Framing and Transforming Shame: Exploring shame from a person-centred perspective.

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Abstract: Shame is a key emotion requiring understanding in therapeutic practice, not only from the perspective of a client but also from that of a practitioner, because shame may be outside of awareness manifesting itself in different ways, affecting behaviour and therapy work. This study explored shame as understood and experienced by person-centred counsellors and psychotherapists. Semi-structured interviews were undertaken with five person-centred therapists and data analysed using interpretative phenomenological analysis (IPA) with two key themes identified: *Framing Shame* and *Transforming Shame*. This paper considers these themes through the lens of person-centred theory, exploring implications for psychotherapy practice, whilst recognising the importance of understanding this master emotion.

Keywords: Shame, person-centred, psychotherapy, interpretive phenomenological analysis, IPA

Introduction

Shame is one of a range of self-conscious emotions (Sanderson, 2015) and definitions vary across different disciplines (Wheeler, 1997). Whilst there is significant research around shame, there appears to be no studies linked to person-centred psychotherapy, this study seeks to address that gap by exploring how person-centred theory and practice help to understanding and work with shame. For clarity, respecting differing views around the terms 'counselling' and 'psychotherapy', they are referred to interchangeably in this article surrounding the delivery of talking therapies with no general distinction but with emphasis on person-centred theory.

Person-centred theory stems from the work of Carl Rogers in the 1940s (Rogers, 1951, 1959, 1980), departing from the therapist as a knowing expert and trusting the human potential within the utility of the client. Free from the threat of evaluation, diagnosis or a prescribed directive treatment plan, the client is met as a unique person in a process of becoming (Rogers, 1967). The person-centred therapist seeks to help the client develop a deep sense of being, trusted and accepted for who they are, without judgment or needing to meet conditions of worth (which relate to implicit and explicit perceived standards of expectations qualifying us to be valued and accepted, Rogers, 1951); facilitated through providing an empathic environment for authentic self-exploration and cradled with unconditional positive regard (UPR), involving a non-discriminatory and non-judgemental interaction (Rogers, 1957, 1962). UPR is linked to understanding another through their frame of reference (Rogers, 1951), is inseparable from empathy (Frankel et al., 2012) and is an important factor in facilitating the processing of difficult feelings (Purton, 2000). Through authentic connection with themselves at the core of their being, client's self-actualising process is nurtured combined with reflective

reinterpretation to facilitate recovery, change and growth. Person-centred personality theory explains that when there is no threat to the self, an effective revision can take place to assimilate and integrate experiences, rather than psychological maladjustment from distorted or denied sensory and visceral experiences (Rogers, 1951, 1959). For example, developing congruence within the self-concept between a self-image and an ideal self, combined with an elevated sense of worth and validity in the world. In contrast, shame may render distortions in how we symbolise matters surrounding perceived flaws impacting upon behaviour (Shen, 2018). It is through the lens of person-centred theory this study sought to explore shame.

The origin of shame is acknowledged as a mechanism linked to human evolution to avoid counterproductive choices and cope with challenging situations (Sznycer et al., 2015), linked to social cohesion to maintain the collective interests of a group and individual identity within it. Whilst acknowledging shame has a complex and dynamic existence with other emotions (Lewis, 1992), commentators have referred to shame as the master emotion (Brown, 2010; Poulson, 2000; Scheff, 2003). Furthermore, definitions vary but converge on common facets involving disruption to thought or functioning and self-evaluation (Lewis, 1992). For example, unconscious associations and conscious behaviour linked to acceptance or defence (Poulson, 2000); a painful and overwhelming experience (Brown, 2006) and a "total experience that forbids communication with words" (Kaufman, 1974:569). The risk of isolation brings fear (Brown, 2010; Kaufman, 1974), combined with self-judgement and feelings of being disconnected (Neff, 2003 as cited in Karris & Caldwell, 2015, p. 348).

Whilst shame is ubiquitous in everyday life, it remains an invisible phenomenon (Scheff, 2014), and is an unavoidable facet of psychotherapy practice (Dearing & Tangney, 2011), highlighting the importance of understanding this natural human emotion within the dynamic of therapy, not only in clients but also as therapists. For example, therapy can trigger shame in clients (Andersson et al. 2014; Gausel & Leach, 2011; Henderson, 2006; Sanderson, 2015), or in the therapist (Deonna et al., 2012); involving uncomfortable or unacknowledged feelings altering the therapeutic relationship, possibly compromising client outcomes (Pope et al., 2006 as cited in Ladany et al., 2011, p. 307). This is relevant to how shame can be a product of how a recipient receives support within the interpersonal transaction (Swerdlow et al., 2023), potentially generating psychological vulnerability (Fortes & Ferreira, 2014), and has been identified as a key factor in non-disclosure to therapists (Hook & Andrews, 2005; Macdonald & Morley, 2001). Therefore, an understanding of shame is necessary for psychotherapists due to the experiences clients bring to therapy, and that speaking about shame also has the capacity to create it (Biddle, 1997). The following literature review will expand upon these elements.

Literature review

In defining shame, it has been described as a very personal experience but varies in how it may be explained (Kaufman, 1974), commonly confused with other emotions such as guilt (Miceli & Castelfranchi, 2018; Nathanson, 1992) or anger (Elison et al., 2014). There is also a sense of exposure of the 'self' to others through feeling out of place or out of context (Schneider, 1977). Deonna et al. (2012) outlined how the exposure can be actual or feared, involving a reluctance to be open to supportive exploration (Dayal et al., 2015). Therefore,

shame seems to depict a boundary of privacy with the world where we may hide and not want to be seen (Drini et al., 2023; Lewis, 1992). Similarly, Talbot (1995) commented "shame is associated with the hidden parts of ourselves, buried deeply enough to avoid scrutiny by others and, in many cases, by ourselves" (p. 339). Whilst there can be shame from what others may think (Calhoun, 2004), it can surface from a privately held value or belief whether the audience is real, imaginary, or non-existent (Buss, 1999), therefore generating a contrasting self-evaluation and social-evaluation perspective independently of any extrinsic feedback (Laing, 2021).

In distinguishing the difference between shame and other similar experiences, it is appropriate to acknowledge some authors may categories these elements as distinct, whereas others may view them as degrees of shame. For the purposes of this paper it is appropriate to frame them as distinct, for example guilt is associated with something done in relation to someone else, whereas shame is a negative view of the self (Morrison, 2011); where guilt may be experienced for *making* a mistake, shame is felt for *being* a mistake, a feeling of inadequacy at the core of who we are (Underland-Rosow, 1996). Humiliation can mirror emotional effects of shame but differs because it is perceived as undeserving or unjust, reducing the degree to which it may be internalised, potentially generating a desire for vengeance to restore and recover status (Gilbert, 2019). Likewise, embarrassment may be uncomfortable but ephemeral and may be a shared experience with others (Tangney et al., 1996). This is an important distinction compared to shame in how the latter may be masked by innate narratives relating to difficult experiences (Poulson, 2000) or denied to awareness, potentially influencing the qualia of the therapeutic relationship for a client.

A challenge in therapy surrounds an association with relational worth (Sanderson, 2015), involving unlovability or unworthiness for connection (Jordan, 1997 as cited in DeYoung, 2015, p. 18), or dishonouring human worth (Parse, 2010). Vulnerability to shame also seems to be linked to unwanted identities and negotiating socio-cultural factors (Brown, 2006), with the effects of shame unique and central to a sense of identity (Pattison, 2000). In contrast, Robertson et al. (2018) found a significant trigger of shame surrounds negative perceptions of the self from others; however, shame can be a dynamic at an interpersonal level between people and intrapersonal within the self, with triggers having either an internal or external origin (Taylor, 2015). For example, Bynym et al. (2021) identified how a shame state can distort an individual's frame of reference, impacting on their capacity to objectively self-evaluate, magnifying negative perceptions. This distortion was not isolated to self-perception but in how people perceive others at an interpersonal level generating judgements, emphasising its relevance to what unfolds between a therapist and a client, as shame straddles both an intrinsic and extrinsic realm.

Nathanson (1992) propounded how people respond to shame by withdrawing, avoiding, attacking the self or others, referred to as the compass of shame representing four main defensive scripts (see figure 1). Subsequently Elison et al. (2006) developed the Compass of Shame Scale (CoSS) to assess how the four coping styles outlined by Nathanson (1992) may be utilised. This has subsequently received supportive validation by Schalkwijk et al. (2016) not only as a measurement of shame regulation styles, but in contributing positively to therapeutic process by identifying aspects around shame which may impede the therapeutic relationship. De France et al. (2017) outlined behavioural expressions of shame termed a 'Shame Code', identifying actions such as freezing, stillness, tension, silence or fidgeting, the latter trait possibly being an unconscious response suggestive of an embodied experience of shame. However, there has been proportionally less research into how these

conceptualisations relate to counselling practice in a meaningful way for therapists, which forms the foundation of this study in exploring shame.

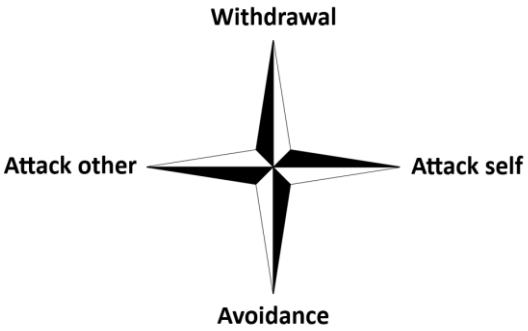

Figure 1 - Compass of shame (adapted from Nathanson, 1992).

Existing research surrounding shame in counselling practice commonly explores the impact on clients and how this influences therapeutic outcomes. For example, Black et al. (2013) looked at the role of shame coping styles influencing the therapeutic alliance, identifying its importance when working with individuals with a propensity to withdraw to avoid overwhelming feelings, disengaging from therapy to protect themselves (Kealy et al., 2021). Arguably, this also highlights the significant value of awareness amongst practitioners, as commented by Longhofer (2013), emphasising the importance of sensitivity concerning its dynamic surrounding identity, gender identity, sexual desire, or orientation. Similarly, the act of seeking help can be shaming, triggering elevated anxiety and vulnerability (Sanderson, 2015). This may be particularly relevant when working with communities or groups who experience discrimination, combined with the fear that accompanies disclosing something to another (DeLong & Kahn, 2014; Gray, 2010).

However, the therapeutic relationship involves both the client and the therapist, where knowledge surrounding shame is relevant to help understand this dyad (Pope et al., 2006 as cited in Klinger et al., 2012, p. 555), yet studies exploring therapists' understanding and experiences of shame are limited, which is surprising given therapy involves shameful events (Ladany et al., 2011). Kulp et al. (2007, as cited in Ladany et al., 2011, p. 309), is an example of research exploring experiences of shame by therapists, where the study examined how shameful events had an impact, for example how therapists reported an embodied experience such as physical tension or its effect on the therapeutic relationship. Importantly, Ladany et al. (2011) defined therapist shame as "an intense and enduring reaction to a threat to the therapist's sense of identity that consists of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (p. 308). This definition summarises and expands on previous discussions in this area, whilst underlining how shame is distinct from other emotional responses such as embarrassment, humiliation, or guilt. Additionally, therapists reported how shame impacted their activity in sessions, such as making apologies, introducing humour, ignoring the event, or alternatively processing shameful events therapeutically with the client in a beneficial way (Ladany et al., 2011).

When considering the broader literature on therapists and shame, there is often a focus on how therapists react or respond, rather than an exploration of how therapists understand and experience it. For example, Mann (2015) outlines how therapists may avoid discussing

matters of an erotic nature due to personal awkwardness. Similarly, Kearns (2011) highlights how shame was evident in therapists who felt unprepared to work with clients in sexual matters on material difficult to approach, causing avoidance or collusion with clients and introjected judgements of incompetence in the practitioner. Given there appears to be little research in this direction, this supports the importance of understanding shame as a surfacing phenomenon within a therapist. For example, Drini et al. (2023) investigated how therapists conceptualise shame, identifying the limited research in this area combined with how shame impacts on the therapeutic process subject to how it is managed and understood by practitioners, emphasising this emotion an important phenomenon.

The value of understanding shame is supported by Fortes and Ferreira (2014), indicating how shame can reduce our empathy towards others and this could have a significant impact on the relationship between a counsellor and a client within the therapeutic dyad. For example, Blundell, et al. (2022) found counsellors faced with boundary issues may respond defensively to avoid feelings of shame. This translates beyond the therapy room in how therapists may find it difficult to share personal material with peers or supervisors fearing invalidation, judgement, or rejection (Smith, 2003). Furthermore, a defensive disposition by a therapist due to shame may influence supervisory processes due to issues linked to self-worth or feeling devalued (Hahn, 2001), with similar issues identified in a study by Yourman (2003), regarding self-doubt and non-disclosure by trainee therapists with their supervisors.

Whilst research into therapists' experience of shame appears limited, studies of shame linked to person-centred therapy are missing, except literature that indirectly associates shame with person-centred concepts. For example, Purton (2000) commented how shame wasn't used in Rogers' writings, yet there should be an interest in this subject given its relevance to person-centred theoretical concepts such as conditions of worth, or the relationship with UPR in creating safe spaces for clients to share difficult feelings. This is supported by Bohart (2017) who argued how a person's conditions of worth is a major factor in their natural capacity for creative and intelligent functioning, self-generation, and self-organizing wisdom in nurturing congruence within themselves. Therefore, shame could be viewed within person-centred terms as a form of incongruence, described as a reduced sense of unity or integration with self and experience or who and how we are in the moment (Rogers, 1956). This contributes to what Rogers (1967) described as the 'fully functioning person' encompassing an open and unrestricted sense of experiencing, trusting, and acknowledging who they are at the core of their being or 'organismic self', with a creative and uninhibited sense of fulfilment, what could be viewed as the opposite of a shame affect. However, there appears to be a significant gap in contemporary literature on shame and person-centred theory, with no published studies on how person-centred therapists understand and experience shame.

This gap is relevant when we acknowledge how therapists' shame has been linked with influencing a variety of therapeutic processes, such as responses to boundary issues Blundell, et al. (2022); disclosures in supervision (Bilodeau et al., 2012) and influencing the therapeutic alliance in both positive and negative ways (Thorburn, 2015). Consequently, this study explored person-centred therapists' understanding and experiences of shame within their practice with a relatively broad approach, examining the findings through the lens of person-centred theory as described in the next section surrounding the methodology and method used.

Methodology

A qualitative methodology was employed utilising interpretative phenomenological analysis (IPA) (Smith et al. 2009), seeking to understand how others make sense of their experiences examining perspectives and meanings. Rather than relying on theoretical preconceptions, this approach explored the phenomenological account on its own terms, exploring how participants make sense of their experiences, committed to an idiographic analysis before encompassing general theoretical claims across accounts. This can be an advantage when examining complex facets of human emotions and experience (Smith & Osborn, 2015), through the discovery of themes, leading to a representative picture of participant accounts and considering how they interconnect. This entails adopting a responsible position given how research may shape what becomes to be known about the experience of participants through interpretation (Willig, 2013). The research findings were contextualised through a critical and theoretical lens of person-centred theory, both authors of this study are person-centred therapists and educators. As authors we aim to cradle the researcher role responsibly through an empathic approach with UPR for the study participants and a non-judgmental attitude towards their experiences; mindful of the dynamic nature of discourse where learning and restructuring takes place. Recent publications surrounding methodological guidance and literature with IPA have been updated with modified terminology such as Smith et al. (2022). Whilst acknowledging how literature evolves, this study unfolded before these amendments were published, rendering this research having fidelity to the available guidance and terminology at the time. To explore meaning and interpretation of a phenomenological lived embodied experience within the delicate territory of shame, IPA was considered an appropriate approach for this study.

Method

Audio recorded semi-structured in-person interviews were undertaken lasting approximately one hour and participants experiences were collected and subsequently transcribed, and then analysed using IPA. Ethical approval was granted by Liverpool John Moores University and in accordance with IPA guidance (Smith et al., 2009), adhering to ethical guidelines for research (BACP, 2019). A sample size of between three to six participants were sought, invited through channels in the therapeutic community, where no reward or payment was offered. For the purposes of this study, they were required to be person-centred or humanistic therapists, being a qualified counsellor or psychotherapist (minimum level 4 diploma) or a student having completed over a hundred hours of clinical practice.

Five participants contributed having met the inclusion criteria, ranging from being newly qualified to having worked in the field for several decades. A pseudonym was assigned to each participant for confidentiality, consisting of four women referred to as Alex, Jackie, Mel, Taylor and one man with the pseudonym Sam. Each participant received information in advance as part of informed consent and referred to at the start of each interview. This

consisted of explaining how exploring the topic of shame may unintentionally trigger something deeply private or uncomfortable, and it was exclusively under their agency to disclose with no obligation. This sought to be clear on the subject area, emphasising sensitive respect to their autonomy and boundaries. This importantly framed the interaction as a safe space to talk, preparing and cradling the participant sensitively and ethically for the interview.

This approach epitomised concepts from person-centred theory applying empathy and unconditional positive regard within a non-judgmental interaction, utilising sensitive engagement and nurturing self-determination (Sandvik & McCormack, 2018). The semi-structured interview consisted of five open questions surrounding participants' understanding and experience of shame and how their experiences as a therapist influenced this understanding. The discussion evolved in an organic way and in a manner where the participant was comfortable exploring and disclosing, this approach was combined with shame awareness by the interviewer (lead author). At the end of each interview, any questions or concerns were reviewed with each participant reviewing any possible impact (Vossler & Moller, 2015).

Analysis embraced the standards outlined by Yardley (2000) for qualitative research, including commitment and rigour from the researchers, engaging in the material with depth and breadth, combined with transparency, coherence, and clarity of process. Transcript analysis utilised the initial steps format in IPA (Smith et al., 2009), where prevalent themes were identified and weighed in terms of interpretation validity regarding what participants were conveying. Themes were subsequently refined where each was repeatedly reviewed to check for plausibility, combined with re-examining interview content as a variation of a recursive, iterative, and accountable interpretative process, to present the following findings.

Findings

The findings represent uniqueness in how shame was articulated (divergence between participants), combined with a degree of convergence supporting existing literature. Two superordinate themes were identified, the first being *'Framing shame'* consisting of two sub-themes of *'Feeling the influence of shame'* and *'Knowing shame'*. The second superordinate theme being *'Transforming shame'* with three sub-themes of '*Impact on practice'*, '*Supervision*' and a term that evolved to be called '*Therapeutic Keys'* as an abstracted sub-theme, describing positive therapeutic processes as depicted in figure 2.

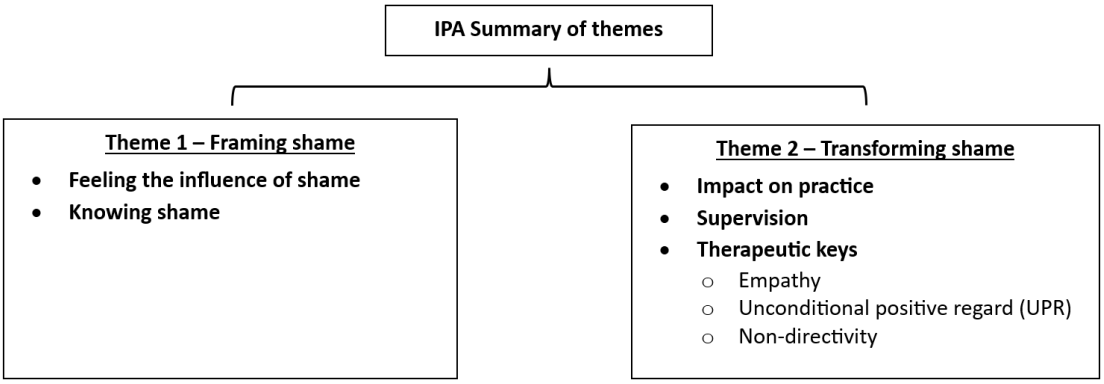

Figure 2.

Theme 1 – Framing shame

Participants explained how they framed shame as an individual and as a therapist, describing various sources of shame that had influenced and shaped their lives. Participants reflected on these sources within the context of knowledge from a therapeutic viewpoint, as well as their personal experiences of shame within the therapeutic relationship or outside of it.

Feeling the influence of shame:
Whilst shame is an innate aspect of being human (Lewis, 1992), its source for all participants was commonly located in the past from personal experiences and childhood traversing time and place, combined with sociocultural issues. For example, Mel articulated **"I think I remember feeling what I'd now associate as being shame from being a small child and I suppose that lies heavily in the judgement of others to our behaviour".** Mel also referred to client work where understanding how shame was embedded in the past appeared important **"look back into his childhood … he never felt as though he was quite good enough …. quite raw feeling of not being praised and not being worthy".**

Another participant (Taylor) suggested how early life experiences shape us in ways that may not be in our awareness, commenting on **"I'm working all the time with people's shame of adverse childhood experiences … shamed by their caregivers … just little critical remarks".** From work with clients, Taylor made specific reference to **"What a shaming society we have become in the way that we shame children and the way we shame people in organisations"** highlighting modern day expectations such as the influence of social media.

The shaming influence of social media was mentioned by Sam, in maintaining a persona or image to others linked to fear of adverse judgement. Referring to values depicted in society through media channels in how a perceived sense of self-worth is associated with visual aesthetics, resources, wealth, or networks. Sam also identified shame with clients located in early life, for example **"the shame tied up with their upbringing … their childhood … but also how they raised their children"** mirroring Sam's personal experience of shame when growing up.

Fitting into cultural demands was expressed by Alex, where she described how self-image and identity can be a source of shame regarding an aspect of who you 'should' be, set against the standards of others to fit in, **"shame I think often is embedded in with what's wrong or what doesn't fit with who you should be …. it's being uncomfortable with part of your identity"** echoing conditions of worth in person-centred theory (Rogers, 1959). Similarly, Jackie highlighted how shame can be associated with culture as to what may be appropriate to say about our parents regardless of their behaviour. She linked this to client work and what may be acceptable and cathartic to express in therapy to address something that would ordinarily be taboo **"so I think for her to say that was quite big 'cause it's not socially normal for people to say that, but in our session because she did … and it was okay, she realised oh actually, that is how I feel".**

Knowing Shame:
All participants explained a converging understanding of shame, regarding the impact on their sense of 'self' yet there was diversity in how it was described, and this may be due to the individual nature of life experiences. In terms of learning about shame, personal experience was a key source of knowledge as commented by Jackie, **"I wouldn't say I've particularly learnt much about shame … through the course, I'd say shame is still my own personal experience"**, explaining her understanding of shame didn't come from training but from life experience and therapy. Additionally, reflective pauses by Jackie during the interview depicted having to think and shape her understanding before continuing, which seems to suggest it can be challenging to frame it discursively even though one may know how it feels. Alex articulated a similar account identifying she had not previously considered shame as something labelled in client work prior to the research interview. Therefore, the interviews highlighted how participants have an idea about shame, but the discussions appeared to activate a reflective process to consider shame in greater depth and the impact on client work.

Hidden in plain sight: Despite being a common phenomenon, participants described shame as being hidden or unspoken. For example, Alex stated **"Shame is something that sits uncomfortably with who I think I am …. if there's something I am uncomfortable with, that's often where shame would arise in me".** Sam highlighted his understanding of shame as natural awareness but recognised it as something hidden, **"from a practitioner point of view, shame seems to be a sort of … a kind of unspoken … kind of thing whereas people may not be able to name it as shame … or feel ashamed of having shame".** This outlined a circular element of 'shame aggravating shame', depicting the challenges of working with clients viewing themselves as unworthy of help and the importance of knowledge around shame. For example, understanding what may be occurring for the client outside their awareness, but also what may be unfolding for a therapist. Taylor also described how the nature of shame can be hidden, stating **"I always describe shame as the hidden emotion … because it's often so well hidden from other people that it becomes hidden from the individual themselves"** and **"it doesn't involve any thought … it's a manifestation of how they are, where they are and how they feel"**; this appears important in terms of how challenging it may be to approach shame with a client. For example, Taylor also added **"shame is one of the basic emotions that would potentially cause us to act out in some way"** and **"the purpose of shame is to keep us on the straight and narrow, so that we are not cast out of the tribe".** This suggests the behavioural influence of shame in how we may react or respond as a natural function of relational interaction.

A discomfort to the core: Shame was described as deeply uncomfortable and distressing to experience, for example Taylor commented **"in my work with people who have experienced shame … it is such a painful experience."** Mel described shame as **"something that's quite dark"** and **"deep rooted messages that you have about yourself"** believing they are not good enough, needing to hide their thoughts and feelings. Furthermore, Mel described how shame renders people feeling **"a need for punishment … to hold on to that shame to punish themselves for what they've done".** This links to how shame may be symbolised for an individual surrounding their personal values and beliefs, societal or cultural values and the challenges in therapy surrounding what may need to be explored to unlock shame for a person.

The nature of shame was described and understood as something embodied as Taylor highlighted **"it's like a nausea … but if the nausea was allowed to come up, it would never actually come out as vomit. It's more like the nausea would cry inside".** This sense of nausea described as crying inside came across very powerfully and there was a convergent aspect around embodied experience of shame by other participants. For example, Mel described **"a real horrible feeling in the pit of your stomach"** and Jackie articulated experiencing being **"hot and sweaty, red faced and wanting to worm out of it".** Taylor reported on client work where shame is experienced in the body such as a burning sensation around the eyes or in the stomach, which echoes work surrounding embodied emotions by Nummenmaa et al. (2014). These accounts of a physical dimension to shame, emphasise how powerful such experiences may impact on our functionality, whether as a client leaning into difficult content or as a therapist handling themselves within the dyad.

Theme 2 – Transforming Shame

This superordinate theme represented experiences within a therapeutic role divided into three further sub-themes of *Impact on practice*, *Supervision* and *Therapeutic keys* consisting of a triune of Empathy, Unconditional Positive regard (UPR) and Non-directivity.

Impact on practice:
All interviews provided converging evidence how shame can impact on clinical work, but with differences between participants as they described their role identity and the dynamic around vulnerability as therapists linked to self-image or professional identity. For example, Taylor outlined how they were not just holding the client psychologically but also themselves within the therapeutic dyad, **"when it's shame it's particularly distressing, certainly distressing for the client … but … might tap into my own stuff".** Sam reported parallel processes surfacing from client work linked to his own personal experience and the challenges facing a practitioner if they risk being triggered by shame. This underlined the importance of self-awareness and how material from clients can be a distraction in the session, highlighting the potential power and influence of emotions on therapists and their work.

Mel emphasised the importance of genuine self-awareness and mindful of forced inner dialogue to convince themselves they are fine when they are not, **"It's just not enough to go oh I'm kind of okay with that now… it's about that real deep rooted '*Okay*', I really do understand where that's come from … and knowing your triggers".** This could be described as congruence within themselves (Rogers, 1959), but also emphasises the importance of self-honesty for therapists. Furthermore, Mel reported how shame was often not named in therapy **"we didn't use the word shame … he spoke about the feelings … that were suggestive of shame"**, outlining how challenging it may be in navigating towards shame and its effects, for example **"this shame … had sort of taken on another entity … within him and he really struggled … and couldn't speak about it".** However, Taylor referred to the importance of courage needed to gently lean into shame issues **"in order to change an emotion you have to arrive at it … and when the time is right it will get transformed … usually with self-compassion".** This was supported in Jackie's interview outlining the sensitivity needed to be sure clients are ready to go down path. Furthermore, Jackie portrayed how self-conscious emotions in a client can make the therapist feel uncomfortable highlighting the importance of awareness, not only in what may be occurring for the client but also what is surfacing in a therapist. This may be particularly important with clients

regarding 'worthiness' if they pick up on subtle discomfort cues from the therapist and empathic connection is reduced.

Supervision:

Three of the participants experienced shame in clinical supervision sessions. For example, Jackie reported how she felt uncomfortable and shamed, impacting on her self-image with surfacing self-judgement at odds with an ideal-self as a practitioner, **"I opened up about something that's very personal to me and I felt like some weeks it's as if she prodded me to speak about it again, when in myself I felt fine … it would bring me down … oh, I've got to deal with this again".** Jackie reported the obligation to acquiesce was at odds with concepts of non-directivity for person-centred therapists, but it strengthened her understanding and value of working in a client-centred way.

Similarly, Alex outlined supervisory experiences impacting on self-image, self-worth, and confidence, questioning themselves **"I think for me shame happens most in supervision"** and **"where it makes me think am I doing the right thing, am I practising the right way, and you kind of question who you are".** It seemed Alex experienced stress during supervision from a combination of duty to be transparent, a sense of exposure and vulnerability, with an impact on how they viewed themselves as a therapist. This may be particularly pertinent to people in training or newly qualified, especially given the unavoidable power dynamic in clinical supervision and the professional framework therapists work within.

In contrast to Alex and Jackie where supervision had triggered shame, Sam outlined how supervision helped transform shame from client work. Expressing a confident openness around his shame triggers with self-compassion, linked to knowledge acquired from developmental reading, self-awareness, positive self-regard, and congruence. This supports the importance of understanding powerful self-conscious emotions such as shame in its influence on practitioners in clinical work.

Therapeutic Keys:

These consisted of a triune of empathy, unconditional positive regard, and non-directivity as key person-centred concepts (Rogers, 1957, 1959, 1980).

Empathy:

Empathy is accurately perceiving the frame of reference of another, including sensitivity to meanings and emotional content (Rogers, 1959), where empathic understanding of clients was evidenced in all five interviews but expressed in different ways. These were linked to participants' personal experiences and how they used it to help clients transform their feelings of shame. For example, Sam referred to his upbringing and how this facilitated empathic depth with clients, aware of the impact of shame, depicting a constructive and liberating level of empathy as **"I get you, it's okay I'm with you".** Likewise, the concept of being in it together and having this unique 'knowing' was evident when Taylor described how her own background was a factor in nurturing and managing empathic connection but can sometimes be difficult, suggesting a fragility to empathy when approaching shame. However, this also included a necessity in trusting the process when the client may be unaware and vulnerable, especially when venturing into unfamiliar or difficult emotional territories with clients. As Taylor commented, **"just watching for signs of it becoming too much and helping**

them to pull back if it is too much", psychologically holding the client in therapy, feeling *with* the client in a balanced supportive way.

This connection as a creation of empathy was also reported by Jackie explaining **"it's as if my heart like contracts more … like I really feel it"** (from a client recounting shameful experiences) and **"the conditions of empathy … I think it sort of aids you to deal with shame, not necessarily … treat the shame, but just assist the person in acknowledging the shame … help you to sort of unravel it".** The accounts outline how shame can inhibit the ability of a client to reflect and speak freely about self, but empathy facilitated a connection to gently approach material in a supportive way, potentially reducing the intensity of shameful experiences.

Unconditional Positive Regard):
Unconditional positive regard (UPR) represents one of the six necessary and sufficient conditions described by Carl Rogers as a 'positive feeling without reservation and without evaluations. It means not making judgements' (1962, p. 94). This appeared important for transforming shame with all participants, for example Alex commented **"there's that trust that there's no judgement in there, I think it's quite a refreshing environment for someone to explore their shame … if you don't feel judged from exposing yourself".** This extract suggests a multifaceted level of processing, freeing for the client, involving not feeling vulnerable and being able to speak the unspoken in a safe yet revealing way. However, Alex also explained the importance of handling inconsistent client narratives or 'untruths' non-judgmentally, outlining how it takes time for clients to trust and accept who they are and feel safe with their shame.

Mel referred to how UPR benefitted a client navigating shame by **"allowing them to get back in touch with themselves and … being the experts of what their experience is",** supported in how Taylor reflected on her own personal shame **"nobody else will ever describe my shame the same".** Therefore, the value of UPR in developing a trusting space to explore shame was beyond what confidentiality could provide. For example, when Jackie described her experiences of personal shame fearing judgement, **"if it was me opening up, whether they would judge me even if I know it was confidential, just to have admitted something"**, framing a depth of connection within UPR in client process.

Non-Directivity:
Non-directivity relates to the therapist following the client's lead when responding to content in a natural non-dominant manner (Rogers, 1951) and this had a convergent value in the narrative of all participants. This was reported as standing back and allowing the process to unfold, sometimes dealing with internal dialogue. For example, Sam referred to **"I feel … should be doing more"** during client work with frequent silences, identifying the urge to help related to their self-image in a therapeutic role, not wishing to appear incompetent to themselves or the client. Therefore, the concept of non-directivity may tug at a therapist's values, motivations or how they may wish to be seen as '*good*' practitioners. However, respecting the client's frame of reference is key as Alex highlighted **"it takes a long time for something like shame to come out and I think it's not about you pushing them … clients give you this … piece by piece rather than telling you outright … a little bit at a time."**

Alex emphasised the importance of '*patience*' laminated within non-directivity, being mindful of what surfaces as a compulsion in a therapist to express or facilitate something. This aspect was mirrored by Mel referring to a balancing act **"there's always that sort of tight rope of wanting to explore those negative feelings … but also being very aware of … is that person going to be able to explore that?".**

Mel underlined a risk to 'pushing it' where it may be too much at that stage for a client to explore, causing withdrawal or avoidance (Nathanson, 1992). This was emphasised by Jackie from personal experience in clinical supervision regarding her experience of being 'pushed', reflecting on their increased sensitivity of whether a client is **"ready to go down that path"** and being there with them for when they are. Furthermore, Jackie's experience of shame in supervision had reframed their understanding of non-directivity significantly and its value as part of a client's experiential process. For example, **"when we're talking about shame … it's something that's uncomfortable for that client … you don't know quite where it's going to go …. And it's just about having maybe a little more ease in allowing that to go where it needs to".** Likewise, Taylor emphasised **"there is a process by which we would just allow emotion to unfold"** suggesting non-directivity as both allowing and accepting.

Besides what was evident in the data, it is appropriate to briefly mention how incongruence did not surface as a key theme linked to shame. This is associated with what Rogers (1959) described as a discrepancy between self as perceived and their actual experience. However, incongruence did indirectly shadow participant accounts and there could be several reasons for this. For example, there may be elements of shame yet to be studied surrounding the degree it can impact on a person's self-concept. Nevertheless, the findings outlined a collective acknowledgment of how influential shame can be, but divergence in how this was articulated given the unique nature of individual experiences which appeared to be the main source of knowledge on this topic. It was evident shame had an impact on practice and the '*self*' in different ways as expanded upon in the following discussion section.

Discussion

Whilst a degree of parallel content would exist between the literature review and this subsequent discussion section, the nature of this exploratory study rendered additional references appropriate as an aspect of the findings and interpretation process, representing an evolutionary facet to this study.

Shame was common in participant histories with continuity into the present. This underlines the variability and complex nature of shame regarding its source in how one can be 'shaped' by early life experiences in ways that may not be in our awareness. For example, shame can stem from a lack of attunement with primary caregivers during childhood, rendering a belief that one is unlovable (Walker, 2011; Yard, 2014). When considering the self-concept (Rogers, 1951), configurations of perceptions between self-image and ideal self may vary subject to introjected conditions of worth, resulting in a 'conditioned self', not authentic to the 'organismic self' (Merry, 1999). In support of this, both Taylor and Sam commented on the collateral impact of shame from adverse childhood experiences. For example, how verbal shaming and degrading treatment reduces self-worth (Coates et al., 2013; Flynn et al., 2014; Wille, 2014) and this translates into adulthood with an over developed 'threat handling system' from a lack of feeling safe when younger (Pinto-Gouveia et al., 2016). This was

supported by Alex describing how shame is embedded in what **"doesn't fit with who you should be"**, suggesting tension between the latter and *how we want to be* in terms of the self-concept. This can translate to unwanted identities (Brown, 2006; Sanderson, 2015) surrounding how to feel, think, and behave as a product of parental or cultural expectations, reinforced through social norms and the media.

However, shame can stem from experiences other than parental influences such as (dis)ability, social class, wealth, race, gender, or sexual orientation (Greenberg & Iwakabe, 2011; Longhofer, 2013; McKenzie-Mavinga, 2016). Nevertheless, whilst the 'self' emerges needing positive regard, if personal experiences are discriminated against by significant others, self-regard become conditional on how others respond (Sanderson, 2015), which may be linked to conditions of worth under person-centred theory (Rogers, 1951). Therefore, how one develops through life to who they are now may influence responses to shame within their frame of reference (Rogers, 1951), combined with the significance given to a situation or event where shame may surface from an activated memory (Nathanson, 1992). This was evident in participant material such the way Mel referred to the impact of feeling not worthy. Whilst participants had converging descriptions of shame from life experience, there were divergent context surrounding individual 'knowledge sources', with little evidence regarding the topic being covered much during training; for example, in how Jackie explained **"I wouldn't say I've particularly learnt much about shame … through the course, I'd say shame is still my own personal experience".** This is supported by Tangney and Dearing (2011) and Sanderson (2015) concerning limited discourse and material on shame during training, rendering challenges for therapists to develop their understanding and impact in therapy. An example concerns how shame is often confused with guilt (Miceli & Castelfranchi, 2018; Nathanson, 1992), the difference is important since shame has an internal locus with the person having greater concern for themselves (Behrendt & Ben-Ari, 2012), whereas guilt is 'other' oriented (Deonna et al., 2012; Yard, 2014). This underlines an important distinction surrounding knowledge on shame compared to other emotions.

Notwithstanding knowledge from training, therapists need to understand their own shame to work effectively with clients (Sanderson, 2015). This links to 'knowledge of self' and Von Haenisch (2011) highlighted the value of personal therapy for trainee therapists in developing self-awareness to use skills confidently and professionally. Supported by Thériault and Gazzola (2006), identifying lack of knowledge as a source of perceived lower competence, which may render a therapist vulnerable concerning self-image and 'worthiness' within a role identity, possibly making it difficult to discuss in supervision. Alex gave an example of this when she articulated **"Am I practising the right way and you kind of question who you are".** Sam referred to **"… a kind of unspoken … not be able to name it as shame … or feel ashamed of having shame"**, using other words for an emotional experience in lieu of acknowledging something difficult to discuss (Lindsay-Hartz, 1984; Tangney & Dearing, 2002). Therefore, given shame can be described as a forbidden communication (Kaufman, 1974; Lewis, 1992), such difficulty may render a reactive measure in people withholding information (Burmeister et al., 2019).

This was evident in this study where the word 'shame' was not used or could not be spoken of, which is reasonable given talking about shameful feelings can generate shame (Biddle, 1997; Yakeley, 2018). Mel gave an example in her client work, **"we didn't use the word shame … he spoke about the feelings … that were suggestive of shame".** Furthermore, this may also be outside of awareness as Taylor commented **"it's often so well hidden from other people that it becomes hidden from the individual themselves".** Therefore, practitioners may not

be aware of their surfacing shame in clinical practice, emphasising the importance of developed self-awareness and understanding. This is supported by literature concerning emotions denied to the self (Talbot, 1995; Wurmser, 2015) or accompanying other feelings where there may be a degree of masking beyond awareness (Wheeler, 1997). Additionally, Lewis (1992) commented how shame reveals its shadow amongst other symptoms or clues, for example where clients use negative self-narratives (Lewis, 1971), in what Morrison (2011) referred to as using a language of shame linked to self-loathing, which may be code for what a client is seeking to express.

Another expression of shame in the findings was through an embodied experience, and whilst it may be hidden or avoided in discourse, understanding bodily felt experiences through careful exploration may be key to reveal what is unfolding. Taylor gave an example in how **"it's like a nausea … it would never actually come out as vomit. It's more like the nausea would cry inside".** Linked to person-centred theory, a facet of experiencing is termed the phenomenal field within which a person discriminates the self or 'organismic self' (Rogers, 1959), yet a person may be unaware of what their emotional reactions symbolise. For example, Rush (1994) explained this as an expression of emotional affect when words may not consciously be available, or where our bodies respond to shame before conscious awareness (Brown, 2006; Brown, 2007). This underpins the importance of shame awareness given what unfolds is beyond just words, where behaviour may contain valuable information on what may be occurring for a client at an interpersonal and intrapersonal level (Rogers, 1980).

Whilst the latter surrounds client material, it is equally important to consider what therapists handle because clients can potentially shame counsellors (Stadter, 2011), such as feedback creating a poor self-image triggering strategies to avoid scrutiny from others (Blundell et al., 2022; Morrison, 2011). Furthermore, clients have difficulty talking about shaming aspects of their stories and this can be exacerbated if the therapist's awareness of shame is limited (Sanderson, 2015). For example, therapists may find it threatening to the relationship, where motives may steer the narrative away from looking at difficult facets of clinical work (Poulson, 2000). This links into earlier references regarding protective measures from a sense of devaluation (Hahn, 2001), either colluding to avoid material (Klinger et al., 2012) or defensive practice due to shame in the practitioner (Blundell et al., 2022). This emphasises the importance of knowledge and awareness of oneself, being congruent with our internal world to stay with a client, as participant Mel commented, **"knowing your triggers".** This is supported in a study by Gross and Elliott (2017), identifying how therapists became momentarily disconnected, overwhelmed, over identifying with material, causing moments of incongruence involving shame and intrapersonal criticism directed towards the self.

Linked to perceptions of self, Sanderson (2015) outlined how shame influences identity within prescribed roles in society, needing to protect boundaries of the '*self*' (Kaufman, 1974; Nathanson, 1992), especially concerning vulnerability to an approving other such as supervision (Biddle, 1997). This highlights how therapists are not immune to feeling inadequate or fear judgement (Gilbert, 2011), with a potential collateral impact on practice (Tangney & Dearing, 2011). This was evident in the account by Jackie in supervision surrounding an expectation to talk about a personal matter disclosing **"it would bring me down".** This rendered a counterproductive effect from triggered shame, what Nathanson (1992) referred to as 'shame-mood', and referencing his compass of shame model, if the supervisee *withdraws* inwards due to self-conscious emotions feeling shame, the time with a supervisor may not be utilised effectively (Fortes & Ferreira, 2014; Ladany et al., 2011).

Furthermore, the supervisor is also vulnerable to shame experiences (Kearns, 2005), where their sense of self-worth and reputation is reliant on the perception of the supervisee (Sherman, 2015). Therefore, the value of understanding shame in training programmes also extends to clinical supervisor courses.

Notwithstanding the important role of supervisors, the power differential can lead to feelings of self-doubt and distress which needs to be recognised (Barnett & Molzon, 2014; Cook et al., 2018), potentially impacting negatively on supervisees with lowered self-perception impacting on client work (Beddoe, 2017). Alex expressed this in her account **"… for me shame happens most in supervision** …. **and you kind of question who you are."** However, as Adams commented (2014, p. 116) "no matter how potentially good the supervisor is, they will only be as good as we allow them to be," and when we experience a reluctance to bring something to supervision, it probably *really* needs to be presented. This highlights the importance and value of supervision, where an emotional impact or feelings of inadequacy can be explored, and options considered in a safe setting (Hawkins & Shohet, 2012).

Within person-centred theory, empathy has a role in generating a safe setting, representing one of the therapist's provided conditions amongst the six necessary and sufficient conditions of therapeutic personality change (Rogers, 1957). Empathy was important for transforming shame from all participants, outlining how their personal experience of shame amplified sensitivity, understanding and empathic capacity. This is supported by Gerace et al. (2017) identifying the value of previous experiences as an asset to help understand others, with the caveat it involves self-reflection independent of the relevant episode. Brown (2010) commented how empathy serves as a strong antidote for shame enabling material to be disclosed, where the client experiences themselves from the mind of another with understanding, validation, and acceptance (Gilbert, 2011). For example, in how Alex described it as **"quite a refreshing environment … if you don't feel judged from exposing yourself".** However, shame can also create a diminished capacity for empathy from focusing inwards and less on another (Fortes & Ferreira, 2014), involving self-orientated reactions from needing to ameliorate their own emotion difficulties (Tangney, 1991). This was supported by two participants such as Taylor describing **"go into oneself and it's all about me … it's about I'm not good enough"** and Alex articulating **"I didn't know what to say … how to react and it didn't feel like normal".** This is particularly important because of how it can affect a therapist in managing emotional demands, especially given shame can surface out of immediate awareness (Brown, 2006; Brown, 2007). This links with the compass of shame model (Nathanson, 1992) regarding withdrawal, avoidance, attacking self or others, combined with limiting empathy from the nature of how shame interrupts communication. These aspects emphasise the importance of knowledge on this topic to 'feel safe with our own shadow material and tolerate being emotionally stirred up by our clients' (Gilbert, 2011, p. 339).

UPR was identified in all interviews which contributes towards feeling safe with such shadow material and this was articulated by Alex in their account using key words of '*trust*' and '*no judgement.'* This is significant in person-centred psychotherapy, for who a person '*is*' at the core of their being is a very private realm, representing the 'organismic self' (Rogers, 1959). Therefore, what clients perceive through interactions can contribute towards a self-affirming identity (Kaufman, 1974), for example not experiencing being judged regardless of what they speak of. Interestingly, UPR was evident when perceiving untruths from clients such as Mel who outlined the challenges of working with inconsistent client accounts, and Alex stating, **"it's about letting them have that time to come round to telling you".** Walker (2011) outlined how lying can be a defence against shame to protect a self-image viewed as flawed, and

Worsley (2012) explained client discourse may carry multiple meanings, revealed progressively, appearing to change as more is discovered. Alex underpinned this in her comment **"it takes a long time for something like shame to come out … a little bit at a time".** This emphasises the value of knowledge and awareness of how shame functions to protect, for example in how Kemp and Lorentzatou (2013) commented on 'truth', where clients reveal more of themselves as trust matures to disclose something difficult, not only to the outside world but to themselves.

Shame also involves a sense of control over what and when a person is prepared to disclose (Velleman, 2001 as cited in Deonna et al., 2012, p. 30). This was depicted by Mel who expressed a balancing act around non-directivity, **"that sort of tight rope of wanting to explore'** and **'is that person going to be able to explore that?"**, emphasising the importance of client freedom to explore and consider their world view or experiences uninhibited (Velasquez & Montiel, 2018). Alternatively, to convince a person otherwise of their experience can deny a sense of reality to feelings, engendering further shame and low self-worth through invalidation (Kaufman, 1974). This is supported by Warner (1991) suggesting clients may doubt their right to have an 'experience' and what it means to them, which may compromise the opportunity to access deeper layers of understanding or therapeutic outcomes, especially given the influential power shame has in the therapeutic dyad (Klinger et al., 2012).

Similarly, Jackie's experience outlined this power from being *pushed* in supervision, combined with the diminishing effects of shame, where powerlessness can be linked to worthlessness (Proctor, 2017). However, Jackie's experience developed an elevated respectful understanding on whether a client is **"ready to go down that path"**, highlighting the value of non-directivity, facilitating the agency of the client surrounding their own internal process and self-organising wisdom (Bohart, 2017). Additionally, Wosket (1999) commented how clients keep things hidden until they're ready to disclose, presenting alternative dilemmas as part of seeking a trust building response (Greenberg & Geller, 2001), because trust is essential in creating a safe space to explore shame (Johnson, 2006). An example was in the account by Alex in how clients give **"a little bit at a time"**. In terms of shame for the therapist, Lyons et al. (2018) commented on issues from a threat to personal and professional identity, for whilst practitioners may be advocates of care for others supported by operational theories, similar kindness may not be directed inwards for themselves. Whilst this study was not structured to specifically explore reflective processes within participants, evidently the interviews nurtured them to think about shame in greater depth, through sensitive and respectful dialogue, framed in person-centred concepts such as being non-judgmental and having UPR. Consequently, the findings suggest practitioner development programmes could include similar reflective discussions surrounding the effects of shame as good practice.

Whilst the findings cannot be generalised from the small sample, they support existing literature in shame affects, its impact in therapy and the apparent limited training on shame (Sanderson, 2015; Tangney & Dearing, 2011). This is important as therapists deal with personal feelings of incompetence throughout their careers, regardless of their efficacy with clients (Thériault & Gazzola, 2006), and shame exists in any encounter as an inherent boundary phenomenon in human interaction (Kearns, 2005). This aspect returns to the earlier theme of 'knowledge' which appears a key implication for practice, not only in terms of skills but self-care; emphasising the value of therapists recognising signs of shame and the conditions within which it can breed, whether in the client or themselves. Watkins (2009) emphasised this in how practitioners need to acknowledge their own wounds and

vulnerability as a component part of understanding the experience of others. This underlines what Rogers (1951) stated in his propositions, for when we understand and accept ourselves, we can be more accepting and understanding of others.

Limitations and critical evaluation:

A limitation in this study surrounds the challenges of discussing shame given it has the capacity to create it (Lewis, 1992; Yakeley, 2018), for example being ethically careful within the research interview cautious of not triggering shame. Whilst interviews were openly contributory, from a 'suspicious interpretative' standpoint (Smith et al., 2009; Willig, 2013), the participant interviews contained terms affiliated with person-centred theory or 'discursive repertoires' (Wetherall & Potter, 1988) which could be linked to a distancing of experience. This could be connected to a phenomenon of interaction where language communicates how we want to be seen and how we see ourselves within that experience, conforming to social roles and expectations (Crisp, 2015). This may involve adopting protective measures, avoiding shame potential exposure during dialogue or 'psychological contact' (Rogers, 1957), because talking about areas of shame may understandably amplify its effects (Biddle, 1997); this may render any degree of reticence by participants unknown. Whilst semi-structured interviews provided freedom to explore participant experiences and understanding without being too rigid, the role of the researcher is acknowledged in how meaning is co-created with participants and how data evolves as a product from this interaction (Finlay, 2011). The exploratory approach of this study has generated more questions around facets of shame from a person-centred perspective, such as understanding incongruence (Rogers, 1959) or the impact of shame on the self-concept (Rogers, 1951), but such territories could be the subject of future studies.

Concluding summary:

There was consistency in the experiences of participants about how influential shame can be, but divergence between participants surrounding the way shame was understood from the unique nature of individual experiences. This was the participants primary source of knowledge and understanding of shame, rather than training, which was utilised to connect and support clients in an empathic and therapeutic way.

In terms of shame and person-centred theory (Rogers, 1959, 1957), the non-directive and non-evaluative nature of this approach cradles the challenges of working with shame. For participants, empathy and UPR facilitated exploration of shame with clients which led to a nurturing of their self-concept, and an examination of their conditions of worth. This report focused on person-centred theory; the issues identified could be applicable to any modality given how this master emotion permeates the territory of therapeutic work. Whilst this study sought to explore how the person-centred approach may help to understand and work with shame, the research generated more questions than answers, emphasising the gap in currently available literature. Nevertheless, this paper argues shame is a key subject area that should not be overlooked in terms of knowledge for therapeutic work, whether during initial training or subsequent professional development. Lastly, given the complex nature of shame, contrasting with negligible literature within a person-centred framework, further research is recommended.

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