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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. Shame may be outside or on the edge of awareness manifesting itself in different ways. 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) which identified two themes: *Framing Shame* and *Transforming Shame*. Shame impacts on the efficacy of therapeutic work and supervision. Therefore, approaching shame from a place of principled non-directivity may be helpful for transforming shame in therapeutic work because it supports the therapist to empathically attune to the client, so clients can explore these experiences at their own pace. This paper considers these themes through the lens of person-centred theory, recognising the importance of understanding this powerful emotion from its source in past events and experiences.

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

Shame is one of a range of powerful self-conscious emotions (Sanderson, 2015); "shame literally makes a person shrink: the eyes drop, the head hangs, the chest collapses, the shoulders curve forward" (Kepner, 2003, p. 36). Definitions vary across disciplines (Wheeler, 1997) and cultures (Silfver-Kuhalampi et al., 2013), and its impact on therapeutic relationships and processes can be extensive (e.g., Blundell et al, 2022). However, whilst there is significant research around shame (e.g., Morrison, 2011; Nathanson, 1992; Poulson, 2000), with some studies focused on dynamics in therapeutic practice (e.g. Allan et al., 2016; Black et al., 2013), there appears to be no evident studies linked to person-centred psychotherapy and shame. Therefore, this study sought to address this gap and build upon existing research by exploring shame through the lens of person-centred theory.

Person-centred theory stems from the work of Carl Rogers in the 1940's (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); helped to develop trust and acceptance for who they are, without judgment or expectations, in what Rogers (1951) described as conditions of worth to be valued and accepted. The client is provided with an empathic environment for authentic self-exploration and cradled with unconditional positive regard (UPR), involving a non-discriminatory 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).

Reality for a person is based on what Rogers (1959) described as the phenomenal field relating to the sensory and visceral experience in the moment and the perception derived from external and internal experiences, interpreted via their frame of reference subject to whether such experiencing is distorted or authentic. Through the client's authentic connection with themselves at the core of their being, their self-actualising process is nurtured. Person-centred personality theory explains that when there is no threat to the self, a revision can take place to assimilate and integrate experiences which facilitates recovery, change and growth through developing congruence within the self-concept between a self-image and an ideal-self combined with a sense of worth and validity in the world (Rogers, 1959). A contrasting position involves psychological maladjustment from distorted or denied sensory and visceral experiences (Rogers, 1951, 1959), perceiving the self as flawed influencing our behaviour (Shen, 2018).

Therefore, this study explored person-centred therapists' understanding of shame, whether from personal experience or within client work in counselling. For clarity, 'counselling' and 'psychotherapy', are referred to interchangeably surrounding the delivery of talking therapies with no general distinction. Building on existing research, the following literature review expands on current conceptualisation of shame and its dynamic within a therapeutic setting.

Literature Review

Defining 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). It contributes to social cohesion, maintaining the collective interests of a group and individual identity within it (Burgo, 2018). Therefore, it can be recognised as a natural phenomenon of the human condition and is linked to survival (Henderson, 2006; Van Vliet, 2008). Lewis (1992) recognises shame has a complex and dynamic existence with other emotions, and other commentators have referred to shame as the master emotion (Brown, 2010; Poulson, 2000; Scheff, 2003). Definitions vary but converge on common facets involving disruption to thought, 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, p. 569). Lee (2003, p. 3) described shame as "that cringe we feel when we discover or imagine that the connection we desire is threatened or impossible…. or more than we deserve." Talbot (1995, p. 339) believed "shame is associated with the hidden parts of ourselves, buried deeply enough to avoid scrutiny by others and, in many cases, by ourselves." Therefore, these varied sources share common themes in describing shame.

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, or non-existent (Buss, 1999), generating a negative self-evaluation or social-evaluation perspective independently of any extrinsic feedback (Laing, 2022). For example, Bradshaw (1988) described how we may have an adversarial relationship with ourselves as a product of shame that can bind us, restricting our liberated selves with a self-directed contempt where oneself may not be trusted, risk isolation and feelings of being disconnected (Bradshaw, 1988; DeYoung, 2015). Whilst shame is ubiquitous in everyday life, it remains an invisible phenomenon (Scheff, 2014), and is an unavoidable facet of psychotherapy practice (Dearing and Tangney, 2011). This highlights the importance of understanding this natural human emotion within the dynamic of therapy, not only in clients but also as therapists. For example, the paradox where 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, and possibly compromising client outcomes (Pope et al., 2006). Many of these cited publications reference other research framing current theory on shame, highlighting a value to this research given the absence of direct studies within a person-centred paradigm.

In distinguishing the difference between shame and other similar experiences, it is appropriate to acknowledge some authors may categorise 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, reducing the degree to which it may be internalised, potentially generating a desire 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 quality of the therapeutic relationship.

Shame and therapy

Existing research surrounding shame in counselling and psychotherapy 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 through utilising questionnaires with patients, identifying its importance when working with individuals with a propensity to withdraw from others to avoid overwhelming feelings. Similarly, Kealy et al. (2021) utilised questionnaires with patients and identified how they disengaged from therapy to protect themselves. The shame strategy of withdrawal and avoidance was conceptualised by Nathanson (1992, p. 312) in his compass of shame model, which also included attack on self or others. Arguably, this also highlights the significant value of shame awareness amongst practitioners, as in a commentary 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, as identified in a study by DeLong & Kahn, 2014 utilising questionnaires with service users. In contrast to the mentioned quantitative studies, Gray (2010) undertook a qualitative study with counsellors within alcohol and drug support services utilising semi-structured interviews, identifying how shame and stigma presented barriers to working therapeutically. These examples outline how this qualitative study on shame through the lens of the person-centred approach presents a novel contribution to existing literature.

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). For example, the dynamic nature of therapeutic work means we can get caught off-guard or tripped up unexpectedly through being triggered. Yet, studies exploring therapists' understanding and experiences of shame are few which is surprising given therapy involves shameful events (Ladany et al., 2011). 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). Whilst therapists have reported processing shameful events therapeutically with the client in a beneficial way, they also disclosed how shame influenced their activity in sessions, reacting by making apologies, introducing humour or ignoring the event (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 on sexual matters surrounding 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, it supports the importance of understanding shame as a surfacing phenomenon within the therapist. In one of the few studies in this area, Drini et al. (2023) investigated how therapists conceptualise shame through discourse analysis from their experience of client work, identifying how shame impacts on the therapeutic process depending on how it is managed and understood by practitioners. The value of understanding shame is supported by Fortes and Ferreira (2014), indicating how shame can reduce our empathy towards others, potentially impacting on the relationship between counsellor and client. This translates beyond the therapy room in how therapists may find it difficult to share 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 from issues linked to self-worth or feeling devalued (Hahn, 2001). This was echoed in a study by Yourman (2003) examining supervisory dyads from a psychodynamic perspective, identifying shame as a cause of non-disclosures by trainee therapists with their supervisors for fear of appearing incompetent, impacting on the supervisory process and personal development.

Shame and person-centred psychotherapy

Whilst there are a few studies into therapists' experience of shame (e.g. Black et al., 2013; Drini et al., 2023; Kavner & McNab, 2005), research on shame through the lens of person-centred theory appears absent. However, there are person-centred therapists delivering training that explores shame and its relationship with person-centred concepts (e.g., Skelton, 2023a, 2023b, 2024), and the popularity of this training evidences a desire from therapists to understand shame from a person-centred perspective. 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 unconditional positive regard in creating safe spaces for clients to share difficult feelings (Bohart, 2017; Purton, 2000). Therefore, shame could be viewed within person-centred terms as a form of incongruence, described as a reduced sense of unity or integration with the self and experience (Rogers, 1956). Nevertheless, there appears to be a significant gap in contemporary research in shame and person-centred theory. Importantly, this gap is relevant in 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, examining the findings through the lens of person-centred theory, utilising a qualitative approach as outlined in the next sections on methodology and method.

Methodology

A qualitative methodology was employed exploring themes utilising interpretative phenomenological analysis (IPA) (Smith et al. 2009). IPA involves a phenomenological approach to explore the conscious experience of a person's life-world by analysing accounts of lived experience (Merriam, 2009). It seeks to understand how they make sense of their lives, examining perspectives and meanings, where this study explored person-centred therapists' understanding and experiences of shame. IPA research aligns with the philosophical facets of a person-centred approach to psychotherapy thus facilitating a cohesive approach to the research process, for example how a person perceives and experiences their phenomenal field (Rogers, 1951, 1959). Furthermore, as person-centred therapists undertaking this research, the empathic, non-directive and non-judgmental attitudes provided (Rogers, 1959), were valuable in creating interview spaces for participants that felt safe, this was especially important navigating issues linked to shame. Findings were contextualised critically through a person-centred theoretical lens, taking care to ensure that interpretations were data, rather than theoretically driven (Finlay, 2011), adopting a responsible position with interpretative processes (Willig, 2013). This study was undertaken before recent amendments to IPA were published (Smith et al, 2022), therefore the available guidance and terminology at the time is utilised.

Data collection and ethics

This study interviewed person-centred therapists about their understanding and experiences of shame using individual semi-structured in-person interviews. A sample size of between three to six participants were sought in line with IPA guidelines (Smith et al., 2009). Participants were invited through channels in the therapeutic community and no reward or payment was offered. Inclusion criteria required being a person-centred therapist, being a qualified counsellor or psychotherapist (minimum level 4 diploma) in the UK or a student having completed over a hundred hours of clinical practice. These criteria were important to explore shame from a person-centred perspective, combined with a minimum requirement in terms of clinical experience which omitted trainee therapists. The latter was considered necessary given trainee therapists have variable experience of client work or theoretical application and may also deal with personal insecurities and doubts (Cartwright & Gardner, 2016; Skovholt & Rønnestad, 2003).

Ethical approval was granted by Liverpool John Moores University in accordance with IPA guidance (Smith et al., 2009), and ethical guidelines for research (BACP, 2019). Participant information was provided in advance as part of informed consent on how the topic of shame may unintentionally trigger something deeply private or uncomfortable with no obligation to disclose; this was repeated verbally as reassurance before

each interview and questions invited surrounding participant care. This study sought to be clear on the subject area from the outset, emphasising sensitive respect to the participants' autonomy and boundaries with shame awareness, responding to any cues of discomfort or difficulty, where interviews were framed as safe spaces to talk. Empathy and unconditional positive regard within a non-judgmental interaction was provided to participants, utilising sensitive engagement and nurturing self-determination (Sandvik & McCormack, 2018).

Five participants consented to taking part, ranging from newly qualified therapists to having worked in the field for decades. For confidentiality a pseudonym was assigned to each participant, consisting of four women referred to as Alex, Jackie, Mel, Taylor and one man with the pseudonym Sam. The individual interviews lasted approximately one hour exploring therapists' understandings and experiences of shame in their therapeutic work, from the perspective of their person-centred modality and its influences on this understanding. Each interview concluded with a review of any perceived impact of discussing shame as part of participant care (Vossler & Moller, 2014).

Positionality

Identifying and understanding our own positionalities as person-centred therapists undertaking research nurtured a thoughtful process of awareness (Jamieson et al., 2023). This represented how our experiences and worldview from clinical practice may inform our understanding and analysis as researchers (Finlay, 2003; 2011). For example, acknowledging we are person-centred therapists, sharing an *inside* position with person-centred participants (Berger, 2015), with conceptual knowledge of its theoretical tenets combined with individual experiences as practitioners and as people with our own private shame stories. A summary of our positionalities is shared below:

David Gwynant Hughes:
My understanding of shame stems from personal experience in early life as a natural product of interacting and learning at a societal and familial level. This understanding evolved through working in the public sector in London and North Wales, bearing witness to suffering in society and how powerful shame can be for anyone, exacerbated by other factors such as trauma, resources, access to services and media. However, my theoretical understanding of shame evolved after studying at post-graduate level in person-centred and experiential practice, this being a core modality alongside other subsequent training. The person-centred approach chimes strongly as it links to previous studies as an undergraduate learning phenomenological psychology, being very aware of the uniqueness of a person's experience and I am only a visitor in their reality. These experiential facets coalesce to help understand the texture of shame with curiosity and humility, whether as a researcher, a therapist or as an individual embodying the human condition.

Peter Blundell:
I am a white gay man who is in his early 40's. I work in multiple professions and roles, including academia, social work and psychotherapy. A person-centred philosophy informs my world view, including my work across these different roles. Aspects of my identity intersect between marginalisation and privilege and these multiple and conflicting 'positions' have influenced my understanding and experiences of shame. As a gay man I have experienced marginalisation because of my sexuality, which has resulted in managing my own feelings of shame and conditions of worth (see Blundell et al. 2022). As a social worker I have observed the impact of oppressive systems on people and how this can cause and/or deepen feelings of shame. However, it has been through my role as a person-centred therapist that I have been able to understand the challenges of working with shame therapeutically and how this can be both slow and painstaking work. I approached this study with a keenness to understand how other person-centred therapists understand and work with shame, and a hope that sharing these stories would help other therapists to understand and consider their own therapeutic work in this area. This insider status to the research topic has been helpful to understand the participants' experiences on a deeper level whilst also enabling those experiences to be placed within a person-centred theoretical context.

Data analysis

The data gathered were analysed by the lead researcher (DGH) using the initial steps under IPA (Smith et al., 2009). This involved listening to each interview and initially creating a verbatim transcript. Then reading and re-reading each transcript, returning to the recording, checking the fabric of what was said, whilst noting language use and semantic content. This developed emergent themes and associated connections reflecting upon 'What is this participant telling me?' Furthermore, there was a process of interpreting one's interpretation, questioning 'Am I getting close to their meaning or is it mine', as an appropriate hermeneutical process in the shadow of potential bias, whilst questioning the quality and validity of the analysis and interpretation (Smith, 2011). Analysis also included a process of numeration (Smith et al.,

2009), using Microsoft Excel spreadsheets to code the data. This step shaped a holistic perspective, identifying potential themes through abstraction, contextualisation and subsumption (Smith et al., 2009). These themes were subsequently critiqued and reviewed by re-examining interviews and creating a mind map of themes as a variation of a recursive, iterative process (Buzan, 2003).

We strove to meet criteria outlined by Yardley (2000) for qualitative research to engage with the material with depth and breadth, commitment and rigour to ensure as far as possible transparency, coherence and clarity of process. Our reflections included interpreting interpretations, evaluating the meanings derived as a hermeneutical process in the

shadow of personal bias, whilst questioning the quality and validity of the work (Smith, 2011). To accomplish this, research journals were used acknowledging how our beliefs, assumptions and judgment systems are unavoidably part of the research process, examining our experience, thoughts and motivation from an observer standpoint (Shapiro et al., 2006). This supported "bracketing" (Husserl as cited in Smith et al., 2009, p. 13), suspending our own bias and innate predisposition to mitigate and examine what we may take for granted (Sorsa et al., 2015; Tufford & Newman, 2012), and owning our positioning and perspective (Elliott et al., 1999). The themes were repeatedly reviewed to check for plausibility through re-examining interview content as a recursive, iterative, and accountable interpretative process, coalescing to present the following findings, supported with participant quotes.

Findings

The findings below present two themes: *Framing Shame* which consists of participants describing shame, even if they couldn't always name it and recognising how it is often hidden in plain sight, and *Transforming Shame* which is about understanding, connecting with, and working on shame with clients through a person-centred therapeutic process. This involved empathic understanding, creating safety with unconditional positive regard, and non-directivity identified as therapeutic keys. Interestingly, some participants found their shame surfaced in supervision. These interconnecting themes are represented in figure 1.

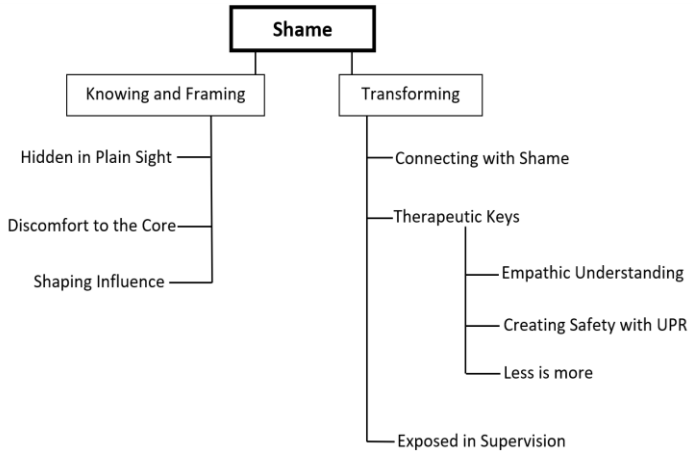

Figure 1: Overview of findings

Theme 1 – Knowing and Framing Shame

All participants explained how they framed shame, both as individuals and as therapists, describing various sources of shame. They reflected on these sources using their personal and professional experiences of shame and therapeutic knowledge. Each participant explained a converging understanding of shame and how it impacts on their sense of self, yet there was divergence in how it was described. 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". 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. The interviews appear to have highlighted how participants have an idea about shame, but the discussions enabled a reflective process to consider shame in greater depth, both personally and with client work.

For example, Alex articulated how she had not previously considered shame as something labelled in client work prior to the research interview:

> I found it quite easy to recognise my own shame when I felt shame in the session, but … I've never really thought about client shame because I think it's that idea that you always come from a non-judgmental way.

Hidden in plain sight - "shame seems to be a sort of … unspoken … thing"

Despite being a common phenomenon, shame was described 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 a 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 recognising shame. For example, understanding what may be occurring for the client on the edge of their awareness, but also what may be unfolding for a therapist. Taylor also described how 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 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 Taylor's understanding of shame as something that corrects our behaviour.

A discomfort to the core – "the nausea would cry inside"

Shame was described as deeply uncomfortable and distressing to experience, both at a personal level by participants and in what they witnessed in client work. 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", involving a self-directed need for punishment, making people believe they are not good enough, or feeling like they need to hide their thoughts and feelings. 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 unmask shame. 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 description 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.

The shaping influence of shame – "it's being uncomfortable with part of your identity"

Whilst shame is an innate aspect of being human (Lewis, 1992), its source for these participants was commonly located in the past from personal experiences and childhood. 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 their understanding of how shame from 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) referred to client work outlining how early life experiences shape us in ways that may not be in our awareness "I'm working all the time with people's shame of adverse childhood experiences … shamed by their caregivers … just little critical remarks". Taylor also referred to social issues "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 citing societal values and expectations through media channels in how a perceived sense of self-worth is associated with visual aesthetics, 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.

Similarly, cultural demands were 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). Likewise, Jackie commented on how shame can be associated with culture and what may be cathartic to express in therapy to address something that would ordinarily be taboo, relating to a client connecting with shame:

> 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.

This theme depicts the nature of shame as a hidden, unspoken phenomenon generating discomfort at a core level; traversing time and place from the past to the present, influencing thoughts, behaviour and capacity. In the context of therapy, this theme framed the importance of understanding as a foundation to its transformation.

Theme 2 – Transforming Shame

This theme represented the importance of person-centred therapy as a transformational process in addressing shame. Participants' experiences were divided into further sub-themes of *Connecting with Shame*, the *Exposure of Therapist Shame in Supervision* and participants described using a triune of *Therapeutic Keys* that helped clients to unmask their shame: *Revealing Shame through Empathic Understanding*, *Creating Safety through Unconditional Positive Regard* and *Less is More*.

Connecting with Shame in therapeutic practice

All interviews provided converging evidence of how shame can impact on clinical work, but with differences between participants regarding how they described connecting to shame with clients. There was also a facet around their own vulnerability as therapists which linked to their personal self-image and professional identity.

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. This underlined the importance of self-awareness and how material from clients can be influential. Mel emphasised the importance of genuine self-awareness rather than convincing 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 emphasises the importance of self-honesty for therapists and congruence with themselves (Rogers, 1951). Mel also reported how shame was avoided 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 to navigate shame and its effects, without naming it. 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 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 experience was further echoed by Jackie outlining the sensitivity needed to be sure clients are ready to connect with shame to unmask and transform it, "it depends which path they want to go on and are they ready to go down that path …. but I'm here if they do."

Therapeutic Keys

Participants reported three *therapeutic keys* important for unmasking and transforming shame with clients. These consisted of a triune of empathy, unconditional positive regard, and non-directivity which are all key person-centred concepts (Rogers, 1957, 1959, 1980).

Empathic understanding to reveal shame - "I get you, it's okay I'm with you"

Empathy is accurately perceiving the frame of reference of another, including sensitivity to meanings and emotional content (Rogers, 1959). Empathic understanding of clients (Brodley, 1996) 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 facilitating empathic understanding with clients explaining "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 personal background was a factor in nurturing and managing empathic connection with deep awareness. For example, she explained "just watching for signs of it becoming too much and helping them to pull back if it is too much", meant psychologically holding the client in therapy, feeling *with* the client in a balanced supportive way.

This empathic understanding was also reported by Jackie in relation to work with a client recounting shameful experiences, she says, "it's as if my heart like contracts more … like I really feel it" 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". These accounts outlined how shame can inhibit the ability of a client to reflect and speak freely about the self, whereas empathy facilitated a connection to approaching material in a supportive way, potentially reducing the intensity of shameful experiences by gently connecting and unmasking them.

Creating safety with unconditional positive regard – "it's …a refreshing environment … if you don't feel judged"

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" (Rogers, 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, which is potentially liberating for the client, if they no longer feel vulnerable and can speak the unspoken in a safe yet revealing way. Alex also explained the importance of handling inconsistent client narratives or *untruths* non-judgmentally, outlining how it takes time for clients to trust and express 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." Therefore, the value of UPR in developing a trusting and safe space to explore shame was beyond what confidentiality alone could provide, as depicted by Jackie describing fear of judgment from disclosing shame, "if it was me opening up, whether they would judge me even if I know it was confidential, just to have admitted something".

Less is more – "ease in allowing that to go where it needs to"

Less is more describes non-directivity surrounding 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, not wishing to appear incompetent to themselves or the client. Therefore, the concept of non-directivity may tug at a therapist's values and motivations in 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." Therefore, non-directivity was key in gradually connecting with and transforming shame.

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 was, also 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 for a client at their stage in process to explore, causing withdrawal or avoidance (Nathanson, 1992). Jackie emphasised personal experience of being *pushed* in clinical supervision, reflecting on her 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 involving a texture of allowing and accepting from the therapist.

Exposed in supervision – "oh, I've got to deal with this again"

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. In contrast to Alex and Jackie where supervision had triggered shame, Sam outlined how supervision helped unmask and transform shame from client work.

The findings outline how shame is phenomenologically framed, understood and experienced by connecting to its presence, unmasking its effects, and combining with key elements that can help transform shame in psychotherapy. These findings are discussed in the next section with consideration of current literature and implications for practice.

Discussion

The processes to transform shame within client work were clearly described in the data, and the way some participants began to think about shame was also influenced by their involvement in this research activity. For example, reflecting on their experience and understanding of shame helped transform it, which drew interesting considerations for practice. The following discussion is informed by the research and literature on shame discussed earlier, and the findings are considered through a person-centred theoretical lens.

Knowing shame - Knowing self

Participants articulated it was important for them to name and understand their own shame, including a deep sense of knowing about the causes and contributory experiences. This included their childhood and aspects of each participant's identity and culture (Greenberg & Iwakabe, 2011; Longhofer, 2013; McKenzie-Mavinga, 2016). This was recognised by all participants as a necessity to work effectively with clients, which is echoed by Sanderson (2015).

As with clients, practitioners may not be aware of their own shame surfacing 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). Such as when Taylor commented "… it's often so well hidden from other people that it becomes hidden from the individual themselves." Importantly, the influence of shame can shape our experiences at an interpersonal and intrapersonal level. For example, under person-centred theory the self-concept involves configurations of perceptions between our self-image and our ideal self (Rogers, 1951). These perceptions may vary subject to introjected conditions of worth, resulting in a "conditioned self", i.e., not authentic to the "organismic self" (Merry, 1999), described as incongruence involving a discrepancy between the reality of experience and their self-image (Rogers, 1959).

Similarly, shame can hide who and how we are, as referenced earlier to Talbot (1995), to avoid scrutiny not only from others but from ourselves, especially as a self-protective measure surrounding low self-worth. For example, how early experiences of verbal shaming and degrading treatment can reduce self-worth (Coates et al., 2013; Flynn et al., 2014; Wille, 2014), translating into adulthood with an over developed threat handling system from not feeling safe when younger (Pinto-Gouveia et al., 2016). Alex described how shame is embedded in what "… doesn't fit with who you should be", suggesting tension between the self-image and *how we want to be* i.e., the ideal self. 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). This

underlines the value of shame awareness for practitioners in understanding how we are shaped by our experiences in social, familial and cultural contexts.

However, what was not so hidden in participants' interviews was the embodied experience of shame, which may be useful to understand when unmasking shame in therapy, especially if clients find it difficult to name shame. Therefore, 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 of this embodied experiencing saying "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 surrounds 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 can be beyond words, where shame may be located within a realm at our core beyond awareness, manifesting in behaviour containing valuable information on what may be occurring at an interpersonal and intrapersonal level (Rogers, 1980). To know and understand this can contribute towards its transformation.

Offering a person-centred perspective to transforming shame

Participants identified that when working with client shame, one of the keys in its transformation was listening more and saying less, this links to the idea of non-directivity, which is a feature of person-centred theory and practice (Merry & Haugh, 2024). Non-directivity is "an attitude held by the therapist from which they trust and relate to their client as a person with agency, autonomy and the capacity to grow" (Stephen, in press, as cited in Merry and Haugh, 2024, p. 50). "From a classical standpoint, this non-directive attitude minimises the possibility that the therapist behaves, either knowingly or not, in ways that assume power over the client or expertise on the client's behalf" (Merry & Haugh, 2024, p. 50). This principled approach to non-directivity (Grant, 1990) is something that has fallen out of favour in many contemporary adaptations of person-centred theory and practice, such as the integrative approach of pluralistic person-centred therapy (Blunden, 2024), which advocates a goal-based approach to client work with both client *and* therapist as co-experts in the therapeutic process. Nevertheless, when working with shame all participants indicated non-directivity was important to gently approach, reveal and examine shameful experiences, underpinned by a deep empathic understanding of the client (Brodley, 1996).

Empathy was indicated as a key element in transforming shame from all participants, supported by how their personal experience of shame amplified sensitivity, understanding and empathic capacity. Within person-centred theory, empathy has a role in generating a safe setting, representing one of the conditions provided by the therapist amongst the six necessary and sufficient conditions of therapeutic personality change (Rogers, 1957). 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, how Alex described it as "quite a refreshing environment … if you don't feel judged from exposing yourself", generating a safe space to connect with shame content.

Such a safe space also involved the therapist communicating their unconditional positive regard (UPR) to the client (Rogers, 1957), enabling the examination and exploration of shameful experiences in a manner that suited the client even when it involved inconsistencies. For example, Mel outlined the

challenges of working with conflicting 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 other 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, where clients reveal more of themselves as trust matures to enable the disclosure of something difficult, not only to the outside world but importantly to themselves (Kemp & Lorentzatou, 2013).

This dovetails into non-directivity in how a client is deemed the expert in their own shame and trusted to know when and how to explore and begin processing their material in therapy, keeping things hidden until they are ready to disclose (Wosket, 1999). An example was from Sam describing "… a kind of unspoken … not be able to name it as shame … or feel ashamed of having shame" utilising alternative words in lieu of acknowledging how difficult it is to discuss (Lindsay-Hartz,

1984; Tangney & Dearing, 2002). Therefore, it is reasonable to view shame as a phenomenon in therapy that cannot be forced.

Conversely, to *push* a person or convince them otherwise of their experience can deny a sense of reality to feelings, engendering further shame and low self-worth through invalidation (Kaufman, 1974). This has been highlighted by Warner (1991), who suggests clients may doubt their right to form their own meanings, risking compromising opportunities to access deeper layers of therapeutic understanding, especially given the influential power shame has in the therapeutic dyad (Klinger et al., 2012). This emphasises the importance of client freedom to explore and consider their world view or experiences uninhibited (Velasquez & Montiel, 2018). Given the diminishing effects of shame involving powerlessness and worthlessness (Proctor, 2017), facilitating the agency of the client is important as a facet of person-centred theory surrounding their own internal process and self-organising wisdom (Bohart, 2017). For example, how experiences distorted or denied into awareness through introjected values from shame can be processed, understood and reshaped, with greater authenticity to themselves or their organismic self (Rogers, 1951). This includes the creation of new personal constructs that exist with a greater fluidity of experience (Rogers, 1967).

Therapist shame

A repeating facet through this paper surrounds the degree to which therapists know and understand shame and how this is utilised in therapy contributing towards client process. Conversely, a lack of knowledge can be a source of perceived lower competence (Thériault and Gazzola, 2006). This may render the practitioner's self-image vulnerable in terms of *worthiness*, potentially making it challenging to discuss in supervision. For example, when Alex articulated "Am I practising the right way and you kind of question who you are." This emphasises the value of knowledge and self-awareness for practitioners around shame, especially given that the data echoed little evidence regarding the topic being covered much during training, such as the account by Jackie. This is supported by Tangney and Dearing (2011) and Sanderson (2015), concerning limited content on shame during training, rendering challenges for therapists to develop their understanding of its impact in therapy. Furthermore, whilst there is research on shame as outlined earlier, studies into how shame is understood and experienced by person-centred therapists appears absent within current research literature. The reasons are unclear but may partly be attributed to challenges in researching shame given doing so can evoke it (Biddle, 1997; Yakeley, 2018).

It is also important to acknowledge how clients can potentially shame counsellors (Stadter, 2011), such as comments or feedback influencing a negative self-image triggering strategies to avoid scrutiny from others (Blundell et al., 2022; Morrison, 2011). This links into earlier research regarding protective measures from a sense of devaluation (Hahn, 2001), either colluding to avoid material (Klinger et al., 2012) or adopting 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) in how therapists become disconnected, overwhelmed or over identify with material, causing moments of incongruence or self-directed contempt (Bradshaw, 1988).

This links into the importance of supervision as a critical, ethical and professional function in clinical practice, with evidence in the findings when Sam stated that supervision provided a safe space to connect with shame from client work. However, what was not expected was the impact of shame on practitioners from their experience of supervision. For example, Alex expressed "… for me shame happens most in supervision …. and you kind of question who you are" and Jackie articulated that an obligation to discuss a personal matter would bring her down. This rendered a counterproductive effect, activating a *shame mood* and a withdrawal inward (Nathanson, 1992). In turn this can negatively impact how the time in supervision is utilised (Fortes & Ferreira, 2014; Ladany et al., 2011). This highlights how therapists are not immune to feeling inadequate or fearing judgement (Gilbert, 2011), especially concerning vulnerability to an approving other such as a supervisor (Biddle, 1997), potentially impacting on practice (Tangney & Dearing, 2011). Furthermore, the supervisor is 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 importance of understanding shame extends to supervisors, as they are integral components in transforming shame for therapists, where client work or feelings of inadequacy can be explored in a safe setting (Hawkins & Shohet, 2012).

Such safety measures whether in supervision or through development and awareness cannot be understated. Empathy is a key feature of how person-centred therapists deliver therapy, but shame can diminish this by focusing inwards and less on another (Fortes & Ferreira, 2014). This may involve self-

orientated reactions to ameliorate their own emotion difficulties (Tangney, 1991). This was supported by Taylor describing how one could "go into oneself and it's all about me … it's about I'm not good enough" and Alex articulating how "I didn't know what to say … how to react and it didn't feel like normal." This is particularly important in how therapists manage emotional demands as an integral part of self-care and ethical practice (BACP, 2018). This is supported by Watkins (2009) on the importance of how practitioners acknowledge their own wounds and vulnerability as a component part of understanding the experience of others, combined with knowledge and understanding of shame to "feel safe with our own shadow material and tolerate being emotionally stirred up by our clients" (Gilbert, 2011, p. 339). This links to person-centred theory in how we can be more accepting and understanding of others, when we understand and accept ourselves (Rogers, 1951).

Critical Evaluation

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). This study involved person-centred researchers studying person-centred psychotherapists and our analysis and interpretations of participants' experiences was through this theoretical lens. Therefore, we were able to conduct an analysis of the data that is deeply person-centred, whilst recognising that additional insights may be gained by examining the data through other theoretical paradigms.

Whilst interviews were openly contributory, from a *suspicious interpretative* standpoint (Smith et al., 2009; Willig, 2013), conversations can contain discursive repertoires (Wetherall & Potter, 1988), communicating how we want to be seen and how we see ourselves within that experience, in this context involving participant self-image as qualified therapists (Crisp, 2015). Therefore, whilst interviews were conducted with care and sensitivity, the discourse may have contained hidden protective measures to avoid potential exposure to shame that was not identifiable in the data, because talking about shame orientated material may understandably amplify its effects (Biddle, 1997).

Reflecting on our different positionalities regarding shame and person-centred theory and practice, it was important that the Findings were data rather than theory driven (Finlay, 2003). In this respect, we aimed to represent participants' experiences honestly and any speculation around person-centred theory applied to those experiences we have included in the Discussion, rather than the Findings section. It is interesting how some elements were not significant in the data but did, in some ways, shadow participant accounts. These areas may represent specific areas of shame yet to be studied. For example, references to congruence of the therapist and incongruence of the client or the nature of how shame experiences may be symbolised or distorted (Rogers, 1951).

Conclusion

The findings support existing literature in shame affects, its impact in therapy and the apparent limited training on shame (Sanderson, 2015; Tangney & Dearing, 2011). New findings highlight how elements of person-centred therapy can help in processing shame and how this powerful emotion can also be present in supervision.

There was consistency in the experiences of participants about how influential shame can be, but divergence surrounding the way shame was understood and experienced, including childhood and cultural experiences. The latter represented the participants' primary source of knowledge and understanding of shame rather than training, where this personal experience was utilised to connect and support clients in an empathic and therapeutic way. In terms of person-centred theory (Rogers, 1951, 1957, 1959), the non-evaluative nature of the approach sensitively cradles the challenges of working with shame, where empathy and UPR facilitates its exploration with clients, contributing to an examination of their conditions of worth and nurturing their self-concept. Approaching shame from a place of principled non-directivity may be helpful for transforming shame in therapeutic work because it supports the therapist to empathically attune to the client, so clients can explore these experiences at their own pace. However, this study generated more questions than answers where further research is recommended because of the complex nature of shame and the available literature on this topic within a person-centred framework. Whilst this report focused on understanding and working with shame within person-centred theory and practice, the issues identified could be applicable to any modality given how this powerful emotion permeates the territory of therapeutic work. Consequently, it is important for psychotherapists and supervisors to understand facets of their personal and professional life linked to shame experiences and how matters may impact upon therapeutic work or supervision. Therefore, this paper argues shame is a key

subject area that should not be overlooked in terms of knowledge for practitioners, whether during initial training or subsequent professional development as a component part of reflective and reflexive practice.

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