dearing, 2002).

Beyond generalized tendencies to experience shame and/or guilt across diverse situations, clinicians often find it useful to consider domain-specific sources of shame and guilt in their clients. Each client is apt to have unique areas of vulnerability—domains in which he or she is especially susceptible to feelings of shame, guilt, or both. For example, whether generally shame prone or not, a given client may be highly sensitive to body shame. Another client may be vulnerable to guilt vis-à-vis a demanding parent. Another may be susceptible to shame in connection with a psychological problem. In this volume, specific approaches for assessing clients' unique "shame triggers" are offered by Brown, Hernandez, and Villarreal (Chapter 15) and by Rizvi, Brown, Bohus, and Linehan (Chapter 10).

Not only do people have particular emotional reactions to specific events, they also can often imagine how they are likely to react to events that have not yet occurred. In this way, shame and guilt can exert their effects on

behavior in anticipation of an event as well as following an event. Tangney, Stuewig, and Mashek (2007b) referred to these as *anticipatory* and *consequential* shame and/or guilt reactions, respectively. It seems probable that one reason clients are hesitant to bring up potentially shame-eliciting issues within therapy is the anticipated shame associated with discussing difficult shame-laden topics. This is apt to be most problematic for shame-prone clients because they are likely to anticipate that feelings of shame will arise across a variety of possible topics and thus are likely to avoid discussing issues that are potentially shaming. Providing a safe, caring therapy environment is essential for overcoming the obstacle of anticipatory shame among clients.

Shame-related concerns can be addressed within therapy both in-the-moment and at the dispositional level. For example, a client may be feeling shame about a recent incident of disciplining her child. Her cognitive interpretation may be, "I must be a horrible person to have yelled at my child." As a means of resolving this particular shame experience, the therapist can help the client shift her cognitive focus to specific eliciting events, associated behaviors, and ways of handling future events differently (e.g., "I had a stressful day at work. I was angry. I've never yelled at her before. Next time I should explain to her why I am upset using a calmer tone."). Similarly, at the dispositional level, therapists can teach their clients the vital difference in emotional outcome between evaluations of "I am bad" versus "I did a bad thing" so that clients can try to minimize their tendencies to think about negative events in terms of negative self-evaluation and instead evaluate the associated behaviors.

These are but a few examples of the approaches and techniques that clinicians have found useful when working with clients who are troubled by shame. The chapters in this book provide clinicians with several approaches, drawing on the wisdom and experience of a remarkable set of master clinicians working from diverse theoretical perspectives. By addressing shame in the context of psychotherapy, the therapist can help clients with the immediate symptoms that led them into therapy and also help clients develop the resources to prevent such problems from developing in the future.

ORGANIZATION AND OVERVIEW OF THIS BOOK

This book is divided into five sections, as follows.

Part I: Shame From Multiple Therapeutic Perspectives

The chapters in Part I illustrate how shame is managed from a variety of clinical orientations and within specific types of therapy. It would have been impossible to include all possible schools of psychotherapeutic thought,

- Trumbull, D. (2003). Shame: An acute stress response to interpersonal traumatization. *Psychiatry*, 66(1), 53–64.
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- Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. New York, NY: International Universities Press.
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3

EMOTION-FOCUSED
THERAPY AND SHAME

LESLIE S. GREENBERG AND SHIGERU IWAKABE

Emotion-focused therapy (EFT) is an integrative approach to psychotherapy designed to foster clients' emotional processing skills and emotional literacy. This helps people better use and regulate their affect and thereby enhance their well-being (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). EFT has been shown to be effective in the treatment of depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), trauma, interpersonal injuries (Paivio, 2001), and couples distress (Greenberg & Goldman, 2008; Johnson, Hunsley, Greenberg, & Schindler, 1999). What is notable about the empirical basis of EFT is that not only has its efficacy been established, but also each step of the successful client change process has been supported through a series of task analytic studies (Greenberg, 2007). Originally, six major change tasks were identified in individual therapy (Greenberg et al., 1993), each dealing with a specific affective-cognitive problem, such as self-criticisms, self-interruption of emotional experience, and unfinished business. Shame was found to be a central ingredient in many of these problems. Recently Greenberg and Goldman (2008) also described the role of shame both in maintaining negative interactions in couples and in resolving emotional injuries.

In this chapter, we look at the role of shame in psychotherapeutic change. We begin by reviewing the theory of EFT and of shame. We then summarize EFT principles for working with shame, discussing relational validation, accessing and acknowledging shame, shame regulation, and the transformation of shame. We then look at differential intervention for different shame processes and for varieties of shame experience and discuss cultural issues in working with shame in EFT. We conclude with a case illustration.

EMOTION THEORY IN EMOTION-FOCUSED THERAPY

EFT emphasizes the central role of emotions in both adaptive and maladaptive psychological functioning. At the most basic level, emotions are seen as an adaptive form of information processing that orients people to their environment and provides action readiness. In EFT, the lives of human beings are viewed as profoundly shaped and organized by emotional experiences. When, for example, shame is activated, we feel our mind going blank and feel paralyzed on the spot, wishing that we could sink into the ground and disappear. We not only are acutely aware of others' gaze, but we also become intensely and rapidly aroused. Immediate physiological changes occur: Blood rushes to the head, and the face blushes. Shame causes the self to curl up and retreat into itself.

Central to EFT theory is the organizing function of emotion schemes. The term *emotion schemes* refers to cue-activated response-producing internal organizations that synthesize a variety of levels and types of information from sensorimotor stimuli, emotion memory, and conceptual-level information (Greenberg, 2002). In contrast to a cognitive schema that produces representations in language, the emotion scheme is an internal organization that is not mediated by thought and that produces nonverbal action tendencies and affective experience. For example, shame schemes, when activated, lead to feeling inferior or worthless, and this involves a tendency to bow one's head and shrink in an effort to sink into the ground and disappear so as to not be seen. At the same time, one becomes acutely and painfully conscious of oneself as gazed on and evaluated by others. Rather than simply believing that one is worthless or thinking that one is inferior, there is the sense of social disdain (real or imagined).

In EFT, affect regulation is seen as a core human motive. People seek to have the affects they want and to not have the affects they don't want because the emotions we seek and avoid promote survival and adaptation. Much human action and interaction, then, is seen as being driven by felt satisfaction—by the felt excitement and suspense of connection and striving and by the boredom, anxiety, and loneliness when these are absent. Emotion that results from

appraisals of situations in relation to our well-being (Frijda, 1986, 2007; Greenberg et al., 1993) guides us as to what is good and bad for us, and we attach, act to maintain our identities, and pursue competence because of how these actions makes us feel.

In addition to being motivated to regulate affect, people also are seen as motivated to seek meaning (Greenberg & Goldman, 2008). People's goals therefore consist of more than simply "feeling good." Thus, at times, under certain circumstances people will seek "negative" emotions, tolerate pain, or sacrifice themselves in the service of higher-order feelings of virtue or love. EFT therefore does not propose a simple hedonistic theory of motivation (i.e., the seeking of pleasure and the avoidance of pain). Although people primarily do seek to feel positive emotions, "negative" emotions, such as sadness and anger, also are highly functional, and people self-regulate the emotions with the aim of achieving goals, not of simply seeking pleasure.

Finally, EFT takes a dialectical-constructivist view of human functioning and proposes that people are in a constant process of making sense of the emotional experiences that arise from scheme activation (Greenberg & Pascual-Leone, 2001; Greenberg et al., 1993). People thus seek to understand the meanings of their experience and actions and to create meaning out of these. Personal meaning, in this view, emerges by the self-organization and explication of one's own emotional experience. An ongoing circular process of making sense of experience—symbolizing bodily felt sensations in awareness and articulating them in language—leads to construction of new experience. Optimal adaptation thus ultimately involves an integration of head and heart, reason and emotion.

TYPES OF SHAME

Shame essentially relates to a person's sense of worth; it makes people want to hide, as opposed to guilt, which prompts apology or the making of amends (Lewis, 1971; Tangney & Dearing, 2002). Shame is connected to the evolutionary mechanisms that link to status and social rank, whereas guilt links to the evolutionary mechanisms that underpin caring behavior (Gilbert & McGuire, 1998). Shame makes us close down and avoid thinking too much about events because it makes us feel bad about ourselves. Guilt propels us to repair.

People feel shame when they feel small or diminished in the eyes of the other. People also feel shame when they feel overexposed, as if appearing naked in public or having lost control of themselves; they feel that other people see them as worthless or undignified. Shame can also arise when people reveal their emotions to another person or show their excitement and these

expressions are not seen or responded to. Children feel shame when no one pays attention to their emotional excitement or their efforts at exhibiting their prowess (Kohut, 1977). When they excitedly yell "Mommy! Daddy! Look at me!" as they stand ready to jump from a diving board into a swimming pool and their parents ignore them, they might shrink away in shame.

In EFT, different classes of emotion, such as primary and secondary and adaptive and maladaptive emotions, are distinguished from one another to guide differential intervention. *Primary emotion* is the first response a person has to a stimulus; *secondary emotions* are those emotions that are reactions to more primary emotion, such as feeling secondary anger in response to feeling hurt or secondary rage in response to primary shame. Secondary feelings also are feelings about feelings, such as feeling ashamed of one's fear. Primary emotion, in addition, can be seen either as providing adaptive information and action tendencies, such as sadness in response to loss or anger at violation, or as being maladaptive. *Maladaptive emotions* are those that no longer enhance survival or are no longer functional, such as fear of loud noises based on combat posttraumatic stress disorder or fear of closeness based on prior childhood abuse that has left one unable to trust.

Thus, *primary adaptive shame* is seen as a person's most fundamental, direct, initial, rapid reaction to a situation of diminishment and in therapy is accessed for its adaptive information and capacity to organize adaptive action. Adaptive shame informs people that they are too exposed and that other people will not support their actions or that they have violated important standards or values. The display of shame also has the function of reducing others' aggression and increasing the likelihood of social reconciliation by evoking affiliative responses, sympathy, and forgiveness from others (Keltner & Harker, 1998).

Primary maladaptive shame, however, which often results from past trauma or a poor attachment history, leads to withdrawal and avoidance and results in treating the self and others badly. Almost all of us have some minitraumatic experiences from childhood, such as being the last player to be selected for a team. Such experiences can result in the internalization of the experience of being shunned. Maladaptive shame resulting from such experiences can be activated in adulthood. What once were adaptive emotional responses, developed as a survival strategy in reaction to abuse, humiliation, or rejection, are internalized and become maladaptive. This type of internalized core shame is one of the more frequently occurring primary maladaptive emotions in therapy, and it must be accessed in order to transform it. In therapy, it is also important to distinguish between external shame (generated by perceptions of how others view us) in reaction to events and internalized shame (generated by internalized judgments, criticism, and contempt; Gilbert, 1997). In EFT, primary maladaptive shame is one of the key negative emotions to be accessed and transformed. These shame responses are not mediated by thought or

self-judgment. Emotion schematic memories, rather, are evoked when a set of cues match the scheme releasers independent of any judgment or automatic thoughts in language. Thus, the face of contempt of the other evokes an emotion scheme of shame, and the person has a sinking feeling in the stomach and begins to feel like hiding.

Secondary shame is an emotional reaction to a primary emotion, such as feeling ashamed of one's sadness or anger. Secondary shame needs to be explored to discover its root cause. Finally, *instrumental shame* is an emotional behavior pattern that the person has learned to use to achieve an interpersonal aim, such as feigning embarrassment in order to appear appropriate. Expressing shame to convey submission is often a cultural form of greeting. Instrumental shame, however, can be dysfunctional when it is used rigidly and repeatedly to satisfy unmet needs. In therapy, clients often need help to become aware of the goal of shame expressed in this manner.

In EFT, working with shame primarily is concerned with exploring and transforming internalized maladaptive primary shame that is part of a core sense of self as worthless, inferior, weak, vulnerable, and/or unlovable. In addition, secondary shame, which is generated by self-critical cognition, contempt, and disgust directed at the self, is also an important focus of therapeutic work. These two forms of shame often are related, and they form a spectrum of a shame-based syndrome, which generates a chronic sense of worthlessness and inferiority as well as a rigid shame-related cognitive-affective processing style.

EMOTION-FOCUSED THERAPY PRINCIPLES FOR WORKING WITH SHAME

Overcoming shame leads to a strengthening of the self, including increased confidence and self-esteem. In addition, once people are deshamed, they are more open to change in different domains of their psychological functioning. Work with shame is thus crucial for many problems that people bring to therapy. Next, we discuss four major EFT principles for working with shame: relational validation, accessing and acknowledging shame, regulating shame, and finally transforming shame.

The first principle of EFT, designed to counteract shame, is the development of a supportive, validating, empathic, and affectively attuned relationship. When relational safety is established, the focus shifts to accessing shame, overcoming the avoidance of shame, symbolizing it, and allowing the painful feelings of shame to be experienced. Interventions then focus on helping clients stay in touch with their experiences of unresolved shame and humiliation and to symbolize these feelings in the immediacy of the session or to regulate the shame if it is too overwhelming. This then allows for the

transformation of shame by exposing the activated maladaptive shame to new emotional experiences generated in the therapy. Mobilization of strengths and internal resources, such as self-compassion, self-empathy, self-respect, empowering anger, and pride, helps undo damaging shame experiences and helps the person construct new meaning from the shameful experiences. Treatment of shame thus aims at accessing the maladaptive shame schematic memories, transforming them by accessing strengths and emotional resources in the personality, and creating new meaning (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg & Watson, 2006).

Relational Validation

Shame operates everywhere in therapy because clients are constantly concerned about what part of their inner experience can be revealed safely and what part must be kept hidden. Clients' struggles with shame may start even before the therapy begins. The mere act of acknowledging that life is too difficult and the idea of laying bare one's deepest secrets to a relative stranger are fraught with shame. Seeking help from professionals about personal matters thus can evoke a sense of humiliation. It requires considerable trust for clients to reveal to the therapist what they consider to be their deepest flaws and those parts of self of which they are most ashamed. The first goal in counteracting shame therefore is to develop a supportive, validating, empathic, and affectively attuned relationship.

Shame is created within interpersonal relationships; therefore, it needs an interpersonal relationship to heal and transform it. To overcome the shame that interferes with self-acceptance, people have to come out of hiding and undo their tendency to bypass and avoid the experience of shame (Nathanson, 1992). An empathic validating relationship helps clients acknowledge and fully experience shame, humiliation, and embarrassment in the session so that these feelings can be exposed to disconfirming experiences with the therapist who is affirmative and compassionate. Clients learn that if they reveal their flaws and shortcomings, they will not be rejected or judged as worthless or defective.

Therapists need to be attuned and responsive to nonverbal as well as verbal indicators of shame-related experience in the session. Nonverbal indicators include downcast eyes, squirming or writhing in the seat, and laughter or shrugging off that covers embarrassment. Clients may joke about "hating" being there, or feel "reduced to paying for help," or give indications that it is somehow degrading to be in therapy. Immediacy in attending to these markers of reluctance is essential to establishing the therapeutic bond. Interventions such as "It's embarrassing to talk about such private things, but it's important" or "It's hard to ask for help; it makes you feel a

bit like a child, but we all need help at times" validate the client's internal struggle and provide support.

Feeling shamed in therapy is highly dependent on the quality of the therapeutic relationship. It is important for therapists to be alert to whether they have unwittingly shamed the client by not being attuned to the client's feelings or by misunderstanding or missing something important. Shaming clients causes ruptures in the working alliance, which is so important to therapy outcome (Horvath & Bedi, 2005). Healing these types of ruptures in the relationship and correcting current misunderstandings can be highly therapeutic (Rhodes, Hill, Thompson, & Elliott, 1994; Watson & Greenberg, 1995). In these instances, an understanding, supportive relationship is not just a precondition to further work with shame but is the essence of the treatment itself, enabling a corrective interpersonal emotional experience.

Accessing and Acknowledging Shame

The second goal of EFT intervention is to help clients recognize and overcome avoidance and acknowledge painful feelings of shame. Clients automatically avoid and deflect from the experience of shame because shame is so painful (Nathanson, 1992). Shame avoidance interferes with people's ability to attend to their internal experience. People may talk about embarrassing or humiliating experiences but avoid the intense discomfort of the immediate experience. Drawing attention to the shameful experience often only intensifies the impulse to retreat and close down emotionally. The therapist thus needs to guide clients to attend to and acknowledge their shame. Responses such as "As you were talking about that, I was aware of how degrading that must have felt" refocus clients' attention on their own internal experience. Therapists also can reflect the discomfort of feeling small, worthless, and humiliated in the presence of another and normalize clients' desire to protect their dignity and the tendency to look away from their therapists while they speak. Clients who express anger that covers shame can be encouraged to express their reactive anger at being humiliated, but interventions should acknowledge their anger as a secondary reaction and a face-saving coping response and should highlight the underlying core experience of shame. An example of such a refocusing intervention would be as follows: "Yes, so angry at him for using you. That's a reaction to that awful feeling of being used like that. That's the most damaging part. I know it's hard, it hurts, it's degrading to feel . . . what . . . unvalued . . . unimportant, belittled?"

Drawing attention to and focusing attention on shame, however, can threaten a person whose self-esteem is fragile. It is therefore important to assess client ego strength; to be unintrusive, delicate, and sensitive to client fragility; and to be respectful of the client's inclination to withdraw in shame.

With many clients it may be necessary first to strengthen their self-esteem before they can tolerate exposing or acknowledging their experience of shame. It is sometimes necessary to provide a rationale for experiencing and disclosing shame because it feels like such a self-damaging emotional state and the client may perceive the therapist as coercive and punitive. For example, when clients express reluctance to talk about embarrassing or shameful material, therapists can encourage them with responses such as, "I know it's hard, but it's so important to say; otherwise, it eats away at you" or "keeps you so isolated."

Helping clients acknowledge shame that is on the periphery of their awareness requires particular sensitivity on the part of the therapist. Intervention involves, first, recognition of surface reactions that cover shame, such as cockiness, bravado at bad feelings, narcissistic anger, perfectionism, or other types of obsessiveness and then empathic conjecture about the underlying experience. A response to bravado about rejection might be "I hear the determination in your voice, like there's this part of you that puts on a brave front to protect against this other part that feels kind of insignificant." An empathic response to the shame underlying a client's social anxiety, for example, might be "It's almost like, if they saw you for who you really are, they'd reject you."

The therapist often can help the client access core shame by empathically highlighting the underlying pain of wounds to self-esteem and the pain of not belonging. Responses that validate how shaming things were and how the unmet longing to belong left one feeling so worthless, while also affirming the adaptiveness of this need, are very therapeutic. Responses that help evoke the shame a client feels include "Yes, as kids we all need so desperately to be accepted, to belong" or "How humiliating to be exposed like that, caught on the toilet, with them laughing at and pointing fingers at you." Clients then might disclose how abandoned and alone they felt as a child, wishing more than anything that they were liked or loved in spite of their deficits. Putting shame into words with a trusted other enables the client to step outside the emotional experience so that the shame no longer seems to permeate his or her entire being; this also helps self-compassion emerge.

Once avoidance and interruption of shame are overcome, interventions such as evocative imagery or psychodramatic enactments (Greenberg et al., 1993; Elliott, Watson, Goldman, & Greenberg, 2004) are needed to help clients bring the shame alive in the immediacy of the session and stay in touch with their particular experiences of shame long enough to symbolize these feelings in awareness. Activation of the shame makes it amenable to the input of new experience, and it is this new experience that can transform the maladaptive emotion schemes that produce shame. A powerful intervention for evoking shame consists of a two-chair dialogue in which the client enacts the harshly negative, contemptuous, self-evaluative processes that produce shame (Greenberg et al., 1993). In this intervention, therapists ask

clients to enact the two parts of themselves—the critic or judge who directs contemptuous statements and the part of themselves that is the recipient of the contempt and disgust. This process heightens awareness of the specific internalized messages, the expressive quality, and the experiential impact of the internalized contempt and disgust—the shame and pain of such self-denigration and the damage to clients' self-esteem.

Regulating Shame

There are both implicit (right hemispheric) and explicit (left hemispheric) forms of affect regulation (Schore, 2003). In people who are more shame prone, the problem often is a deficit in implicit, automatic forms of shame regulation that modulate affect, nonverbal communication, and unconscious process. Although the primary therapeutic goal in EFT for shame-prone people is for them to learn to automatically regulate the intensity of their affective arousal so that shame does not become overwhelming, initially deliberate behavioral and cognitive forms of regulation—a more left hemispheric process—are useful especially for those who feel out of control. *Explicit shame regulation* refers to the processes by which people attempt to voluntarily control when, and how intensely, they experience shame. Helping clients to find ways consciously or purposively to cope with their shame often is a first therapeutic step, especially for people who are highly distressed. Thus, taking a warm bath to calm down (sensory regulation), learning to distract when feeling shame (cognitive regulation), or consciously reconstructing the situation can improve coping to limit distress to a more manageable level.

Over time, however, it is the building of *implicit* or *automatic emotion regulation* capacities that is important for shame-prone clients. Directly experiencing aroused shame being soothed by relational or nonverbal means—a more right hemispheric process (Schore, 2003)—is one of the best ways to build the internal capacity for implicit self-soothing. Soothing most centrally comes interpersonally in the form of empathic attunement and responsiveness to affect and through acceptance and validation by another person. Clients with underregulated affect have been shown to benefit both from validation and the learning of emotion regulation and distress tolerance skills (Linehan et al., 2002).

Forms of meditative practice and self-acceptance often are helpful in achieving a working distance from the overwhelming core maladaptive emotion of shame. The ability to regulate breathing and the ability to observe emotions and let them come and go are important processes to help regulate many types of emotional distress. As well as being mindful of internal experience, it is helpful to guide dysregulated clients to be mindful of what is going on outside of their immediate internal emotional experience by redirecting their attention to the external environment.

Shame thus can be regulated by developing tolerance for negative affect and by soothing at a variety of different levels of processing. Physiological soothing involves activation of the parasympathetic nervous system to regulate heart rate, breathing, and other sympathetic functions that speed up under stress. At more deliberate levels, promoting clients' abilities to allow and be compassionate to their emerging painful emotional experience is the first step toward tolerating shame and developing the capacity to self-soothe (Gilbert, 1997; Gilbert & Procter, 2006; see also Chapter 14, this volume). It often is the relationship with an attuned other that is essential in developing shame regulation, but as we have seen, self-soothing involves many components, including diaphragmatic breathing, relaxation, development of self-empathy and compassion, and positive self-talk (Greenberg & Watson, 2006).

Transforming Shame

The transformation of shame involves both generating new, more resilient emotional responses and validating the new feelings and the emerging more confident self-organization (Greenberg, 2002; Greenberg & Watson, 2006). One of the best ways of changing emotion is with another opposing emotion that acts to undo the first emotion (Greenberg, 2002). Once clients have accessed core dysfunctional emotion schemes that involve maladaptive shame, the scene is set for transforming the maladaptive state by mobilizing alternative emotional responses based on adaptive needs and goals to expand clients' emotional response repertoire. For example, withdrawal and avoidance responses of a defeated and demoralized self that come from core shame are paired with new approach responses associated with empowered anger, comfort-seeking sadness, or expansive pride and other positive emotions that undo the effects of paralyzing shame.

In promoting access to new emotions, therapists need to validate the spontaneous emergence of more adaptive emotion (Greenberg, 2002). Therapists need to shift clients' focus of attention to help them pay attention to background or subdominant more adaptive feelings. Accessing needs and goals is another key method to help undo shame. Therapists can ask clients what they need when they are in painful shame. Raising a need or a goal to a conscious self-organizing system evokes and heightens a sense of agency. If a client, in a state of shame, experiences a need for validation, an anger-based sense of pride often emerges at not having the need met. Expressive exercises such as positive imagery, expressive enactment of the emotion, and remembering another emotion can also help clients experience another more adaptive emotion in the present. Often the adaptive emotions that help transform shame are empowered anger and the sadness of loss that supports comfort seeking. Therapists also can suggest that a client focus on something in a

different way; for example, the therapist may ask clients to focus on what they didn't like about their abusive parents instead of focusing on their own negative self-appraisals. Changing how one views a situation or talking about the meaning of an emotional experience often helps clients experience new feelings (Gross, 2002). Therapists might express on behalf of the client the outrage, pain, or sadness that the shamed client is unable to express. A new emotion can also be evoked in response to new interactions with the therapist. The therapist might, for example, self-disclose to create a sense of closeness or commonality to communicate acceptance and to evoke a feeling of calmness.

Shame also interrupts positive emotions such as joy, pride, and interest (Nathanson, 1992; Tomkins, 1987). Many clients who have a strong sense of shame tend to hide their strengths and joys. Therefore, it is helpful to have them own their strengths and enjoy them. The therapist's focus on a positive feeling will have an effect on the client and will deepen the positive feeling or evoke other feelings attached to it. Attempting at appropriate times to evoke and amplify positive emotions by asking clients to repeat certain self-affirming and self-expressive statements and to elaborate what they imply helps them overcome embarrassment and constriction of the expression of these feelings. Encouraging clients to boast about their achievements, for example, helps them express pride and gives them permission to feel it. It is helpful to ask clients first to allow the positive feeling to flow in their bodies, to feel the excitement and let it build, and then to show it on their face and in their voice and express it in their bodies (Greenberg & Watson, 2006).

Therapists also need to be attuned to spontaneously emerging challenges to shame, such as a client's adaptive resources or positive emotional responses—for example, humor and pride—that can counteract shame. There often is a part of the self that doesn't quite believe the self-criticism. For example, a client who was berating herself for "chickening out" of a direct confrontation with her parents suddenly switched to "Oh, well, at least I sent the letter." The therapist could have focused on her self-criticism. Instead, the therapist chose to support the emergence of client strength by responding, "Yes, that seems like a real accomplishment. How did it feel to put all those things on paper?" The following week, the client brought in a copy of the letter, and this was used as an opportunity to explore her capabilities that had been often overlooked and devalued and to strengthen her self-respect.

The final aspect of therapeutic work transforming shame with EFT is the consolidation of new meaning and the reconstruction of narratives that confirm or change clients' identities and the views they have of their experiences. When clients who have experienced core maladaptive feelings of primary shame and worthlessness are able to symbolize these feelings in awareness and acknowledge that this is what they feel at their core, they begin to gain some

reflective mastery over their experience. With the symbolization of their core feeling, they create a separation from it. The feeling now is not simply an overwhelming experience of "I am worthless," but rather an experience of "I feel worthless," which is a feeling I have, rather than who I am. The feeling becomes an object or product of the self, one that produces distress, rather than being the self, and thus can be regulated more easily. This symbolization creates an inner space for clients to reflect on themselves apart from the shame experience and to get to the core resilient self that wishes to survive and thrive.

When clients are able to reflect on their shame experiences, with the help of the therapist they make connections between different elements of their lives, begin to posit alternative explanations for their experiences, revise their views of themselves or their history, and develop new narratives (Greenberg & Angus, 2004). This process is often accompanied by a sense of greater connectedness and mastery in their lives. With clients troubled with varieties of shame-related problems, one important therapeutic goal is to help them develop a new set of lenses through which to view themselves, the past, and the future. Clients can develop narratives that emphasize their resiliency and newly acquired sense of agency, thus reconstructing their views of themselves. When this occurs, the self is no longer judged as a failure but rather as capable of success in the face of obstacles and able to thrive even when confronted with experiences that previously might have been perceived as threatening to survival. Thus, clients' views of the self, the world, and their experience are revised and reconstructed as these views become illuminated and reflected on in therapy.

DIFFERENTIAL INTERVENTION FOR VARIETIES OF SHAME EXPERIENCE

A number of different goals of shame work EFT have been distinguished, each requiring different sets of in-session interventions to facilitate change (Greenberg, 2002; Greenberg & Paivio, 1997). The major goals of shame work identified are (a) being informed by primary adaptive shame; (b) transforming primary maladaptive core shame and strengthening the self to overcome societal shame; and (c) overcoming secondary shame generated by self-critical cognitions.

Being Informed by Primary Adaptive Shame

Shame felt in response to violations of implicit or explicit personal standards and values, such as shame at engaging in deviant behavior, shame at a public loss of control, or shame at being a neglectful or abusive parent, is adaptive shame. It helps people not alienate themselves from their group and

maintain a sense of connection and belonging while also protecting their privacy. It does this by preventing people from erring too much in public or breaking the rules that form the social fabric.

In therapy, feelings of adaptive shame need to be acknowledged because they provide valuable information about socially acceptable behavior and action tendencies that can be used to guide conduct. Recently we found that in couples suffering from emotional injury in which one partner felt betrayed or invalidated, the expression of shame by the injurer as part of the apology appeared to be a key ingredient to rebuilding trust and promoting forgiveness (Greenberg, Warwar, & Malcolm, 2010).

Transforming Primary Maladaptive Core Shame

Shame in therapy usually presents in its maladaptive form. Internalized maladaptive shame involves a pervasive sense of oneself as defective, worthless, or unacceptably flawed. This form of shame often is at the center of self-critical depression (Greenberg & Watson, 2006). Shame also is important in chronically shy clients; most people experience some shame, but a very high percentage of clients with social anxiety disorder suffer from excessive shame. If anxious and depressed clients are not helped to reduce their core shame, relapse often occurs very quickly. Core shame is a more enduring part of the person's self-experience that influences his or her personality. It forms the undercurrent of experience without emerging into awareness. An early learning history of rejection, ridicule, and criticism as well as abuse and neglect generally leads to the development of a core sense of self as flawed, worthless, unlovable, or bad. Repeated experiences of core shame lead to an overall sense of low self-esteem.

Maladaptive core shame also arises from child-rearing practices that teach children that their feelings, desires, or behaviors are unacceptable. Shaming is a common child-rearing practice, and to a certain degree we all are damaged by it. More intense core shame occurs as a result of abuse, neglect, and other forms of childhood maltreatment. People who were emotionally, physically, or sexually abused as children have internalized a sense of themselves as "spoiled goods" and feel defective, unlovable, and/or worthless (see Chapter 11, this volume). People who were harshly punished often feel debilitating shame for having transgressed moral standards, whereas others who were invalidated fear being the object of social denigration or stigma. People who were treated with contempt learn to treat themselves the way they were treated by significant others—that is, with self-contempt—and they often experience total humiliation for being who they are. The problem for many abused clients is the sense that somehow they were responsible for a shameful act over which they had no control, that they deserved the abuse and brought it on themselves. Pathogenic beliefs about the self as defective

or spoiled were poignantly illustrated by one client who, speaking about having been sexually molested as a girl, cried, "Who would want me now?"

x Sometimes core shame develops from experiences of rejection due to class, race, gender, or sexual orientation or being somehow "different" and judged inferior. One client, for example, felt deep shame about her infertility. Primary maladaptive shame from this type of social comparison or rejection is not essentially different from the internalized shame arising from childhood maltreatment except that the shame is not imposed by a primary caregiver. Nevertheless, the person has internalized a core sense of himself or herself as inferior, unacceptable, deviant, or somehow deeply flawed.

x Intervention with shame-prone survivors of maltreatment and abuse, who often feel responsible for the abuse, involves appropriately externalizing the blame, or "putting the blame where it belongs." In addition, among people who have been abused, the abuse is often a closely guarded secret, yielding pervasive shame anxiety (anticipatory anxiety about feeling shame) and fear of intimacy. In psychotherapy, therapist empathic affirmation of vulnerability (Greenberg et al., 1993) is the initial therapeutic strategy of choice when the therapist notes indicators of maladaptive shame during therapy sessions. In such instances, the therapist helps clients stay with their shame so as to experience the acceptance of the therapist and find their own resiliency, for example, by allowing themselves to experience other adaptive emotions. Sadness or anger can be fundamentally growth producing in that they point to adaptive actions appropriate to the situation. For example, sadness can lead to reaching out to connect to others, or anger can lead to asserting one's right to live one's own life without shame (Greenberg, 2002; Greenberg et al., 1993). People with core shame also rarely experience positive emotions to their full intensity. They may feel too vulnerable to feel joy or interest because of the fear that good feelings will be taken away as soon as they start to enjoy them. Individuals who have experienced repeated core shame may also feel unworthy of experiencing positive emotions. Therapy can help these clients access joy and pride in self and open up to the therapist.

x Work with core shame involves restructuring the shame-based emotion scheme by accessing and supporting the emergence of internal healthy resources via self-soothing and self-validation. Shame often is transformed by accessing primary adaptive empowering anger in therapy to assert oneself, to stand up to abusers in imaginal confrontations, and to empower oneself and challenge self-blame and contempt (Paivio, Hall, Holowaty, Jellis, & Tran, 2001). This form of imaginal confrontation, using gestalt empty chair work for resolving unfinished business, often is an important intervention for maladaptive shame (Greenberg et al., 1993). In working with the expression of anger to undo shame, adaptive, empowering anger at maltreatment needs to be distinguished from maladaptive rage associated with narcissistic slights

and reactions to humiliation. Maladaptive rage is overly intense, chronic, destructive, and/or inappropriate and is often in reaction to minor insults or failure experiences. The EFT therapist helps clients attend to and intensify the experience of adaptive anger, which is empowering. The focus of such work is on asserting the self rather than destroying the other. In contrast, maladaptive rage, which is aimed at destroying the other, is bypassed, not intensified. Once anger is validated, clients generally shift their focus to their internal experience of being wounded and hurt.

When clients access introjected shaming messages associated with their core maladaptive shame, such as "You're so selfish" or "Homosexuality is deviant," which originated with significant others (e.g., parents, those in authority positions in society), therapists need to clarify the interpersonal origins of such messages and not reinforce self-blame. Once clients feel validated, they are encouraged to own that they are agents in the construction of their own misfortune by having internalized these shaming messages. As the client understands that shame is internally generated, the target problem becomes an intrapsychic struggle for self-acceptance.

Overcoming Secondary Shame Generated by Self-Criticism

Self-criticism is one of the most commonly occurring dysfunctional processes associated with secondary shame. People harshly judge themselves for their mistakes, flaws, or shortcomings and feel shame. This cognitive-affective process generates feelings of worthlessness or inferiority, damages self-esteem, and often leads to depression. The self-critical process differs from maladaptive shame in that the shame is activated periodically and in specific situations. If it is pervasive and occurs chronically across situations, it is a more central self-organization and then is symptomatic of primary maladaptive shame.

Secondary shame is evident in therapy when one part of the self is the harsh critic and judge, a part that rejects certain behaviors or characteristics of another part of the self; at the same time, the accused part of the self feels like a failure and feels ashamed but may react defensively or with hostility. The therapeutic objective in working with secondary shame generated by self-criticism is to access the underlying primary emotional experience of which the person feels ashamed. This is accomplished by bypassing the secondary shame. Rather than focusing on it, the therapist focuses on the person's underlying feeling of, say, anger or sadness of which the person feels ashamed. If that is not possible, the therapist works with the shame-producing self-criticism until a shift to the more primary experience occurs. Two-chair dialogue for self-criticisms is the intervention of choice for this form of shame (Greenberg et al., 1993).

In secondary shame one also can be ashamed of particular emotions or self-experiences, such as feeling ashamed of feeling hurt, weak, or needy or

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introjected

feeling ashamed of feeling sexual or angry. Feeling fearful that these internal experiences will emerge leads to shame anxiety, a feeling often indistinguishable from feelings of vulnerability. Shame anxiety is associated with fear of revealing internal experiences and fear of being judged. At moments of shame anxiety, clients may interrupt their emotional expression by tensing their muscles, holding their breath, and becoming silent.

Empathic attunement, support, and affirmation of the need to protect oneself are the most appropriate interventions for this form of shame. Provision of safety and empathic affirmation of vulnerability reduce interpersonal anxiety and allow the person to take the risk of accessing and disclosing the hidden aspects of self so that they can be exposed to new disconfirming information in the therapy session.

X Another form of secondary shame is societal shame. In contrast to core maladaptive shame, which involves a chronic and pervasive sense of worthlessness, societal shame tends to occur as a result of perceived life failures such as getting divorced or losing a high-paying job that the person fears reflects defeat, poor judgment, immaturity, and so on. Clients with societal shame feel humiliated and ashamed in the eyes of others. Although societal shame is often situational due to loss of social position, sense of identity, and one's public image, it often evokes past trauma and unresolved conflicts in the area of confidence, self-worth, and efficacy. People who experience societal shame also feel isolated and alienated because societal shame blocks them from seeking others with whom to share their sense of loss and sadness and to rebuild their interpersonal network. The internal experience of societal shame often is associated with disappointment, exploitation, or traumatic loss. Therapy here involves dealing with the loss.

Two-chair dialogue for splits is frequently used to work with shame-producing self-criticism (Greenberg et al., 1993). This involves encouraging a client to engage in a dialogue between two aspects of the self; one aspect is expressed while sitting in one chair, and the other is expressed while sitting in the other chair. In therapy, markers of shame are obvious or implied self-critical statements accompanied by harsh vocal quality and facial expressions, such as a curled lip or sneer, that indicate feelings of contempt and disgust toward the self. When people engage in shame-producing dialogue, part of the self negatively evaluates, and expresses contempt or disgust toward, another part of the self. Here, intervention involves highlighting or analyzing the expressive quality of contempt, specifying the shame-producing cognitions, heightening awareness of agency in the shame-producing process, and countering shame by supporting the emergence of the healthy part of self with feelings of pride. An example of the contempt expressed from the Critic's chair (i.e., the self's critical voice) might be "You're pathetic," and this will evoke shame expressed from the other aspect of self: "I feel so worth-

less, like curling up into a ball and hiding." In this dialogue, people come to see that by denigrating themselves, they are agents in the production of their experience of shame and that they can change how they relate to themselves. People resolve this split as more adaptive feelings such as anger and sadness and later more self-assertion such as "Leave me alone; stop attacking me like that" evolve to counteract the shame. Resolution of the split is seen when the Critic softens into compassion, saying, "I don't want to make you suffer; I do care about you." An integration of the two aspects can then occur, resulting in self-acceptance and a stronger sense of self.

Two-chair dialogue highlights not only the cognitive content of the critical message but also the contempt and disgust directed at self along with the painful reaction of the self to this harshly negative self-evaluation. As we said, an important step in this intervention is that the person's awareness of agency in producing feelings of shame is heightened: He or she realizes that shame-producing messages are internally generated and, therefore, that he or she can change them. The tendency to protect the self from the criticism and to protest and challenge the shaming message spontaneously occurs in the other chair. The negotiation between the two sides of the self leads to a more self-accepting and self-soothing attitude, which weakens the negative evaluations and allows positive emotions such as pride and love to emerge.

CULTURAL ISSUES IN WORKING WITH SHAME IN EFT

In Asian collectivist cultures in which group harmony, social hierarchy, and the interdependence of individuals are socially emphasized, the sense of self is more closely related to one's membership in groups and fulfilling one's obligations to others. In Western cultures, autonomy, independence, and the uniqueness of each individual are prized (Markus & Kitayama, 1991). It is often argued that shame has a more primary role in regulating social roles and behaviors in collectivist cultures. In addition, the expression of negative emotions such as anger and sadness is apt to be suppressed, whereas nonindividualistic positive emotions such as joy and interest (as contrasted with pride and contentment) are used instrumentally to maintain and strengthen ties among group members (Doi, 1973).

In collectivist cultures, an emphasis on social hierarchy based on seniority contributes to the instrumental use of certain shame-related emotional expressions for role management. Being humble and acting with reserve are considered virtuous and respectful, whereas the expression of negative emotions is viewed as showing disrespect and disloyalty rather than as a spontaneous and direct expression of internal experience. Public humiliation and other forms of shaming are often used in child rearing and education.

Owing to its prevalence in Asian cultures, shame plays a prominent role in a variety of types of psychological dysfunction. For example, *taijin kyofusho* (anthropophobia or interpersonal phobia) in Japan refers to a class of phobic disorders associated with fear of a potential shaming experience in public such as interpersonal shaming, others' gaze, humiliation, exposure, and inappropriate behaviors, and is one of the most typical forms of neurosis (Morita, Kondo, & Levine, 1998). In collectivist cultures, clients often present problems related to maladaptive shame such as societal shame as well as secondary shame generated by self-criticism.

Although the main principles of EFT treatment with shame remain the same in therapeutic work with clients from a collectivist cultural group, therapists are advised to make sure that such clients understand the rationales behind accessing, tolerating the experience of, expressing, and understanding shame and other related emotions in therapy. In particular, they need to know that expression of negative emotions in front of the therapist is not only allowed but also is essential to therapeutic work. Clients from a collectivist culture may be under the assumption that they need to behave in ways that show respect to the therapist, who is in a position of authority. They may put on a social face, inhibiting themselves from experiencing and showing negative emotions such as anger and sadness while more frequently expressing instrumental emotions (Greenberg, 2002), which are emotions expressed for their effect on others. Particularly problematic is that the expression of positive emotions such as pride and contentment that counteract shame may be prohibited. Sometimes a client's inability to access immediate emotional experience in the presence of the therapist may be reflective of underlying shame anxiety that inhibits more spontaneous emotional reactions in interpersonal situations that would otherwise provide crucial experiential input to guide judgment and action. This disconnection from feelings, aimed at maintaining group harmony and a sense of belonging, unwittingly causes a sense of isolation and alienation because the person's own idiosyncratic experience is kept hidden behind the mask of instrumental emotions; thus, it is rarely known, validated, or understood by others. Exploration of the interruption and blocking of emotional experience can be a powerful intervention. It is also important to help clients become aware that emotional expression is being used to achieve an aim and to illuminate its function as well as its negative consequences.

CASE ILLUSTRATION

A male client in his 30s sought therapy for depression. He exhibited a number of shame-related issues. He had been diagnosed with attention-deficit/hyperactivity disorder as a child, was cruelly teased in school, and had devel-

oped a core sense of himself as a "loser." He learned to act like a clown by intentionally making "silly" mistakes and comments that were out of place and that invited others' laughter. His classmates were laughing at the mask that he created, catching his deliberate mistakes and failures but not his core shameful self. He was able to control and avoid the experience of deeper and more painful primary maladaptive shame by this deliberate instrumental shame; however, his sense of isolation grew as this maneuver became more refined and adept. His feeling of shame also grew deeper.

Facing his core sense of shame in therapy was excruciatingly painful for this client. Therapy then involved accessing strengths and anger at unfair treatment to help restructure his sense of himself. First, the therapist validated the client's need to hide and protect his vulnerable self and also emphasized his longing and his adaptive need to belong that lay beneath his acting like a clown. The therapist then empathically highlighted the underlying pain of the wounds to his self-esteem and the pain of being an outcast as a child. This evoked tears and activated the client's core shame-related emotion scheme. He disclosed how alone and lonely he had felt even when he was with other children. He lived with intense shame anxiety, always fearing he would be exposed as inadequate because he couldn't keep up with his classmates in academic work no matter how hard he tried. The therapist helped him acknowledge his core feelings of inferiority and his constant struggle with feelings of "falling behind" and "falling short" by responding, "All you wanted was to be like the other kids. You weren't asking for much: You didn't need to excel in anything. You just wanted to get along and be like everyone else instead of always being the one the other kids pointed a finger at." In an imaginal confrontation with the other children using an empty chair dialogue, he accessed and expressed his primary adaptive sadness and his need to feel emotionally connected, and he began to feel he deserved more. This led him to access primary adaptive anger, and he asserted, "I deserved to be treated as a worthwhile person and to be protected." The therapist supported and validated this stronger sense of self.

Therapeutic work also involved a series of self-soothing dialogues in which the client talked to his lonely and depressed child self, saying, "You're not bad at all. There is nothing wrong with you. I know it hurts. I know that it kills you when other kids laugh at you. You are a sweet kid. Everything will be all right. I am with you." The therapist had him repeat these phrases and pay attention to how he felt inside as he was saying and listening to these words. This work helped him look at himself with compassion. Two-chair dialogues were occasionally introduced to examine his self-critical processes that occurred in response to challenging situations in which he questioned his ability and his confidence and became shaky when the feeling of shame was evoked. Chair work that facilitated exploration and meaning creation, as well as the unflin-

validating and empathic relationship with the therapist, helped him access a sense of worth and work through shame at multiple levels.

CONCLUSION

EFT recognizes both adaptive and maladaptive roles that shame may play in psychological well-being. Identification of different classes of shame allows for more differentiated intervention strategies specifically dealing with complex cognitive-affective processes involving the combination of self-critical processes, self-contempt, shame anxiety, and sense of worthlessness. EFT therapists can help clients achieve experiential mastery over this most painful emotion by helping them develop the capacity to regulate the intensity and distress of shame experience by self-soothing and self-compassion and helping them transform it by gaining access to more adaptive emotional experiences.

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