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'Handle with Care'. Working 'wisely' with the shamed client: An evidence-based exploration of the transformation of meaning.

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Abstract

Toxic shame is experienced as an extremely painful affective state where both external and internal worlds are seen as persecutory, and this drives many other emotional experiences and can hinder therapeutic growth. This thesis is a scoping study that considers how toxic shame experiences might be transformed in therapy through using 'wise' interventions, an exciting development borne out of social psychological research (Walton, 2014). Wise interventions work on underlying psychological processes to change the meaning of subjective experiences. Two rapid evidence assessments were conducted; one to explore how shame is experienced between therapist and client, and the second on what works in reducing toxic shame in therapy. These findings were synthesised to inform creation of a range of intervention techniques based on 'wise' principles, which were refined through consultation with five counselling psychologists in training.

Seven themes were produced from the experiential review, covering aspects such as identity, fear, and relational ruptures. The review on shame reduction found limited evidence of impact, but provided a range of therapeutic modalities from which to draw strategies. Consultees noted that the research brought insight in to experiences that might be tapping in to shame, and welcomed 'wise' strategies that might help alleviate and transform clients' toxic experiences.

The thesis provides a tentative first step in producing wise interventions that would benefit from further, broader consultation, and testing in therapeutic settings. They provide a novel way of thinking about, and working with, shame, especially in pluralistic/integrative therapy. The principle driven nature of interventions means that they may have wide applicability given that the shame experiences discussed can occur in a broad range of contexts and may underpin a range of psychological problems, impacting on the efficacy of therapy. Further implications and caveats around wise interventions in relation to counselling psychology are discussed.

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1 Literature Review/ Background

My Name is Toxic Shame, by Leo Booth and John Bradshaw (n.d.) (edited version)

I was there at your conception
In the epinephrine of your mother's shame
You felt me in the fluid of your mother's womb
I came upon you before you could speak
Before you understood
Before you had any way of knowing
I came upon you when you were learning to walk
When you were unprotected and exposed
When you were vulnerable and needy
Before you had any boundaries
MY NAME IS TOXIC SHAME

I existed before conscience
Before guilt
Before morality
I am the master emotion
I am the internal voice that whispers words of condemnation
I am the internal shudder that courses through you without any mental preparation
MY NAME IS TOXIC SHAME

I come from "shameless" caretakers, abandonment, ridicule,
abuse, neglect – perfectionistic systems
I am empowered by the shocking intensity of a parent's rage
The cruel remarks of siblings
The jeering humiliation of other children
The awkward reflection in the mirrors
The touch that feels icky and frightening
The slap, the pinch, the jerk that ruptures trust…
MY NAME IS TOXIC SHAME

My pain is so unbearable that you must pass me on to others
through control, perfectionism, contempt, criticism, blame,
envy, judgment, power, and rage
My pain is so intense
You must cover me up with addictions, rigid roles, re-enactment,
and unconscious ego defenses.
My pain is so intense
That you must numb out and no longer feel me.
I convinced you that I am gone – that I do not exist –
you experience absence and emptiness.
MY NAME IS TOXIC SHAME

I twist who you are into what you do and have
I murder your soul and you pass me on for generations
MY NAME IS TOXIC SHAME

1.1 Opening reflections on shame and orientation to the research

I began to realise as I researched this thesis that I did not choose the topic, rather it chose me, to allow me to work through my own experiences as well as to better understand shame-filled experiences of others. I have been on a journey of self-discovery and empowerment. As a child I suffered my own shame through the loss of my father's affection due to his alcoholism. For many years I believed myself to be unloveable, and this drove how I lived my life. I internalised the rejection, splitting off the 'bad' parts of my father from him and making them my own. I pushed people away and ensured that I made it very difficult for others to love and commit to me, thus fulfilling my own prophecy. When I was bullied in my early teens I found a physical feature to obsess over, using this as a hook for my shame. I felt this so intensely that it took me a very long time to even express what it was that I hated about myself, believing that if I said it out loud people would notice more and be disgusted by me. Where once I had been eager to learn and confident in my friendships, I began to inhabit the shadows of the school corridors hoping no one would see me.

I dragged my toxic shame around for many years, letting it haunt me and taunt me even when times were good. It was only once I sought therapy and began to sort through where my thoughts and feelings were coming from, that I began to realise that I was loveable after all. I no longer needed to feel shameful. My inner critic who told me I was not good enough began to fade into the background. However, an emotion as intense as shame does not magically disappear. It can still be triggered now if I am caught unawares, tapping into that core part of me that was so damaged in my childhood. The shamed inner child still tries to shield me, but now I have louder voices that can protect me through compassion rather than self-blame. These themes are all things that came out within my research, hitting home just how much I had been ruled by shame. My own journey through therapy showed me that there were sometimes small moments that occurred that brought about greater clarity in my thinking and shifts in my identity. I became fascinated with how seemingly small interactions could transform how we make sense of our selves and our worlds.

The ensuing discussion will demonstrate the central importance of shame as an affect, and the wide-ranging impact it can have on individuals in the development of psychological problems. This thesis goes on to consider how toxic shame affects therapeutic growth and

what can be done to facilitate transformation of its meaning so that a client can change their experience of shame, through the use of 'wise' interventions.

1.2   Defining shame

Shame has been considered to be a primary affect that emerges at a very young age; although there is still debate around precisely what age this can occur (Mills, 2005; Brown and Trevethan, 2010; Akbag and Imamoglu, 2010). Brown and Trevethan (2010) regard shame as the 'master affect' due to the influence it can have on all other affects and development of the sense of self. Mills (2004) notes that:

> *Shame can become linked to affects…physiological drives…or innate interpersonal needs…Once it is internalized, shame can be activated wholly from within…in an internal shame spiral that reinforces shame and extends it to other parts of the self. Shame can now be experienced as a deep sense of defectiveness (p.35).*

This can lead to defensive strategies that underpin psychological processes (both conscious and unconscious) such as anger, denial, projection or splitting (Lewis, 1992). A systematic review considering correlates of shame and stigma found, *'a striking and robust negative relationship between internalized stigma and a range of psychosocial variables (e.g. hope, self-esteem, and empowerment)'* (Livingston and Boyd, 2010, p.2150).

Shame can be differentiated from guilt in that guilt is related to negative evaluations of behaviour, whereas shame is related to negative evaluations of the self, producing far greater pain (Akbag and Iamamoglu, 2010). Research has shown that shame and guilt are associated with differing areas of brain activity, suggesting we make sense of each emotion quite differently (Bastin *et al.*, 2016). Broadly speaking, guilt is more likely to be externalised and shame is more likely to be internalised. For instance, a person who feels guilt might wonder how they can make amends for something they have done. A person feeling shame might feel that they cannot possibly make amends, as it is they that are bad. It is therefore likely to be much more difficult to process and work through shame when it afflicts the self at such a deep level. Making amends becomes almost impossible, especially if this is directed at the self.

Although it can be an adaptive emotion, encouraging reflection on actions or restraining people from engaging in potentially dangerous activities (Tangney and Dearing, 2003),

shame does not always have a positive function. For some people it becomes toxic, driving maladaptive behaviour as it activates threat-based systems. Shame can come from within (negative evaluations of the self) or from external sources (feeling that others view the self negatively). This external shame may be a reason why the emotion is closely associated with secrecy and hiding (Gilbert and Procter, 2006). When parts of the self become 'toxic' there is a desire to hide them away and deny their existence. They perhaps *'become frozen, carrying the pain, terror and betrayal of abuse'* (van der Kolk, 2014, p.281).

The shamed individual sees the self as powerless, weak, exposed, defective and devalued in relation to others (Claesson and Sohlberg, 2002; Tangney and Dearing, 2003). Shame is therefore a highly distressing emotion that can encourage the bearer to withdraw from the world around them, creating on-going issues with interacting with others in social situations (Mills, 2005). As Thibodeau *et al*. (2011) state, *'the actor possesses knowledge that others condemn her' (p.1).* This message becomes internalised, providing a source for distress and an understanding of the self as defective, even dangerous. For the person experiencing toxic shame there is nowhere to run or hide, as both the external and internal worlds are seen as persecutory. This leaves little opportunity for self-soothing (Gilbert and Procter, 2006). Whilst there is no single agreed definition of toxic shame, a good starting point is provided by Kolts (2016) who suggests it is, *'an acutely painful affective state related to negative evaluations of the self as bad, undesirable, defective and worthless'* (p.14). It is clear to see that self-views such as this could be extremely damaging and offer limited potential for growth. It is this toxic shame that is the focus of this thesis. Herein, unless otherwise specified, the terms 'shame' and 'toxic shame' are used interchangeably.

1.3   **Shame as a social emotion**

Shame can be considered a social emotion as the way it is experienced and understood may be context-dependent and in relation to others. As external shame often involves thinking about how other people may view us, those who feel shamed may be concerned that *'social bonds…may be at risk when we imagine how we look in others' eyes'* (Guassora *et al.,* 2014, p.198). We therefore may self-monitor by keeping in mind how others might judge us. This can be useful in situations where self-monitoring may stop us from committing bad or dangerous acts and in adhering to social norms (Scheff, 2000), but it can become maladaptive when the self-monitoring becomes excessive and not based in reality. Dayal *et al.* (2015) noted that:

Sociocultural context has been identified as a potential source of shame for individuals with eating issues whose feelings of worthlessness emerge from failure to meet unattainable socially prescribed standards (p.154).

The 'other' does not have to be physically present for a person to feel shame, but can instead be an internalised sense of the other. If one constantly feels they cannot live up to particular standards, then the social threat-based system may kick in, sensing a risk to identity and status and the possibility of being rejected. This may lead to a desire to run away or hide, alienating the person (Guassora *et al.,* 2014; Gilbert, 1998; Jones and Crossley, 2008; Harman and Lee, 2010; Allan *et al.,* 2016; Cheston, 2005).

The psycho-evolutionary approach discussed by Gilbert (1998) suggests that this threat based system developed early on to manage risks to challenges of rank and status and to promote safety-seeking behaviours. Shame acts to:

alert the self and others to detrimental changes in status, provoking a submissive response in the shamed and hopefully a subsequent de-escalation in attack from the shamer (Harman and Lee, 2010, p.15).

For those that already have mental health issues, or have received a psychiatric diagnosis, shame may be heightened due to the perceived social stigma this brings. One potential way to work with shame, therefore, is to pay attention to the social threat system and work to reduce the shame-based responses. Allan *et al.* (2016) suggest increasing social connections may be helpful in order to strengthen social bonds so that imagined risks are minimised. Returning to the eating disorder example above, Dayal *et al.* (2015) found that shame reduction interventions for this client group focused on fostering a sense of connection and similarity to others, and that this was consistent with shame interventions across a range of dimensions. Interpersonal psychotherapy can be used to effectively strengthen social bonds, as this attachment-focused therapy considers everyday interactions outside of the therapy room, and the systems that the client lives within (Talbot *et al.,* 2011).

Cultural context is another important aspect, as a person is likely to be influenced by the expectations put upon them by their particular culture (Johnson & Yarhouse, 2016). In this respect, shame can be considered as a, *'psycho-social-cultural construct'* (Brown *et al*., 2014, p.358). For instance, the way men and women experience shame may differ depending on the expectations put upon them. Perhaps for some women this manifests as an expectation

to be perfect at everything, and some men may feel an expectation to be masculine (i.e. 'not weak') (Brown *et al.,* 2014; Dayal *et al.,* 2015.). Deconstructing shame experiences through broadening perspectives, and linking it to other social and cultural issues that the client may have experienced, could potentially have a transformative effect. As Dayal *et al.* (2015, p.155) noted:

> *identifying and verbalising experiences of shame proved to effectively ameliorate feelings of shame by opening up dialogue…providing a safe arena for rebuilding relationships and sharing without fear of rejection or failure.*

In this way, therapy considers all three parts of the construct – the psychological, the social and the cultural.

1.4   Shame, attachment and achieving relational depth

Many therapeutic approaches are underpinned by using a relational stance to engender the Rogerian 'core conditions' (Rogers, 1962), and research has often demonstrated that, no matter what therapeutic model is used, the therapeutic alliance is of central importance (see, for example, Bachelor, 2013). Because shame occurs in an interpersonal context, the therapy room can be a useful place to explore and work with this affect. As Finlay and Evans (2006) note, *'both client and therapist are seen to affect one another as they 'co-mingle' and mutually share a range of emotions generated in the therapeutic process'* (p.34). However, the largely hidden nature of shame can make it difficult to access successfully (Claesson and Sohlberg, 2002). A cross-sectional study by Black *et al.* (2013) analysed measures of shame, shame coping styles, therapeutic alliance and intimate relationship functioning in 50 adults receiving treatment for common mental health issues. They found that particular shame coping styles were risk factors for poorer development of the therapeutic alliance. Specifically, those that tended to withdraw when dealing with shame were at the highest risk of not developing an effective therapeutic alliance. If withdrawal is severe in a client, then they may be unwilling to engage with their therapist, especially when dealing with shame inducing experiences. Taking a detached stance can make progressing in therapy difficult as the client defends themselves from dealing with their feelings (Ibid.).

Research has demonstrated that shame proneness can be predicted by anxious and insecure/avoidant attachment styles (Brown and Trevethan, 2010; Mills, 2005). Fearfully avoidant individuals may have learnt to express shame as a strategy to gain parental

approval in early life (Consedine and Magai, 2003). Expressions of shame may serve as a way of appearing to appease others by exposing the self in a way that the individual feels the parent expects to view them, by hiding their perceived inadequacies. Anxious and avoidant attachment styles may also be related to less developed formations of identity and a lack of self-acceptance; both of which may be exacerbated by shame-proneness (Brown and Trevathan, 2010). If secure attachment bonds are not formed early on and the relational bond is disrupted, then an individual is likely to experience mistrust and doubt in their self-competence and lovability. They may be especially predisposed towards shame due to the development of these negative models of the self (Lopez *et. al.,* 1997; Mills, 2005). If the shamed client fears negative evaluation from others, and this induces anxiety within them, then it is likely that they will find intimate relationships with others challenging (Black *et al.,* 2013). Schore (cited in Mills, 2005) argued that children develop differing attachment styles according to how they learn to regulate shame. For example if a parent is emotionally inaccessible, a child will learn to self-regulate through disengaging and inhibiting emotional expression related to attachment. This will lead them to become, *'anxious, inhibited and prone to felt or conscious shame'* (p. 38).

From a psychodynamic perspective, shame may be linked to the psychodynamic concept of narcissism, or the need to feel unique to a significant other. Morrison (2014) suggests that if this is not granted, such a when a parent fails to give a child love and affection, then the self may become fragmented and feel lacking in some way, leaving the person vulnerable to shame. He describes the evolution of shame as being,

> *'from infantile failure in merging or mirroring from the maternal caregiver; to independence and objective self-awareness, with potential inferiority that seeks support from an idealized, omnipotent parent/father; to the ideal self, in which we ourselves become the source of judgment about attaining our ideals'* (Morrison, 2014, p.27).

The psychodynamic idea of projection may be closely linked to shame as self-condemnation may be projected onto the therapist, thus condemning the other rather than owning highly critical (and shaming) aspects of the self (Jacobs, 2012). The shamed client may defend against painful emotions through the process of splitting. DiCaccavo (2006) explains this in relation to parentification. If the person defends against this by conjuring up an idealised version of their parent, then in turn they may have to explain all of the bad as being from within the self, leading to a negative self-evaluation, which allows them to maintain a sense of the parent as 'all good'. Another version of splitting that may occur is when the client

maintains the other as 'all bad', projecting their own experience of being devalued onto others. In these cases the client may experience the therapist as the parental figure and will defend against expressing their true self, for fear of inducing shame and being abandoned. Fisher (1985) refers to this as holding an, 'identity of two', both the self as bad and the parent as good. The person internalises the parent that rejected them, and thus rejects the self. He states:

> *Shame represents a complete mother-child system. The infusion of shame has the feel of a placental exchange, an osmotic quality. Shame disallows firm boundaries between mother and child because the image of the self cannot be detached from the image of the other (p.104).*

This demonstrates just how deeply engrained shame can be, and how difficult to untangle. When a person experiences high levels of shame they may feel powerless, unable to see themselves as an autonomous being with control over their own lives. This can result in anger, withdrawal or denial, which may be used as safety mechanisms to keep the therapist at a distance and establish boundaries. The shamed person may feel safer with the thought of being abandoned by the therapist, rather than treated with love that may engulf them (Fisher, 1985). The experience can be so deeply felt that explanation is beyond the constructs available in everyday language (Johnson and Yarhouse, 2013). The client may do anything they can to hold on to their shameful secret as a way to protect the self from revealing their true identity as something repulsive and disgusting. Concealing shame can therefore either stop people from seeking treatment, or interrupt the process of therapy through lack of disclosure (Bauman and Hill, 2016; Dayal *et al.,* 2015; DeLong and Kahn, 2014).

Shame can lead to difficulties in empathising with others, which can make the individual feel disconnected (Jordan, 1997). Working relationally with clients to help them feel better connected with others by focusing on intersubjective dynamics can help with forming more positive relational models, thereby reducing the influence shame has on all other affects (Finlay and Evans, 2009). However, achieving relational depth can be problematic when the client is not able to fully connect with the therapy. The therapist may internalise these feelings, experiencing shame in their own disempowered state, affecting their ability to empathise with the client and stunting therapeutic growth (Allan *et al.*, 2016; Dayal *et al.,* 2015; Tangney and Dearing, 2003).

Taking a pluralistic, principle driven approach using a range of strategies borrowed from differing schools of thought can help the therapist and client connect and work through differing shame experiences (Cooper and McLeod, 2011). For example, *'surrendering to the relational space'* (Finlay and Evans, 2006, p.31) with empathy and authenticity (as in the Gestalt tradition), and focusing on shared embodied aspects of experience (from existential phenomenology) can provide a focus on the here and now. Psychodynamic ideas regarding holding of clients (in verbal, interpersonal or emotional ways rather than physically) when shame can help build trust between the therapist and client by communicating, *'not so much affection as protection and security, the basis of trust'* (Kaufman, 1996, p.169). This, combined with relational and intersubjective understanding of the importance of developmental conscious and unconscious aspects and both past and present relationships, can allow the therapist flexibility to, *'help the client construct meaningful new narratives'* (Finlay and Evans, 2009, p.34).

1.5   Shame and different problem dimensions

The consequences of experiencing shame can be wide ranging, affecting many areas of a person's life and driving their emotional experiences and how they make sense of the world (Gray, 2010). The following examples shed light on just a few of the ways toxic shame may impact on people's lives. A review on correlates of shame and stigma found that people experiencing higher levels of internalised stigma were less likely to stick to treatment, and had more severe psychiatric symptoms (Livingston and Boyd, 2010). Brown and Trevethan (2010) noted that homosexual men with high levels of shame were likely to have an anxious/avoidant attachment style, and have issues of internalised homophobia. In these cases, early shame experiences may have impacted on successful formation of their identity and quality of relationships. Similarly, research found that students in the US that were prone to shame were less likely to report successful use of collaborative problem-solving strategies in their intimate relationships than those not prone to shame (Lopez *et al.*, 1997).

A review of theory and research on the developmental consequences of proneness to shame indicated that, *'it may be a vulnerability factor in the development of problems such as depression, aggression, social anxiety, and immune-related health problems'* (Mills, 2005, p.26). For example, shame may be activated in the depressed persons' negative ruminations, increasing the propensity to criticise the self and turn shame inwards. Matos *et al.* (2013) found that internal shame and depressive symptoms were correlated with shame memories

involving attachment figures, suggesting that addressing these memories may help in ameliorating depression. Shame may also heighten levels of social anxiety as it leads the shamed person to focus on others perceived negative evaluations of them, resulting in increased anxiety in social situations (Mills, 2005; Hedman *et al.,* 2013). With regards to physical health, research has demonstrated that cortisol responses (which are produced when the body is stressed or challenged) were higher in contexts where stressors could lead to negative evaluation and uncontrollability (such as failure at a task). These are typical aspects of shame (Mills, 2005).

Shame may be central in problems that stem from physical abuse, such as that inflicted by parents (Kaufman, 1996). The child may experience intense feelings of humiliation, and a loss of power and control over their life. It may also be that the parent themselves has experienced abuse and shame in their past, and this is re-enacted in the dealings with their child. Therefore, this creates a continuous cycle of shame-enactment, and formation of *'shame-based family systems'* (Kaufman, 1996, p.118). Similarly, shame is very often a central affect experienced when a person has suffered sexual abuse. As well as experiencing humiliation and powerlessness, the person may also experience an intense feeling of having their body violated, adding to the sense of shame (Ibid.). As in the physical abuse example above, the perpetrator too may be compelled to act due to intense feelings of shame from past experiences they have had. Shame is so central to these issues as the sufferer lacks experience of kindness and warmth from others. This becomes internalised and the person may become more prone to self-criticism rather than self-compassion, feeding in to feelings of shame through perceiving oneself as flawed and lacking (Kelly *et al.,* 2014).

For individuals with post-traumatic stress disorder (PTSD) and high levels of shame-proneness, PTSD may be maintained not by fear, but by internal attacks on a persons' psychological integrity (Harman and Lee, 2010). This finding from research has led to revisions in DSM-V on PTSD diagnosis, recognising the importance of self-critical thinking and related feelings (Au *et al.,* 2017). For these individuals, it may be beneficial to incorporate strategies that address self-critical thinking, such as compassion-focused work as developed by Gilbert (1997, 1998).

Cook (1991) argues that, *'one of the primary psychosocial roots of addiction can be found in the internalization of shame and how shame becomes related to attachment issues'* (p.406).

In the paper Cook notes that for people with a self-structure dominated by shame, they may use alcohol or drugs to defend against painful feelings triggered by shame-inducing social situations. Luoma *et al.* (2014) found that, in a residential treatment centre for people with addiction issues, length of stay was positively related to higher levels of shame and stigma variables. This demonstrates just how often shame forms part of clients' enduring problems, and how it can impact on a wide range of behaviours and emotional responses.

1.6 Working with shame

In more recent years acknowledgement has grown that shame is an aspect of experience that ought to be given greater consideration. This can be seen in the proliferation of third wave CBT approaches such as such as Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT), which target shame directly through affect regulation and teaching self-compassion, and Dialectical Behaviour Therapy (DBT) which targets aspects such as emotion-regulation. CBT is a popular form of talking therapy that is helpful in demonstrating the links between thoughts, feelings, behaviours and bodily sensations, and how automatic thoughts can often unconsciously drive our behaviour (Clark, 2011). Currently a mainstay of IAPT (Increasing Access to Psychological Therapies) services, evidence suggests it can be useful for addressing a range of problems, in particular, anxiety and depression (Ibid.). It may work with shame by addressing some of the thought patterns, safety behaviours and coping mechanisms that keep shame cycles going. For example, CBT for social anxiety disorder may alleviate anxiety felt by clients who fear the scrutiny of others, a common feature for those who feel high levels of shame (Hedman et al., 2013).

ACT, like other third wave therapies, is principle-driven in its approach and places importance on contextual and experiential second-order strategies such as cognitive defusion, mindfulness and acceptance in order to facilitate change (Hayes, 2004; Hayes *et al.,* 2006). Therapy may focus on aspects of the self, issues around spirituality, and consideration of a client's values (Hayes *et al.,* 2006). DBT, originally developed for working with chronically suicidal clients, is now used to treat a range of psychological difficulties (Dimeff and Linehan, 2001). DBT uses techniques from behaviour therapy as well as mindfulness strategies, with a focus on consideration of opposites, self-regulation and distress tolerance. Therapy intends to reduce rigid black and white thinking by enhancing the ability to think dialectically. Dimeff and Linehan (2001, p.10) state that the prominent dialectic, '*is between validation and acceptance of the client as they are within the context of*

simultaneously helping them change'. CFT in particular has a strong emphasis on working to reduce shame, seeking to help clients learn to be kinder to their inner selves (Kelly *et al.,* 2014; Gilbert, 1997, 1998). Gilbert and Procter (2006) developed CFT as an alternative to focusing on thought-challenging (as in classic CBT approaches). It is based on an understanding that the brain is well equipped to regulate emotions and a sense of self, and that this can be improved through focusing on social roles such as gaining a sense of belonging and/or status, and caring for others. In CFT difficulties are seen as being borne from problems in social relationships, and so aims to address these through,

> *developing people's capacity to (mindfully) access, tolerate, and direct affiliative*
> *motives and emotions, for themselves and others, and cultivate inner compassion*
> (Gilbert, 2014, p.6)

Evidence suggests that high shame proneness is correlated with lower levels of mindfulness and self-compassion, and that self-compassion levels can predict shame-proneness (Woods and Proeve, 2014). Lower levels of self-compassion are also associated with anxiety around evaluations made by others (Werner *et al.*, 2012), and mediate the relationship between shame and life stressors, such as infertility (Galhardo, *et al.,* 2013). Self-compassionate approaches may work through increasing feelings of safety and care, delivered through improving attachments and providing emotion regulation strategies (Au *et al.,* 2017). This may explain why recent interventions have therefore often focused on increasing self-compassion and developing mindfulness as strategies for dealing with shame (Woods and Proeve, 2014).

Kelly *et al.* (2014) point to a number of studies that suggest increasing self-compassion can have an impact on reducing body anxiety, disinhibiting eating, and reducing compulsive exercise, related to clients with eating disorders. Additionally, research has shown that, *'eating disorder patients with higher trait self-compassion also report less severe eating disorder pathology'* (Ibid, p.55). CFT has also been used to develop treatments for working with people diagnosed with personality disorders, who experience high levels of shame (Lucre and Corten, 2013). A randomised control trial of group-based ACT targeting shame in substance abuse appeared to lead to improvements in attendance at treatment, and reduced substance use (Luoma *et al.,* 2012).

Au *et al.* (2017) argue that studies have shown some efficacy in brief interventions targeting and reducing shame, although it does not appear clear if there is one particular way that is effective above all others. Johnson and Yarhouse (2013) hypothesise that research on what

works with shame is limited perhaps due to the difficulty in diagnosing shame, and the complex systems in which it exists. However, there is a general understanding that acknowledging and working with shame is important if one is to develop insight into their thoughts and actions (if shame is a driver) (Cheston, 2005; Gilbert, 1997). Helping clients to understand the source of their shame, and working to counteract maladaptive strategies for dealing with it, can equip them with the tools necessary to transform experiences both in and out of therapy.

1.7   Wise methods

This thesis considers an exciting development borne out of social psychological research, and its application within the counselling psychology arena. That development is the notion of 'wise interventions'. Gregory Walton, a social psychologist at Stanford University, refers to these as brief, precise interventions that are more akin to everyday experiences than what one typically thinks of as an intervention. They aim to, *'alter a specific way in which people think or feel in the normal course of their lives to help them flourish'* (Walton, 2014, p.73)*. They are 'wise' because they consider the underlying psychological processes involved in a problem, aiming to make changes to these directly. They require an understanding of the individuals' reality to pinpoint what is causing harm and seek to change this, and they are *'wise to the meanings and inferences people draw about themselves, other people or a situation they are in'* (Walton and Wilson, 2018, p.617). This is a central feature of wise interventions, referred to as 'subjective construal' (Ibid.). Unlike 'nudges' (from social science and behavioural economics) that target particular behaviours in a particular context, wise interventions target psychological processes that continue to develop into the future, and can affect a number of outcomes. In this way, they can transform maladaptive meanings into healthier, functional interpretations that affect both the present and future understanding of the self, others and the social world.

Studies have demonstrated the impact of wise interventions in a range of areas, such as educational achievement, self-affirmation, self-esteem, social connection, sense of control, social norms, parenting problems, trauma, social belonging, social networks, conflicts in relationships, and test-taking (see figure 1, and also Walton, 2014; Sherman and Cohen, 2002; and Garcia and Cohen, 2012, for a review of several). Walton and Wilson (2018) suggest that there are five principles that make interventions wise: they focus in on altering a specific meaning to foster change; these meanings take place within complex systems;

creation of new meanings create change in on-going cycles; the interventions are developed and tested using methodological rigour; and ethics are considered in the design, testing and implementation of interventions. Interventions focus on one of three differing desires (or motivations), these being a 'need to understand' (selves or other), a 'need for self-integrity' (seeing the self as adequate) and a 'need to belong' (to feel connected to others), and then consider psychological processes that may be involved in changing meanings regarding specific questions. Figure 2 shows the process of moving from desires (on the left) to differing categories of desires, which are then broken down into questions that are the starting point for transforming the meaning of experiences (on the right). For example, focusing on a desire to understand the self, a growth mindset intervention might be used to transform understanding of one's intelligence from being seen as a fixed aspect of the self to something malleable.

Typically, interventions have been based on social psychological theories tested out in scientific research in laboratory studies, and then examined in the field. For example, Randomised Control Trials (RCTs) have been used to demonstrate how, *'a psychologically "wise" deliberate practice intervention improved expectancy-value beliefs, deliberate practice, and academic achievement among non-experts'* (Eskreis-Winkler *et al*., 2016, p.741). Deliberate practice here is akin to that which professionals (such as pro tennis players) may undertake to improve their performance. Theory and prior research suggested that both expectancy and values were related to persistence and performance in tasks, and so the research set about to manipulate these variables to see whether deliberate practice could be increased. Wise interventions of either 25 or 50 minutes were given to students, incorporating informational and motivational aspects. Intervention effects were found among both middle school and college students, and across a variety of achievement-related outcomes, demonstrating the potential far-reaching impact of a small, precise intervention.

Interventions fall in to one of four broad categories, direct labelling, prompting new meanings, increasing commitment through action, and active reflection. 'Direct labelling' interventions are underpinned by the belief that assigning a positive label to define an aspect of the self (or other) engenders a desire to act in a way that befits the label. Interventions that fall under 'Prompting new meanings' find a way to, *'revise [a person's] implicit stories without directly telling them what to think'* (Walton and Wilson, 2018, p.625). This might be through using leading questions which encourage a person to assume an idea

and explain its' significance, rather than being asked whether the idea relates to them or not. For example, a study on receiving compliments asked participants with low self-esteem how a compliment was significant to them, rather than if it was, which reduced the ability of the participant to dismiss the importance of the compliment (Marigold, 2007; 2010). A third intervention category is 'increasing commitment through action', borne out of evidence on the efficacy of cognitive dissonance as a tool for change. This category suggests creation of situations that allow people to act congruently with a new idea (also referred to as 'saying-is-believing, Walton and Wise, in press). The final intervention category, 'active reflection exercises', provides ways to reframe negative experience or encourage positive meaning making (Ibid.).

Walton (2014) states that a focus on an unfolding process, or a 'snowballing' effect is one aspect that sets apart wise interventions from other strategies. Yeager *et al.* (2014) theorised that the effects of prior experience, '*can be indirect through their impact on mental representations that shape interpretations and guide behaviors in the present*' (p.807). For example, a social-belonging intervention (increasing commitment through action) demonstrated the impact of adaptive responding (Walton and Cohen, 2011). In a one-hour exercise with minority college students, those in the experimental condition learned that all students initially worry about belonging when transitioning to college (changing attribution of struggles to 'normal' difficulties rather than as confirmation that the racial divide) over three years, and also reported better health at the end of the three years. The researchers also took daily-diary measures, which showed that the experimental group students began to see issues as unrelated to lack of belonging, changing their outlook, and so their performance. This achievement gap was also positively affected through an attributional retraining intervention (Yeager *et al.,* 2014). The intervention altered mental representations around mistrust in school, affecting how minority students interpreted critical feedback. Mental representations can be thought of as akin to the notion of schemas in CBT, or psychodynamic ideas on the effects of early experiences. A study on grateful recounting demonstrated that subjective well-being rose in those in a 'gratitude 3-blessings' treatment group, and continued to rise after treatment, outperforming both a memory placebo group and a 'pride 3-blessings' group (Watkins *et al.,* 2015). The recursive aspect of

Figure 1. Example wise interventions

Having adults with neuromuscular disease write what they were grateful for increased positive affect, decreased negative affect, and increased life satisfaction and connection with others, and improved sleep (Emmons and McCullough, 2003)

Having adolescents write for 15 minutes about receiving unconditional regard from a peer reduced feelings of shame among students who received poor grades (Brummelman et al., 2014)

WISE

Teaching a growth mindset lesson about neuroplasticity and that 'with practice' the brain 'will grow stronger' improved maths scores and attitudes to learning (Outes et al., 2017)

Asking young adults to adopt a self-distancing perspective when recalling an experience in which they felt overwhelming sadness and depression, compared to adopting a self-immersed perspective, reduced depressed affect and recurring thoughts about their depressive experience 1 & 7 days later (Kross and Ayduk, 2008)

these interventions allowed the participants to build new mental representations and have these confirmed through further, positive experiences. Importantly, interventions do not have to be 'recursive' through repetition by teacher and pupil (or therapist and client), but through being taken on and used in daily life by the participant. Learning and transformation of meaning becomes a repeated exercise with ever-greater impact.

Finkel *et al*. (2013) demonstrated a large impact over time when they tested the effect of three, seven-minute perspective-taking exercises on married couples over the course of a year. Couples were asked to write about how a neutral observer, '*who wants the best for all'* (p.1597) would view a conflict in their marriage, and how they could use this perspective in any future conflicts, and this was repeated at three intervals throughout the year. Over the course of the study period those in the experimental group maintained marital quality, whereas control couples (who solely reported on conflicts) declined in marital quality. The process under consideration here was that, *'a third-person perspective may prevent*

reciprocal patterns of negative affect between couples, making conflicts not distressing' (Walton, 2014, p.75). That is to say, the intervention did not aim to eradicate conflicts, but to change the way they were understood and worked through. This can be argued as a realistic approach to take towards change. Perhaps we do not seek to eradicate behaviours or emotions, but learn how to deal with them differently. This is particularly true in the context of this thesis – perhaps learning new ways to live with and alleviate the pain felt through toxic shame rather than seeking to eradicate it, by responding in more adaptive ways (Walton, 2014), is the way forward to enable a wiser, future-proofed perspective on the problem.

Although many studies have been conducted across areas with limited applicability to the therapeutic relationship, others concern aspects of the self that are often targeted in therapy. For instance the Marigold *et al*. (2007) intervention mentioned earlier was based on theory that suggests people with low-self esteem have a lack of self-worth and so tend to dismiss compliments. Individuals were asked to *recall* a compliment given by their partner, and to write about its personal meaning for the individual and its significance for their relationship, but importantly not asked to consider *whether* the compliment had meaning (as this might lead to instant dismissal). Individuals in a control condition were only asked to describe the context in which the compliment occurred. Those in the experimental condition were found to express value and feel more secure in their relationships, both immediately after the intervention, and in the following weeks. They were also noted to have more positive interactions with their partners than those in the control condition. This demonstrates the long-lasting effect of relatively simple interventions.

Another aspect of wise interventions is a focus on mindsets (or core beliefs/self-theories) regarding how changeable certain traits, abilities and so forth might be (Yeager *et al*., 2013; Broz, 2016; Folk *et al.,* 2017). Beliefs around how fixed or otherwise aspects such as intelligence, creativity and empathy affect how a person interprets their world and how they respond to situations. So, if one feels that intelligence is fixed, they may attribute achievement problems to lack of ability rather than needing to improve their skills through effort (Broz, 2016; Folk *et al*., 2017). A wise intervention can target these ideas about the fixed or malleable nature of aspects of a persons' mindset. Broz discusses these ideas in relation to people with substance misuse issues and co-occurring disorders, to consider how wise interventions can be used to reduce stigma and reduce likelihood of relapse. She

argues that an intervention can be used to change the mindset that ability to recover is fixed rather than open to improvement through effort. This is useful for those in recovery as:

> *If a client relapses after a period of abstinence and the meaning they attribute to the experience is that they won't be able to maintain belonging in recovery, the psychological effect can destabilize emotional and psychological well-being (Broz, 2016, p.163).*

Folk *et al*. (2017) also make this point in relation to psychotherapy more generally, noting the benefits of psychoeducation around malleability and discussion of this with clients (such as through group discussions or individual letter writing tasks). In the case of a client such as that described by Broz (2016), one could refer to the strength model of self-control that depicts self-control as a muscle that can be strengthened, with the client then writing to a significant other to describe how they could apply this theory to themselves to help develop self-control and prevent relapse (Baumeister *et al*., 2007; Folk *et al*., 2017). This can help reinforce the relapse prevention component of the treatment the client receives. Therefore a wise intervention can be seen to *complement and support* other resources available to the individual (in this instance, resources such as education, peer support, and addiction therapy). With regards to shame, one could consider how to support the notion that emotions such as this are malleable rather than fixed, and how this idea could be integrated in to a client's self-view.

Additionally, consideration of how a person's psychiatric diagnosis may affect their self-concept may be important. The social psychological Self-Categorization Theory (SCT) proposed by Turner *et al.* (1987) suggests that defining the self happens at a number of levels. Self-concepts may change depending on the context, and a person may adopt the 'stereotypical' norms and behaviours of a group they see themselves as belonging to. If that group has negative connotations (such as 'mentally ill'), then that may increase psychological symptoms. For example, someone who receives a psychiatric diagnosis may start to view themselves as helpless or unable to work/have functional relationships, as this is what they expect of the group they now belong to (Folk *et al.,* 2017). A wise intervention in therapy might be to help the client shift focus from comparison with others, to consideration of personal changes over time (to demonstrate malleability), and focus on other aspects of their identity (Ibid).

Walton (2014) argued that wise interventions work best in *'contexts in which positive experiences facilitate later positive outcomes' (p.79).* Therapy may be the perfect arena, due to the use of a supportive relationship that aims to facilitate changes that last long into the future. Periods of transition might be critical junctures in which to intervene wisely, as a persons' sense of identity might be in a state of flux, and social support may be lacking. Wise interventions can offer a helpful new way of thinking about and developing identity, and understanding social relationships and interactions. They are typically delivered indirectly, which may offer a less threatening invitation for change. If a client can feel like the messages of the intervention came from them, rather than happened to them, then they may be more likely to take ownership of the messages (Ibid.). For example, Broz suggests a writing intervention for those affected by trauma. This is based on social psychological ideas around story-editing to change a person's narrative about the world and themselves. With regards to a traumatic event, this is consistent with ideas around re-framing trauma (Gersons and Schnyder, 2013, although evidence is patchy – see for example, Koopman *et al.*, 2005), particularly for those who display emotional expressiveness (Niles *et al.*, 2014). The intervention not only works on reducing re-experiencing through intrusive thoughts, but can also use the social support around the client to 'test' out a new narrative. With regards to use by counselling psychologists, therapy can be one place that the person can safely use this technique to test out a new narrative. As Broz states (p.18):

> *The encouragement the individual receives can affirm their sense of belonging and safety in the present, and the person's ability to integrate the experience into their lived experience of recovery going forward.*

This view is also supported by Folk *et al.* (2017), who argue that feedback (or reflections) that direct attention on effort and strategy can move a client to focus on process rather than outcome, which allows, *'room for growth and promotes an incremental mindset'* (p.412). Focusing on malleable aspects has been seen to improve motivation, optimism, and enjoyment and to elicit positive emotions (Ibid.).

The more clients can shift their view towards consideration of the process, the more they may be able to develop a positive sense of self. For instance, research suggests that self-affirmation can increase tolerance to threatening situations in a range of contexts (Folk *et al.*, 2017; Sherman and Cohen, 2002). Defensiveness or rumination may be reduced if a person has the resources to see themselves as worthy and adequate when faced with a

threat to their self (Sherman and Cohen, 2006). Folk *et al.* (2017) discuss the example of a client whose defensiveness is triggered during a cognitive restructuring exercise when receiving CBT. They may begin to feel inadequate due to being told that their thinking is somehow flawed. If prior to this the client has had a self-affirmation intervention (such as considering areas of personal strength, values, and other areas that focus on the self as capable), then this could potentially reduce the levels of defensiveness felt, as the threat to their self-esteem may not feel as large. Some approaches (such as ACT and DBT) do provide focus on values, but as Folk *et al.* (2017, p.413) point out:

> *self-affirmation has a function distinct from this goal. In addition to motivating behavior, self-affirmations bolster self-worth, which increases openness to threatening information, buttresses self-esteem, and reduces defensiveness and reactivity.*

Folk *et al*. (2017) suggest a number of small wise interventions (or additions) that may be useful in the therapeutic context. Consideration of transference processes in many areas of the client's life might be important, to tap into self-concept at other times in their life. How did clients perceive themselves when in relation to another? What aspects of other people trigger particular relational schemas, and how might these be influencing current relational contexts? Interventions that seek to change body posture may be beneficial, due to the mind-body link. This is used to some extent in DBT (such as the 'half-smile' or 'opposite-action') to encourage a more relaxed posture (and also in relaxation training), and research has shown that manipulating posture to display negative emotions increased self-reports of the same negative emotions by participants (Duclos *et al.*, 1989; Folk *et al.,* 2017), and confident postures improved confidence in written thoughts (Brinol *et al*., 2009). Interestingly, experiments in which participants were asked to either nod or shake their heads whilst receiving a potentially persuasive message demonstrated attitude change through overt head movements, which could be replicated in therapy. It was found that:

> *When the message arguments were strong, nodding produced more persuasion than shaking. When the arguments were weak, the reverse occurred. These effects were most pronounced when elaboration was high. These findings are consistent with the "self-validation" hypothesis that postulates that head movements either enhance (nodding) or undermine (shaking) confidence in one's thoughts about the message.* (Brinol and Petty, 2003, p.1123).

At present wise interventions do not appear to be routinely used within therapy services, and this is something the research considers. They may be beneficial for counselling

psychologists who integrate a range of therapeutic modalities in to their practice, offering a novel way of considering how to use a principle driven, rather than protocol driven, approach. They are not what is commonly considered as an intervention (in terms of several weeks or months using a particular approach), but perhaps can be considered as a new way of conceptualising and working with problems. Wise interventions, as noted earlier, can be a complementary part of therapy or treatment that is principle, rather than protocol driven (Cooper and McLeod, 2011). A recent paper by Folk *et al.* (2017) discusses the use of wise interventions within clinical psychology. As clinical psychologists share many similarities with counselling psychologists, not least as reflective scientist-practitioners, many of the arguments they make will be similar in considering crossovers to therapy. From this standpoint, counselling psychologists aim to work collaboratively, and what better way to demonstrate this than by drawing together research and practice form across a range of disciplines. There is much of relevance to counselling psychologists in the field of social psychology. As Folk *et al.* (2017) suggest:

> *Basic social-cognitive, emotional, and interpersonal processes have long been recognised as crucial to the development and treatment of psychopathology…Integrating social psychological concepts into clinical practice can not only improve understanding of emotional problems and emotion regulation dysfunction, cognitive distortions, and maladaptive behaviours, but it can also augment the basic research support base for therapeutic techniques (p.407).*

Social psychology ideas around self-concept can be integrated into thinking about how to deal with individual differences when considering therapeutic approach and responsive style, in order to increase effectiveness of therapy (Ibid.). Folk et al. focus on five areas of social psychology theory that have applications in clinical psychology practice, these being self and identity, self-affirmation, transference, social identity, and embodied cognition. In their paper they refer to 'wise additions' rather than interventions, which is perhaps a more useful term for considering how they fit with other larger interventions and treatment plans. Wise interventions (or additions) can use processes for targeting, *'matters in the setting at hand'* (Walton, 2014, p.79), they may require active rather than passive exposure to target the key psychological processes at hand, and they should, *'alter critical recursive processes'* (Ibid, p.80). These dimensions will be considered in thinking about how counselling psychologists can actively influence shame experiences in the therapy room.

Figure 2. Psychological processes impacted by wise interventions
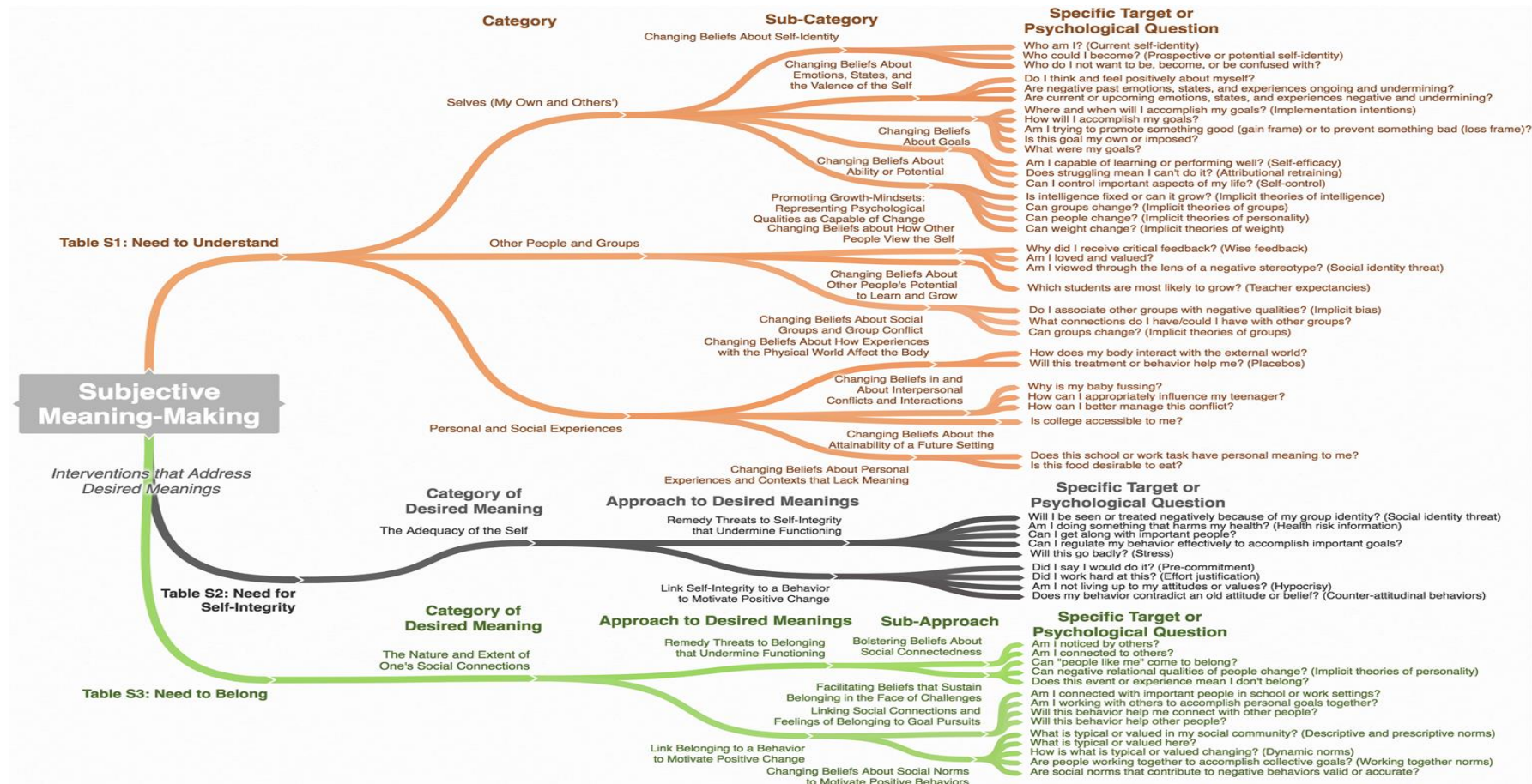
Source: Walton and Wilson (2018, p.626)[1]

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[1] Gregory Walton has given kind permission for the Walton and Wilson (2018) paper to be cited in this thesis. See appendix A for evidence

1.8   Rationale

As a counselling psychologist I work from an integrative stance, with a relational/psychodynamic leaning. As such, I am greatly interested in looking at the development of shame from the perspective of early childhood experiences and learnt patterns of relating. I believe this offers a useful lens through which to understand how shame can develop and remain entrenched in later life. My background in social science more broadly (and training/experience in social research) has pushed me towards drawing together aspects of my experience to attempt to answer this difficult question of what constitutes effective treatment of shame. I spent several years working as a social researcher in government, and then academia, and am a great believer that research should be produced with the intention of applying it to the real world to improve practice. I therefore wanted to put my experience in my former career to good use. I have previously spoken about and taught how to drive forward good practice in research, and supported charities in understanding what good research looks like and how to evaluate the impact of their services. I therefore feel it is very important to me to continue to aim for best practice in my own work, even if the timescale and the resources that I have within one thesis limit me. I wanted to produce something based on the best available evidence to understand what we know about what works, in order to make decisions on how to potentially work wisely with shame. Using robust methods to draw together credible, recent research on both experience of shame and impact of interventions provides a sound basis for starting to identify small transformational exercises that might be used within integrative and/or pluralistic therapy, to counteract negative experiences of toxic shame that affect therapeutic growth.

This research therefore considers if there are smaller 'wise' interventions (transformational exercises) that can be introduced within integrative therapy to help counselling psychologists work more effectively with an emotion as difficult to work with as toxic shame. I came across Walton's (2014) notion of wise interventions when working as a social researcher for the National Offender Management Service, as it was something we began to consider introducing to interactions between officers and offenders in prisons to help build better therapeutic relationships focused on rehabilitation rather than punishment. I see this ethos as transferable to the therapy room, where therapists can (and often do) work 'wisely' to help clients create a new narrative for their lives. As counselling psychologists work from

an integrative, pluralistic perspective, it is beneficial to consider ways of working that can be integrated into a range of therapeutic approaches (Folk *et al*., 2017; Broz, 2016). Rather than inventing a new therapeutic model to work with shame (which is provided by approaches such as compassion-focused therapy), the idea is to consider simpler ways of wisely addressing shame when enacted within a therapeutic context (and that hinders personal growth), whatever that context may be. Central to wise interventions is the transformation of meaning, and, *'the exploration of…meaning, especially emotional, of events and experiences'* is a central paradigm of counselling psychology (UWE, 2014, p.20).

1.9   Aim

Wise interventions seek to make new meanings for people in a range of areas. In each area:

> *the key actor…has developed maladaptive views of themselves and/or their circumstances. Understanding the nature of these views, how they arise, and how they can be changed, can change people's behaviour and improve outcomes (Walton and Wise, in press, p.4)*

This thesis aimed to consider how to introduce 'wise' precise interventions within therapeutic work to alter meanings around the experience of toxic shame. The process was split into two broad parts, taking a thorough evidence-based approach to producing wise interventions. The first phase of the research considered the question, ***'How is shame experienced in a relational context, and how is this dealt with in the therapy room?'*** The aim was to consider how toxic shame was experienced relationally between client and therapist (the nature of maladaptive views and how they arise). As noted by Black *et al.* (2013), '*the literature normally… does not assess how individuals respond and manage the affective experience* [of shame]*'* (p.647). This research sought to address this gap. This phase also endeavoured to understand which interventions had demonstrated some positive impact on toxic shame within therapy (how maladaptive views can be changed). The aim of this phase was to enable me to gather robust evidence to pinpoint experiences in therapy that might be driven by toxic shame, so that counselling psychologists (and other therapists) might better understand when shame might be affecting the therapeutic process. This provided a starting point for determining intervention strategies that might be used Wisely to transform shame-based experiences.

The findings from this first phase were then used to consider the principal research question in phase two, ***'How might we transform the meaning of shame through wise interventions?'*** In this part of the research, evidence from the two parts of phase one were brought together to produce a list of possible interventions that could be developed into strategies that would fit within the principles and overarching categories of Wise interventions. Counselling psychologists in training were consulted to seek their views on the efficacy and value of using therapeutic strategies from a range of disciplines as wise interventions to transform shame-based experiences. It was envisaged that, after further research to test these interventions out, these could be used within integrative, pluralistic modes of therapy whenever experiences of toxic shame appeared to arise (changing behaviour and improving outcomes). The scope of this research did not include a testing phase, and so findings were only intended to provide a robust starting point for further research and discussion.

2 Methodology

2.1 Epistemological assumptions

The approach taken to this research is based on an ontological belief in critical realism, suggesting that there is some universal truth (reality) to the world, but that this reality is socially constructed (Finlay and Evans, 2009). Within critical realism, there are three modes of reality – the empirical (observable reality), the actual (existing in time and space), and the real/deep (often unobservable mechanisms of reality that generate phenomena) (McEvoy and Richards, 2006; Kempster and Parry, 2011). This stance takes a pragmatic approach, providing a basis for universally defining concepts such as shame whilst simultaneously accepting that experiences of this concept might differ depending on how they are constructed and understood, and that understanding may be at the subconscious level.

Epistemologically, critical realism has much in common with constructionism. Constructionist epistemological assumptions suggest that we create knowledge (and truth) though engaging with the realities we see around us. In other words, reality is constructed through context. Critical realism also has a subjective understanding of how knowledge is constructed, suggesting that our view of the world is shaped by, among other things, our expectations and beliefs (Madill *et al.,* 2000). From this viewpoint, the experience of shame can be understood through the relationships between subject and object(s) and the interplay of these and the surrounding environments. The meaning of how shame is experienced and dealt with is therefore socially constructed, but explanations of this meaning may exist at a deeper level than that which is readily observed between client and therapist. It is therefore useful to try to consider this experience through generating theories through a process of 'retroduction'. This critical realist approach refers to '*moving from the level of observations and lived experience to postulate about the underlying structures and mechanisms that account for the phenomena involved'* (McEvoy and Richards, 2006, p.71).

Whilst I accept that there may not be one universal truth with regards to the reality of toxic shame, it does appear that there are many core elements that likely make up this affect (as defined earlier), and so I have taken this as being the core 'truth' that this research rests on. As a counselling psychologist working from a relational perspective, I do tend to err towards an interpretivist epistemology, but a critical realist approach allows me to go beyond solely interpreting what is in front of me, to looking for deeper layers of meaning and

understanding. From this standpoint, I am aware that the research will reflect my own subjective interpretations, influenced by my beliefs and experiences, but will be borne out of the various realities constructed within the data (Finlay and Evans, 2009). As my own experience and understanding is bound up in the research, I have tried to maintain a reflexive awareness of my part within the work, as both witness and author (Ibid.).

2.2 Methodological approach

The methodological approach taken for this thesis is that of a 'scoping study', combining a review process using systematic strategies with a consultation exercise, *'to inform and validate findings'* (Arksey and O'Malley, 2005, p.27). Scoping studies offer a useful way to explore a complex problem. As Mays *et al.* (2001) noted:

> *Scoping studies might aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as standalone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before* (p.194).

As can be seen from Figure 3, the research is split into 4 parts. Each will be discussed in turn. Parts 1 and 2 enable consideration of a broad question, which is, '***How is shame experienced in a relational context, and how is this dealt with in the therapy room?'***

Part 1 answers the sub question:

> *How is shame experienced in the therapy room?*

Part 2 answers the sub question:

> *What works in reducing (or increasing tolerance to) shame in individual therapy?*

Parts 3 and 4 consider how to transform findings from 1 and 2 into wise interventions, and how counselling psychologists might integrate these in to active therapy, to answer the question, ***'How can we transform the meaning of shame through wise interventions?'***

Part 3 answers the sub question:

> *What might Wise interventions for working with shame look like?*

Part 4 answers the sub question:

> *Do practitioners see value in using therapeutic strategies as wise interventions to transform shame-based experiences?*

Figure 3. The research process
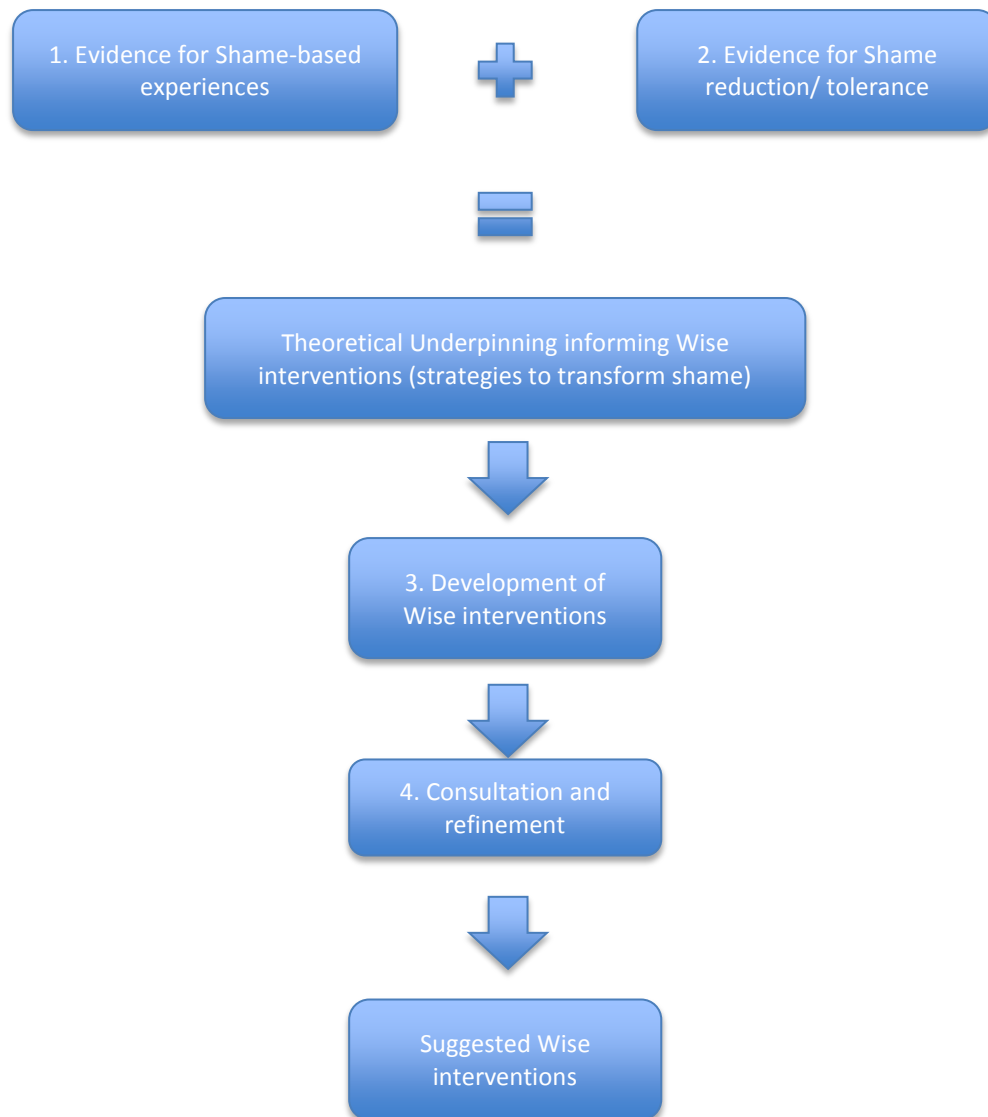
2.3   Parts 1 and 2: Rapid Evidence Assessments

Parts 1 and 2 were answered through employment of Rapid Evidence Assessment (REA) methodologies. An REA is a shortened version of a full systematic literature review. The features that distinguish a systematic review from a literature review are:

- Use of explicit and transparent methods
- It is considered a piece of research in itself, following a standard, well-defined set of stages
- It is accountable, replicable and updateable
- It incorporates user involvement to ensure outputs are relevant and useful to the field. A good explanation for this is provided by the EPPI centre (EPPI, 2015).

An REA applies the same principles as a systematic review but with certain concessions to breadth or depth of the process due to the need for the 'rapid' element (usually due to time or resource constraints). Usually, an REA takes between four and six months to conduct, as opposed to a full systematic review, which can take upwards of a year. Concessions might include:

- A narrowly defined question
- A less extensive search (using a shortened search string)
- Less (or no) use of 'grey' and print literature
- Either no mapping stage, or one of limited breadth
- Data extraction only on results and key data for simple quality assessment
- Simple quality appraisal and/or synthesis of studies

Two REAs were conducted, to answer the questions in parts one and two, and the processes and differences are explained in 2.2 and 2.3 below.

2.4   Part 1: REA 1. How is shame experienced in the therapy room?

a) Research question and conceptual framework

An a priori method was used to determine the review protocol, including the research question, underlying assumptions, conceptual framework and methods. However, owing to the qualitative nature of the research question, an iterative process was also used to inform the process (Thomas & Harden, 2008). With regards to the research question, *How is shame experienced in the therapy room?,* the focus was on research studies with adult clients (18+)

in individual therapy/counselling, where there was discussion of shame as it occurred between therapist and client.

b) Quality assessment and study relevance (see appendix B)

The following were considered:

1) The methodological quality of the study

2) The relevance of the research design for answering the REA question

3) The relevance of the study focus for answering the REA question.

c) Inclusion and exclusion criteria

Inclusion criteria can be viewed as similar to a researcher defining the sample and population that they intend to study when carrying out primary research. For this project they included:

- Nature of what is studied: experiences of toxic shame in therapy (as defined in the introduction)

- Setting and population: any individual therapeutic setting in the Western world (including the USA and Canada). Only clients over the age of 18. Any problem dimension. Group therapy was excluded. Self-help interventions were included[2].

- Date of research: Within the last ten years only (2007 to 2017).

- Research methods: Qualitative studies using any method to understand *experience*, such as IPA, grounded theory, thematic analysis. Case presentations where findings were not easily identified were excluded. Mixed method studies were included if the qualitative element was clear.

- Language: English language only

d) Search strategy

This was principled, planned, rigorous, explicit, and grounded in the research question. It included three elements:

1) Inclusion criteria (as above)

2) Sources to be searched. This included electronic databases as detailed below. Further searching of grey literature or references did not form part of the initial search strategy (due to resource and time limitations). As so few papers of relevance

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[2] Group interventions were excluded, as it may be something about the group process itself, rather than solely the intervention, which may have caused changes. Self-help or computer based interventions were included as these are more akin to interventions within one to one therapy. However, it is noted that outcomes could be impacted by the presence or absence of the therapist

were found, additional papers that met the criteria but were found during the REA2 search were included.

3) Search terms were defined in agreement with my dissertation supervisor

The search was purposive rather than exhaustive as the aim of the research was to interpret and explain phenomena, rather than seek to predict effect (as in quantitative reviews). Therefore, the search aimed for 'conceptual saturation' rather than inclusion of every study possible (Thomas & Harden, 2008).

The literature search was conducted in February 2016 and updated in December 2017. Only the University of the West of England library search engine and EBSCOhost were used for searches. Therefore it may be that some studies of value have been missed. Figures 4, 5 and 6 show the search terms used. The search used the following electronic databases:

- BioMed Central
- Business Source Premier
- Cambridge Journals Online
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- DOAJ (Directory of Open Access Journals)
- Emerald
- Encyclopaedia of Life Sciences
- ERIC
- Intermid
- Internurse
- JSTOR
- Library Information Science and Technology Abstracts
- Medline
- ProQuest Sociology
- PsycARTICLES
- PsycBOOKS
- PsycINFO
- PubMed
- SAGE Journals Online

- Science Direct

- SocINDEX

- Springer Link

- Taylor and Francis

- UWE Bristol e-journals at OVID

- Web of Science

- Wiley Online Library

Figure 4. Search terms, broad search, shame experiences

All terms were searched for within abstracts (broad search).

Client* OR patient* OR "service user" OR therapist* OR counsellor* OR counselor* OR psychotherapist* OR psychoanalyst*
AND

↓

Therapy OR "therapeutic relationship" OR counselling OR counseling OR treatment
AND

↓

Shame OR embarrass* OR humiliat* OR dishonour* OR pride OR defam*
AND

↓

Experience* OR reliv* OR felt OR enacted OR re-enacted OR recreate* OR reform* OR restructure* Or re-experience* revive*
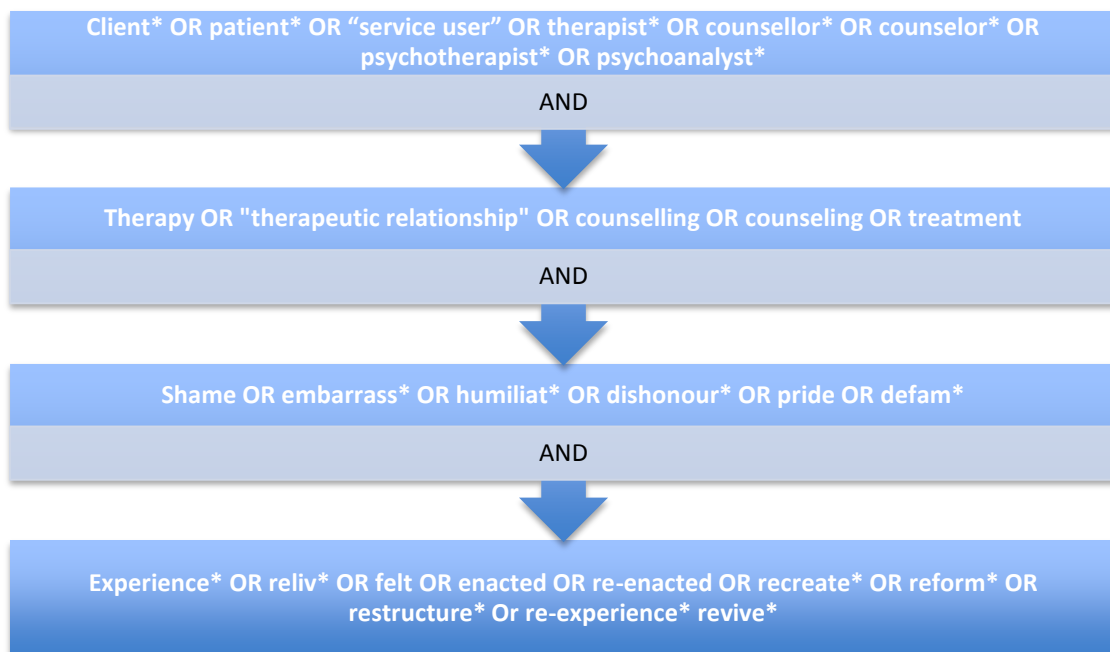
Figure 5. Search terms, highly controlled search 1, shame experiences

All terms were searched for within titles (for a highly controlled search)

Client* OR patient* OR "service user" OR therapist* OR counsellor* OR counselor* OR psychotherapist* OR psychoanalyst*
AND

↓

Shame OR embarrass* OR humiliat* OR dishonour* OR pride OR defam*
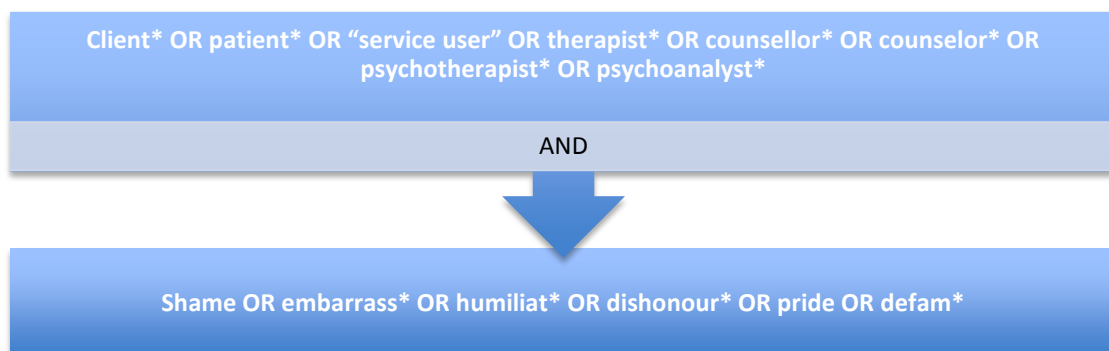
Figure 6. Search terms, highly controlled search 2, shame experiences

All terms were searched for within titles (for a highly controlled search)

Therapy OR "therapeutic relationship" OR counselling OR counseling OR treatment
AND

Shame OR embarrass* OR humiliat* OR dishonour* OR pride OR defam*
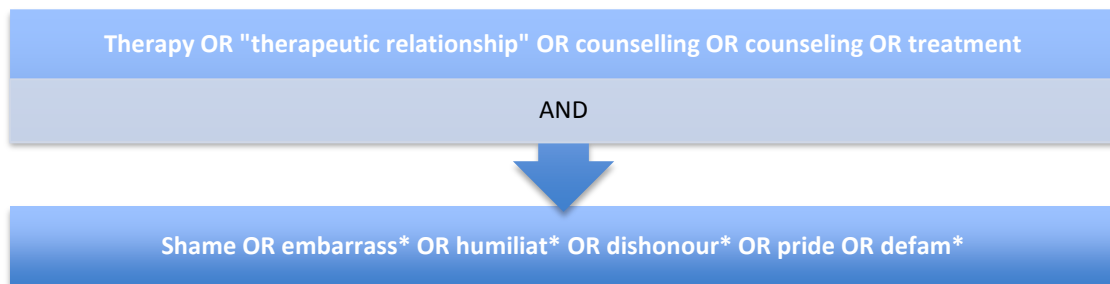
e) Screening selected studies

All studies in the REA search were recorded and accounted for. The first stage in screening was reviewing abstracts for comparison against the inclusion criteria. If studies were not screened out at this stage, the full report was then read and compared to the inclusion criteria.

Selection Procedure and Outcomes

568 studies were found through initial searches, and 225 abstracts were examined for relevance. After removing duplicates, 85 reports were then downloaded for further examination, plus an additional 10 were added from the REA2 searches. The final number of studies that met the search criteria, and could be accessed within the time frame, was ten, plus five from the REA2 searches. After quality appraisal seven studies were included in the synthesis, two of these from the REA2 search.

Figure 7. Screening process REA1

568 articles screened across all searches	225 abstracts sreened	85 articles retrieved for full text, plus 10 articles from REA2 search	5 eligible studies + 2 from REA2 search (met criteria and quality standards)
• 343 articles excluded by title, or as duplicates	• 140 articles excluded by abstract screening	• 75 excluded, plus 5 from REA2 search	• 7 articles synthesised
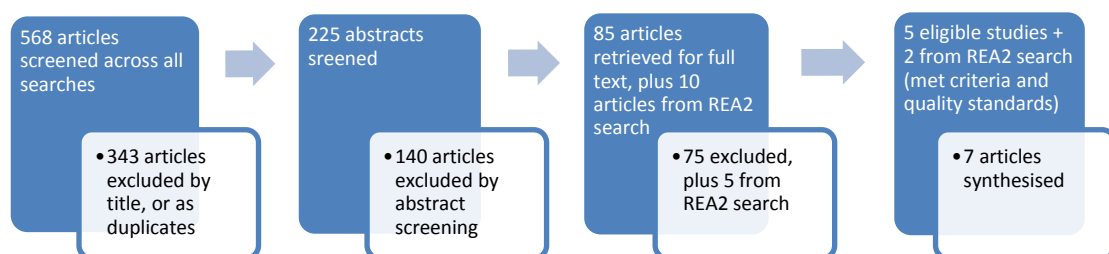
f) Quality appraisal

The questions from step 2 were used to critically appraise each study. Consideration was given to study design and how well the method was applied and reported. There is often much debate over how quality should be assessed in qualitative studies, and what it should look like (see for example, Thomas and Harden, 2008). It is not necessarily easy to assess quality in qualitative studies, as there is so much variation in both methods and reporting. For the purpose of this review, quality was considered to be the degree to which the studies represented the views of the participants, and how clearly the methods, analysis and so forth were reported (for a discussion on this, see Thomas and Harden, 2008). All studies were included, no matter the quality, although the quality assessment was considered during and after synthesis. Quality assessment criteria were set out using a range of questions based on a modified version of the CASP (see Critical Appraisal Skills Programme, 2017) used by McInnes and Chambers (2008) and criteria used by Thomas et al. (2003) (for detail see Appendix B). This appraisal takes the form of a set of questions that help to establish the quality of the reporting of all parts of the research, and following of procedures that provide clarity on the reliability and validity of data collection, analysis and findings (Thomas and Harden, 2008). As it was expected that there would be few studies within the review, the sensitivity analysis remained quite broad. Studies were only excluded if the description of methodology was too limited to enable consideration of appropriateness of methodology, for example. Studies that remained in the REA after critical appraisal formed a map of the evidence to be synthesised.

g) Synthesis/analysis

Thematic synthesis

Thematic synthesis was used as it offered a realist approach, which provides a clear synthetic product for use by practitioners (Barnett-Page & Thomas, 2009). The approach is broadly adapted from meta-ethnography and grounded theory approaches to synthesis. For example, analytical themes are developed within the synthesis, which can be seen as comparable to third order interpretations found in meta-ethnography (ibid). The stages for analysis and synthesis, as described by Thomas and Harden (2008) are as follows:

1) Text coded
2) Descriptive themes developed
3) Analytical themes generated

The first stage was to consider all qualitative data within the research. This was anything within the findings or results section of the included studies (unless they were strictly quantitative data which would not add to information on experience). Some of the papers did not have formalised results or findings sections, therefore text was drawn out from the paper that appeared to be evidence, such as analysis or quotes. For instance, within case studies, information regarding context and case history was not included as findings. The text was copied into NVivo, and free coded line-by-line, by both meaning and content. As all text was considered within coding, this allowed me to reduce bias due to the a priori nature of the search and research question. In other words, I had freedom to consider anything that came up within the data, regardless of whether or not it initially appeared to 'fit' with the research question (Thomas and Harden, 2008). The benefit of this approach is that it allowed for identification of concepts across studies. This is much like the process of axial coding in grounded theory research (Charmaz, 2006). The difficulty here is that I was working alone, and therefore there were some limitations with subjectivity of coding. I therefore checked the first few codings (and descriptive themes) with the doctoral supervision team, to ensure some level of inter-rater reliability.

Once the data were coded, descriptive themes were developed. Much like in grounded theory approaches (see for example, Glaser and Strauss, 1967), an inductive, 'constant comparison' method was used to develop themes. During initial coding the data were checked and rechecked to ensure findings were captured sufficiently, and that they were grounded in the studies. Additional codes were added where necessary until saturation occurred. After initial free coding, the data were organised into new themes by interpretation of connections between categories and concepts. During this phase I considered similarities and differences between the codes produced, grouping them into super-ordinate codes. These codes aided the formulation of descriptive themes that became apparent within the data. As Thomas and Harden (2008) point out, these first two phases of analysis do not stray far from the findings as written in the research paper. It is only in the final phase of analysis that the synthesis goes beyond that which is written in the original data. It is this final phase that brings the review together to enable an answer to the research question.

The third stage of analysis, generation of analytical themes, involved considering the research question in light of the descriptive themes developed at stage two. At this point I attempted to infer how shame was experienced in the therapy room in light of the findings, and I considered any *'implications for interventions suggested by each theme'* (Harden *et al.,* 2006, p.21). The themes developed at this stage appear more abstract in nature, taking a 'higher order' approach to analysis (Thomas and Harden, 2008; Harden *et al.,* 2006). The data were re-examined in light of the analytical themes that emerged, and the themes were refined until they adequately captured all information from the descriptive themes. These themes were discussed with supervisors to provide a level of justification and scrutiny to the data transformation. On the basis of discussion, final themes were reduced from ten to seven in number.

2.5 Part 2: REA 2. What works in reducing (or increasing tolerance to) shame in individual therapy?

a) Research question and conceptual framework

An a priori method was used to determine the review protocol, which included the research questions, underlying assumptions, conceptual framework and methods.

With regards to the research question, *What works in reducing (or increasing tolerance to) shame in individual therapy?*

1) The population: adult clients (18+) in therapy receiving an intervention to reduce shame, or increase tolerance to shame

2) Definition of the intervention: any individual therapy/counselling (both short and long-term)

3) The comparison group: adult clients (18+) receiving treatment as usual (TAU) or other therapy

4) Outcome measure(s): reductions in levels of internalised and/or externalised shame, heightened levels of shame tolerance. Whilst studies that measured increased self-compassion were searched, they were only included if they also measured shame. Shame could be a primary or secondary outcome measure, as the literature suggests there are relatively few studies directly assessing the impact of interventions in therapy on shame (Johnson and Yarhouse, 2013).

b) Quality assessment and study relevance

The following were considered:

1) The methodological quality of the study

2) The relevance of the research design for answering the REA question

3) The relevance of the study focus for answering the REA question.

c) Inclusion and exclusion criteria

- Nature of what's studied: interventions targeting reductions in shame or targeting increasing tolerance to shame/increased self-compassion. All studies needed to have a measurement of shame as a construct, measured either as a primary or secondary outcome.

- Setting and population: any individual therapeutic setting in the Western world (including the USA and Canada). Only clients over the age of 18. Any problem disorder. Group therapy was excluded. Self-help interventions were included[3].

- Date of research: Within the last ten years only (2007 to 2017).

- Research methods: As we are interested in outcome studies, only quantitative studies were included. These could include Randomised Control Trials (RCTs), pre-post studies, systematic reviews, case control studies, meta-analyses

- Language: English language only.

d) Search strategy

This was principled, planned, rigorous, explicit, and grounded in the research question. It included three elements:

1) Inclusion criteria (as above)

2) Sources to be searched. This included electronic databases. Further searching of grey literature or references did not form part of the search strategy. However, a second search focused on interventions to increase self-compassion was conducted, to try to encapsulate as broad a range of interventions as possible.

3) Search terms to be used were defined in agreement with the dissertation supervisor

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[3] Group interventions were excluded, as it may be something about the group process itself, rather than solely the intervention, which may have caused changes. Self-help or computer based interventions were included as these are more akin to interventions within one to one therapy. However, it is noted that outcomes could be impacted by the presence or absence of the therapist

The search aimed to be exhaustive as the aim of the research was to seek to understand evidence on what works. The search used the same databases as for REA 1. Figures 8 and 9 show the search terms used.

Figure 8. Search terms, broad search, shame interventions.

All terms were searched for within abstracts (broad search).

Client* OR patient* OR "service user"
AND

Therapy OR counselling OR counseling OR treatment OR intervention*
AND

Shame OR embarrass* OR humiliat* OR dishonour* OR pride OR defam*
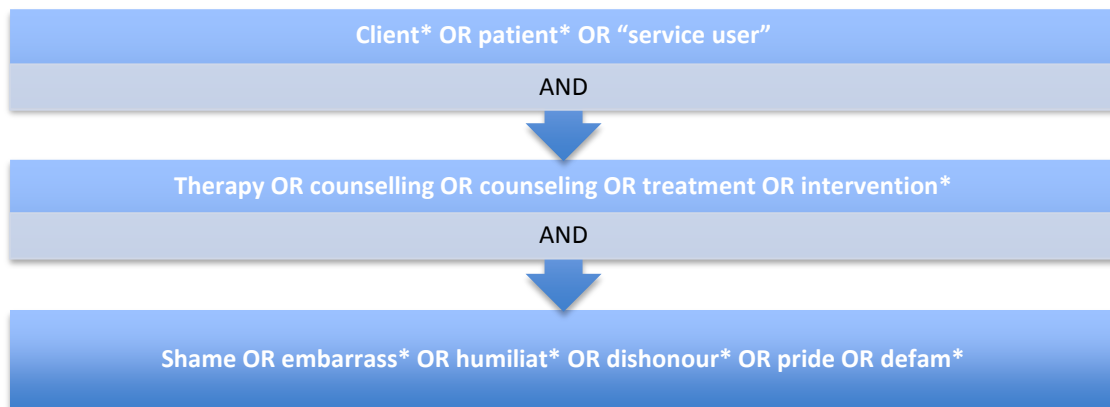
Figure 9. Search terms, broad search, compassion interventions.

All terms were searched for within abstracts (broad search).

Client* OR patient* OR "service user"
AND

Therapy OR counselling OR counseling OR treatment OR intervention*
AND

Compassion* OR 'self-compassion* OR mindful* OR 'ACT' or 'CFT' or acceptance
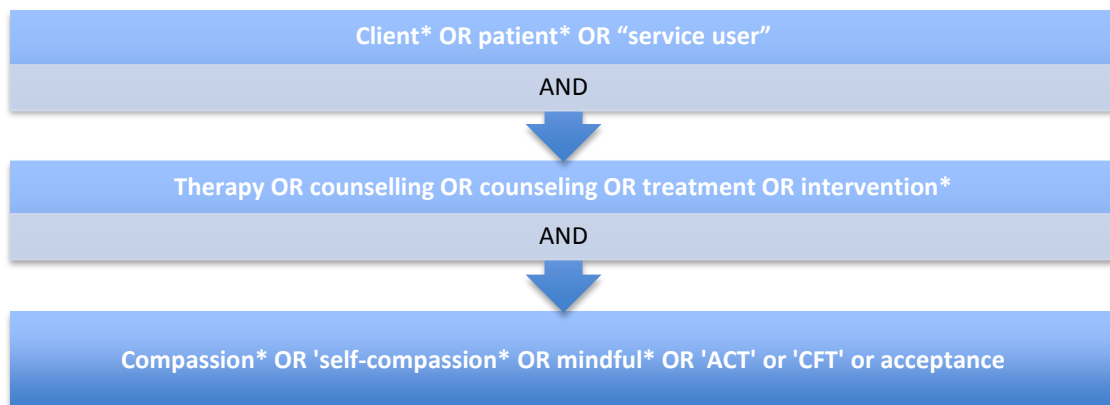
e) Screening selected studies

Selection Procedure and Outcomes

1194 studies were found through initial searches, and 138 abstracts were examined for relevance. After removing duplicates, 30 reports were then downloaded for further examination, plus an additional 36 were added from the compassion searches. The final number of studies that met the search criteria was 17, plus three from the compassion searches. After quality appraisal 14 studies were included in the synthesis, two of these from the compassion search.

Figure 10. Screening process REA2

1194 articles screened	138 abstracts sreened	30 articles retrieved for full text, plus 36 articles from compassion search	17 eligible studies + 3 from compassion search
• 1056 articles excluded by title, or as duplicates	• 109 articles excluded by abstract screening	• 13 excluded, plus 33 from compassion search	• 14 studies mapped (met criteria)
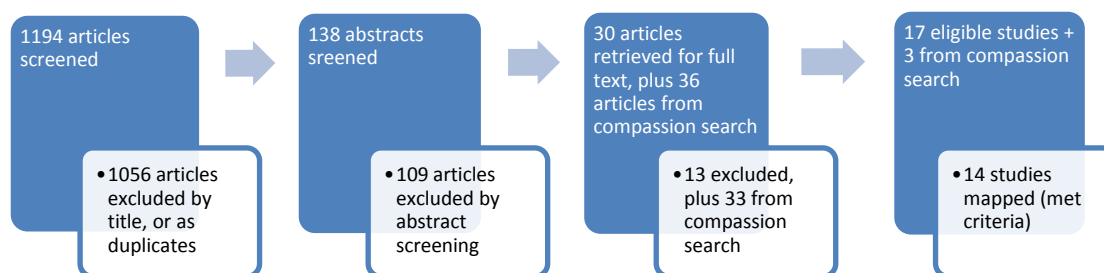
f) Quality appraisal

The questions from 2.1.2 (b) were used to critically appraise each study. Consideration was given to study design and how well the method was applied and reported, as well as the validity of the data (such as use of pre-validated scales and of robust research methods). This takes a more rigorous approach than for REA 1, as appraising quantitative studies can be much more tightly controlled. Studies were not weighted, but notes were made on the level of risk of bias found within each study to help inform quality assessment (see Higgins *et al.,* 2011 for a discussion on this)[4]. For example, an RCT that fails to provide information on the randomisation process would have high selection bias, as one would be unable to assess how successful the randomisation process was.

Critical appraisal included the Maryland Scale of Scientific Methods (MSSM) for quantitative studies (Sherman *et al*, 1997), and risk of bias assessment (Higgins *et al.,* 2011). See appendix C for individual study assessment information to be collected (based on work by Taylor *et al.,* 2013) and risk of bias assessment criteria (Higgins *et al.,* 2011).

g) Synthesis/analysis

Descriptive synthesis/mapping

Although this REA considered quantitative data, a descriptive synthesis/mapping of data was undertaken. The relative strengths and weaknesses of studies were considered, and consideration was given to the methodological weighting afforded. The narrative element

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[4] Whilst a Research Associate at the University of Bristol, I worked with the team who collaborated on ROBES (Risk of Bias in Evidence Synthesis) and contributed to the Cochrane Handbook. Due to discussions with them, and undertaking training by them (including Jelena Savovic and Julian Higgins), I felt assured that this was an excellent way of judging quality of research studies for inclusion in systematic reviews.

allowed the review to be inclusive of lower quality studies, and provided descriptive information rather than solely numerical (Taylor *et al.,* 2013; Leaviss and Uttley, 2014). This meant that due consideration could be given to the core elements that might make a Wise intervention successful. The studies were expected to consider a wide range of interventions and problem disorders that could not be easily combined (they were not comparing like for like), therefore statistical synthesis and meta-analysis were not considered possible or appropriate. Instead, mapping of the studies provided information on the common and disparate aspects of interventions that have had some success at reducing shame within therapy.

2.6   Part 3: Synthesis. What might Wise interventions for working with shame look like?

The aim here was to synthesise the findings from the two REAs to consider the psychological processes that were activated during shame experiences, and to consider types of possible intervention that might transform these experiences. Experiential themes (from REA1) were extracted to provide a framework for when differing interventions might be needed. Intervention strategies were drawn from the most robust studies identified in REA2, across a range of approaches. All possible strategies that addressed transformation of meaning were considered. Wise motivations and psychological questions to be addressed were then considered, fitting them to intervention strategies. These strategies were considered in the context of the four wise intervention categories (active reflection, increasing commitment through action, direct labelling and prompting new meanings), and any adjustments needed to make them fit appropriately were made. This produced a possible list of wise interventions for consultation.

2.7   Part 4: Consultation. Do practitioners see value in using therapeutic strategies as Wise interventions to transform shame-based experiences?

The fourth stage of the research involved a single consultation with trainee counselling psychologists, based on the findings from the previous steps. Views were sought from five counselling psychologists nearing the end of their training (my peers) with specific

experience of, and/or interest in, working with shame. Using my peers allowed me to begin to consider and test out the idea of wise 'additions' with people who had studied a similar integrated approach to counselling psychology as me, with the idea being that future research could widen the scope of consultation (and ultimately, testing). A qualitative approach was appropriate for this part of the research, as the aim was to understand counselling psychologists' perspectives on wise interventions for reducing shame experiences in the therapy room. The aim of the consultation was to open a dialogue with participants, allowing me to gain feedback on the interventions suggested, such as appropriateness, value and usability, and to gauge interest. Consideration was also given to how and when they might be used in therapy. Consultation interviews were held face-to-face, via telephone and via Skype.

The steps for consultations were as follows:
1) Recruit participants
2) Send out literature and explain the purpose of the work. Allow time for digesting the literature and any questions to be asked (via email/phone)
3) Conduct interviews, including a presentation of the work so far
4) Write up outcome of consultations

Counselling psychologists were presented with the outcomes of parts 1, 2 and 3 via a presentation and invited to discuss ideas for working wisely with shame presentations in the therapy room. It was important to allow participants to form their own judgements and recommendations without input from me. However, as a counselling psychologist with a deep interest in this topic area, I provided guidance on understanding the findings of the REA and explaining the notion of wise interventions, in order that the research participants were able to undertake informed debate. Participants were asked open-ended questions via use of a topic guide in order to obtain detailed feedback on efficacy and appropriateness of the interventions suggested, and consideration of how to incorporate wise methods to deal with toxic shame in therapy (see appendix D). All interviews were audio recorded and transcribed verbatim. The aims of the study, including information regarding requirements of participation, were made explicit prior to the study to enable full informed consent (see appendices E and F for participant consent and study information form). Participants were made aware that they could withdraw their data from the study up to the point of analysis. They were given the opportunity to receive a short summary of the findings when the

research was completed. In accordance with GDPR (General Data Protection Regulation, 2018) electronic data/information was stored in password-protected files. All data were anonymised to protect participants' identity. The researcher was the sole person who had access to the data. Audio recordings were stored in locked filing cabinets or password protected digital files. Ethical consent was sought, and approved, through the UWE HAS Faculty Research Ethics Committee (see appendix G for the approval notification).

Consultation Analysis

Data from the consultation were not analysed in depth, as a full thematic or content analysis was beyond the scope of this project. However, analysis kept in mind the framework approach developed by Ritchie and Spencer (1994) to draw out the main points from interviews. Like thematic analysis (Braun & Clarke, 2006), framework analysis is free of the constraints of one particular epistemological position (Parkinson *et al.*, 2016). However, analysis is guided by both a priori themes and emergent data (Ibid; Ritchie and Spencer, 1994). This approach ensured, *'familiarisation with the data collected, followed by the identification and interpretation of key topics and issues that emerge from the accounts'* (Newbronner and Hare, 2002, p.24). Due to the need to undertake this stage within the bounds of the whole research project (with time and space limitations), analysis was kept as simple as possible. Framework categories were thus guided by:

- Comments on REA findings
- Comments on value and use of the approach and wise interventions
- Experience with shame
- Feedback on specific intervention strategies (with each suggested wise intervention providing a separate category)
- Next steps

When interviewees provided suggestions for interventions these were fed forward to the next interviewee for comment. This allowed an iterative picture to build of each intervention.

3 Findings

3.1 Part 1. How is shame experienced in the therapy room?

In this section, results are discussed from REA1 concerning the research question '*How is shame experienced in the therapy room?*' Through systematic searching seven studies were found to be of relevance and included in this write up. Table 1 provides a summary of each of the seven included studies. Five of the studies analysed single case studies, meaning that the findings might not necessarily be generalizable to wider populations. However, the recurring themes that were found across the data provided a good starting point for considering the experience of shame within therapy sessions. Lawrence and Lee's (2014) study had the largest dataset (n=7). Their study was conducted with clients with a diagnosis of PTSD. They were primarily interested in the development of self-compassion during therapy (rather than shame), but it was included as much of the process of developing self-compassion in the paper was directly related to working through feelings of shame. Some of the case studies were presented as case analysis (see for example Pickles, 2007). I thought carefully about whether to include these, having to make a judgement as to whether they could be considered as 'research' or not. Those that have been included were chosen as they have enough data to be equivalent to 'findings' and they are of great relevance to the research question, providing rich experiential data. In total, data from 18 clients was collated (the total number of therapists is unclear).

During the first phase of coding, 242 initial codes were created. Whilst this might seem a large number, it was important that I stayed close and true to the data. Line by line coding picked up the full range of meanings within each part of each data source. This enabled me to really get to grips with the context and process of each and every part of the experiences presented within the data. After the initial coding had been completed, descriptive themes were developed, resulting in the creation of 22 superordinate themes, with 25 sub themes. (See appendix H for a table of all descriptive themes and initial codes assigned). Within one sub theme (transforming experience) there were a further ten sub themes. Many of the initial codes were relevant to more than one theme, hence repetition within the table. Whilst some of the themes could have been grouped together, they were left separate if it was felt that the theme offered something distinct. For example, 'forgiveness' could have been grouped under 'new ways of coping' and 'transforming experience'. However, it was

Table 1. REA1 study characteristics

Study	n	Design	Purpose of study	Population	Therapy type	Problem dimension(s)	Main finding on shame experiences
Bradfield, 2016, South Africa	1	Narrative description.	To describe a challenging psychotherapeutic process from the therapist's subjective experience	Female client. Male therapist	Psychotherapy	Abuse	A journey through therapy is described in which fear and shame both pull apart and unite therapist and client. Maintenance of the therapist's psychophysical integrity was important to hold the terror and despair felt by the client.
Lawrence and Lee, 2014, UK	7	Interpretative Phenomenological Analysis	To explore the process of becoming self-compassionate	5 female clients, 2 male clients. Therapists unknown	Compassion-Focused Therapy	Trauma	Developing self-compassion could be a frightening process when asked to give up a self-critical identity that clients have held for many years. Working with resistance to compassion was a key part of the therapeutic process.
Pickles, 2007, USA	1	Case analysis	To describe a co-created story of psychoanalytic psychotherapy	Female client. Female therapist	Psycho-analytic psycho-therapy	Physical & sexual abuse	Both therapist and client experienced intense levels of affect, often affecting the therapist in surprising and challenging ways.
Sundermann et al., 2016, UK	1	Single case study	To demonstrate efficacy of CBT with EFT to specifically target shame and anger-based past experiences	Male client, therapist unknown	Cognitive Behavioural Therapy (with Emotion Focused Therapy)	Body Dysmorphic Disorder	Emotion-focused techniques enabled processing of shame-based experiences that had occurred in the past and were hindering the clients' growth.
Sweezy, 2011, USA	1	Single case study	To explore clinical relevance of differences among shame, guilt that is linked with shame, and pure guilt	Female client, female therapist	Internal family systems (ITS)	Trauma	Working with parts of the self (and applying self-compassion) enabled the client to regulate shame-based systems through transforming understanding of experience.
Hoffer, 2017, USA	1	Single case study	To examine secrecy as an adaptive way to avoid shame, manage isolation, and hold onto the threads of identity	Male client. Female therapist	Unclear	Secret self, abuse	Secrecy around shameful past experiences could dominate therapy and the relationship between the therapist and client.
Pascual-Leone & Greenberg, 2007, USA	6	Task analysis of videoed therapy sessions (Study 1)	To examine observable moment-by-moment steps in emotional processing as they occurred	Male and female clients	Experiential therapy	Depression and ongoing interpersonal problems	When shame is present, it may be experienced as many undifferentiated emotions (or global affect). Undifferentiating these could help with processing of experience.

kept as a separate category as it was felt that there was something distinct about the desire for, and experience of, forgiveness that might be central to working through shame.

Once of all of the codes had been assigned I was able to generate analytical themes, which involved considering the research question in light of the descriptive themes mentioned above. At this point I attempted to infer how shame was experienced in the therapy room, and I considered any implications for interventions as I went through the themes (as many of the findings referred to potentially transformative aspects of the experience). This allowed me to move away from the data towards a more abstract consideration of the findings. The final seven analytical themes were: *Finding the toxic part(s) of me; Your shame is my shame. The relational experience; I live in fear. I need to feel angry; Secrets and ghosts; The child within; A bodily experience,* and*, Out of the darkness, comes light.* Evidence for each of these themes is discussed in turn[5]. Section 3.1.8 provides concluding remarks on the findings as a whole.

3.1.1   Finding the toxic part(s) of me

Both clients and therapists referred to (and worked with) parts of the self that were damaged or shame filled. For many of the study clients, it seemed as if the shame that they lived with formed part of their very being. Identity was tied up in this pervasive, toxic shame leaving the person feeling that they themselves were toxic, disgusting, and damaged. This served a purpose for the frightened, confused child as a way of making sense of their early experiences, often of abuse:

> *The earliness of the abuse convinced her that it happened because she was bad…There had to be something about me that wasn't good enough or unlovable or something because if there wasn't, then why did it all have to happen? Why wasn't I worth protecting? (S3)*

The inner critic began to fill them with a sense of unworthiness and defectiveness. This in some ways seemed to protect them from further pain as they began to feel that this is what they deserved. This defence mechanism was experienced in the room as a sense of hiding of the toxic parts, and belief in the self as undeserving of a better life:

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[5] Within the findings the studies have been coded as: S1 (Bradfield et al, 2016); S2 (Lawrence and Lee, 2014); S3 (Pickles, 2007); S4 (Sundermann et al., 2016); S5 (Sweezy, 2011); S6 (Hoffer, 2017); S7 (Pascual-Leone and Greenberg, 2007).

It provided Mark with a refuge from a painful past, yet it also led him to live reclusively in the depths of shame and despair and hide parts of himself from me. (S6)

The shamed person desperately searched for something that might give meaning to their disturbing early experiences, providing a 'hook' or reason for their own self-loathing. Splitting meant that the person could assume the identity of the 'bad' that they had experienced, rather than having to see their abuser as bad. They assumed an identity as a defective person, which coloured every experience and ruled their emotions:

In describing his chronic sense of personal inadequacy and shame, Client 505 covered his face and said, "I have to monitor everything I say, even while I'm saying it because I'm . . . I know, or feel that everything I say is a bit off . . . People will do a double take when I speak and disregard me as a nutcase" (S7)

Clients were unable to move forwards as overwhelming negative feelings plagued them and all sense of who they really were was lost, even to the therapist:

I could not really find the essence of who he was despite my efforts to search. (S6)

The self-criticism that gave voice to shame seemed to have great power and control over both clients and therapists. As this had been such a familiar coping strategy there appeared to be great resistance to giving it up. Clients easily fell back in to old habits of listening to the inner critic, keeping them stuck in persecuting the self and placing greater value in others:

Others have better skin than me and therefore are better humans than me…Unfortunately Michael's 'solutions' namely his extensive avoidance, mirror checking and all the other BDD behaviours had kept him stuck in his preoccupation for the last 12 years (S4)

As this had become such an ingrained part of the shamed persons' identity, the idea of giving the critic up and changing their beliefs (or listening to other parts of the self) was often met with fear:

their experience of being asked to give up this previous way of coping evoked a void in which they began to question their self-identity…who am I if I am not self-critical? (S2)

Trying to imagine another, non-toxic identity was a fearful experience because often this was all they knew. Sometimes this was experienced as hostility and anger towards the therapist, who appeared to be asking the impossible of them. This identity had consumed

them to the point that clients felt there might be nothing left if this self-belief was stripped away:

> *You are asking me to give up what my whole being has been about ever since I was born, do you realize that? If I believe you and your point of view, all my life and all the paying back that I have done for years because of killing my mother, being bad, all the beatings and perversions, all the mutilations, all the fear, pain, the abortion, what am I supposed to do about all of that? Just shrug it off and say, oh well, it happened??? It's not really about coming around to your point of view; it is giving up almost my whole life, what I have been about forever. Will there be anything left?? If I take the path you want me to follow, it is unbearable, and if I stay on the one I have been on, that too is unbearable. (S3)*

Being kind to themselves and building a new identity as a worthy person was therefore seen as a huge challenge. Being toxic was their safety net that they did not know how to give up, or even if they could. This part of their identity could be discussed and worked with in therapy, if and when the client was able to go there. Sometimes in sessions there would be a sense of the internal push/pull struggle between feeling worthy enough to be loved (the thing they most desired) and staying stuck with their toxic identity:

> *On the one hand, I have the sense that I am a really unlovable/ unworthy person [negative evaluation]—and on the other hand and at the same time, I feel like I desperately need that love/validation [need]. (S7)*

Making sense of these two opposing emotional experiences through constructing new meanings about the self and past experiences was therefore critical in transforming shame. Unpicking aspects of the client's identity sometimes helped clients shift their self-views, by processing and making sense of the parts, and learning to love themselves. This might happen through allowing grieving for the past self, or through learning to self-soothe, understanding that hurt and grief, assertive anger and self-soothing can all live simultaneously within one person. This allows clients to express their need to be loved and start to feel important enough to be worthy of love:

> *Eventually, the contradiction is overcome by the creation of new meaning through a dialectical construction…Within the context of a supportive relationship in which the need [to be loved] is attended to and activated, a new more positive evaluation of the self emerges as a synthesized outcome (i.e., the conclusion that "I am entitled to be loved/ valued"). This evaluation regards the self in a new and positive way (S7)*

Sometimes it happened through working with, or witnessing, the part(s) of the self, to differentiate them:

> *We met…several exiled parts that responded to this abuse with shame and despair, another protector that wanted to kill Angie to spare her further shame, another protector that felt disgusted with the vulnerable part that had been jealous when Angie discovered her "uncle" was having sex with her parents, and yet another protective part that wanted to kill all the people who had hurt her…Next we checked with the suicide voice, which had fallen silent…The part explained that she had shielded Angie throughout her life from the little girl's feelings of worthlessness. (S5)*

Experiencing these self-parts enabled clients to start to shift their identity through allowing some measure of kindness and compassion towards the self. It was not they that were toxic, but toxic things had happened to them. The shame then became less prevalent for the client as they no longer needed its' protection, which allowed other parts of the identity to come to the fore:

> *Angie became attuned to her early experience of being chronically shamed by her mother, and she set an intention to help that youngest part with her burden of historical shame. (S5)*

> *Participants described the process of shifting from believing that they were to blame for their previous traumatic experiences, to the realization that they were not responsible for such experiences. (S2)*

Another way this was experienced was by testing out new ways of being, through behavioural experiments. For example, Michael was able to consider a possible theory that how he looked did not reflect his identity:

> *We…worked on strengthening Michael's belief in Theory B. According to Theory B his problem was one of preoccupation with his appearance and the perceived flaws in his facial skin are not as noticeable as they feel to him and do not mean that he is unacceptable. (S4)*

However, this process did not always run smoothly, as this part of their identity was hard for clients to fully let go of. One client who had worked with her therapist for many months and had suffered severe sexual and physical abuse in childhood stated:

> *I still don't feel real at times. I want to bleed blood like everyone else, instead of seeing semen…I still hate myself and I hate any part of me that seems like my father. (S3)*

This theme demonstrates just how ingrained feelings of toxic shame were within a person's identity, and how frightening the experience of being asked to give up old, self-critical coping strategies could be. However, learning to make new meanings out of the past through separating emotional experiences from identity allowed clients to begin to shed the belief that the badness was all them, and to start to create more positive self-views.

3.1.2   Your shame is my shame. The relational experience

One of the most salient relational aspects was the re-experiencing of past relationships and incidents that were steeped in shame. These held a pervasive, frightening quality that seemed to rattle to the very core of the client, and often the therapist too. For example, in one paper, as the client and therapist got deeper into the client's narrative of abuse, the therapist became less able to provide the empathic state he wished to:

> *our relationship became associated with the fear and anxiety associated with unformulated experience…Manifold shapeless unknowns found their way into our relationship, contributing to an overall sense of confusion, terror, and danger. (S1)*

In S1 the therapist began to take on his client's emotional states associated with her shameful past. This had a dramatic effect on the therapeutic alliance:

> *my ability to respond in a caring manner deteriorated I became increasingly destabilized by my own somatic and affective states. In turn, Dorothy remembered consoling her father who cried while he raped her. (S1)*

This powerful excerpt shows how the relationship in the room played out past experiences through transference and countertransference. Not only did the therapist take on the qualities of the shaming father, but also felt and reacted to the client's shame through experiencing her sense of instability and powerlessness. Other evidence also reflected the powerful transferences experienced when shame was present. For example, S6 noted the push and pull from the client between desire for closeness and fear of rejection, and how this brought about a sense of irritation for the therapist, as though the therapy would never progress:

> *I found myself feeling pessimistic and irritated with him… He wanted me connected to him, searching after him, while he held back like an oppositional child…I alternated between feeling angry and then deeply empathic and loving. (S6)*

This back and forth in the relationship perhaps reflects the client's desperate desire for a relationship with the therapist, which is marred by the terror at having to reveal and work through the source of their shame. This element of fear appeared to rise when considering shameful experiences, and was often sensed by both therapist and client, hindering the therapeutic process through transference of emotion or of responsibility:

> At times I felt I was doing all the work, taking all the risks while being asked to read his mind. (S6)

A longing for fusion reverberated against a need to hide:

> Despite her longing for closeness, she often felt humiliated when I saw her, especially when her feelings of dependence, shyness, despair, and rage were exposed. (S1)

> He wanted a relationship with me, and he wanted my help figuring out what was happening to him and how he had survived his childhood, but words did not come easily. (S6)

This desire for connectedness sometimes pulled the therapists to divulge information about themselves that they would not ordinarily share with clients:

> Dorothy's desperate efforts to feel safe manifested as pressure to know intimate details about my life, including my physical health, my sexuality, and my emotional robustness. I felt a visceral "pull"… to disclose more than was comfortable or normal for me. (S1)

The use of disclosure was also mentioned as a way of clients experiencing their therapists as human, addressing the power imbalance within therapy. Those who have been abused have suffered a great deal of powerlessness; so feeling equal to their therapist could be an empowering experience as part of their growth. A genuine relationship between client and therapist was therefore of utmost importance, where both parties demonstrated some vulnerability:

> "When you are simply human, I relish those moments, even little things, like when you told me that you had the same obstetrician as I had, and that he was late for the delivery of your first child. We were just woman to woman." (S3)

> Of particular importance to participants was their perception of the therapists as human beings, rather than just professionals, who genuinely cared for them rather than providing them with the tools to feel better. (S2)

Clients sometimes became hostile or challenging when they felt their identity was being threatened, and this had the effect of shaming the therapist too:

> Then she challenged, "Why should I believe your story? You tell me that it wasn't something about me, that I wasn't bad and didn't cause my father to abuse me, that I didn't deserve it, but rather that they let me down, exploited me, and didn't protect me. You're telling me how I should think and feel just like everyone else in my life." (S3)

Others used control as a means of defending against powerful feelings, giving them a sense of power in a situation in which they ultimately felt powerless:

> Ann insisted, "You need to talk with me first, before you ever call the police or anyone else. I need you to live with my choice, with my right to live or to kill myself…Otherwise, I won't be able to do this therapy with you." (S3)

In a sense, shame itself controlled the therapy, dictating how the therapeutic space was felt and understood by both participants in the room. When clients resisted change, sometimes therapists responded by resisting clients' wills too. Just as the client was hindered in their ability to connect and move forward therapeutically by their shame, so too was the therapist, especially as they took on the identity of the 'shamer':

> I resisted feeling vulnerable with her and thus did not feel wholehearted when we were together. This resistance does not fit with how I prefer to see myself and was a primary source of my shame…My feelings of powerlessness led to my defensive resistance; I could not accept the possibility that I participated in this process as an actively engaged subject rather than as a passive recipient (S1)

Dissociation and projective identification were also common defence mechanisms brought about by shame:

> Later, after Ann had read a draft of this paper, she told me that she did not remember making that phone call about wrapping herself in a bow for me. She did remember that after that session, she had gone to the grocery store where she saw a man who looked like her father and had run out of the store in a panic. She thought maybe she had called me after that, but did not remember…That night she went into a fugue state (S3)

> Her traumatic history influenced her defensive processes, of course, which manifested as projective identification and thwarted introjection, insulating her from me and deadening our relationship (S1)

These defences at times caused confusion and a sense of helplessness (or even dissociation) in the therapists, reflecting the clients' own experiences:

> *I felt bewildered and helpless, and this influenced my conviction that my identification with Dorothy's autistic contiguous anxieties reflected a process of projective identification in which not-me experiences became my own, against my will. (S1)*

> *I struggled to slow myself down to gain some reflective capacity. I found myself alternating between an empathic listening stance, from within Ann's perspective, and then listening and responding from my own perspective, searching to make sense of this drama that we were in. (S3)*

Whilst for some this created a difficulty in relating, it also allowed for 'witnessing' or sharing of experience, if the therapist was able to attune to what was going on in the room:

> *Without my own experience of becoming projectively identified with her unformulated terror of destructuralization, of falling apart, I do not believe that I would have fully grasped her horror and terror. (S1)*

> *I said that he looked distressed and asked for his feelings about what I had said…My attunement to his thoughts and feelings was a new experience for Mark. (S6)*

Sometimes this attunement was reflected through the therapist's interpretations of the client's descriptions, whilst also reflecting on the difficult feelings that were occurring for the therapist:

> *I carefully said, "I wonder if the way that I'm feeling, helpless and hostage to your refusal to allow us to draw on outside protective resources, is similar to how you felt helpless and hostage to your father and grandmother when you couldn't turn to anyone inside or outside the family for help or for protection?" (S3)*

This allowed for the therapist to help the client experience a new way of relating, in which they experienced genuine care:

> *I don't experience you as a disgusting bad person and I don't want you to kill yourself. (S3)*

When relationships between client and therapist were strong, this provided a powerful tool for change, both diminishing negative feelings and increasing ability to take on a different self-view through tolerating kindness and compassion from another:

Mark's anxiety subsided slightly as his attachment to me strengthened (S6)

[the participants] spoke of the difference between thinking that they were not to blame and feeling that they were not to blame. They identified the therapeutic relationship as an important means through which this became possible, in that the therapists' belief in them enabled them to shift their beliefs about themselves. (S2)

The therapist was able to hold a safe space for the client in which they could test out new ways of being. Clients could also use this relationship as a model for relating and making sense of situations in between sessions:

One of the strongest things was the actual therapists themselves…I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard (S2)

I was discovering that I was more important to him than I thought I was. He had found a way to take me with him between sessions with these conversations in his head. (S6)

Many clients valued principles such as acceptance, honesty and trust, as they enabled them to feel safe enough to begin to deal with their shame. They appreciated having the stability of someone who was there for them no matter how bad things got:

"We have a lot more work to do, and it's very possible that you might have some, even many, difficult moments. I assume that you will have ups and downs, and I'll want to be with you through all of them, through thick and thin." (S3)

The experience of feeling safe in the mind of another was…of fundamental importance. (S2)

This theme demonstrates the importance of a strong therapeutic relationship in which the client feels safe enough to strip themselves back and work with their inner, hidden parts. They also show how difficult this process can be for both client and therapist, and how shame can make both people in the room feel powerless, stuck and unable to move forwards. Through paying attention to transference and countertransference, it is possible that the therapist can become aware of any defence mechanisms either one may be using, and how this may be linked to an unbearable sense of shame lingering in the room.

3.1.3   I live in fear. I need to feel angry.

Many clients seemed to be driven by fear – of the past, of the future, and of giving up the only way of coping that they knew. Learning to move beyond this at times required

transformation of fear to healthy, assertive anger, where emotional experience could be turned outward. Feeling emotions such as anger and grief could signal processing of past events changing from 'me' to 'not-me'. However, typical emotions that appear to have been experienced during reliving of shame were unhealthy anger and fear, which, when undifferentiated, manifested as a global feeling of distress:

> *Characteristically the marker of global distress emerges suddenly, the person becomes dysregulated, and the specific concern at hand is often very vague and global…Sometimes, when therapists initially explore this, clients explicitly state that they do not know why they are feeling so inundated with distress. For example, in a prototypical statement of global distress, Client 407 described, "I feel hurt, miserable, and angry and I'm tired of it. It's so overwhelming," followed by, "I don't know what that pain is" (S7)*

For traumatised clients, it appeared that many of their darkest moments occurred when they triggered and relived affect from the time of an earlier shaming experience, often without recollection of the initial context. This might manifest in a 'fugue' state when the client acts out in distress, or might lead to increased volume from the suicide voice within:

> *That night she went into a fugue state. When she "came to," she found broken windows, mirrors, and picture frames. The pictures she had brought to her session were torn up, she had cut herself, and a razor was in her hand. I felt confused, and I wondered to myself if this sequence of events served as one possible context for her fugue state. (S3)*

When a client relived shameful experiences, they began to feel overwhelmed by a sense of unworthiness and a desire to run away and hide from the pain:

> *Michael was initially not aware that he was experiencing the same affect (from a time when his earlier life had felt out of control) without recollecting the context. (S4)*

Inner voices might tell them that the best way out was to end it all, as they were too disgusting and shameful to stay alive if they were exposed and humiliated:

> *During an intense period of describing her memories of abuse, Ann for the first time during treatment became actively suicidal. She told me she had a plan to end her life by driving 80 mph into a certain tree that she passes on the way home. (S3)*

This could be an extremely frightening experience for the client, and therefore shied away from as much as possible. Feeling and processing shame meant feeling vulnerable, which was an experience that was too much for the client to tolerate. Clients might have

experienced a range of emotions that were linked to this deep and toxic shame, where affect was not linked to prior experience. Fear was often quite palpably present in sessions, as if reliving the fearful initial experience itself. The therapist also viscerally felt this in the moment:

> I felt confused, ashamed, and frightened by her memories for reasons that were not entirely clear. I also felt physically exhausted and enraged. (S1)

> When she did not respond, I grew more alarmed. Ann mumbled, "I'm afraid. I'm afraid I can't trust myself." (S3)

Fear could disrupt the ability of clients to move forward therapeutically, as they withheld the most distressing and secret parts of themselves. When clients felt suicidal, it may well have been because the shame had become too hard to bear, as they struggled to let it out and feel safe enough to share it without being repulsed and feeling too repulsive to carry on. The fear was that, by letting the shame out, someone would be destroyed:

> the boy feared that the confession of the teenager would stir the shame of the little girl, which in turn would activate the suicide part. (S5)

> Dorothy and I both share a fear being destructive of, as well as being destroyed by, another person. These feelings heightened our individual experiences of shame, all the while infusing and intensifying our relationship. (S1)

> He feared that he would decompensate from the power of telling or I would decompensate from the impact of being told (S6)

Anger was also frequently experienced, but usually towards the self. Perhaps this was due to the way early experiences of anger, rage and abuse from another were made sense of:

> Anger, rage, and sex are forbidden, because it puts me on my father's level. My worst fear is that I might turn that destructiveness onto someone else. My attitude is that it's better to have my rage attacks aimed at myself than risk it being directed toward others. (S3)

If a client could experience outward anger within therapy, this might have been a sign that they were beginning to process their shameful past, by taking back emotions that were rightfully theirs for things that had been done to them:

> What initially makes this emotion adaptive is that it is an agentic rejection of some noxious experience, as opposed to shrinking away or closing down, which as we have

seen is characteristic of maladaptive fear and shame… A client who expresses rejecting anger essentially protests the noxiousness of a given situation but does not go on to elaborate the subjective experience of that situation. (S7)

These emotions, once identified, could then be worked through using interventions targeted at releasing and transforming the emotional experience. This sometimes led to shame being experienced with much less force within the room, and weakening its hold on the client's life:

In our discussions it became clear that Michael had been left with intense feelings of anger towards his mother, and in particular towards his brother… First, Michael wrote letters towards both his mother and his brother in which he expressed his feelings of hurt and anger; to his brother for bullying him and 'making my life hell', and to his mother for 'not protecting me'…He started to break the emotional link between shame-driven experiences and current triggers. (S4)

Client 505 went on to differentiate the meaning of his [rejecting] anger in an imaginary dialogue with his father: "It's not right. I should have had a father who loved me . . . I didn't deserve the way you treated me, it wasn't a way to treat a child"…In another instance of assertive anger Client 516 stated, "I can love, I am loveable. I have been mistreated and abused by you…It's my right and I'm walking away, I want you to leave [me] alone!" (S7)

Once clients were able to make sense of their emotions, they were sometimes more open to grieving and experiencing hurt. Whilst this could feel difficult, clients who were able to experience and work through their emotions in the safety of sessions were better able to move on from self-loathing. This offered palpable relief:

it was like getting a drink of water in the desert. Erm. Once I had kind of given up the addictions of blaming myself it was like this whole guilt trip had gone (S2)

The findings in this section indicate that feelings of global distress, fear and anger may all be markers of shame that can be worked with. These feelings may be triggered through reliving previous shaming experiences, and need delicate handling due to the increase in vulnerability, suicidality and dissociation that may occur. However, if emotions such as anger are worked with so that the client can transform their meaning in different contexts, then they may be able to better tolerate and externalise both affect and experience.

3.1.4   Secrets and ghosts

In many of the findings, there was a sense of the unspoken ruling much of the therapy.
There was something too terrifying to give name to, as it might destroy both therapist and
client. Holding a secret both gave the client power (as it formed part of their identity – it was
theirs and theirs alone) but also left them powerless to change:

> *Within our relationship, the secret created tantalizing intrigue as well as a painful*
> *distance between us…Seamlessly, the secret became a link between us while also*
> *creating a huge space. (S6)*

S6 worked with a metaphor of the elephant in the room:

> *Sometimes our elephant barreled in and we could feel the palpable shame in the room;*
> *sometimes it tiptoed in, hovering closely and quietly wreaking havoc between us…But*
> *the elephant was always there, taking up a great, big, thick, gray space, and creating*
> *an enormous impact on both of us.*

Clients did not necessarily know how to make sense of their feelings, creating confusion and
fear in the therapy room. Very much like a ghost that does not seem quite real (and causes
terror because of this), the shameful secret causes pain and suffering without ever truly
being exposed. These secrets haunt the soul, turning up in the client's dreams and
nightmares. Always on the edge of consciousness, lurking in the shadows. Trying to access
these ghosts and lure them out was fraught with danger and fear, as they held the key to
clients' shame. This could happen when the shame came so close to the surface that affect
drove their behaviour, but they were unable to talk about what was happening. They might
have gone into a world of phantasies within that allowed them to withdraw from their
experience. These phantasies might have appeared as dreams:

> *Shortly after establishing he had a secret, Mark reported a dream. He was riding on an*
> *elephant. The elephant was clumsy, but huge and impossible to avoid…I shared that*
> *the elephant in the dream could be a metaphor for the elephant in the room with*
> *us…my words had knocked him off his majestic elephant, trampled him, and intruded*
> *on his private and secret space…I felt badly for saying what needed to be said and*
> *thought about how engaging his inner thoughts without shaming him was impossible*
> *to do. (S6)*

> *in response to the anticipated exposure of her story, she did have nightmares about her*
> *father killing her, me, and those she loved. She said, "I know what you'll*
> *say!"   "What?" "That by going public with my secret life, I'm standing up to my father,*
> *refusing to be intimidated by his threats, and then expecting punishments." (S3)*

Or as out of body experiences:

> *I picked up the phone between sessions and heard Ann speaking in a frightened little girl voice, saying "The car is filling up with semen; I'm going to drown in semen!" I talk her through getting off the freeway and shifting her state until she is oriented to her surroundings in the present and able to safely drive home. (S3)*

Clients did or said things that they could make no sense of, retreating in to their inner worlds:

> *Later…she told me that she did not remember making that phone call about wrapping herself in a bow for me. She did remember that after that session, she had gone to the grocery store where she saw a man who looked like her father and had run out of the store in a panic. She thought maybe she had called me after that, but did not remember. (S3)*

Therapists too were haunted by shame when they experienced it, affecting their ability to process their clients' experiences:

> *I felt ashamed of my neglect and frightened by my capacity to hurt her, and this interfered with my ability to fully grasp her experience of feeling left alone. (S1)*

This theme exposes the hidden nature of shame, which is what often makes it so hard to identify and work with. The haunting nature of shameful experiences can take on nightmarish qualities, where the original experience may become almost unreal or out of reach, but the affect and meaning for the client's identity becomes deep-rooted in their psyche. This keeps the client tied to the past, disrupting the therapeutic process due to the overwhelming desire to conceal the truth, both from themselves and the therapist.

3.1.5   The child within

As shame was most often associated with events that occurred early in life, it is of no surprise that the inner child was often referenced and worked with during therapy. If a client began to talk about these distressing experiences a lonely, confused, terrified child often surfaced, but did not always know how to proceed:

> *Ann's telling me over several sessions how she was made to perform oral sex repeatedly with her father and forced to swallow semen from a young age. During this time, Ann had let me know of her shameful longing to call me and tell me from within her little girl state that she was hurt. (S3)*

Although she is a grown woman, she relates as though she is a child, with the awkwardness, lack of sophistication and naivety that this entails (S1)

I was looking at an adult but I felt as though I was speaking to an inconsolable little boy who had locked himself behind his bedroom door and was not sure he was going to let me in… He wanted me connected to him, searching after him, while he held back like an oppositional child. (S6)

S5 accessed and work with the parts of the person such as the inner child, conversing with them and their protectors:

The part explained that she had shielded Angie throughout her life from the little girl's feelings of worthlessness… Since his job was to keep the little girl alive, the boy felt compelled to block and suppress the voice of the guilty teenager. His tool was shame. (S5)

Working with this sometimes meant conversing at the level of the child, allowing the inner child to feel safe and protected enough to tell its story:

Mark then told me he wanted me to know the secret, but he wanted me to know without revealing it…I thought about the little child who wants their mother to magically know what they need without asking for it. "That's a very young wish," I said with my most gentle voice. (S6)

Relatedly, the client conversing as an adult with their younger self could begin to alleviate shame:

Through a process of 'mental time travel' he was able to imagine his adult self going back in time to rescue his younger self and confronting the abusers confidently, chasing them away and demanding apologies for their bullying behaviour. (S4)

The findings here demonstrate the importance of recognising, and working with, the damaged inner child. This might mean thinking like a child and working with their abilities and levels of processing, rather than expecting an adult understanding of experiences and emotions.

3.1.6   A bodily experience

This theme considers the somatic experiences that occurred when feeling shame or reacting to another's' shame. It also includes bodily aspects that might induce shame. In the case of

Michael, a client with Body Dysmorphic Disorder (BDD), his inward shame became an outward focus of disgust with his skin:

> *Michael's preoccupation and the felt impression of his perceived flaws in his skin was particularly strong when something reminded him emotionally of his early experience of being shamed, which subsequently triggered a need to control his skin, or hide from others. (S4)*

This lead to physical behaviours such as checking and avoidance, which helped him resist the urge to face his fear head on, and so kept his shame from being processed. The therapist in this instance was able to use the bodily aspect as a place for experimentation with new ways of being, providing healthier coping strategies.

Sometimes physical appearance could hinder the therapeutic relationship, as it triggered traumatic memories for clients:

> *From the beginning, Dorothy was especially aware of my bodily presence, a reflection of her particular anxieties as a survivor of early childhood sexual abuse. For example, my beard was unsettling, as it reminded her of her father. (S1)*

Use of posture and gaze also indicated internal struggles. Shame seemed to at times be characterised by a desire to avert the gaze (by either client or therapist), as if the very act of looking was too intrusive. A need to hide oneself might manifest in an urge to look away or cover the face, much like a young child does when playing hide and seek:

> *I experienced these frozen and silent states as unbearable, and sometimes hid my face behind my fist. Dorothy experienced this gesture as evidence that I was aggravated with her. (S1)*

> *Although such periods of unbroken eye contact sometimes felt intimate, at other times, when a sense of safety was lacking, such contact felt perverse. (S1)*

> *In describing his chronic sense of personal inadequacy and shame, Client 505 covered his face and said, "I have to monitor everything I say, even while I'm saying it" (S7)*

Paying attention to gaze also helped the therapist recognise when a client was accessing internal parts of the self:

> *When a person is in this witnessing stage of interaction with a part, she may close her eyes or look down or sideways; she often becomes settled and still in the way of an intent observer (S5).*

In other papers the body was discussed through experiences of felt pain that mirrored internal feelings:

> *Rejecting anger is a generic type of emotion… This is usually expressed with relatively high arousal (i.e., angry tears, shaking head, fists, etc.) Moreover, the action tendency is one of either distancing or sometimes even destroying. (S7)*

Pain could then be worked with to transform experience:

> *"They're like knots of wood all over her" Angie reported…the girl took the knots out of her body and burned them. (S5)*

Sometimes aspects of the client's experience could be felt strongly within the body of the therapist, and dictated how they reacted to the client:

> *I am aware of a slight tremor in my body, and feel sickened by the possibility that she may experience me as a violent man in relation to whom she may not be able to protect herself...Consequently, I often avoided looking at any part of her body other than her face. Similarly, her eyes never strayed from mine. (S1)*

In S1, this was so keenly felt that it led to physical collapse for the therapist. Both he and his client were able to reflect on this moment as his connection with her inner pain:

> *there was a sort of perverse bodily self–other identification. As a colleague said to me, "Her stomach hurts ... your stomach hurts. Your stomach growls ... she caused it."…Eventually, my anxiety and fragmentation manifested neurologically when, during a session with Dorothy, I suffered a severe epileptic seizure. By witnessing my collapse, Dorothy felt more confident that I had an embodied sense of her terror, misery, and helplessness. (S1)*

For others, physical symptoms and postures reflected the feelings of helplessness and shame of both therapist and client:

> *I was aware of leaning forward in my seat, feeling tense and anxious, trying to contain myself… Ann was slumped over, head in her hands, and slowed down… My heart was racing. I felt caught in an impossible dilemma of wanting to protect Ann from her potentially lethal behavior, while feeling that my hands were tied behind my back. (S3)*

In some findings therapists' physical reactions were discussed within sessions. For example, S3 discussed how her palpable shock at her client's disclosure was an important bonding experience for the client, as she was able to view her therapist as human and real, and to understand how some of the atrocities that had happened to her were horrifying, rather than normal. Paper S1 referred to an incident where the therapist shared his fear he was about to laugh whilst his client disclosed atrocities inflicted on her. His bodily reaction opened up a dialogue with his client, who likened his fear to her experience of laughing whilst being raped. The bodily experience here provided new depths to the therapeutic relationship:

> *It is noteworthy that Dorothy experienced my laughter as empathic, as resonating with her horror. It was almost as though I had been with her in a terrifying moment, and I now knew something about her experience that previously had been incommunicable. (S1)*

When discussing the transformation of experience towards a more self-compassionate outlook, bodily, feeling-based aspects of this experience were discussed, which demonstrated to clients that what they were experiencing was a shift in being, rather than solely a superficial belief:

> *In the beginning I didn't believe it. I would say I'm trying to be compassionate to myself…But I never felt it. But as it went on, now, I can feel it. You know, I can feel it in my body than, rather than just in my mind (S2)*

> *I had a reaction that I could feel. No question about it there was a definite wow, that sort of feeling that you get shivers all the way down your back. It's like wow! (S2)*

Physical exercises such as breathing and posture also formed part of the transformation process to help clients induce a kinder, more positive mind-set:

> *Throughout treatment we helped Michael to develop and consolidate his self-soothing skills and compassionate skills such as soothing rhythm breathing. (S4)*

The findings here show how important paying attention to bodily aspects can be to identify when shame is being experienced, and also in transforming that experience to something positive. For example, when clients are unable to talk about their experience, it might manifest in bodily self-other identification.

3.1.7 Out of the darkness, comes light

When therapist and client have been able to lure out the ghosts and examine them in the safety of the therapy space, this has been an opportunity for transformative experience. Some of these transformations have been mentioned in other themes, so won't be repeated here. Quite often the transformation of shame appeared to have involved clients learning to be more self-compassionate, allowing healthy anger to be expressed, and learning to forgive. This had not been an easy journey for the clients who resisted kindness due to feeling they were not deserving or worthy of this:

> *Several participants understood self-compassion to be something that they did not deserve…a number of participants commented on the experience of self-compassion as not feeling 'right', suggesting that this was not their usual way of relating to themselves. (S2)*

If self-compassion was pushed too hard, too soon, this could cause clients to disengage as fear took over and the inner critic became too loud:

> *Participants described strong aversive responses to self-compassion such as it feeling frightening, overwhelming, terrifying and dreaded…'I didn't want to be kind to myself. Because I still felt I didn't deserve to be happy or to have nice thoughts or to be kind to myself. I thought that by [being compassionate], there were things that would make me smile and I felt, well, I know it sounds silly, as if I wasn't allowed to smile' (S2)*

If this concept was introduced steadily and gently, some clients could shift from feeling hopeless to hopeful of living in a different way. They were able to work with their therapists to make sense of the past in different ways that were not dependant on self-blame:

> *Within the context of a supportive relationship in which the need is attended to and activated, a new more positive evaluation of the self emerges as a synthesized outcome (i.e., the conclusion that "I am entitled to be loved/ valued"). This evaluation regards the self in a new and positive way (S7)*

> *An interesting characteristic of the participants' experiences of this process was that they spoke of the difference between thinking that they were not to blame and feeling that they were not to blame. (S2)*

The very fact that shame had been examined in the light somehow diminished its power over the client, as they were able to see it for what it really was. Studying the shame in the therapy room, as though under a microscope, allowed it to take on new meanings:

To further enhance breaking these emotional links Michael wrote a compassionate letter to himself that summarized his new formulation of his difficulties…In this letter he explained to himself why it was understandable that he felt and behaved the way he did, but that the world was now much safer than he had feared. (S4)

Using letter writing as a means of sense making and forgiveness proved to be a powerful transformative tool, as did giving forgiveness to others:

His brother told Michael that he loved him and asked for his forgiveness, expressing his wish to have a good relationship with Michael from now on. This was the moment that Michael truly recovered from his BDD as it allowed Michael to forgive and put his shame based memories to rest (S4)

In the letter the girl apologized to her brother, explaining her feelings that day and afterward. She asked his forgiveness. She put the letter in an envelope and handed it to the cricket, who hurried off. (S5)

For some, learning forgiveness was a frightening process that did not come quickly. Some clients were worried about how they would deal with future difficult situations, whether they would go back to punishing themselves as they had always done:

"What happens the next time I have a bad time, or throw up my walls or retreat, flake out, or get suicidal? Am I going to feel horrible because I screwed up again or caused you a problem, or am I going to be able to tell you more easily than before, and really listen to what you say back?" (S3)

When clients were able to loosen the vice-like grip of the inner critic, they experienced living in a new way. This new way allowed them to experience kindness and acceptance towards themselves and enjoyment in living through feeling deserving of positive experiences:

Participants expressed a shift in their understanding of what mattered to them in the way they live their lives… gaining a sense of enjoyment from life rather than just living or always striving to achieve life goals…They had developed a new belief that they deserved to be happy, which they had not held previously. (S2)

The dialectical synthesis…creates the new experience of acceptance and agency: "I will survive and can cope. I accept the past wounds/losses. I can let go and move on with the rest of my life." (S7)

Shedding light on inner shame gave some clients a sense of bravery, to take what they had experienced in therapy out in to the world. The more they could talk about and share their

experiences, the less frightening they became. By experiencing compassion in the therapy room, and learning to apply this to themselves, clients were also able to learn to self-soothe. In this way they could move on from healthy anger to an inward focused tenderness towards the self:

> *This state can appear in several forms, including explicit self-soothing, attributed self-nurturing (as when the client roleplays a caring significant other), or acknowledgment of and reflection on existing resources (such as available social support, past personal successes, etc.). Some prototypical examples include when Client 521 spoke to herself reassuringly from the role of her parents, saying, "I love you. It's going to be alright"…or when Client 076 spoke to herself and considered her loved ones: "You deserve to be treated well. You have your husband who loves you, your sister…" (S7)*

Being able to soothe oneself and lay the past to rest enabled a sense of peace, lightness and hope for the future:

> *"Is she ready to leave that time?" "Yes" So the teenage girl moved out of the past. Her exit was followed in this session by a last, ceremonial step signifying change [called] unburdening. I asked if the teenage girl was ready to let go of the beliefs and feelings she had been carrying from that experience. She was. "How is she now?" I asked. "She feels light," Angie said. (S5)*

This final theme demonstrates some of the transformative aspects of experience in the therapy room, through learning to be kind to oneself. However, the evidence suggests this is not an easy task, as it requires leaving behind a lifetime's way of being and seeing the world. Much of the effort here may be in laying the groundwork for compassion, through increasing motivation and belief that the client deserves kindness, both from the self and others.

3.1.8   Discussion of REA1 findings

I have interpreted the findings as a challenge between exposing the haunting, ghostly past (Loewald, 1960) and finding new ways of relating and believing in oneself, through the power of the relationship between therapist and client. The findings demonstrate aspects of the client's self-experience of shame as weakness, powerlessness, defectiveness, disgust and inferiority, similar to previous research and theory (Claesson and Sohlberg, 2002; Tangney and Dearing, 2003). These aspects often appear to have ruled the therapy and at times prohibited therapeutic growth. With regards to the therapist's role in helping the client access their shame, Brenner (2010) suggests the therapist becomes the ghost hunter helping to bring the shadowy realms of the unconscious in to the light:

Ghosts that are invoked in the daylight of the therapy session…can be examined, interrogated, and ultimately relieved of their power to torment (p.260).

The findings suggest there is a clash of needs that the client battles – both the need to hide their shame, and the need to hide from it. This push and pull reflects the anxious insecure/avoidant attachment patterns of relating and identity development, as discussed by Brown and Trevathan (2010). van der Kolk (2014) discusses ideas that are similar to the experience of withholding a secret (based on trauma), where letting it out might lead to annihilation of client or therapist. He notes that:

Posttraumatic stress is the result of a fundamental reorganization of the central nervous system based on having experienced an actual threat of annihilation (or seeing someone else being annihilated), which reorganizes self-experience (as helpless) and the interpretation of reality (the entire world is a dangerous place) (p.256).

Van der Kolk explains how different parts of the self-system may end up at war with one another, where self-love battles against self-hatred, for example. This echoes the findings around working with toxic parts of the self, and the push/pull battle between wanting to feel love and feeling too unworthy to receive love. Working with parts of the self is also covered in CFT (see for example Multiple Selves Practice, Kolts, 2016).

Experiences in the therapy room in which parts of the self and past experiences were differentiated from emotional states enabled clients to drop some of their defence mechanisms. This reflects psychodynamic theories of use of coping strategies such as parentification (Dicaccavo, 2006), which can be transformed through learning that good and bad can be held simultaneously within one person. If internal shame is related to shame memories involving attachment figures (Matos *et al.,* 2013), then the client may start to separate experience from identity and learn that bad things happened to them, but this does not mean they are bad. Gradually this allows the inner critic to fade in to the background, as the client develops a broader identity, which can be tested out through the safety of a secure base such as the therapist. They no longer have to hold an, 'identity of two' (Fisher, 1985). The safety and power of the therapeutic alliance can support the client to understand love and kindness and start to apply these concepts to the self, allowing a new identity to develop. As they become able to believe in their own worth, they may learn to forgive and move on from the past. As the client sheds their toxicity they can begin to move from the dark in to the light, and in doing so, become lighter themselves.

The experiential aspects demonstrate the importance of considering several features – the relationship between the client and therapist, past relationships and their impact on attachment and identity formation, unconscious processes (such as defence mechanisms), conscious actions and shared embodiment of the client's experience. This suggests that reference to a range of relational based approaches might be helpful in understanding the client's experience of shame (Finlay and Evans, 2009). Using the immediate relationship between client and therapist as a lens through which to discover other, hidden aspects of the self, differing approaches can provide different foci.

An important point to note regarding the findings for REA1 is that, whilst a rigorous process was used and coding was checked with supervisors, the findings were based upon one person's interpretations. I found conducting this part of the research extremely emotive, and at times raw. I vividly remember stopping at one point to write a letter to myself, the shamed little girl I had once been, based on what I had learnt about my own shame and the need to be kind to myself. This was extremely cathartic in respect of my personal growth, and gave me a deeper understanding and familiarity with the shamed client. I am aware that this dual process, of writing about others shame and recognising my own, means that the interpretations made will be bound with my own experiences. I have tried to maintain a reflexive awareness and draw back from the material to endeavour to ensure that the analysis has been drawn from the findings rather than my own story, but it is inevitable that some of me will be reflected in the structure and narrative of the themes. I have sought to be both witness and author as a relational-centred researcher (Finlay and Evans, 2009), and I hope I have provided an honest analysis of the findings across the studies.

3.2 Part 2. What works in reducing (or increasing tolerance to) shame in individual therapy?

(See appendix I for a table of study details for all fifteen included papers from REA2).

3.2.1 Design

There were six RCT designs out of 14 studies, mostly pilot studies. Two of these were considered to have a high risk of bias (based on Higgins *et al.,* 2011. See appendix J for quality assessment data). Only one of the RCT's fully explained their randomisation procedure (Morrison *et al.,* 2016). This study was the only one to be rated as 'low' risk of bias. Four studies were rated as 'medium/low' (Harned *et al.,* 2012, 2014; Resick *et al.,* 2008, and Talbot *et al.,* 2011). One study was rated as 'medium' risk of bias (Albertson *et al.,* 2015); all others were rated as 'high'. In some studies assessors were blinded, participants generally were not. This is acceptable however for studies of this nature, as treatments received tend to obviously differ between conditions (rather than a placebo as in clinical drugs trials). Some of the RCTs used a waitlist control group. Whilst this is an acceptable design, it does mean that participants are aware of which group they are allocated to, and the intervention is not compared with another intervention/treatment as usual to compare effects. Five studies used a pre-post design. Two studies used single subject experimental designs, although one of these randomised participants to different lengths of baseline assessment (Au *et al.,* 2017). Lack of a control group in these studies meant that the quality of date were lower than for those with controls. However, the designs meant that participants acted as their own controls. Most studies reported attrition rates, although not all of them included non-completers in analysis, increasing attrition bias.

3.2.2 Scales

Although most of the measurement tools were pre-validated, comparison was limited due to the wide range of tools used, and the differing aspects of shame (internal, external, global and body). The scales used were[6] ISS (two studies, internalised shame); GASP (one study, shame trait proneness); ESS (four studies, state shame – specific areas); TOSCA-3 (two

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[6] ISS: Internalised Shame Scale; GASP: Guilt and Shame Proneness Scale; ESS: Experience of Shame scale; TOSCA-3: Test of Self-Conscious Affect-3; OAS: Other As Shamer scale; BISS: Body Image Shame Scale; OBCS: Objectified Body Consciousness Scale; DES: Differential emotions scale.

studies, although one was a modified version. Global trait shame); OAS (two studies, externalised shame); BISS (one study, body image shame); OBCS (one study, body shame sub scale), and DES (one study, shame sub scale). Most measures were self-report, which offer a subjective view of participant experience. This was not always triangulated with objective measures.

3.2.3 Sample

Generally, sample sizes were fairly small, especially within studies using clinical samples (though this may have been due to the pilot nature of studies). There appeared to be a gender bias in treatment population, in that most were female. Seven of the fifteen studies used non-clinical samples, which may have implications for the application of results to clinical populations. There was a range of problem dimensions considered across all of the sample populations. Four studies assessed symptoms of trauma/PTSD (one assessed sexual abuse specifically, two used samples with BPD as well as PTSD); one study considered binge eating disorder, one researched social anxiety disorder, one assessed schizophrenia spectrum disorder, and one considered problem acne (on a non-clinical population that was assessed with the clinical tool SKINDEX).

3.2.4 Outcomes

All studies bar two showed significant effects for shame reduction. Duarte *et al*. (2017) found no significant effect for shame over time, and Rodriguez *et al*. (2015) found no association between shame and drinking intentions. One has to be careful when interpreting the positive results, as it may be due to publication bias (and other issues) rather than strength of effect. It proved hard to extrapolate data on shame, and whether particular parts of the intervention assessed shame better than others, as results were mostly provided for the intervention as a whole. This may also have been because shame was typically considered to be a secondary outcome. In fact, shame was a primary outcome measure in only four of the studies (Au *et al*., 2017; Hedman *et al*., 2013; Matos *et al*., 2017; Ojserkis *et al*., 2014). Two of the studies in which shame was a primary outcome assessed trait shame and used cognitive interventions. Ojserkis *et al*. (2014) did not find evidence of correlation between PTSS severity and shame proneness, but did find that the intervention reduced state shame, both using cognitive distancing (similar to ACT exercises) and cognitive challenging (from CBT). Hedman *et al*. (2013) found that CBT reduced trait shame in participants with Social Anxiety Disorder.

Participants of a 'mindful rational living' intervention had significantly reduced shame-negative-self-evaluation and shame withdrawal after the intervention, although this effect disappeared when controlling for religion (many participants were Buddhists) (Chenneville *et al*., 2017). Eight out of 10 participants with elevated shame and trauma-related PTSD symptoms receiving compassion-based therapy had significantly reduced levels of internalised shame after intervention (over six weeks) and at follow-up four weeks later (Au *et al.,* 2017). Internalised shame was also reduced using cognitive therapy for people with schizophrenia spectrum disorders, both over the four months of the intervention and at seven months post-treatment (Morrison *et al.,* 2016). This was potentially the most robust of all the included studies, as judged by risk of bias. Of the four studies that used the ESS (Experience of shame scale, measuring characterological, behavioural and bodily shame), two used DBT and PE (Harned *et al*., 2012; 2014), one used social mentalities theory and compassionate mind training (Kelly et al., 2009), and one used CPT and written accounts of trauma (Resick *et al.,* 2008). All four studies found reductions in shame after intervention in the treatment groups (reductions were noted in all three conditions for Resick *et al*., 2008). Studies by Kelly *et al*. (2009) and Resick *et al.* (2008) used relatively short interventions – one hour plus practice over two weeks, and 6 weeks with twice-weekly sessions respectively. Although interventions in the Harned *et al*. studies (2012, 2014) were both conducted over a year, the average number of sessions was relatively low, at 13.

Studies that measured perceptions of shame by what others might feel about the person (rather than what they feel about themselves) both found significant improvements in this aspect of shame through the use of compassionate mind training. One used a two-hour intervention followed by practice over two weeks (Matos *et al*., 2017), and one used a self-help website (average length of time spent on it was 199 minutes over five weeks). As such, these were both relatively brief interventions. Albertson *et al*. (2015) used a guided self-compassion meditation intervention once a week for three weeks (plus practice), and found a medium effect (d=0.68) for reductions in body shame in the treatment group when compared to a waitlist control group. Depressed women with sexual abuse histories treated with interpersonal psychotherapy showed larger reductions in shame than women treated with usual care psychotherapy over a period of 36 weeks (Talbot *et al.,* 2011).

3.2.5   Interventions

Appendix K provides details of the interventions characteristics for each study. Intervention length ranged from one hour to up to a year with the average length being 14 weeks, or 8 weeks if the two year-long interventions are not counted. Six interventions comprised one individual session, sometimes with additional practice expected. Individual sessions were generally one hour long, with some for 90 minutes. Typically the briefer interventions were self-help interventions. Seven interventions were based on elements of compassionate mind training (or similar) and/or mindful meditation (and a further study used 'cognitive distancing' from ACT, referring to acceptance of thoughts but not buying in to them. Compassionate interventions used techniques such as compassionate imagery, body scan, loving kindness, soothing rhythm breathing, compassionate self-talk, friendly facial expressions/voice tone, mindfulness, meditation and/or letter writing.

Two studies used written accounts as all or part interventions. One of these was from that used within Cognitive Processing Therapy, writing around trauma (Resick *et al.*, 2008), another used written accounts of trauma to elicit trauma responses to then apply soothing techniques (Ojserkis *et al.*, 2014). Three studies used CBT /cognitive therapy methods, with others using aspects from cognitive therapies. These included guided discovery, normalising, behavioural experiments, validating experience, fact/opinion, psychoeducation, thought modification, attentional shift, and Socratic questioning. One study used interpersonal psychotherapy, (time-limited therapy focusing on interpersonal contexts), and two studies used DBT (Dialectical Behaviour Therapy) with prolonged exposure (in vivo and imaginal exposure and DBT techniques such as dialectics, irreverence and validation).

3.2.6   Discussion of REA2 findings

When considering papers for inclusion as starting points for wise interventions, only the six studies that were rated as medium or low risk of bias were considered as the findings from these could be considered the most robust (see appendix J for an assessment of bias for each study). Interventions included those from cognitive therapy (Morrison et al., 2016), Cognitive processing therapy (Resick *et al.* 2008), DBT and prolonged exposure (Harned *et al.*, 2012; 2014), manualised interpersonal psychotherapy (Talbot et al., 2011) and self-compassion meditation training (Albertson *et al.*, 2015). Using these papers, a list of possible intervention categories was drawn up (see Table 2), with interventions then chosen from within some of these categories. (Appendix L provides a detailed list of what these

incorporate). It should be noted that, where possible, intervention strategies were taken from those mentioned in the included research papers. If there was not enough detail within these papers, then the sources referenced within those research papers were referred to.

Table 2. Intervention categories from medium/low bias studies

Possible interventions from REA2
Self-Compassion (Albertson et al., 2015)
Compassionate body scan
Affectionate breathing
Loving kindness meditation
CT/CPT/WA (Morrison et al., 2016; Resick et al., 2008)
Psycho-education
Guided discovery for stigma
Normalising
Belief change through behavioural experiments
Exploration of meaning of diagnosis
Validation of experience of stigma and discrimination
Considering the pros and cons of responses
Written account of trauma with processing
Interpersonal Psychotherapy (Talbot et al., 2011)
Grief and loss
Role transitions
Interpersonal conflict
Interpersonal patterns
DBT & PE (Harned et al., 2012; 2014)[7]
In vivo and imaginal exposure
Monitoring of potential negative reactions to exposure, and targeting of problems that may occur
Dialectics
Irreverence
Validation

I was encouraged to find that there was evidence of shame reduction across a number of problematic experiences, and using differing approaches. This provided reassurance that a pluralistic approach might be suitable when considering wise interventions, favouring the

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[7] Intervention strategies are taken from van Dijk (2012).

experience and the individual over theory (Cooper and McLeod, 2011). The principle driven approach I have taken could be termed 'technical eclecticism' (Cooper and McLeod, 2011) where, *'the best parts are joined together, rather than a form of integration from which a new whole is created'* (Athanasiadou, 2012, p.19). By deconstructing each approach to its technical components, I could examine the parts that might best work with the range of experiences that might be driven by shame. For instance, role transition or interpersonal conflict strategies from interpersonal therapy might help foster a sense of connectedness to transform the alienation felt by the shamed (Dayal *et al.,* 2015), and improve attachment bonds (Talbot *et al.*, 2011). Similarly, strategies focused on changing ones' identity could focus on similarities to others and strengths rather than differences and weaknesses. Therapist disclosure (a DBT strategy) could enhance these transformations as well as building trust. As Finlay and Evans (2009) note, *'therapist self-disclosure is increasingly seen as a powerful intervention in the unfolding of the therapy process, especially with regard to the nature and meaning of resistance'* (p.34). Both compassionate strategies and emotion regulation strategies might enable the shamed person to transform the meaning of emotional experiences, and learn new ways of communicating with the self, in line with the CFT approaches to shame (Gilbert and Procter, 2006; Au *et al.,* 2017).

One must be aware that the evidence presented here only provides a tentative starting point. As was expected, the evidence base was not particularly robust or prolific. This may be due to problems in constructing and measuring shame, as it sits under so many other emotions and issues (Johnson and Yarhouse, 2013; Black *et al.,* 2013). As there is no universal definition of shame (or toxic shame), this makes defining exactly what it is that interventions are seeking to address difficult. Shame was often measured as a secondary outcome, meaning that interventions may not have been designed with shame reduction (or tolerance) in mind, but that this impact was a welcome by-product. Additionally, as interventions were focused on differing clinical and non-clinical populations, and number and length of dosages were variable we cannot be certain that findings could be generalised to other settings and variations. A certain 'leap of faith' has had to be taken in extrapolating findings as the basis for wise interventions, and this should be borne in mind when considering how well justified the suggested wise interventions might be. Further better-targeted research would be useful to provide a better understanding of what works in reducing shame, and for whom.

3.3 Parts 3 and 4. How might we transform the meaning of shame through Wise interventions?

Parts 3.4, 3.5 and 3.6 consider the primary question, *'How might we transform the meaning of shame through Wise interventions?'* through the sub questions:
'What might Wise interventions for working with shame look like?' and, *'Do practitioners see value in using therapeutic strategies as Wise interventions to transform shame-based experiences?'*

Section 3.4 draws together the findings from the two REAs to produce a draft list of wise interventions based on therapeutic strategies drawn from the best available evidence in REA2. The interventions are intended to positively transform a range of shame-based experiences, these being dictated by the experiential themes developed from REA1. Section 3.5 presents the views of counselling psychologists in training who were asked for their expert opinions on the efficacy and relevance of the draft list of interventions. Section 3.6 provides the final list of wise interventions based on feedback from 3.5.

3.4 Part 3. What might Wise interventions for working with shame look like?

The first stage in creating Wise interventions was to synthesise the findings from both REAs, to answer the sub question, '*What might Wise interventions for working with shame look like?'* With an understanding of how and when shame is experienced relationally between client and therapist (the nature of maladaptive views and how they arise, in 'Wise' speak), and consideration of the evidence base for what works in reducing shame in therapy (how they can be changed, in 'Wise' speak), findings were used to inform ideas for wise interventions that might alter client's shame based experiences (change behaviour and improve outcomes, in 'Wise' speak). Therefore, in the following paragraphs I have attempted to draw together the findings from the REAs by highlighting (in bold) experiential elements that could be worked with if and when they arise (or that may help the therapist understand the experience as toxic shame arising), and considering which intervention strategies might 'speak to' and help transform that experience, so that the toxic shame is

addressed in some way (see references). I have written this as a narrative account to reflect a potential 'story' of therapy that a client may experience. This story also speaks to other transformational elements that may not be considered within the strategies from REA2, but which the reader may additionally wish to consider. This narrative is based on my interpretation of the findings (and quite possibly bound up in some of my own therapeutic journey), and therefore will not reflect exactly how toxic shame may be expressed or experienced between every client and therapist.

Working with clients' identity and the fear of stripping this away might be useful, perhaps through consideration of core beliefs (Morrison *et al.,* 2016) or role transitions (Talbot *et al*., 2011). Understanding that toxic shame might be experienced as the essence of who they are could provide the therapist with an understanding of the **extreme resistance and defence** that they might be presented with. If the therapist begins to **question their own identity, or starts to feel stuck, helpless or de-skilled**, this may be a reflection of the client's shameful inner selves. **Finding the toxic parts** of the client could aid the therapist in supporting change, by working with these parts. Perhaps supporting the client to find, and **'unblend'**, the differing parts of the self could do this. Or perhaps helping them to understand the **process of splitting** and the functions it has served them, or seeing identity as malleable rather than fixed.

Noting, accepting and validating the feelings that arise within therapy when shame is present or near the surface might be useful (Harned et al., 2012; 2014). Clients might express **fear and terror,** which could manifest in several ways. If a client **resists** exposing their inner thoughts, it might be that they are bound by fear and shame. Equally, if they do begin to unravel their story, it would be wise for the therapist to be aware that this **process of exposure can be extremely frightening and destabilising**. The client might begin to **feel suicidal; they may begin to have nightmares, or may withdraw in to a 'psychic retreat'** where they become mentally unable to move forwards. Using strategies to help process traumatic events such as normalising (Morrison *et al*., 2016), or self-distancing (Resick *et al*., 2008; Morrison *et al*., 2016; Kross and Ayduk, 2008; Park *et al*., 2015) might alter the level of pain felt through re-experiencing. Defence mechanisms might come in to play, such as **dissociation, projective identification, controlling, or challenging**, and these may be useful cues for the therapist that the toxic shame is taking over. The **therapist could begin to embody** some of these states and defence mechanisms, which might hinder the therapeutic

process. However, an awareness of this process could help the therapist interpret what is happening for the client, and could be used as a **catalyst for opening up dialogue** and working with the felt experience. Importantly, if the therapist was able to be **vulnerable and authentic** in these moments, this could strengthen the relational bond and help the client to feel safe. A therapists **desire to divulge personal details,** for example, might be an indication of the client's need to **address the power imbalance** in order that they feel more able to share themselves. Using therapist disclosure carefully here might be valuable (Harned *et al*., 2012; 2014).

Other emotional experiences that might indicate shame was present include **vague expressions of global distress and pain**, where context is not necessarily clear, or **expressions of anger turned towards the self**. The therapist at this point might need to help the client to **differentiate and label their emotions**, perhaps helping them **contextualise** their origins (Harned et al., 2012; 2014). If a client was able to express **adaptive anger**, turned outward, this might be a sign that they were beginning to process their shame in a healthy manner. The therapist might need to be aware that along with this may come **expressions of grief and hurt**, as the client starts to make sense of their past. They might grieve for the childhood they have lost, for the frightened inner child, and also for the process of **giving up their old identity**. This process could be frightening and challenging for the client, as they might be **at their most vulnerable** when emotions are running close to the surface, with less of their usual coping strategies to fall back on. Using emotional processing strategies such as **letter writing, mental time travel, rescripting, unblending and imaginal dialogue** may be useful here (Resick *et al*., 2008; Morrison *et al*., 2016; Kross and Ayduk, 2008; Park *et al*., 2015). This also taps in to working with **the inner, shamed child,** so that they no longer need to be protected by feelings of worthlessness and despair. This could be achieved through role-play, where the client is encouraged to put themselves in the shoes of their younger self in order to apply what they have learnt in the present about past experience (Talbot *et al*., 2011).

There might be times within therapy when the inner child surfaces, noted either through **clients' childlike behaviour, demeanour, or expression of emotions**. **Talking to this child** on their level could sometimes be helpful, as this both acknowledges their presence, and helps build a bond with them in order that they can experience the therapeutic space as somewhere safe (Harned *et al*., 2012; 2014; Talbot *et al*., 2011). Other ways of accessing and

understanding inner experience might be through **paying attention to the body, both of the therapist and client**. An awareness of language, tone, posture, gaze, and so forth can help in making interpretations and in expressing emotions (Harned *et al.*, 2012; 2014). Working to release inner pain could be done through **focusing on releasing physical pain** (such as knots, stomach aches, and so on) (Albertson *et al.*, 2015), or through discussing the **physical embodiment of the client's issues** that the therapist is experiencing in the room.

Finally, when a client has begun to process and let out their shame, they may be able to **turn inwards with compassion and acceptance rather than self-loathing** (Harned *et al.*, 2012; 2014). This might require gentle encouragement, as the process of being kind to oneself could feel both **alien and overly challenging**. The more clients are able to **talk about their experiences with a range of people**, the less frightening they might become. **Working with forgiveness** could be a powerful tool in helping clients process their emotional experiences and **reframe** them in order to lay them to rest (Albertson *et al.*, 2015). Therapist **modelling of compassion and kindness** would be an important part of the therapeutic experience for the client as they learn a new way of being. If a client starts to look towards the future with **hope**, and expresses **wishes and desires that relate to enjoyment rather than pain**, this might signal that they are shifting towards believing in themselves, and feeling self-compassion rather than just thinking it.

The elements above provide a basis for focusing in on specific parts of the narrative, considering the wise motivations and questions (see figure 3) that might fit within experiential themes from REA1. I then considered which interventions from REA2 could be transformed (or used directly) as wise interventions, choosing those that directly affected meaning making (subjective construal). This gave me a list of potential starting points for wise interventions, as proposed in Table 3. The next step was to consider which of the four wise intervention categories these would fit within (direct labelling, prompting new meanings, increasing commitment through action, and active reflection exercises (Walton and Wise, in press)), and whether any changes would need to be made to make the interventions 'wise'. The full (draft) list of interventions for presentation to counselling psychologists is provided in appendix M.

As an example, we can consider an exercise working with core beliefs suggested by Morrison *et al.* (2016). This strategy involved discussing how others might see a new (positive) core

belief, in order to transform shame-based assessments such as 'I am unloveable' or 'I am bad/rotten' to 'something bad happened to me, but that does not mean that I am bad'. A wise intervention using this strategy might consider the client's motivation for a *need to understand* the self by asking *Who do I want to be?*, or, *Can people change?* This could enable clients to consider other self-views by separating negative early experiences from global assessments of the self. With these questions in mind, one could use a 'direct labelling' intervention utilising a survey:

Ask 3 people close to you what 3 positive qualities they assign to you. The therapist then also gives 3 positive qualities. Discuss the list and decide what this says about who you are.

As the client seeks feedback on how others view them they may be able to establish that there are parts of the self that are not toxic. This intervention may invite questions as to who they really are, and allow them to try out new, positive labels. If others can see good parts of the self then perhaps these parts do exist after all, and the client may begin to notice how others do not always persecute them (setting off a recursive process). The therapist and client may discuss what a new belief about the self might look like based on these qualities the client possesses. Similarly, an 'increasing commitment through action' intervention might be used to help build on this new version of the self, whilst acknowledging how the toxic part of clients' identities helped them to cope with and understand their past experiences:

How do you like to see yourself and your actions? What are the advantages and disadvantages of being this way, versus the pros and cons of seeing yourself as worthless/bad/unloveable? What would you suggest to someone else in your predicament?

These interventions could help transform the meaning of 'what it means to be me', or make some sense of identity as being malleable and open to change, rather than fixed. They are wise because they focus on transformation of meaning through recursive processes of understanding and creating one's identity. The recursive element of these interventions is provided through a 'snowballing' effect, where ever greater change occurs the more than the client begins to understand the self in a new way, and applies this understanding to new situations and relational experiences that occur.

Table 3. Possible Wise interventions, by experiential theme and wise motivation

Theme	Motivation	Question	Intervention(s)
Finding the toxic part(s) of me	Need to Understand	Who do I want to be?	IPT role transitions
		Am I loved and valued?	CBT core beliefs exercise
		Can emotions change?	IPT trouble experiencing emotions
Your shame is my shame. The relational experience	Need to belong	Can negative relational qualities of people change?	Normalising exercise CBT
		Am I noticed by others?	DBT opposite action to shame
		Can people like me come to belong?	CBT normalising
			DBT therapist disclosure
		Does this event/experience mean I don't belong?	CBT normalising
		Am I connected to others?	IPT communicating experience
			Loving-kindness
	Need to understand	Am I connected to important people? How can I better manage this conflict?	DBT therapist disclosure
			IPT role play (younger self or recent conflict)
			DBT coping ahead
I live in fear. I need to feel angry	Need to understand	Are negative past emotions, states and experiences ongoing and undermining?	CBT imagery modification
			CPT written accounts of trauma
			DBT validating emotions
Secrets, ghosts and psychic retreat	Need to belong	Will this behaviour connect me to other people?	IPT reinforce disclosure
	Need for self-integrity		DBT opposite action
	Need to understand	Can I control important aspects of myself	CBT imagery modification
			CPT written accounts of trauma
		Am I loved and valued?	IPT reinforce disclosure
The child within	Need to understand		IPT role play (younger self or recent conflict)
A bodily experience	Need to understand	How does my body interact with the external world?	Compassionate body-scan
			Affectionate breathing
			DBT half smile
			IPT non-verbal communication role-play
Out of the darkness, comes light	Need for self-integrity	Am I doing something that harms my health?	DBT devils advocate
			DBT acceptance practice
	Need to understand	How will I accomplish my goals?	DBT making lemonade out of lemons
		Do I think and feel positively about myself?	Loving-kindness meditation

3.5 Part 4. Do practitioners see value in using therapeutic strategies as Wise interventions to transform shame-based experiences?

Five consultation interviews were conducted with counselling psychologists nearing the end of their doctoral training at the University of the West of England. Four interviewees were female, and one was male. All had some experience of working with toxic shame, either at the time of interview or in the past, and in a range of services (private practice, IAPT, in-patient psychiatric and charitable organisations). Additionally, consultants had worked with a range of issues such as pain management, addiction, eating disorders, sexual abuse, suicide and self-harm, depression and anxiety.

Consultees were given a presentation on the entire research process to contextualise the findings (appendix N). This was then briefly discussed before moving on to the interview topic guide. The presented list of interventions (see appendix M) was grouped by therapy type, but discussed in relation to the experiential elements so that interviewees were able to move away from the idea of following one mode of therapy to an integrated, pluralistic approach. The findings here are presented by general interview themes. Suggested interventions have been shaped by the feedback, and are presented within the findings.

3.5.1 Comments on theoretical underpinnings

All interviewees welcomed new ideas for working with shame, and found the literature on experience in the therapy room enlightening. They felt there was something important in the naming of shame and not being afraid to work with it. Interviewees articulated that these interventions might be a useful way of helping a therapist to recognise and name when shame is being experienced, and to consider bringing it to the fore to *'embrace the shame'* (Interviewee two). Interviewee one stated that they had never considered shame as being associated with so many emotions, especially fear. They also noted that, although they recognised many of the experiences discussed, they had never thought about them in terms of shame before. This perhaps demonstrates just how hidden shame is, even when it is right in front of us.

Interviewees connected with the hidden nature of shame, feeling it was often something that was not directly discussed or named. Like the back and forth mentioned in the REA1 findings, interviewee four referred to working with shame as like a dance, but also like, *'a black hole, stuck in treacle together…You need to sit in the darkness with them and not be*

afraid of what it's going to bring'. This reflects the difficulty clients have discussing shame and the powerful hold it has over the lives. Fear is felt on both sides of the room. Interviewee one shared a powerful metaphor that they sometimes used with clients who were struggling to move on where shame, *'becomes a sort of heavy coat. It's battered and fallen to bits, but they would rather keep it on than have a new one'.*

Interviewees felt that it was useful to see how interventions from different therapeutic standpoints seemed to hold a common thread, which they saw as strengthening the argument that working integratively can be beneficial, *'what's fascinating is that you can see the continuity of the thread between each therapeutic approach'* (Interviewee two). One does not *'need to belong to a particular approach'* (Interviewee five). Sometimes following one approach too closely was felt to hinder working effectively with shame, which is where integrative skills could come in useful, which is part of the skill set of the counselling psychologist. Interviewee four noted *'In the CBT manual there's not much in there about working with that* [shame]…*As a counselling psychologist I make space for it'.* There were differing levels of familiarity with the therapeutic modalities interventions were drawn from, but feedback suggested that each approach brought its' own particular strength. For instance, *'The interpersonal perspective gives us a scaffolding for bridging to the community…it provides a collective approach'* (interviewee two). Other strategies focused on emotional literacy (such as DBT) or learning to be kind to the self (self-compassion), providing a well-rounded approach to work with differing ways that shame is experienced.

3.5.2   Feedback on Wise interventions
During the process of considering interventions it became apparent that there was scope to amalgamate strategies from different therapies where there was crossover, using particular experiential aspects as a guide. For example, an IPT role-play intervention could be used to re-play or practice relationships and transform meaning of prior or future experiences. A role play focused on working with the inner child might get the client to play their younger self, expressing their hurt and anger to the person that had shamed them as a way of processing early experiences, incorporating compassionate strategies of kindness to the self. As interviewee one noted, this could transform anger from an inward to an outward experience. So in this instance, one might use a role-play intervention to increase commitment through action that works on the client's *'need to understand, how I can better manage this conflict'* (from Figure 3 motivations and psychological questions) by considering interpersonal conflict:

> *__Increasing commitment through action.__* *Role play: 'Imagine you are the young child and I [therapist] am the [significant other]. Say to me the things you would like to have said as a small child about how the situation (that is causing shame) has made you feel. Afterwards, what would you like to say to your younger self now, that you wish they had known then?'*
>
> *You may wish to get the client to move chairs when practising this intervention, so they are physically moving from one version of themselves to another. Or you could run this role play addressing different parts of the self, where the child part talks to other parts, through use of cushions, empty chairs or squares on the floor, which represent the differing parts of the self. Using a compassionate breathing or body scan exercise prior to the role-play might help the client enter a more compassionate frame of mind.*

Whilst *'processing the shame in a healthy manner is so important'* (interviewee five), interviewees noted that interventions such as this needed to be used only when there was felt to be a strong relational bond between client and therapist, as they could be very emotionally charged and overwhelming. This could also be used if the client was still in touch with the critical/shaming other (such as a parent), as it might help them release some anger and reduce self-blame. Interviewee four felt that this might help with management of self-harming behaviour because even if *'they can't change the situation* [if they still live with the parent, for example]*, it might make life more bearable'.* One important aspect discussed was how the therapist would communicate with the person at this moment (or just after the role play). Interviewees stated it might be important to communicate with the inner child on their level, perhaps by sitting with their emotions rather than rationalising, *'You can't really apply adult voices to these emotions. What do you do with a child? You sit with them'* (interviewee two)*.* Yet communicating with the child could feel difficult for the therapist if it was new to them, *'From the therapist perspective I think this takes a bit of confidence…*[they might think] *why are you talking to me like a child?'* (interviewee one). This might therefore require some practice in clinical supervision before use.

A role-play could incorporate DBT elements regarding non-verbal communication and coping ahead with interpersonal scenarios and communication strategies (IPT) by running through a scenario (such as a job interview or expected conflict) and the therapist providing feedback on use of verbal and non-verbal communication strategies. Clients might practice use of assertive strategies such as eye contact and upright body posture, which may also have a similar effect to the half-smile in DBT (bringing about change in emotion through action) and opposite action, which mirrors the wise intervention strategy of increasing

commitment through action through 'saying-is-believing'. Training in assertive verbal communication could also be incorporated here. If a client could act less shamed, they might begin to feel less shame, without having to name it or delve in to the shameful experience. An intervention thus might seek to use bodily experiences to motivate *a need to understand how the body interacts with the external world*, through working with non-verbal communication, as well as a *need to understand personal and social experiences* to change beliefs about interpersonal conflicts and interactions As interviewee three noted, this facilitates, *'rescripting the presentation of the self':*

> *<u>**Active reflection exercise.**</u> Start by providing psychoeducation on the use of assertive verbal and non-verbal communication (such as 'I' statements, body posture and eye contact). Ask the client to imagine they are giving a presentation/at an interview/having a difficult conversation that they are anticipating (such as at an upcoming event) and to act out the situation. 'I (therapist) will play the role of the audience. Afterwards, I will comment on the communication strategies you used. We will then re-run using different non-verbal communication strategies'.*
>
> *Pay attention to cues such as eye contact (are they able to hold or maintain eye contact), body posture (are they upright and outward), body movements (are they 'shrinking in' or using nervous movements, such as covering their mouth or eyes), and use of I statements. For example, you could note how averting the gaze made it difficult for the audience to connect with the client. Pay close attention to any cues within your own body, and reflect these back to the client.*

Again focusing on bodily aspects, the therapist might use an intervention using opposite action DBT strategies to help a client process the shaming incident as 'not-me'. Interviewees felt that this was an interesting strategy that they would be keen to test out. Interviewee one suggested that an intervention they sometimes used was to ask their client *'what would you say to a seven year old child about this'*, perhaps when considering how to be kind to oneself. This removed direct scrutiny from the person, but still allowed them to take on the ideas. The intervention again considers the *need to understand, how my body interacts with the external world,* through use of body language and facial expressions to transform the meaning of early experiences:

> *Active reflection exercise.* Ask the client to write a story about how others would see a traumatic incident in the client's life (such as early abuse). Or write a story around forgiveness of the self. Read the story to the client whilst they practice eye contact, upright posture, a half-smile and nodding their head, to encourage conviction in the story's messages and changes in emotion.
>
> If the client struggles with this, you could ask them to imagine if this had happened to someone else, what would the client say to them? Or, if the incident was from early childhood, perhaps ask them, 'what would you say to a child [of the age they were when it happened] if it happened to them?

Other bodily focused interventions used compassionate mind strategies. All interviewees used these within their therapy and found them to be beneficial. There were no revisions made to the body scan or compassionate breathing interventions, as interviewees felt these worked well as they were. These focused on the client's possible *need to understand how their body interacts with the external world* through direct labelling (labelling the self as kind and compassionate prompts this behaviour towards the self). These interventions also motivate a *need for self-integrity* through *regulating behaviour to accomplish goals,* or *living up to attitudes and values* (I value kindness and compassion, but do I show this to myself?):

> *Direct labelling.* Affectionate Breathing. Read the following to the client: Get in touch with your body by doing a quick body scan and noticing any sensations. Take three deep breaths to let out any tension and then allow breathing to return to normal. Notice where the breath is felt most strongly without trying to control the breath. Adopt a little half smile and observe how she feels. Set an intention to breathe in affection and kindness for yourself and with each out breath, breathe out affection and kindness towards others who are suffering just like you. Try not to judge your mind when it wanders. Appreciate each breath and allow the breath to comfort and soothe, and finally rest in the feelings of kindness you are generating.

> *Direct labelling.* Compassionate body scan. Read the following to the client: Lie down and rest a hand on your heart as a reminder to be kind to yourself. Starting with the feet and working up to the head, notice the sensations of the various body parts. If judgmental thoughts arise, place a hand on your heart, breath deeply, and return to feeling simple sensations.

The loving kindness intervention also met this need, through allowing kindness to the self. Interviewee one felt that this was the strategy they preferred of the three as, '*some phrases to tune in to can help them feel they are more successful…they are really connecting that mind body experience'*.

> *Direct labelling. Loving-kindness meditation. Read the following to the client: 'Have self-compassion for a personal experience of suffering. First, be present in the moment, notice any sounds that are arising, and then focus on the breath. Bring attention to a trait or behaviour that has generated negative emotions and allow whatever feelings are connected with this perceived inadequacy to arise. Locate the physical sensation of these emotions in your body and allow them to be there. Place both hands over your heart, to soothe and comfort yourself for the difficult thoughts and emotions you are experiencing. Silently repeat the following phrases to yourself: "May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am."*

These compassion-based interventions might also serve a useful purpose at a time of identity transition. When clients are considering moving on from their critical self-view, using exercises to build compassion could help them to connect with a new way of viewing, and behaving towards, the self.

Using metaphors and accessing dreams were discussed as important parts of the therapeutic process, particularly when working with emotions or experiences that might be unnamed, unconscious or too frightening to discuss directly. For example, interviewee one had experienced clients discussing something shadowy or ghost like in their dreams, which were often related to a sense of something that was lurking but that they could not quite grasp (such as a deeply held sense of shame from some frightening experience). This might be worked with through drawing what was seen in the dream, or discussing in simple terms, such as the shape, colour, movement, or where it is in the room with them. This allows the client to bring the experience in to the room, in to the light and out of the shadows. I felt this fitted with a suggested intervention based on IPT, in which the client is asked to recall an interpersonal incident where they have experienced distress, to seek to draw out that emotion when they have trouble in experiencing emotions.

Metaphor is used as a dialectical strategy in DBT as a less direct (and therefore less threatening) way of making suggestions. The underlying wise motivation here is a *need to understand whether emotions can change.* An active reflection exercise could therefore use a dream, metaphor or experience as a starting point to access the emotions, through use of simple language and imagery. As interviewee four suggested, this may help the client to *'know the demon they are fighting with'.* A useful suggestion from EMDR protocols was made by interviewee two, who felt that, before conducting interventions using scripts, role plays, or imagery, it might be important to get the client to define shame (or whatever

aspect is worked on) in their own terms. For example, one could ask, 'What does shame mean to you, what does it look like, what does it feel like?' This gives the client ownership of the idea and helps the therapist see in to their inner world (giving some form to the 'ghost'). Similarly, if something like a 'compassionate other' is to be used, or a safe place, this needs to be made explicit and based on the client's own metaphor or image. The suggested intervention incorporates these ideas:

> *__Active reflection exercise.__ Get the client to discuss an incident/metaphor/dream where they have experienced distress/fear/sadness/anger (whatever emotion you are trying to get to). Intent- to bring up the emotion and sit with it in a safe space.*
>
> *The 'discussion' might take a simple form of questioning, such as 'What shape is it? What colour is it? How does it move? Where is it now? Does it make any noise? What size is it?' This can help bring structure and form to the emotion, and help to bring it in to the room.*

Other intervention strategies that also used metaphor were similar to wise 'self-distancing' techniques (Kross and Ayduk, 2008; Park et al., 2015), either through imagery or story-telling/narrative methods, to lessen the felt shame from traumatic experiences. All interviewees described these types of interventions as having great transformative powers, particularly with regards to moving on from fear towards a healthier experience of their shame. Interviewee one suggested an intervention where the client is asked to imagine the person shrinking or fading away. For example, '*imagine they are in a car that is getting further and further away, what would you do with that car?*' Use of metaphor was deemed extremely useful, perhaps alongside use of one-word nouns to describe things in simple ways. Interviewee two felt that creating distance was a very powerful tool in working with shame, and discussed how this idea is prevalent in the ACT literature (the idea of being an observer).

Interventions here came from both CPT/written accounts and CBT, but I also attempted to include compassionate imagery (through a compassionate 'other'). There was mixed feedback on the usefulness of this, as some interviewees wondered how easily the shamed client could call up a compassionate other as they, '*would need sufficient work to build a compassionate rescuer in*' (Interviewee five). This was echoed throughout the interviews; therefore the interventions have been presented without this aspect. Imagery modification techniques might use a metaphor of the distressing image appearing on the television or as getting further away from the client could help them distance themselves from the distress.

The intervention would help meet the *need to understand whether negative past emotions, states and experiences are ongoing and undermining* through self-distancing:

> *__Active reflection exercise__. Ask the client to visualise a recurring distressing image and imagine they are watching it getting further and further away from them. Perhaps they are riding on a train, watching it disappear out of the window. Perhaps they are watching it on the television. Try to elicit their own metaphor to help them take ownership of the practice. What does it look like? What does it feel like? What do they do to the image? Remind them to practice visualising this image.*

Similarly, a writing intervention could help a client distance the self from the initial affect through helping to process the situation. This would meet the same needs as the imagery intervention. Three interviewees noted that imagery, scrap-booking, journey mapping or other creative exercises might be useful either for non-literate clients, or those that prefer to express themselves in different ways. Interviewee two pointed out that it might be helpful to work on a 'safe space' for the client before undertaking this task, particularly if working with very traumatic memories:

> *__Prompting new meanings__. Ask the client to write about a traumatic event (either the worst trauma or one that is slightly easier, and work towards the worst trauma). Write how they feel before and after doing the task (you could use a SUDs rating here). Get the client to read their account to you (therapist). The therapist will elicit responses regarding emotions, review learning, and discuss any details to add. The client is to read the story every day between sessions and record feelings before and after. Consider 'hotspots' together and then move to next trauma when ready.*
>
> *If the client prefers, this could be carried out as a creative exercise, using scrapbooking, collage, drawing, or other means chosen by them to tell their story. This could still be reviewed in the same way as above.*

Interventions around changing identity were thought to be important when dealing with the inner critic, although interviewees felt that shifting identity was often a difficult and drawn out process. Once a client enters a period of therapy where they are able to acknowledge other, possibly healthier, identities that are not wholly toxic, then an intervention might help them to consider what parts of their identity they would like to keep, and what they would like to change. Interviewee one provided a helpful suggestion for a role transition/ identity exercise using imagery rather than words, where the client draws two people, representing where they are and where they want to be, and then considers the gap in between and how to get across it. Other interviewees suggested similar strategies such as journey mapping,

timelines or using cushions as different parts of the self, as sometimes imagery or creative activities could enable transformation better than words alone.

Considering how parts of the identity, and strategies used to protect the self, had been helpful was thought to enable clients to understand why they had developed the defences they had. This also enabled the client to decide what to keep and what to change, having a *'clear focus on things they want to change'* (Interviewee five). Importantly, accepting some good and bad parts of the self might also demonstrate a commitment to self-compassion (Interviewee four). The client may be motivated to *understand the self* through asking '*Who am I? Who could I become?'* An intervention based on CBT and IPT might therefore be:

> ***Active reflection exercise.*** *Conduct an activity around what the client's future, compassionate self might look like, and who they feel they are now. Consider the pros and cons of both the old and new identities, and what they need to put in place to achieve the new identity. Validate loss, anxiety and/or ambivalence around the new identity, and use this to motivate change.*
>
> *This activity may be conducted as a writing or drawing task, such as drawing the old and new person on differing platforms, or as a journey along a road. You could ask the client what they would keep and what they might drop. What has kept them safe, and does it still serve this function? What behaviours might be useful (e.g. coping strategies) and which are no longer useful? What support might they need on their journey?*

An additional intervention on identity transformation was for the client to conduct a survey of what qualities others thought they possessed. This cognitive strategy would have the intention of helping them see beyond the 'toxic' parts of their identity, focusing on the wise motivation to understand the self. The client may wonder if they are loved and valued (as shame may come from how we feel others view us), and so asking others for their take on the clients' positive qualities might help them realise that they were not wholly toxic. Interviewees felt this was beneficial but for some clients they may hear this but not connect with it. If they could not accept the positive qualities it might exacerbate their problems even further (interviewee five), or at the very least be, *'very difficult to shift'* (interviewee four). This might then require further work or repetition of the exercise. Interviewee one had used this type of intervention strategy and stated that for one client, *'it put a new slant on things…She did actually experience a bit of a shift'.* The intervention was thus:

> *__Direct labelling.__ Get the client to ask 3 people close to them what 3 positive qualities they assign to the client. The therapist then also gives 3 positive qualities. Discuss the list and discuss with the client what this says about who they are*

There was some reticence to use normalising as a strategy, as consultees wondered if it might invalidate the client's uniqueness. Whilst normalising was understood to be useful, there was also the risk that this could be a de-individualising experience for the client. Although fostering a sense of belonging could be helpful, it is important to consider this in terms of 'belonging to what'?

> *Belonging to 'normal society' might give the message that 'I am not normal', or 'I have to fit a certain way of being', invalidating their experience* (Interviewee two).

Therefore, fostering belonging should go hand in hand with appreciating the individual, and *'finding an individual thread to it'* (interviewee two). As interviewee five noted, clients could attend group therapy or other group programmes when they were wishing for this closeness, and also strategies where therapists used self-disclosure could also have a great deal of power in normalising aspects of experience. For these reasons, I dropped a normalising intervention from the list.

Three interviewees noted that self-disclosure might feel uncomfortable for many therapists (and something they would need to consider very carefully), but all five could see the value in that it might help shift the power dynamic. Interviewee one stated that one client who had been raped had said to them how much they had valued having a previous therapist who had also had a similar experience. Interviewee two also saw the value in this intervention as a way of empowering the client, but worried about the possible implications, *'how far does the disclosure go?...'what if the client's experience is different [to the therapists], will they feel blamed for their experience?'* Interviewee four recalled having used disclosure in therapy sessions, and noted the powerful effect this had had of decreasing clients' sense of isolation when they (as therapist) appeared to, *'come off their pedestal'*.

Both interviewees three and five felt that when they had used minor disclosure it had strengthened the relational bond with their client. It offered an opportunity for clients to feel understood and to experience effective modelling of communicating shameful experiences (a suggested IPT intervention). A disclosure intervention was also suggested in

the DBT literature. It meets the wise motivation of a *need to belong*, where the client might wonder, *Can people like me come to belong? Am I connected with important people?* Disclosure offered an opportunity to transform shame through shifting power dynamics, providing a human and genuine relationship through which to affect change. Interviewee one stated, *'I really like the thought of it in this way. That I own a bit of shame. That I'm human too.'* An intervention might therefore be:

> *Prompting new meanings.* *When a client is struggling with a problem, disclose how you [the therapist] have worked through a similar problem. Work through the problem together. Perhaps seek feedback on how it feels to have others understand their experience, and how the client might help others [outside the room] to understand their experience. Or perhaps disclose a situation when you have felt ashamed. If for example, you arrive late to a session or forget what the client has said/ make a mistake, owning this may provide access to the human side of the therapist.*

Related to the intervention above is considering how well the client feels others have understood their experience, and finding new ways of learning to communicate their experience (as suggested in IPT). An intervention that considers the *need to belong* might help transform a feeling that a shameful *event or experience means I don't belong,* or whether not disclosing *helps me to connect with other people* by fostering connectedness through sharing experience. This could prompt new meanings about the shameful experience, through considering others reactions. Interviewees felt that this sharing aspect could be beneficial relationally. Interviewee two suggested that if they had not experienced being understood before, *the therapist could ask 'how do you feel I have understood your experience?'* Interviewee three pointed out that looking for small interactional experiences could be crucial here, *'this could be as small as someone smiling at them'.*

> *Prompting new meanings.* *Ask the client to write about or discuss how someone close to them has understood their experience and the significance this has had for them in moving forwards (perhaps a time when they have disclosed something, no matter how small. Explore even seemingly minor interactions (such as a smile or compassionate gesture) that has impacted on their day. If they cannot think of an example, the therapist could ask, 'how do you feel I have understood your experience?' or 'how did it feel when you told me X?'*

With regards to interventions focused on transforming negative emotional experiences such as fear and unhealthy anger, interviewees felt that this was an extremely important aspect

of therapy. Interventions aimed at validating and accepting emotions (from DBT and IPT) could be used a time when the client was having difficulty experiencing a particular emotion, and could help foster a sense of compassion towards the client's own experiences. Clients could be asked to recall an experience to help them elicit an emotion and start to feel and acknowledge it, taking a step towards processing painful emotions.

Validating was seen by interviewees to be important for shamed clients, who often struggled to name and process emotions. The experiential literature suggests that many emotions are buried or turned inwards (particularly frightening ones) with defensive strategies used to push the experience away. As interviewees two, four and five noted, sometimes all that is needed is to sit with the client in silence to let them experience their emotions in a safe space. An exercise in validating emotions could therefore help clients find a way to practice feeling their emotional experiences and make sense of them. Perhaps they give permission for shame to be expressed in the room, or foster learning in how to experience anger in healthy ways. This could meet a *need to understand* whether *negative past emotions, states, and experiences are ongoing and undermining* through prompting new meanings that empower the individual:

__Prompting new meanings.__ Tell a client, 'When a difficult emotion arises, acknowledge but don't judge it. Give yourself permission to feel the emotion'. Then try to understand the emotion (without judgement)'. For example, the client might try to say to themselves 'it makes sense that I feel unhappy, given the difficulties I have in managing my emotions and the chaos this causes in my relationships and my life'

Practicing accepting emotions would allow clients to actively invite emotions in rather than hiding from experiences. This was acknowledged by interviewees to be difficult to accomplish and so may require regular practice. Over time, negative emotions and states might be transformed through losing their power over the client:

__Prompting new meanings.__ The client may need to practice this regularly, building from perhaps 30 seconds a day to longer and longer periods. Ask the client to consider a difficult situation that brings up negative feelings.
  1) Decide if it's a situation you want to accept
  2) Make a commitment to yourself to accept the reality you are fighting
  3) Notice when you stars fighting reality again
  4) Turn the mind back to acceptance, and remind your self of the commitment you made

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3.5.3   Next steps and concluding remarks

I felt that the refined interventions above captured the essence of the most directly relevant intervention strategies. Interviewees stated that having a bank of 'wise' interventions to refer to would be helpful; to help guide therapeutic progress when experiences that tapped into shame occurred. The strategies were seen to provide flexibility rather than a prescribed way of working. As interviewee two noted, *'It gives us a sense of wonder…you don't fall in to the traps of following standardised protocols or measures'.* Other feedback suggested that the notion of using small, precise strategies within a broader piece of work was useful as (much like the recursive nature of wise interventions themselves), each intervention can build on the last, but following the journey of experiences rather than a set protocol, *'I like the idea that it's concrete and it can start off small. It's incremental'* (Interviewee three). Overall there was a sense of excitement about the approach taken, with all five interviewees stating how they would be able to make use of the interventions, feeling it was extremely useful to have explicit ways to tackle toxic shame and not be afraid to work with it. Interviewee one stated, *'You could really stamp out new ground with this'.*

Whilst excitement was expressed, there was also a certain level of trepidation. This was perhaps for two parallel reasons. One was experience of working with the shamed, knowing how fragile they were. This meant that therapists were reluctant to do anything that did not appear to tread very carefully, so the way interventions are used would need to be carefully considered. This fits with Walton's (2014) argument that wise interventions might feel more akin to everyday experiences. If the client experiences them as a normal part of therapy, rather than an intervention separated out from the usual therapeutic process, then this may be less laden with fear and negative expectation. The other reason for fear that was reflected on by interviewees was to do with their own feelings of shame, or triggering of a sense of not being 'skilled enough' to deliver certain interventions. It was not clear whether this was an actual case of not having the skills (which seemed unlikely due to the high levels of experience interviewees had with this client group) or worries about 'getting it wrong' or doing harm to clients.

As far as next steps were concerned, interviewees were keen to try out some of the strategies they did not already use. However, they saw the benefit of further consultation to refine the interventions further with a view to testing them out (as per wise interventions). The difficulty was in how this would be done. It was suggested that further consultation with

research teams and therapists might be useful to think about a way forward with this aspect, to ascertain direct impact on shame of each strategy. Issues to consider further included:

- timing of interventions – do they require waiting for the right level of therapeutic depth/safety?

- Transitions – identifying these and using them as points in time for intervention

- Considering the interpersonal, social aspects, such as connectedness, whilst also not denying the client's unique experiences

- Using imagery, art, or other creative avenues for clients who may struggle with writing.

- Use of metaphor was an important aspect seen as a powerful tool for change, which could be used within interventions

- Considering cultural differences and appropriateness of interventions

4 Discussion

4.1 Limitations

This scoping study aimed to be quite broad in its coverage, in order to ensure that wise interventions were evidence based and well justified. However, there were several limitations that should be considered. For example, one potential issue with an REA as opposed to a full systematic review is that the risk of bias is greater. Excluding unpublished material may introduce bias as positive results are more likely to get published. Additionally, only focusing on research in the last ten years means that the reviews may be missing valuable studies that do not fit within this date range – something that would not be missed within full systematic reviews. The nature of the literature searches being so defined means that some studies of value may be missed. For example, there may be many studies which do measure shame, but as a secondary measure (as was often found). If shame was not explicitly mentioned in the title or abstract, then the literature searches would not have picked up these studies. It may be prudent to consider repeating the reviews (in particular REA2) with a search of 'all text' to pick up some of these studies, which may offer additional insight and therapies that have worked effectively with shame (such as studies using psychodynamic approaches). The limitations of the reviews have been clearly set out (see also the discussion in 3.2.6), and conclusions are therefore tentative.

Full systematic reviews on shame experiences and shame reduction would provide a more rounded view of the evidence in both cases, but the time and sheer amount of work made conducting the impractical within the limits of a doctoral thesis. Providing detailed and transparent methods allows full reviews to be conducted in future, building on what has already been conducting and reducing the risk that studies have been missed. Another option may have been to conduct the research in a different way, such as interviewing therapists about their experience of shame in the therapy room. Whilst this would be very valuable, I felt that reviewing the literature that had already been conducted would provide a better starting point for a more generalised view of the evidence as it currently stands. Using REAs meant that I could be fairly confident in picking up a broad range of studies to answer both research questions, providing a thorough analysis of the published literature in the field, but within constraints imposed by the scope of the project. Whilst the approach is not perfect by any means it has provided a means of scoping the field that can be built on in future.

Whilst I sought feedback and checking of coding for REA1, the bulk of the analysis was conducted independently, meaning that inter-rater reliability was not that high (issues around subjectivity and reflexivity are discussed in 3.1.8). With regards to REA2, the evidence base was fairly weak, and it was not clear which (if any) specific strategies focused on reducing (or transforming) shame experiences. As time frames for measurement of impact of interventions varied (as with dosage) I could not be confident in extrapolating this information and applying it to wise interventions. Most interventions were tested with female populations and with Western populations, meaning that cultural and gender differences have not been assessed. Therefore the leap from the interventions in the papers to suggested wise interventions has been fairly large and open to interpretation. Additionally, the consultation phase of this study was limited, meaning that there is scope for further refinement of, and input into, suggested wise interventions. Further scoping of the topic with a range of practitioners, as well as service users, would be beneficial to gain a better understanding of the potential use and efficacy of wise interventions for transforming the meaning of shame in therapy.

A further potential limitation of the work is in the use of a pragmatic, principle-driven approach. Particularly for counselling psychologists new to the field, using strategies from a range of therapies may appear confusing or difficult to employ. If this is not done well, a pragmatic approach could be unsettling for the client if strategies did not appear to be well connected to experience within the room. If the wise interventions provided here are to be used in future, one may need to ensure that the package as a whole is clearly defined, with examples given of how to use the strategies in alignment with shame experiences noted within the therapy room. However, a major advantage of the approach taken is that therapists may have the confidence to work more openly with shame in whatever context they are working. The wise interventions keep at the core the relationship between the therapist and client, using this as a mechanism for introducing transformative strategies and encouraging the therapist to really connect with the felt experiences in the room, in order to better understand when they may be driven by shame. Additionally, the wide variety of techniques drawn from different schools of thoughts means that strategies can be matched to experience in a broader range of ways, bringing freedom and creativity to therapeutic work.

4.2   Concluding Discussion

This research has hopefully provided a thoughtful insight into the journey to conceptualise wise interventions that might transform the meaning of toxic shame for clients. Through an iterative, incremental process I have developed a series of wise interventions for transforming the meaning of particular shame-related experiences in therapy. I first built up a picture of differing ways in which shame, or aspects of shame, might be experienced in therapy. I then considered which interventions have demonstrated some impact on shame in therapy, and used these as a basis for developing strategies that could become wise interventions. The interventions suggested in section 3.5 were developed through a process of feedback and continual refinement in consultation with counselling psychologists in training. Whilst they are by no means definitive, I believe they offer a useful starting point for further research in this area.

In addition to those interventions suggested, there are others within the wise literature that have already been tested, and may also be appropriate to test out for use with shame. These could sit alongside the new wise interventions, to offer a wider remit of opportunities for transformation. For example, a deliberate practice intervention from the wise literature (see Eskreis-Winkler *et al.,* 2016) could be used to increase motivation to practice self-compassion exercises when clients are feeling resistant or stuck. Or an intervention strategy that works on attributional retraining might be helpful for clients that are struggling with perceptions around failure. For instance clients may learn that struggling does not mean that they cannot change, but that change can be a difficult process. This is facilitated through a trusting relationship, where critical feedback is seen as an expression of belief in the person's ability to achieve, rather than a focus on failure as, *'trust permits people to disambiguate feedback and to see criticism as information that can help them improve rather than as possible evidence of bias'* (Yeager *et al*., 2014, p.805). However, this may be very difficult for the deeply shamed client, as they may not feel capable of listening to voices other than the inner critic who might only hear criticism and rejection. Alternatively, a relationship in which there is a strong relational bond based on trust (such as in therapy) may be the perfect place to try out these strategies. However, further consultation would be needed on the use of these strategies, particularly with clinical populations as tests so far have mainly been on non-clinical, student participants.

When I started this process I was unsure as to what the final interventions would look like, and from what approaches they would be borne. It has been interesting to see them develop (in

many cases) as integrative strategies in themselves, which bring together common threads from differing traditions. In this way, the wise interventions offer a pluralistic, process driven approach to working with shame, rather than a protocol driven approach (McLeod and Cooper, 2011). Counselling psychologists (and other therapists) working integratively could use these wise interventions flexibly, by focusing on the 'here and now' experiences in therapy and using these as a way of determining when shame may be driving what is happening in the therapy room. With a bank of wise interventions to turn to, they may be able to use strategies that fit the experience, to help both elicit shame (bringing it in to the light) and transform its meaning to something less damaging and fearful.

Accepting the pluralistic stance that there are many differing ways through which to affect change opens the therapist to a multitude of techniques which may help clients progress, and which can be tailored to the unique experience of each individual. In this way, wise interventions might help bolster the counselling psychologists' confidence in working pluralistically through opening, '*a conceptual space in which all psychological theories (and other ideas, from sociology, human ecology and other disciplines) can co-exist*' (McLeod and Cooper, 2011, p.2, original parentheses). In particular, as shame underpins many problem dimensions it is perhaps easier to envisage ways of transforming shame within the course of therapy that is not focused directly on the shame itself (which may in any case be too much for the client to tolerate). Wise interventions perhaps allow shame to be worked with in the normal 'conversation' of therapy, without wholly focusing on it at all times. They allow counselling psychologists to bring flexibility in to the therapeutic journey, using differing techniques at differing times rather than relying on some prescribed notion of what works for a particular 'disorder'. Wise interventions are envisaged as subtle interventions that appear to have come from the participants themselves. Therefore if we are attuned to the experience in the room, one can argue that the client is leading their own change by telling us what they most need to work on in that moment (McLeod and Cooper, 2011). Additionally, by relieving some of the burden of toxic shame, we allow the client to become ever more free and able to make decisions which enable focus on change and recovery.

An interesting argument for use of differing approaches to enhance therapy has been made by the psychoanalyst Wheelis. Her 2010 paper 'Mending the Mind' sought to illuminate how her clients benefited from her use of DBT, straying away from her psychoanalyst focus on unconscious processes. Adding a principle driven approach (DBT) to her work with clients

enabled new ways of understanding and working with problems, offering a more rounded understanding of her clients based on their need in that moment:

> *As a DBT therapist, I place principal emphasis on utilizing contingencies and teaching skillful behavior to replace the dysfunctional behavior. As a psychoanalyst, I attempt to utilize the structural construct of depth, to help patients develop a compelling narrative about themselves in the context of exploring the therapeutic relationship (Wheelis, 2010, p.334).*

Bringing together ideas from two traditions enabled Wheelis to bridge the gap in both therapies. Psychoanalysis allowed her to explore the meanings of problems (but did not really provide solutions), whilst DBT provided solutions (but did not explore meanings). The use of strategies from differing traditions brings a rounded approach to the use of wise interventions, bridging gaps that might ordinarily exist within therapy when shame disrupts the process. In addition, the brevity, specificity and conciseness of wise interventions might allow them to be introduced within long-term psychodynamic or person-centred therapy without altering the overarching frame, or diluting the potency of the work.

Criticisms of the pluralistic stance taken may come from purists whose preference is to stick to one particular therapeutic approach. Staunch realists may argue that some approaches cannot be brought together as they differ greatly in epistemology and methods and there is only one universal truth (Finlay and Evans, 2009). However, one can take a critical realist approach, which acknowledges that there may be a universal truth in terms of a 'real' illness or 'real' trauma, but that, *'people experience and understand it in different ways, deriving* meanings *that may vary considerably and cannot be predicted'* (Ibid., p.19, original emphasis). This is the standpoint that I believe this research has taken, and which is reflected in the wide variety of ways I have shown shame to be experienced by both clients and therapists. Considering the impact of interventions meant I had to accept some universality about shame, as this gives a basis for conducting quantitative research of impact. Yet the fact that the research is so scant on this aspect perhaps is because of the lack of universality of the shame experience, and the way that it filters in to so many differing problematic experiences for clients. As Black *et al.* (2013) argue, problems in knowing how to assess shame (and which measure or measures to use) might be reflected in the lack of good quality research in this area. My own review of the literature demonstrated a number of differing ways in which shame was measured (whether trait, state, or other), and this leads to questions regarding further testing of the wise interventions and which measurements would be used. At present I do not have a definitive answer to this question, and I feel it would be important to consult on this with both

researchers and practitioners with an understanding of shame, in order to seek a way forward. Additionally, seeking the views of clients themselves is a crucial next step, in both designing/refining, and testing interventions.

If further research were conducted to test out the impact of the suggested wise interventions, timing and dosage would be important considerations. If we are trying to affect recursive processes, it might help to feed in to these as early as possible in order for the changes to have time to bed in and for the intervention to provide focus (Broz, 2016; Walton and Wilson, 2018). In fact, for this reason Walton and Wilson suggest that timing may be more important than dosage:

> *If the goal is to build skills and/or change associations, practice or repetition may be required…and interventions may have dose-response effects…But if the goal is to change meanings then a single dose that alters a recursive process may cause lasting change* (p.6).

Whilst this may be true in some circumstances, there are a number of studies within the wise literature that do use repeated doses over time (for example Frederickson et al., 2008; Finkel et al., 2013). This suggests that the issue of dosage is not quite clear-cut, and it may be perfectly feasible for a repeated exercise to be considered 'wise' if it meets the other criteria. The primacy effect may also be important here, as well as the social context in which the intervention is delivered (McCarthy *et al.,* 2017). Walton and Wilson (2018) see the social context as the, '*primary object of analysis'* (p.637). In this instance, one must consider whether the therapy itself is the social context, or the client's external world. Each client will have a differing intersubjective experience that might impact on whether and how well he or she use the strategies presented. For example, if a client is very isolated they might find it difficult to use an intervention surveying others for personal qualities, and so this intervention might have little (or negative) effect for them.

Another important issue to consider is interaction between interventions. Understanding the incremental impact might be difficult to tease out, so one would need to decide whether to test interventions independently or together. As the interventions are not intended to be completed in a particular order, it may be difficult to test them out together. However, this leaves question marks over the potential for negative interactional impacts. As Walton and Wilson (2018) suggest, it will be important to consider, '*which components will be most important in what contexts and what adaptations are needed for different settings and*

problems' (p.636). Gaining feedback (not just through impact measurement) on the interventions would be an important part of both testing and further use. Inviting feedback is suggested as important in pluralistic therapy, based on evidence that clients get more from therapy when their views are sought (Cooper and McLeod, 2011) and has the added benefit of helping us know how and why the intervention is working (if the right questions are asked).

Research to test the interventions might use randomized control trials (RCTs) or other quantitative methods, but this in itself is difficult. Questions to consider include what mode(s) of therapy to integrate them in, how impact would be measured, and ethical challenges around testing and measurement in a therapeutic setting. As the interventions are intended to be used only when an experience occurs, how would one test the intervention? Would we have to wait for a particular experience, or would we need to manipulate that experience? These are all questions that I cannot answer in the present moment, as they require conversations with researchers and practitioners with experience of applied research in this complex area. However, this scoping study has hopefully opened up a new way of approaching shame within therapy. If nothing else, I hope it gives counselling psychologists the confidence to begin to talk about shame, whether with clients in therapy, in supervision or in wider work settings, and to understand the far reaching impact it may have on their work.

4.3   Closing reflections

The process of designing and conducting this research has taken me on a long and challenging journey. There were times when I thought that I might not make it, that it was all too much to bear. There were times I struggled to convey my thoughts to others, and self-doubt began to creep in. I began to shy away from the work, it being too fearful to contemplate. What if I failed? What if I was wrong in my conviction that this was a necessary and useful piece of work? It became a distressing beast that always hovered at the edge of my consciousness. A few years ago my then therapist asked me, 'Why are you so afraid of finishing anything? Why do you disconnect from the results of your work?' Through this journey I think I have discovered the answer, and I am no longer afraid to really put my self and my work out there. As I disentangled my sense of self from my early shame, I began to see that to stick with my convictions and to really try to do my best could fill me with pride

rather than terror. If I received criticism of my work when I had done my best then that did not fulfil the prophecy that I myself was a failure, but rather that I could listen to and learn from what was being said, and apply it to the work rather than my sense of self. Today I am no longer living in the shadows of the school corridors, but in the bright lights of a world of promise, hope and possibility. I hope you have enjoyed the fruits of my labour, and I truly welcome (and invite) feedback.

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Appendices

Appendix A. Permission to cite material from Walton and Wilson (in 2018)

Re: Permission to cite your paper in press

<div style="background-color:#a01040; color:white; text-align:center;">GW</div>

Greg Mariotti Walton <gwalton@stanford.edu>

<u>Reply all</u>|
Fri 13/07/2018 17:41
To:
Jessica Haskins
Inbox
Hi Jess
Thanks for your note. Certainly!

Greg

PS What links don't work?

On Jul 13, 2018, at 1:30 AM, Jessica Haskins <Jessica2.Haskins@live.uwe.ac.uk>
wrote:

Dear Gregory

I have been following your work on wise interventions with great interest ever since
I first came across them working as a social researcher at the National Offender
Management Agency (NOMS) in London. I am now training as a Counselling
Psychologist and am just finishing my thesis, titled *'Handle with care: Working wisely
with the shamed client. An exploration of the evidence, and consultation with
counselling psychologists in training'*. I started this work in 2014, so things have been
changing as I have been writing! My aim is to try to draw together research across
different areas of psychology to inform therapeutic practice. I recently came across
your website (which I have sent some feedback about as the pdf links don't work),
which has been an extremely helpful source of information. From that, I also came
across your most recent paper (2018) *'Wise interventions. Psychological remedies for
social and personal problems'*, and wanted to ask your permission to cite the paper
within my thesis, as it really helps set out a precise framework for wise
interventions.

For information, my research study considers how to integrate working 'wisely'
through precise interventions with therapeutic work, to alter meanings around the
experience of toxic shame. The research considers how shame is activated and
experienced relationally between client and therapist (the nature of maladaptive
views and how they arise), and considers the evidence base for what works in

reducing shame in therapy (how they can be changed). These findings (from two separate rapid evidence assessments - shortened systematic reviews) are used to inform ideas for wise interventions that might alter client's views of themselves with regards to their toxic shame. I have then conducted a short consultation exercise to seek others views on these potential interventions, with the intention that further research could refine and test these out.

I do hope to hear from you soon, and many thanks for writing such helpful and interesting papers

Kind regards
Jess

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****
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Appendix B. REA 1 qualitative study assessment criteria

(Based on McInnes and Chambers, 2008, and Thomas et al., 2003).

Table B 1. Qualitative study assessment criteria

No.	Question	Yes	No	Partially	Unclear	Notes
		Assessment				
**Quality of study reporting**					
A	Are the aims/research question clearly reported?					
B	Is there an adequate description of the context of the research?					
C	Is there an adequate description of the sample and sampling methods?					
D	Is there an adequate description of the data collection methods?					
E	Is there an adequate description of the data analysis methods?					
F	Is ethical approval/informed consent given?					
	Quality of data: Is there good or some attempt to establish:					
G	Reliability of data collection tools?					
H	Validity of data collection tools?					
I	Reliability of data analysis?					
J	Validity of data analysis?					
K	Has data saturation been discussed?					
	Bias					
L	Is researcher bias in data collection addressed?					
M	Is analysis not biased by the researcher (e.g. more than 1 analyst, triangulation, checked with participants)					
	Quality of methods for research with clients in therapy and therapists					
N	Have they used appropriate data collection methods for helping clients and/or therapists express their views?					
O	Have they used appropriate methods for ensuring the data analysis was grounded in the views of the participants?					
P	Have they actively involved clients/therapists in the design/conduct of the study?					
	Findings					
Q	Are the findings presented in sufficient detail and made explicit?					
R	Are the findings discussed in context and in relation to the research question?					
S	Are the implications discussed?					
T	Are the limitations of the study discussed?					

Value						
U	Is it made clear how the research adds to existing knowledge?					
V	Is it clear how/if the research can be generalised to other populations?					

Appendix C. REA 2 study assessment tables

Table C 1. REA2 study details

(based on Taylor et al., 2013)

No.	Question	Description of what should be recorded
1	Name, date, refworks reference	
2	Study background	
2.1	Aim/purpose of the study and research questions/hypothesis	
2.2	Broad type of study	(1) Randomised experiment; (2) non-randomised experiment (control and experimental group, tested before and after intervention); (3) one group pre-post-test (no control group, measured before and after intervention); (4) one group post-test only (no control group, measured only after, *not* before intervention – e.g. just ask study participants about perceived effects); (5) case study; (6) secondary data analysis; (7) systematic review; (8) non-systematic (narrative) review; (9) other
2.3	Reason why study approach was selected	Any discussion/justification of approach, why it is suitable, etc.
3	Programme or intervention: description	
3.1	Name of programme/intervention being studied	
3.2	Content of the intervention/treatment (components)	
3.3	Location of the intervention	In therapy setting? Country
3.4	Duration of the intervention	
3.5	People providing the intervention	Any information about the practitioners delivering the programme, their background, training, type of therapist
3.6	Dosage	How many sessions were planned? How many were actually attended by the sample?
3.7	Theory of change	Does the study articulate any theory about how the intervention will work? What outcomes are parts of this theory?
4	Sample achieved	
4.1	Number of people in sample	Those who participated in the *whole* study and who are represented in the study findings
4.2	Types of client in sample	Nature of issues/diagnoses. Clinical/non-clinical
4.3	Countries of the participants	
4.4	Age	
4.5	Sex	
4.6	Ethnicity	
4.7	Any other useful information about study participants	
5	Sample: strategy	
5.1	Sampling frame and method used to select study participants	Of all participants in a given intervention, how many took part in the study? How were the study participants selected? Any issues around voluntary participation in the study? Were incentives given to recruit people into the study? How were participants allocated to conditions?
5.2	Did any of the sample drop out over time and if so, were the members of the sample who dropped out different? (the attrition rate)	
5.3	Are the authors trying to produce findings that are representative of a given population? If so, how representative was their sample?	
6	Methods: data collection	
6.1	Methods used to collect data	(1) Interviews; (2) observations; (3) self-completed questionnaire; (4) administration of psychological or other tests; (5) secondary data; (6) other (describe)
6.2	Any issues about the validity of tools, problems with data collection methods	Were tools piloted? Were instruments pre-validated?
7	Programme or intervention – outcomes	
7.1	How is reduced shame/increased tolerance operationalised, and over what period is it measured?	Using self-reported data/other sources? What is the follow-up period? Is shame a primary or secondary measure?
7.2	Apart from shame, what other outcomes are	List all the outcomes which are mentioned at all, and whether or

8	Results and conclusions	
	mentioned?	not they are measured (and how, if useful) Include information about time periods, any measurement tools used, data sources
8.1	What are the results of the study, as described by the authors?	Cut and paste from abstract/conclusions. Write in authors' description if there is one. Elaborate if necessary, but indicate which aspects are reviewers' interpretation
8.2	What are the detailed findings about shame?	Cut and paste exact results: numbers, percentages, etc. If applicable, note whether or not authors say findings were statistically significant (and report numbers), report effect sizes, confidence intervals, etc.
8.3	Ability to generalise and link to other research evidence	Do the authors say that the results can be generalised beyond this study population? Do they cite other research with which this study agrees or disagrees?
9	Methods: data analysis and bias	
9.1	Which methods were used to analyse quantitative data?	For example, type of regression or other statistical analysis technique
9.2	Do the authors describe the strategies used to control for bias? Consider selection bias, performance bias, detection bias, attrition bias, reporting bias and other bias (Higgins et al. (2011)	Any attempt to minimise bias within study data and reporting
9.3	Was data analysis carried out for all starters, or only programme completers?	
10	Final questions	
10.2	Overall quality assessment	

Table C 2. Cochrane collaboration's tool for assessing risk of bias

(from Higgins *et al.,* 2011)

Bias domain	Source of bias	Support for judgment	Review authors' judgment (assess as low, unclear or high risk of bias)
Selection bias	Random sequence generation	Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups	Selection bias (biased allocation to interventions) due to inadequate generation of a randomised sequence
	Allocation concealment	Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen before or during enrolment	Selection bias (biased allocation to interventions) due to inadequate concealment of allocations before assignment
Performance bias	Blinding of participants and personnel*	Describe all measures used, if any, to blind trial participants and researchers from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Performance bias due to knowledge of the allocated interventions by participants and personnel during the study
Detection bias	Blinding of outcome assessment*	Describe all measures used, if any, to blind outcome assessment from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Detection bias due to knowledge of the allocated interventions by outcome assessment
Attrition bias	Incomplete outcome data*	Describe the completeness of outcome data for each main outcome, including attrition	Attrition bias due to amount, nature, or handling of incomplete

Bias domain	Source of bias	Support for judgment	Review authors' judgment (assess as low, unclear or high risk of bias)
		and exclusions from the analysis. State whether attrition and exclusions were reported, the numbers in each intervention group (compared with total randomised participants), reasons for attrition or exclusions where reported, and any reinclusions in analyses for the review	outcome data
Reporting bias	Selective reporting	State how selective outcome reporting was examined and what was found	Reporting bias due to selective outcome reporting
Other bias	Anything else, ideally prespecified	State any important concerns about bias not covered in the other domains in the tool	Bias due to problems not covered elsewhere

*Assessments should be made for each main outcome or class of outcomes.

Appendix D. Consultation interview topic guide

Outline plan for 'Handle with care' interviews
<u>**Activity Schedule**</u>

Activity	Content	Time (estimate, mins)	Total time (mins)
a) Welcome	Introductions	1	1
	Purpose	3	4
	Information	1	5
	Presentation	10	15
b) Interview		59	74
c) Closing remarks		1	**75**

A) WELCOME

1) Introductions
- Thank you for agreeing to be part of the consultation. We appreciate your willingness to participate
- Introduce self
- General housekeeping

2) Purpose of interview
- Explain reason for conducting interview, check consent form received
- We need your input and want you to share your honest and open thoughts with us.
- Check whether information sent has been read prior to interview, and any questions

3) Information
- ➢ **I will start with a short presentation on the research so far, with an explanation of wise interventions**

- ➢ **There are no right or wrong answers**

Your experiences and opinions are important, whether you agree or disagree. I will be asking some fairly open questions on a few topics that I would like you to tell me about.

- ➢ **I will be tape recording the interview**

I want to capture everything you have to say. I will be conducting several interviews with counselling psychologists, and will be analysing the content to pick up on the main themes discussed. I won't identify anyone by name in my report. You will remain anonymous. You have the right to remove consent to use of your material at any time (up to analysis when all information is combined). You will be provided with a copy of the report for comment.

- • Any questions or issues that need clarifying?

4) *Presentation*

A short PowerPoint presentation will be given on the research (either provided beforehand or shown on screen, depending how the interview is conducted)

B) INTERVIEW
Topic guide
1) What are your experiences working with shame in the therapy room?

May need to probe for e.g. does it fit with the findings of REA1?
Probe for difficulties/challenges/recognition of shame in self and client

2) I would like you to tell me about how you tend to work with shame
   - Any particular interventions
   - Any particular approaches
   - Your experience of using these interventions/approaches

   Probe for: effectiveness, what could be done better, what worked particularly well, how interventions were

3) Do you have any comments on the findings from REA2 (what works with reducing shame/increasing tolerance)

   Probe for: does it agree with your experience, if it differs, how does it differ, do the findings make sense as they are presented?

4) What is your understanding of wise interventions as I have presented them?

5) What is your opinion of the suggestions for wise interventions:
   - Are they the right ones (based on evidence)?
   - What is missing?
   - How could they be used?
   - Do you already do these things?
   - Would you use them?
   - How might they be used integratively?

6) What do you feel the next steps should be?

7) Any other comments?

C) CLOSING REMARKS

1) Thank you for attending
2) Remind them of consent
3) Any questions
4) Provide my contact details, can contact me for debriefing if anything has been distressing today

Appendix E. Consent to participate in consultation

Consent to participate in an interview for the 'Handle with care' project

You have been selected to participate in a consultation interview sponsored by the University of the West of England (UWE); this is because you have expertise in the field of interest (working with shame). The purpose of the interview is to get your views on how the usefulness and acceptability of wise interventions for working with shame, based on the material presented to you. Prior to the interview you will be provided with information related to the research already conducted. It would be useful if you could read this ahead of the interview. The interview will last about an hour and 15 minutes, and will cover a few different topics around the project. The first 15 minutes will be a presentation of the research so far, including an introduction to wise interventions. The information learned in the interviews will be used to help us evaluate the potential use of wise interventions, and to make recommendations going forward.

You can choose whether or not to participate in the interview and can stop at any time. If you do not wish to participate, then you do not need to do anything. There are no negative consequences if you decide not to take part – it is completely up to you. The interview will be tape recorded, but your responses will be made anonymous on transcription and no names will be mentioned in the final report. After the interviews have taken place, all of the material will be transcribed and analysed to identify relevant themes from the discussions. You are able to withdraw consent to use your material up until analysis has taken place (roughly 2 weeks after this interview), as this is when all material will be combined and it may be difficult to extract individual responses after this. You will be provided with a copy of the findings after analysis for comment.

The thesis researcher (student on the Professional Doctorate in Counselling Psychology), Jess Haskins, will run the interview, analyse the data and write the report. All material will be kept by the evaluator in a locked cupboard, or in password protected files if electronic. Raw data (including recordings) will be destroyed within 6 months of project completion. You can contact Jess Haskins at Jessica2.Haskins@live.uwe.ac.uk for further details or if you have any queries or concerns. There are no right or wrong answers to the questions that will be asked. We want to hear your honest views during the consultation. If you are happy to take part please (electronically) sign and return the slip below via email.

I have read this information sheet and I understand the nature of this research. I am happy to take part.

Signed……………………………………………… Date…………………………………………….

Print name…………………………………………………………………………………………..

UWE Bristol | University of the West of England

Participant information sheet for the 'Handle with care' project

Thank you for participating in the consultation for this project. As noted in the consent form your responses will be made anonymous on transcription and no names will be mentioned in the final report. After the interviews have taken place, all of the material will be transcribed and analysed to identify relevant themes from the discussions. You are able to withdraw consent to use your material up until analysis has taken place (roughly 2 weeks after this interview), as this is when all material will be combined and it may be difficult to extract individual responses after this. You will be provided with a copy of the findings after analysis for comment.

If you have found any of the content of the interview distressing, please do get in touch with the UWE wellbeing service. Details can be found here:
http://www1.uwe.ac.uk/students/healthandwellbeing/wellbeingservice.aspx

Opening times:
Term time
- Monday to Thursday 08:30–17:00
- Tuesday late evening 08:30–19:30
- Friday 08:30–16:30
Out of term time
- Monday to Thursday 08:30–16:30
- Friday 08:30–16:00
  If you would like to speak to someone, please call 0117 32 86268 or email wellbeing@uwe.ac.uk.

For urgent crisis support you can contact:
- The Samaritans
- NHS Urgent and Emergency Care
- Bristol Crisis Service.

Appendix G. Ethics approval notification

UWE REC REF No: HAS.18.05.163

2nd July 2018

Jessica Haskins
XXXX
XXXX
XXXX

Dear Jessica

Application title: 'Handle with care'. Working wisely with the shamed client

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at
http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: https://intranet.uwe.ac.uk/tasks-guides/Guide/writing-and-creating-documents-in-the-uwe-bristol-brand

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.

2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.
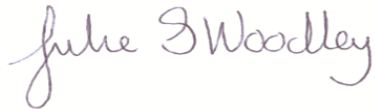
The Faculty and University Research Ethics Committees (FRECs and UREC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance. Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher remains responsible for ensuring that the project complies with UWE's policies, and with relevant legislation. If you need help with legal issues please contact safety@uwe.ac.uk (for Health and Safety advice), James2.Button@uwe.ac.uk (for data protection, GDPR and privacy advice).

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please remember to populate the HAS Research Governance Record with your ethics outcome via the following link: https://teams.uwe.ac.uk/sites/HASgovernance.

We wish you well with your research.

Yours sincerely

Julie J Woodley

Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c.   Dr Miltos Hadjiosif

Appendix H. Coding labels, REA 1

Table H 1. Codes and themes at level 1 (initial codes) and level 2 (descriptive themes)

Code no.	Name
	Descriptive theme 1: Accessing early experience
1.1	Accessing chronic shame in early experience to unburden
1.2	Accessing the client's past experiences through imagery
1.3	Accessing the inner child
1.4	Attuning to early experience
1.5	Client history invokes anxiety
1.6	Inner self defending client child
1.7	Inner world is childlike
1.8	Reliving affect from early experience, without recollecting context
1.9	Reliving past experience to enable forgiveness
1.10	Shame becomes a memory repeated
1.11	Taking care of the inner child
1.12	The fear of unformulated experiences
1.13	Traumatic early experience leading to shame
1.14	**Unburdening**
	Unburdening\accessing chronic shame in early experience to unburden
	Unburdening\I did something bad when I was young
	Unburdening\unburdening past experience
1.15	Use of imagery to uncover past traumatic experience
1.16	Working with the inner child
	Descriptive theme 2: Alone or together (shame is isolating)
2.1	I am not alone in my struggles
2.2	I must deal with this alone
2.3	I would feel less alone if I knew others were experiencing this too
2.4	Lack of secure peer relationships
2.5	The impossible situation of needing love and being unlovable
	Descriptive theme 3: Coping strategy
3.1	A reluctance to give up old ways of coping (self-criticism)
3.2	Becoming rude or insecure due to own shame
3.3	Coping strategies that keep you stuck
3.4	**Defence mechanism**
	Defence mechanism\avoidance as a strategy for dealing with shame
	Defence mechanism\avoidance is easier than becoming compassionate
	Defence mechanism\client building walls
	Defence mechanism\Client challenge
	Defence mechanism\client feels abandoned, protects therapist

Code no.	Name
	Defence mechanism\control as a strategy for dealing with shame
	Defence mechanism\defending against shame
	Defence mechanism\Denial of situation due to own shame or embarrassment
	Defence mechanism\desire to withdraw or disengage
	Defence mechanism\dissociation and projective identification
	Defence mechanism\exile of the self. Cut it off or die
	Defence mechanism\it's best if I walk away. I can't change
	Defence mechanism\rumination as a strategy for dealing with shame
	Defence mechanism\shame as therapist as a remedy for error
	Defence mechanism\shame is easily triggered
	Defence mechanism\therapist avoidance to deal with own embarrassment or shame
	Defence mechanism\to withdraw means to protect myself from a rejecting world. Reject them first
3.5	I go between healthy anger and self- soothing, and grief and hurt
3.6	Inner self defending client child
3.7	Mirror checking to cope with appearance
3.8	One must strive and achieve to avoid thinking that I am bad
3.9	Shame and secrets help maintain relational distance
3.10	Shame as a protection against suicide, by suppressing parts of the self
3.11	Trying to hide
3.12	Use humour to deal with shame or embarrassment
Descriptive theme 4: Emotions	
4.1	**Anger and shame**
	Anger and shame\anger and shame are linked
	Anger and shame\anger creates distance or destruction
	Anger and shame\anger makes me want to act out
	Anger and shame\assertive anger as opposed to rejecting anger
4.2	**As release**
	As release\emotional experience of gaining shared understanding
	As release\emotional immediacy witnessing
	As release\emotional release through burning dead wood
	As release\emotional release through reliving
	As release\letter writing to express feelings by those who have wronged you
	As release\separating parts of the self to transform emotional experiences
	As release\use of the body to release emotions
4.3	**As shamer (emotionally unavailable other)**
	As shamer (emotionally unavailable other)\drawing out feelings towards the inner critic
	As shamer (emotionally unavailable other)\feelings of hopelessness stifling change
4.4	**As trigger**
	As trigger\feelings about the inner critic

Code no.	Name
	As trigger\feelings brought on by shame
	As trigger\I go between healthy anger and self- soothing, and grief and hurt
	As trigger\internal emotional reaction and struggle
	As trigger\reliving affect from early experience, without recollecting context
	As trigger\shame is easily triggered
	As trigger\shame is hard to leave behind
4.5	**Emotional experience of self-compassion**
	Emotional experience of self-compassion\feeling self-compassion as a wow
	Emotional experience of self-compassion\feeling versus thinking compassion—realizing it's not my fault
	Emotional experience of self-compassion\learning to feel self-compassion, not just think it
	Emotional experience of self-compassion\self-compassion as a positive emotional experience
	Emotional experience of self-compassion\self-compassion is a new feeling for me
	Emotional experience of self-compassion\thoughts of compassion provoke a powerful emotional response
4.6	**Expressing negative emotions**
	Expressing negative emotions\it is easier to articulate negative emotional reactions than positive ones
	Expressing negative emotions\negative beliefs and feelings as knots on the body
4.7	**Fear and shame**
	Fear and shame\behaving through fear
	Fear and shame\fear controls me
	Fear and shame\fear in confessing
	Fear and shame\fear of loss of identity if give up inner critic
	Fear and shame\fear of self-compassion
	Fear and shame\Fear or destroying others or being destroyed
	Fear and shame\fear shame component more specific than global distress
	Fear and shame\learning to name feelings and reduce fear
	Fear and shame\self compassion is a new frightening experience
	Fear and shame\self-compassion is terrifying, overwhelming, dreaded, frightening
	Fear and shame\shared fears of therapist and client
	Fear and shame\the fear of unformulated experiences
	Fear and shame\the therapist as safety in a challenging environment
	Fear and shame\the therapist can take my fear away and allow me to be kind to myself
4.8	Global distress
4.9	**Guilt**
	Guilt\client as guilty
	Guilt\desire to make amends for guilt
	Guilt\experiencing regret

Code no.	Name
	Guilt\from shame and guilt to self compassion
	Guilt\I did something bad when I was young
	Guilt\jealousy fuelling 'bad' behaviour
	Guilt\self blame to self compassion, allows differentiation of shame and guilt
	Guilt\taking pleasure from others misfortune
4.10	Hopefulness versus hopelessness
4.11	The emotional experience of therapy
Descriptive theme 5: Enjoyment	
5.1	Achievement through enjoyment rather than goal oriented
5.2	Enjoying life rather than just living it
5.3	I look forward to the day now as I enjoy what I achieve.
5.4	New understanding of what matters to me and what achievement is (not ruled by inner critic)
Descriptive theme 6: Family	
6.1	Family attending sessions
6.2	Problematic familial relationships dyads
Descriptive theme 7: Forgiveness	
7.1	Desire to make amends for guilt
7.2	Forgiveness as powerful transformer of shame
7.3	Reliving past experience to enable forgiveness
Descriptive theme 8: I can't change (stuck)	
8.1	Fear controls me
8.2	**Helpless (futility)**
	Helpless (futility)\feelings of hopelessness stifling change
	Helpless (futility)\hopefulness versus hopelessness
	Helpless (futility)\it's best if I walk away. I can't change
8.3	Rejecting change through lack of self worth
8.4	Shame disrupts creation of analytic third
8.5	Shame is hard to leave behind
8.6	The battle to give up the inner critic
8.7	The hard work of drawing out a client's shame
Descriptive theme 9: Identity	
9.1	How I look is shameful. It puts people off
9.2	I am bad
9.3	I am unlovable
9.4	**Inner critic**
	Inner critic\conversing directly with the inner critic
	Inner critic\drawing out feelings towards the inner critic

Code no.	Name
	Inner critic\fear of loss of identity if give up inner critic
	Inner critic\feelings about the inner critic
	Inner critic\inner critic as identity
	Inner critic\inner critic is a bully
	Inner critic\inner suicide voice, voice of despair
	Inner critic\it's hard to be nice to yourself
	Inner critic\locating the inner critic
	Inner critic\new understanding of what matters to me and what achievement is (not ruled by inner critic)
	Inner critic\removing the hold of the inner critic
	Inner critic\removing the inner critic creates a void
	Inner critic\self blame to self compassion, allows differentiation of shame and guilt
	Inner critic\self-criticism increases if you ask me to be compassionate to myself
	Inner critic\self-criticism protects me from a negative self-identity as it helps me achieve
	Inner critic\shame as weakness
	Inner critic\silencing negative inner voices or parts
	Inner critic\suicide voice related to worthlessness protection
	Inner critic\the battle to give up the inner critic
	Inner critic\the tight hold of the inner critic on the client
9.5	**Self-worth**
	Self-worth\Comparing self to others - I am not worthy
	Self-worth\Feeling equal or needed makes me feel less shameful
	Self-worth\Finding a sense of purpose
	Self-worth\I am not worthy of kindness
	Self-worth\I am worth it
	Self-worth\I deserve happiness
	Self-worth\if you can believe in me as not to blame then maybe I can believe in me too
	Self-worth\making a mistake means I'm a bad person/therapist
	Self-worth\One must strive and achieve to avoid thinking that I am bad
	Self-worth\rejecting change through lack of self worth
	Self-worth\self-accusations 'you are a slut'
	Self-worth\suicide voice related to worthlessness protection
	Self-worth\the impossible situation of needing love and being unlovable
9.6	Testing out new ways of coping. I am not shameful
Descriptive theme 10: Inner child	
10.1	Accessing the inner child
10.2	Inner self defending client child
10.3	Inner world is childlike
10.4	Mental time travel to help younger self
10.5	Taking care of the inner child

Code no.	Name
10.6	Working with the inner child
	Descriptive theme 11: Inner communication
11.1	Communicating with parts of the self
11.2	Conversing directly with the inner critic
11.3	Creating self compassion by self talk
11.4	It is easier to articulate negative emotional reactions than positive ones
11.5	Pushing through discomfort of communicating with the inner self
11.6	Self-criticism increases if you ask me to be compassionate to myself
11.7	**Suicide voice**
	Suicide voice\confessing secrets as bringing shame and activating suicidal thoughts
	Suicide voice\inner suicide voice, voice of despair
	Suicide voice\regulating behaviour of the shaming protector (suicide or angry voice)
	Suicide voice\shame as a protection against suicide, by suppressing parts of the self
	Suicide voice\silencing negative inner voices or parts
	Suicide voice\suicide voice related to worthlessness protection
11.8	Therapist encouraging inner dialogue
	Descriptive theme 12: Internal access or gaze
12.1	Accessing protective parts of the self
12.2	Internal challenge
12.3	Internal emotional reaction and struggle
12.4	Looking away (down or side), observing self
12.5	My appearance is flawed therefore I am flawed
12.6	Reflecting clients' inner thoughts shames them
12.7	Reflecting the client's shame as my own, projection of father
12.8	Regulation of one part to hear other parts and deal with them
12.9	The client's internal world
12.10	The intimacy or perversion of looking
12.11	Use of internal focus to draw out subjective experience
	Descriptive theme 13: Loss and grief
13.1	Grieving for part of the self
13.2	I am wounded in my loss
	Descriptive theme 14: New ways of coping
14.1	Attentional training to shift focus outwards
14.2	Behavioural experiments to drop safety behaviours
14.3	Family attending sessions
14.4	Finding new ways out of bad experiences
14.5	Forgiveness as powerful transformer of shame

Code no.	Name
14.6	I look forward to the day now as I enjoy what I achieve.
14.7	Living with your values
14.8	Medication
14.9	**Past present distinction**
	Past present distinction\a more positive outlook in the present and for the future
	Past present distinction\contextualising past and present experiences to differentiate
	Past present distinction\moving experience to the here and now
	Past present distinction\separating past experience from current triggers
14.10	Testing out new ways of coping. I am not shameful
14.11	**Transforming experience**
14.11.1	Transforming experience**becoming human. Seeing the whole of me**
14.11.2	Transforming experience**emotional release**
	Emotional release\emotional experience of gaining shared understanding
	Emotional release\emotional immediacy witnessing
	Emotional release\emotional release through burning dead wood
	Emotional release\emotional release through reliving
	Emotional release\letter writing to express feelings about those who have wronged you
	Emotional release\separating parts of the self to transform emotional experiences
	Emotional release\use of the body to release emotions
14.11.3	Transforming experience**Imagery and visualisation**
	Imagery and visualisation\accessing the client's past experiences through imagery
	Imagery and visualisation\dealing with shame in our dreams
	Imagery and visualisation\mental time travel to help younger self
	Imagery and visualisation\use of imagery to uncover past traumatic experience
	Imagery and visualisation\use of imagery/visualisation
14.11.4	Transforming experience**internal to external gaze**
	Internal to external gaze\attentional training to shift focus outwards
	Internal to external gaze\changing inner focus to one of worry rather than who I am
	Internal to external gaze\just because I have flaws doesn't mean I am flawed
	Internal to external gaze\looking forward rather than back
14.11.5	Transforming experience**letter writing**
	Letter writing\letter writing as form of amends
	Letter writing\letter writing for self-compassion and reformulation
	Letter writing\letter writing to express feelings by those who have wronged you
14.11.6	Transforming experience**reformulation or rescripting**
	Reformulation or rescripting\mental time travel to help younger self
	Reformulation or rescripting\new understanding of what matters to me and what achievement is (not ruled by inner critic)
	Reformulation or rescripting\rescripting the past to reduce shame
	Reformulation or rescripting\the fear of unformulated experiences

Code no.	Name
14.11.7	Transforming experience**regulating parts**
	Regulating parts\regulation of one part to hear other parts and deal with them
	Regulating parts\separating parts of the self to transform emotional experiences
14.11.8	Transforming experience**reliving**
	Reliving\emotional release through reliving
	Reliving\reliving past experience to enable forgiveness
	Reliving\therapist checking client can withstand reliving experience
	Reliving\use of internal focus to draw out subjective experience
14.11.9	Transforming experience**through dialogue**
14.11.10	Transforming experience**Unburdening**
	Unburdening\accessing chronic shame in early experience to unburden
	Unburdening\unburdening past experience
14.11.11	Transforming experience**witnessing**
	Witnessing\witnessing and sharing experience
	Witnessing\witnessing stage of conversing with a part of the self
14.11.12	Transforming experience**working with the inner child**
Descriptive theme 15: Pervasiveness of shame	
15.1	Shame as sensed in the air
15.2	Shame controls the therapy
15.3	Shame disrupts creation of analytic third
15.4	Shame is autobiographical
15.5	Shame is easily triggered
15.6	Shame is hard to leave behind
15.7	The hard work of drawing out a client's shame
15.8	The impossible situation of needing love and being unlovable
Descriptive theme 16: Physical body	
16.1	Bodily function
16.2	Bodily reaction to embarrassment or shame
16.3	Bodily self-other identification
16.4	Breathing to prepare for hard work
16.5	Events relating to the therapist's physical body
16.6	External appearance as a hook for shame
16.7	Fell asleep
16.8	How I look is shameful. It puts people off
16.9	Hyperarousal awareness of body and tone trying to control reaction to own shame
16.10	Just because I have flaws doesn't mean I am flawed
16.11	Looking away (down or side), observing self
16.12	Mirror checking to cope with appearance
16.13	My appearance is flawed therefore I am flawed

Code no.	Name
16.14	Negative beliefs and feelings as knots on the body
16.15	Positive bodily changes, tingling excitement at compassion
16.16	Shame as sensed in the air
16.17	The intimacy or perversion of looking
16.18	Trying to hide
16.19	Use of the body to release emotions
Descriptive theme 17: Secrets in therapy	
17.1	An elephant in the room
17.2	Confessing secrets as bringing shame and activating suicidal thoughts
17.3	Confession in therapy, revealing secrets
17.4	Confidentiality of the session is threatened
17.5	Fear in confessing
17.6	Letting the therapist in is hard
17.7	Lie to cover up the event, deny to client, use excuses
17.8	Secrets control my life
17.9	Shame and secrets help maintain relational distance
17.10	Shame is hard for me to talk about
17.11	Shame stops me from speaking
17.12	The hidden self
17.13	Therapist desires to disclose to help alleviate client shame
17.14	Therapist disclosure clients' desire to know secrets
Descriptive theme 18: Self parts	
18.1	**Accessing**
	Accessing\accessing protective parts of the self
	Accessing\locating parts of the self
	Accessing\techniques for
	Accessing\use of imagery/visualisation
18.2	**Communicating with**
	Communicating with\communicating with parts of the self
	Communicating with\regulation of one part to hear other parts and deal with them
	Communicating with\silencing negative inner voices or parts
	Communicating with\witnessing stage of conversing with a part of the self
18.3	Emotional release through burning dead wood
18.4	Grieving for part of the self
18.5	Protective and vulnerable parts of the self
18.6	Separating parts of the self to transform emotional experiences
18.7	Shame as a protection against suicide, by suppressing parts of the self

Code no.	Name
	Descriptive theme 19: Self-compassion
19.1	Converting to self-compassion is hard
19.2	**Creating**
	Creating\creating self compassion by self talk
	Creating\developing self-compassion
	Creating\learning to be generous with myself
	Creating\learning to self-soothe
	Creating\letter writing for self-compassion and reformulation
	Creating\self-criticism increases if you ask me to be compassionate to myself
19.3	**Feelings about**
	Feelings about\developing self-compassion alien and aversive
	Feelings about\fear of self-compassion
	Feelings about\feeling positive about self-compassion surprised me
	Feelings about\feeling self-compassion as a wow
	Feelings about\feeling versus thinking compassion—realizing it's not my fault
	Feelings about\from shame and guilt to self compassion
	Feelings about\learning to feel self-compassion, not just think it
	Feelings about\self blame to self compassion, allows differentiation of shame and guilt
	Feelings about\self compassion is a new frightening experience
	Feelings about\self-compassion as a positive emotional experience
	Feelings about\self-compassion is a new feeling for me
	Feelings about\self-compassion is terrifying, overwhelming, dreaded, frightening
	Feelings about\thoughts of compassion provoke a powerful emotional response
19.4	Self-compassion\self compassion and CFT
	Descriptive theme 20: Source of shame
20.1	Being unprepared for session
20.2	Blaming shaming mother
20.3	Events relating to the therapist's physical body
20.4	Fell asleep
20.5	Forget/confuse client information
20.6	Fumbled in a way that was noticeable to the client during session in the moment of the event
20.7	Jealousy fuelling 'bad' behaviour
20.8	Late for appointment
20.9	Making a mistake means I'm a bad person/therapist
20.10	Misspoke
20.11	Neglect and abuse
20.12	Reason for therapy
20.13	Scheduling error as source of therapist embarrassment or shame

Code no.	Name
20.14	Sexual abuse
20.15	Sexual references made by client
20.16	Therapy for trauma
20.17	Time management difficulty during session
20.18	Use of wrong client name
20.19	Visibly tired and unfocused
Descriptive theme 21: Therapist-client relationship	
21.1	**Countertransference and transference**
	Countertransference and transference\client feels abandoned, protects therapist
	Countertransference and transference\client history invokes anxiety
	Countertransference and transference\countertransference or frustration at lack of progress
	Countertransference and transference\reflecting clients' inner thoughts shames them
	Countertransference and transference\reflecting the client's shame as my own, projection of father
	Countertransference and transference\therapist analysis of clients' actions
	Countertransference and transference\therapist desires to disclose to help alleviate client shame
	Countertransference and transference\therapist shame interrupts transferential experience
21.2	**Feeling safe and being vulnerable**
	Feeling safe and being vulnerable\a longing for fusion
	Feeling safe and being vulnerable\attachment to therapist helps reduce anxiety
	Feeling safe and being vulnerable\letting the therapist in is hard
	Feeling safe and being vulnerable\the therapist as safety in a challenging environment
	Feeling safe and being vulnerable\the therapist can take my fear away and allow me to be kind to myself
	Feeling safe and being vulnerable\therapist resistance to being vulnerable creates shame
	Feeling safe and being vulnerable\to trust the therapist is hard. They might reject me
21.3	**Relational aspects and warmth**
	Relational aspects and warmth\acceptance, non-judgement, feeling valued and understood and believed in by the therapist
	Relational aspects and warmth\genuine care more important than practical tools. Human warmth
	Relational aspects and warmth\I am not alone in my struggles
	Relational aspects and warmth\if you can believe in me as not to blame then maybe I can believe in me too
	Relational aspects and warmth\kindness of the therapists as humans
	Relational aspects and warmth\relational fragility
	Relational aspects and warmth\shame and secrets help maintain relational distance
	Relational aspects and warmth\shame disrupts creation of analytic third
	Relational aspects and warmth\shared fears of therapist and client
	Relational aspects and warmth\the importance of the therapeutic relationship
	Relational aspects and warmth\the impossible situation of needing love and being unlovable
	Relational aspects and warmth\therapists make us work hard but are kind and empathic
	Relational aspects and warmth\thoughts of compassion provoke a powerful emotional response

Code no.	Name
	Relational aspects and warmth\witnessing and sharing experience
	Relational aspects and warmth\witnessing stage of conversing with a part of the self
21.4	Shame as therapist
21.5	The emotional experience of therapy
21.6	**Therapist action**
	Therapist action\acknowledged and/or gave a truthful explanation
	Therapist action\apologized, took responsibility, admitted fault
	Therapist action\consulted with colleague and/or supervisor
	Therapist action\directly discussed issue with client and client's and therapist's feelings concerning the event, and sometimes use it as a teaching moment
	Therapist action\lie to cover up the event, deny to client, use excuses
	Therapist action\no direct action taken by therapist
	Therapist action\shame as therapist as a remedy for error
	Therapist action\therapist avoidance to deal with own embarrassment or shame
	Therapist action\therapist checking client can withstand reliving experience
	Therapist action\therapist desires to disclose to help alleviate client shame
	Therapist action\therapist disclosure clients' desire to know secrets
	Therapist action\therapist encouraging inner dialogue
	Therapist action\took action to remedy/correct situation
	Therapist action\use humour to deal with shame or embarrassment
21.7	Therapy will help me
	Descriptive theme 22: Traumatic memories haunting
22.1	Dealing with shame in our dreams
22.2	**Hidden nature**
	Hidden nature\shame is hard for me to talk about
	Hidden nature\shame stops me from speaking
	Hidden nature\the hard work of drawing out a client's shame
	Hidden nature\the hidden self
	Hidden nature\trying to hide
22.3	Reliving affect from early experience, without recollecting context
22.4	Shame becomes a memory repeated
22.5	Shame controls the therapy
22.6	Shame is autobiographical
22.7	Traumatic early experience leading to shame

Appendix I. REA2 included studies

Table I 1. REA2 study details

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Albertson et al. (2015) Various	meditation intervention group (N = 98) waitlist control group (N = 130) Initial n at randomisation = 479. Intervention group at follow up n=51	RCT waitlist control	Any female who responded to the advert	self-compassion meditation training	waitlist control	Body Appreciation Scale, Compassionate Body Scan, Body Shape Questionnaire, Contingencies of Self-Worth Scale, **Objectified Body Consciousness Scale (Body shame subscale)**, Self-Compassion Scale	compared to the control group, intervention participants experienced significantly greater reductions in body dissatisfaction, body shame, and contingent self-worth based on appearance, as well as greater gains in self-compassion and body appreciation. All improvements were maintained when assessed 3 months later.	Body shame lessened after participants completed the intervention, with a medium effect size indicated (d= 0.68). It appears that helping women to take a more compassionate stance toward themselves lessened this sense of shame, consistent with other research findings that self-compassion attenuates shame and other self-conscious emotions.
Au et al. (2017) USA	10 (17 randomised)	randomized, non-concurrent, multiple baseline across participants design	Community sample of individuals with elevated trauma-related shame and PTSD symptoms (8/10 female)	compassion-based therapy for trauma	None (participants act as their own control)	Drug Abuse Screening Test-10; Mood Disorders Questionnaire; Psychiatric Diagnosis Screening Questionnaire; PTSD Checklist for DSM-5; Protocol Evaluation Survey; Alcohol Use Disorders Identification Test; Beck Depression Inventory–II; Credibility/Expectancy Questionnaire; Posttraumatic Cognitions Inventory; Traumatic Life Events Questionnaire; Self-Compassion Scale; **Internalized Shame Scale**	9 /10 participants demonstrated reliable decreases in PTSD symptom severity, while 8/10 participants showed reliable reductions in shame. Improvements maintained at 2- and 4-week follow-up. The intervention was also associated with improvements in self-compassion and self-blame. Participants reported high levels of satisfaction with the intervention	By the end of treatment 8 of 10 participants showed reliable reductions in shame. These improvements were maintained at 2- and 4-week follow-up

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Chenneville et al. (2017) USA	33 (17 completed)	Pilot study. Pre-post	adults enrolled in an MRL program	Mindful Rational Living (MRL)	None	Clinical Anger Scale; Depression Anxiety Stress Scale; Ruminative Responses Scale; Program Satisfaction Questionnaire; Subjective Happiness Scale; **Guilt and Shame Proneness Scale**	participants showed significant decreases in anger, rumination, anxiety, depression, and shame after the intervention. There were no significant increases in subjective happiness.	t-test results comparing scores between pre- and post intervention assessment revealed significant decreases on the shame-negative-self-evaluation subscale of the GASP, t(16) 5 6.08, p , .001, d 5 1.67 and the shame-withdrawal subscale of the GASP, t(7) 5 3.47, p 5 .01, d 5 1.33; There was a significant negative correlation between adherence to daily homework and the shame-negative-self-evaluation subscale of the GASP measure, r(17) 5 2.77, p , .001. Buddhists reported lower scores on the shame-negative-self-evaluation subscale of the GASP (M 5 4.69, SD 5 1.39) compared to non-Buddhists (M 5 6.11, SD 5 1.15), t(15) 5 2.31, p 5 .04, d 51.13. There was no significant pre/post difference for shame-negative-self-evaluation when controlling for religion F(1,15) 5.07, p 5 .80.
Duarte et al. (2017) Portugal	n=33 eligible after assessment (randomised n=17 T, n=16C), n=11T post-treatment, n=9C post-treatment. N=8T follow-up, n=3Cfollow up (5 enrolled in treatment)	Pilot RCT	Females diagnosed with binge eating disorder	compassion, mindfulness, and acceptance	waitlist control	Eating Disorder Examination 17.0D, Binge Eating Scale; **Body Image Shame Scale**; Depression, Anxiety, and Stress Scale; Cognitive Fusion Questionnaire—food craving; Body Image Acceptance and Action Questionnaire; Five-Facet Mindfulness Questionnaire; Compassionate Engagement and Action Scales; Self-Compassion Scale; Forms of Self-Criticism and Self-Reassurance Scale; Feedback data	in the intervention group, there were significant reductions in eating psychopathology symptoms, binge eating symptoms, self-criticism, and indicators of psychological distress; there were significant increases in compassionate actions and body image-related psychological flexibility	The fact that both groups had disclosed difficult body image experiences and problems with controlling eating behaviour in the assessment session may have accounted for the lack of significant effects of the intervention on body image shame and the hated-self form of self-criticism (time x group). Wilcoxon signed rank tests indicated that, compared to participants in the WLC, participants in the IC condition presented a significant reduction in body image shame (BISS d=0.74).

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Harned et al. (2012) USA	n=13 ITT, n=7 DBT+PE protocol	Development & pilot testing of a protocol - open trial (ITT)	Females with BPD, PTSD, and recent and/or imminent serious intentional self-injury	DBT+ PE	ITT (1 year of DBT completed before PE protocol introduced)	International Personality Disorder Examination; Posttraumatic Stress Disorder Symptom Scale— Interview; Dissociative Experiences Scale— Taxon; Hamilton Rating Scale for Anxiety; Global Social Adjustment Score; Childhood Experiences Questionnaire; Suicidal Behaviors Questionnaire; **Experience of Shame Scale**; Hamilton Rating Scale for Depression; Client Satisfaction Questionnaire; Structured Clinical Interview for DSM-IV; Expectancies Questionnaire; Trauma-Related Guilt Inventory; Traumatic Life Events Questionnaire	The treatment was associated with significant reductions in PTSD, with the majority of patients no longer meeting criteria for PTSD at post-treatment. Improvements were also found for suicidal ideation, dissociation, trauma-related guilt cognitions, shame, anxiety, depression, and social adjustment. There was no evidence that the DBT PE Protocol led to exacerbations of intentional self-injury urges or behaviours, PTSD, treatment dropout, or crisis service use.	Moderate to large pre-post effect sizes were found for all secondary outcomes (including shame) among DBT PE Protocol completers, and for all secondary outcomes except depression in the ITT sample (ITT: pre-post, d=0.9, Pre-FU, d=0.8; DBT+PE pre-post d=1.3, Pre-FU d=1.1). Mixed-effects models found significant reductions across time for the majority of secondary outcomes in both samples and all treatment gains were maintained in the 3 months after treatment ended.
Harned et al. (2014) USA	26 randomised (17: DBT+PE, 10 completed, 5 lost to follow up, 17 analysed) (9: DBT, 5 completed, 3 lost to follow up, 9 analysed)	Pilot RCT	Females with BPD, PTSD, and intentional self-injury	DBT+PE	DBT	International Personality Disorder Examination; Feasibility of Treatment Scale; Dialectical Behavior Therapy Adherence Measure; Suicide Attempt Self-Injury Interview; Childhood Experiences Questionnaire; Structured Clinical Interview for DSM-IV Axis I Disorders; Client Satisfaction Questionnaire; Traumatic Life Events Questionnaire; PTSD Symptom Scale-Interview Version, **Experience of Shame Scale**	Compared to DBT, DBT + DBT PE led to larger and more stable improvements in PTSD and doubled the remission rate among treatment completers (80% vs. 40%). Patients who completed the DBT PE protocol were 2.4 times less likely to attempt suicide and 1.5 times less likely to self-injure than those in DBT. Among treatment completers, moderate to large effect sizes favoured DBT + DBT PE for dissociation, trauma-related guilt cognitions, shame, anxiety, depression, and global functioning	Among treatment completers, between-condition effect sizes at post-treatment were large in favour of DBT+ PE for shame. In addition, a majority of completers in DBT + PE (60-100%) showed reliable and clinically significant improvement in this outcome at post-treatment and/or follow-up, compared to 0-20% of completers in DBT.

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Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Hedman et al. (2013) Sweden	n=67 with SAD; main healthy controls n=72; replication healthy controls n=22	a case-control study. within group pretest-posttest design	a sample with SAD with two samples of healthy controls, a main sample and a replication sample	CBT	No treatment	Mini Social Phobia Inventory; **Test of Self Conscious Affect**; Liebowitz Social Anxiety Scale-Self Report; Missing Completely at Random Test; Beck Depression Inventory; Structured Clinical Interview for DSM-IV Axis I Disorders; Social Interaction Anxiety Scale	Shame, social anxiety, and depressive symptoms were significantly associated among participants with SAD. After CBT, participants with SAD had significantly reduced their shame. CBT is associated with shame reduction in the treatment of SAD	The results showed that shame was elevated in persons with SAD compared to the control replication sample, but not to the main control sample. In addition, shame, social anxiety, and depressive symptoms were significantly associated among participants with SAD. After CBT, participants with SAD had significantly reduced their shame (Cohen's d = 0.44).
Kelly et al. (2009) Canada	75 (73 at time 1) n=23 self-soothing, n=26 attack-resisting, n=24 control	Unclear. Random assignment to one of three conditions. Pre and post tests	chronic and current acne sufferers. Majority undergraduate students (87%), n=17m, n=58f	a self-soothing intervention, an attack-resisting intervention	No treatment	DEQ, BDI, **ESS**, SKINDEX-16, compliance with intervention	The self-soothing intervention, developed to cultivate a compassionate, warm, and reassuring style of self-relating, lowered shame and skin complaints, but not depression. The attack-resisting intervention, developed to elicit a strong, confident, and retaliatory style of a self-relating, lowered depression, shame, and skin complaints. It also lowered depression significantly more for high than for low self-critics. Overall, our hypotheses were partially supported for the self-soothing intervention and mostly supported for the attack-resisting intervention.	As anticipated, both the attack-resisting and self-soothing interventions reduced shame experiences over the two-week study period. These changes in shame were not only statistically significant but also clinically significant. Mean levels of shame among participants in the intervention conditions dropped to a level characteristic of a general population of undergraduate students (i.e., M = 55.58, SD = 13.95; Andrews et al. 2002).

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Matos et al. (2017) Portugal	117 randomised. 93 completed CMT (n = 56) and wait-list control (n = 37)	Pilot RCT	general population & students. The majority of the sample comprised college students (78.5%). 9 (9.7%) men and 84 (90.3%) women.	CMT	waitlist control	Compassionate Attributes and Action Scales; Self-Compassion Scale; Fears of Compassion Scale; Types of Positive Affect Scale; **Other as Shamer Scale**; Forms of Self-Criticising/Attacking and Self-Reassuring Scale; Depression, Anxiety and Stress Scale; Perceived Stress Scale; Practices Feedback Questionnaire; Psychophysiological Measures	Compared to the control group, the experimental group showed significant increases in positive emotions, associated with feeling relaxed and also safe and content, but not activated, and in self-compassion, compassion for others and compassion from others. There were significant reductions in shame, self-criticism, fears of compassion and stress. Only the experimental group reported significant improvement in HRV.	Regarding shame, the effect of time was non-significant, but there was a significant time × group interaction, which may be explained by the fact that, while there were significant decreases in the CMT group, there were also increases (although non-significant) in the control group.
Morrison et al. (2016) UK	29, CBT n=15 (3 lost to follow up), TAU n=14 (2 lost to follow up)	Single-blind, Pilot RCT	People with schizophrenia spectrum disorders. 23 =m, 3=f	CT plus TAU	TAU only	Internalized Stigma of Mental Illness Scale-Revised; Semi-Structured Interview Measure of Stigma; Process of Recovery Questionnaire – Short Form; Self-Esteem Rating Scale – Short Form; Beck Hopelessness Scale; Beck Depression Inventory for Primary Care; Social Interaction Anxiety Scale, **Internalised Shame Scale**	There was no effect on our primary outcome, with a sizable reduction observed in both groups, but several secondary outcomes were significantly improved in the group assigned to CT, in comparison with TAU, including internalised shame, hopelessness and self-rated recovery.	CT significantly improved levels of internalised shamed d=0.56 at end of treatment (4 months) and d=0.34 at follow up (7 months). The fact that we observed changes in internalised shame and a favourable trend for an interview-based measure of dimensions of internalised stigma suggests that individual CT may be capable of achieving more specific effects.

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
Ojserkis et al. (2014) USA	n=445 screened, n=55 completed, n=45 analysed	randomised experiment	Undergraduate psychology students, 78% female	CD	Cognitive challenge	Moral Disgust Scale (MDS); Three Domain Disgust Scale (TDDS); Positive and Negative Affect Schedule (PANAS); **Test of Self-Conscious Affect–3 (TOSCA-3) (only the Shame and Guilt scales were analysed)**; Life Events Checklist (LEC); PTSD Checklist, Civilian Version (PCL-C); Impact of Event Scale, Revised (IES-R); Posttraumatic Cognitions Inventory (PTCI); Trauma-Related Guilt Inventory (TRGI); **Visual Analogue Scales (VAS) on all outcomes including shame**; Manipulation check forms; Treatment history form	there were no significant differences between the exercises in the reduction of negative emotions. In addition, PTSS severity was correlated with trauma-related guilt as well as state guilt and shame, but not trait or state measures of disgust or moral disgust.	Participant scores on a trait measure of shame (TOSCA shame) were not significantly correlated with any measure of PTSS. The results confirm that state shame is relevant to posttraumatic stress responses, as reduced by laboratory-based, ideographic trauma scripts. In light of these findings, CD and other acceptance-based therapeutic techniques may be viable alternatives for treating shame reactivity in PTSS, especially for individuals who are not responsive to more dialectic interventions such as traditional CBT for trauma, or those who find these therapeutic methods off-putting (Olatunji, Deacon, & Abramowitz, 2009).
Resick et al. (2008) USA	162 randomised CPT n=56 (27 completed, 6 lost to follow up, 53 in ITT analysis). WA n=55 (30 completed, 8 lost to follow up, 50 in ITT analysis) CPT-C n=51 (29	ITT analysis, randomised experiment	Females with PTSD	Group 1: cognitive therapy only (CPT-C) Group 2: written accounts only (WA)	Group 3: CPT (Cognitive Processing Therapy)	Physical Punishment Scale of the Assessing Environments-III; Physical Assault Scale of the Revised Conflict Tactics Scales; Beck Depression Inventory–II; **Experience of Shame Scale**; Structured Clinical Interview for DSM-IV Axis I Disorders; Personal Beliefs and Reactions Scale; Posttraumatic Diagnostic Scale; Sexual Abuse Exposure QA State-Trait Anger Expression Inventory; Trauma-Related Guilt Inventory	Analyses with the ITT sample and with study completers indicate that patients in all 3 treatments improved substantially on PTSD and depression, the primary measures, and improved on other indices of adjustment. However, there were significant group differences in symptom reduction during the course of treatment whereby the CPT-C condition reported greater improvement in PTSD than the WA condition	Using HLM with estimates of missing data across the three time points, all groups decreased significantly on ESS, and the three groups did not differ on either the ITT or completer samples. Effect sizes for ESS: CPT: ITT= -0.94, completers= -0.82; WA: ITT= -1.02, completers= -0.96; CPT-C: ITT= -0.92, completers= -0.97

Study	n	Design	Population	Intervention	Control	Measure(s)	Main outcomes	Findings on shame
	completed, 9 lost to follow up, 47 in ITT analysis)							
Talbot et al. (2017) Canada	14 (9 completed)	A single-subject experimental design (AB)	university students & employees	Self-compassion website	None	Self-Compassion Scale. **The Other as Shamer Scale**. Rumination-Reflection Questionnaire-Self-Rumination Subscale. Treatment adherence. Treatment benefits questionnaire.	Analyses revealed significant improvement in self-compassion and shame for the majority of participants, but limited changes in rumination. Changes were observed as early as after 2 weeks into the treatment phase. Participant 6 only spent a few minutes navigating the website at the beginning of the treatment and participant 8 chose to purchase the website's accompanying workbook instead of using the website.. Most participants reported having benefited from the self-compassion website. Most (75%) also appreciated the self-compassion exercises, with 62.5% reporting that they intended to continue using the exercises.	all but one of the participants who showed a statistically significant increase in self-compassion also showed a statistically significant reduction of their OAS scores compared to baseline levels.
Talbot et al. (2011) USA	n=70 randomised; IP=37; UCP=33	randomized effectiveness trial	Females with major depression and sexual abuse before age 18	Interpersonal psychotherapy (IP)	Usual Care Psycho-therapy (UCP)	Modified Posttraumatic Stress Disorder Symptom Scale–Self Report; **Differential Emotions Scale (subscale)**; Beck Depression Inventory–II; Social Adjustment Scale-Self Report; SF-36 Health Survey; Hamilton Rating Scale for Depression; Structured Clinical Interview for DSM-IV Axis I Disorders; Traumatic Life Events Questionnaire; Childhood Trauma Questionnaire--Short Form	Compared with women assigned to usual care, women who received interpersonal psychotherapy had greater reductions in depressive symptoms, posttraumatic stress disorder symptoms and shame. Interpersonal psychotherapy and usual care yielded comparable improvements in social and mental health–related functioning	Depressed women with sexual abuse histories treated with interpersonal psychotherapy showed more reduction in shame than women who were treated with usual care (p = .002, d = .38).

Appendix J. REA2 Quality assessment of included studies
Table J 1. REA2 risk of bias assessments

Study design	Study	Areas of concern	Risk of bias (low, medium, high)
Multiple baseline experimental design	Au et al. (2017) USA	No control group, small sample, but followed up. Randomised to length of baseline assessment groups, but process not explained, and high attrition. Only completers assessed, but this is justified, as is design.	High
RCT waitlist control	Albertson et al. (2015) Various	Only intervention group followed up, waitlist control (no blinding). Non-clinical. Only females. High attrition rate	Medium
Pilot study. Pre-post	Chenneville et al. (2017) USA	Small sample size. High attrition rate but non-completers analysed. No control, no follow up. Non-clinical	High
Pilot RCT	Duarte et al. (2017) Portugal	Only females. 'It is not possible in the current study design to dissociate the effect of the intervention content from the setting in which it was conducted (e.g., interactions with the investigators who had a vested interest in the outcome). The present analysis did not control for such effects. This may have inflated the effect size estimates in this study'. Waitlist control. Only completers analysed	High
Pilot RCT	Harned et al. (2014) USA	Small sample, high attrition but all randomised were analysed. Good blinding of assessors	Medium/Low
Pilot, single case open trial design (ITT)	Harned et al. (2012) USA	Small sample size. Female only Open trial. No blinding	High
Case-control, pre-post	Hedman et al. (2013) Sweden	Pre-post assessment. No randomisation (although from an RCT sample for treatment group)	High
Randomised experiment (randomised after initial battery of tests to one of 3 conditions) pre-post	Kelly et al. (2009) Canada	Randomisation procedure unclear, no effect sizes. No information on attrition	High
RCT (pilot)	Matos et al. (2017) Portugal	Waitlist control. General population, randomisation procedure, blinding, etc. not reported. Only completers analysed	High -
RCT (pilot). Single blind. Used ITT	Morrison et al. (2016) UK	Good - 7m follow up. Blinding of assessments, concealment of allocation and independent randomisation.	Low
Randomised pre-post	Ojserkis et al. (2014) USA	Undergraduates. Incentives given. High attrition, Only completers analysed. No follow up. Randomisation procedure, blinding, etc. not reported.	High
ITT analysis. Randomised pre-post	Resick et al. (2008) USA	Blind assessments good; good completers & non-completers considered. Unclear how randomisation conducted. ITT analysis	Medium/low.
Single-subject experimental design	Talbot et al. (2017) Canada	Non-clinical, small sample, no control group.	High
Randomized effectiveness trial	Talbot et al. (2011) USA	Assessors not blinded, although participants possibly were. Randomisation process said to be effective, but procedure unclear.	Medium/low.

Appendix K. Intervention characteristics from REA2 studies

Table K 1. Intervention characteristics

Study (author, date, country)	Clinical/non-clinical population	Therapist details	Duration of intervention	Number of sessions	Components of intervention
Albertson et al. (2015) Various	Non clinical	Self-help	3 weeks	3 meditation interventions, 1 each week. Practice once a day (avg. 3x per week)	**Self-compassion meditation training**. 3 audio podcasts of guided self-compassion meditation interventions (taken from a Mindful Self-Compassion programme, Neff and Germer 2013). 1. Compassionate Body Scan, 2. Affectionate Breathing, 3. Loving kindness meditation
Au et al. (2017) USA	Clinical (although no diagnostic assessment conducted)	In-person assessments and treatment sessions were conducted by the lead investigator of this study, a master's-level clinician in an APA-approved doctoral program in Clinical Psychology.	6 weeks	6 sessions of 60-90 minutes	**Compassion-based Therapy.** Manualised treatment. Each session included didactic psycho-education on a treatment concept (e.g. conceptualization of PTSD, self-compassion) followed by an in-session experiential exercise (e.g., loving kindness meditation), which participants were asked to also practice on their own between sessions. Sessions 1–3 focused on building general mindfulness and self-compassion skills for everyday difficulties that were not trauma-related. Session 1 focused on PTSD psycho-education and mindfulness. The concept of self-compassion was then explicitly introduced in Session 2, and self-compassion exercises were practiced in sessions 2–3. Sessions 4–6 focused on directly applying the self-compassion skills from Sessions 2–3 to the index trauma.
Chenneville et al. (2017) USA	Non clinical	A former Buddhist monk with expertise in mindfulness meditation and a psychologist with extensive training in REBT	90 days	12 1hour meetings, plus daily meditation and homework tasks	**Mindful Meditation and REBT.** Several components, including: (a) twelve consecutive weekly 1-hour face-to-face meetings between the student and the teacher or mentor whereby students were trained in mindfulness meditation and REBT strategies, (b) daily mindfulness meditation practice beginning at 20 minutes and extending to at least 60 minutes each day, and (c) daily homework including journal activities and other assignments designed to increase awareness of factors affecting the student's meditation practice and to allow students to practice questioning their own beliefs and experience the impact of doing so on their thoughts, feelings, and behaviours.
Duarte et al. (2017) Portugal	Clinical	Experimenter (?) for psychoeducation, self-help for intervention practise	4 weeks	2.5 hour group education session, asked to practice daily	**Compassionate Attention and Regulation of Eating Behaviour [CARE].** A psycho-education presentation on factors underlying difficulties in regulating eating, emotion regulation systems, and the binge eating cycle. It also focused on the concepts of mindfulness and compassion, with mindfulness meditation and compassionate imagery exercises. Participants were given a programme support manual with instructions and audio exercises. Week 1 practices included (a) mindfulness of the breath, (b) body scan, and (c) mindful eating. During this week, participants were also asked to practise soothing rhythm breathing. During Weeks 2–4, participants practised compassionate imagery, which included (a) building the compassionate self, (b) cultivating compassion for others, (c) cultivating compassion for someone with eating difficulties, and (d) cultivating compassion for the self.

Study (author, date, country)	Clinical/non-clinical population	Therapist details	Duration of intervention	Number of sessions	Components of intervention
Harned et al. (2012) USA	Clinical	Therapists (n ¼ 6) were primarily female (83.3%), doctoral (50%) or masters-level (50%) clinicians, and had an average of 6.5 years of post-degree clinical experience (SD ¼ 4.2).	1 year	Average 13 sessions completed	**Dialectical Behaviour Therapy + Prolonged Exposure.** The DBT PE Protocol is based on PE (Foa et al., 2007) and utilizes in vivo and imaginal exposure as the primary treatment components. DBT strategies and procedures were incorporated into PE to: (1) increase monitoring of potential negative reactions to exposure (e.g., pre-post exposure ratings of urges to commit suicide), (2) target problems that may occur during or as a result of exposure (e.g., via DBT skills and protocols), and (3) utilize DBT therapist strategies (e.g., dialectics, irreverence, validation) that address the particular needs of severe BPD patients.
Harned et al. (2014) USA	Clinical	Therapists (n = 19) primarily female (84.2%), master's degree (66.7%), median of 2.0 years of clinical experience since their last degree at time hired (range = 0-39, SD = 9.2). A majority of therapists were doctoral students in training (52.6%), followed by licensed professionals (36.8%), postdoc. fellows (10.5%).	1 year	One 120min session per week (DBT PE protocol + DBT) or two sessions per week (one DBT PE protocol session (90 min) + one DBT session (1 h)), group DBT skills training and phone consultation.	**Dialectical Behaviour Therapy + Prolonged Exposure.** The DBT PE Protocol is based on PE (Foa et al., 2007) and utilizes in vivo and imaginal exposure as the primary treatment components. DBT strategies and procedures were incorporated into PE to: (1) increase monitoring of potential negative reactions to exposure (e.g., pre-post exposure ratings of urges to commit suicide), (2) target problems that may occur during or as a result of exposure (e.g., via DBT skills and protocols), and (3) utilize DBT therapist strategies (e.g., dialectics, irreverence, validation) that address the particular needs of severe BPD patients.
Hedman et al. (2013) Sweden	Clinical (for experimental group only)	Seven therapists (five psychologists, one nurse and one psychiatrist) delivered the treatments.	16 weeks	16 sessions	**CBT** components were: (a) deriving an individualized version of the cognitive model using patients' thoughts, images, anxiety symptoms, safety-behaviours and attentional strategies, (b) conducting a behavioural experiment to demonstrate the adverse effects of safety behaviours, (c) using video feedback to modify distorted self-imagery, (d) training externally focused attention (i.e., to shift attention away from oneself and onto the social situation), (e) conducting behavioural experiments to enable patients to test the validity of their negative predictions in a variety of social situations, (f) identification and modification of problematic anticipatory and post-event negative processing, and (g) identification and modification of dysfunctional assumptions.
Kelly et al. (2009) Canada	Non-clinical (although had to meet SKINDEX measures on distress caused by acne)	Self-help	2 weeks	1 hour, with daily practice suggested over the 2 weeks	**Self-Soothing/Attack-Resisting.** The authors developed two self-help interventions based largely on social mentalities theory and compassionate mind training. Both interventions used imagery to try to change the socio-emotional stance from which participants self-relate. The self-soothing intervention invited participants to engage in compassionate, nurturing, and reassuring imagery and self-talk, and the attack-resisting intervention asked participants to engage in strong, resilient, and retaliating imagery and self-talk. The exercises also incorporated elements from Gestalt therapies, such as two-chair dialogues for self-critical splits, and from cognitive therapies, such as the challenging of depressogenic thoughts and inner speech. The core tasks of the interventions, however, were to visualize a particular image (i.e., an ''inner soother'' or ''inner challenger''), to focus on and feel its socio-affective qualities, and to incorporate this image in one's self-relating.

Study (author, date, country)	Clinical/non-clinical population	Therapist details	Duration of intervention	Number of sessions	Components of intervention
Matos et al. (2017) USA	Non clinical	Self-help	2 weeks	2 hour group explanation, daily practice suggested. n = 36) reported that they practiced three or four times per week, and n = 18 practiced five times or more per week.	**Compassionate Mind Training.** A written manual outlined the evolutionary theory behind the CMT, with explanations of emotion regulation and the value of compassion. Audio files were provided of the CMT practices for subsequent independent practice, which included (1) a soothing rhythm breathing practice; (2) a practice focused on creating friendly facial expressions and voice tones as part of compassion; (3) a practice aimed to develop mindfulness and increase attention to one's current mental state; (4) a practice aimed to develop the sense of a compassionate self that is based upon feelings of wisdom, strength and commitment to be supportive and helpful to self and others; (5) an imagery practice aimed to develop a compassionate image of another mind that has caring intent towards the self; and (6) a practice aimed to develop a compassionate self that has caring intent towards the self and how to use compassion focusing to work with self-criticism and life difficulties.
Morrison et al. (2016) UK	Clinical	Four therapists contributed to the delivery of cognitive therapy. The number of participants treated by each therapist ranged from 1 to 6 (Mean1⁄42.8, SD1⁄42.4). Three therapists were clinical psychologists (doctoral level) and one was a trainee clinical psychologist.	4 months	up to 12 sessions (mean sessions = 9.3)	**Cognitive Therapy.** The intervention included a number of CT techniques, focused on working towards the stigma-related goals: guided discovery, skills development, normalising and belief change strategies, including behavioural experiments targeting stigma-relevant appraisals and evaluation of negative beliefs about self, including public stereotypes of psychosis. In addition, time was allocated to allow for exploration of the meaning of participants' diagnoses, validation of experiences of stigma and discrimination, and consideration of pros and cons of different ways of responding to stigma and discrimination. Therapy was enhanced by the use of published normalising guided self-help manuals, which include chapters such as 'Are my experiences abnormal?', 'What is normal?' and 'Feeling good about yourself' (Morrison et al., 2008)
Ojserkis et al. (2014) USA	Non clinical	Experimenter (not therapy)	1 hour	1 session	**Comprehensive Distancing/Cognitive Challenge.** Participants generated personalized trauma scripts. Experimenters guided all participants through an introductory lesson for their assigned strategies. CD group- given a description of the CD technique modelled from texts on ACT, developed by the study investigator. CC group description was modelled from a text on cognitive therapy, developed by the study investigator. All participants practiced their assigned thought strategy prior to the experimental session. Participants were reminded of their assigned strategies, and then were asked to read their trauma scripts to themselves one time. After reading their written accounts of their traumatic events, participants were instructed to utilize their assigned strategies to respond to thoughts provoked by this reflection on their past traumatic experiences. Scripts for thought exercises and follow-up questions for the experimental session were identical to those for the practice session.

Study (author, date, country)	Clinical/non-clinical population	Therapist details	Duration of intervention	Number of sessions	Components of intervention
Resick et al. (2008) USA	Clinical	Therapists included eight women with master's degrees or doctorates in clinical psychology and training in cognitive behaviour therapy. Client assignments were balanced so each therapist conducted approximately equal numbers of therapy cases in each condition.	6 weeks	CPT and CPT-C = 12 sessions, each 60 min in length, 2xper week. WA had, in the 1st week, two separate 60-min sessions; thereafter, sessions were 2hrs 1x per week, for seven sessions.	**Cognitive Therapy/Written Accounts.** In CPT, the cognitive component was predominant, with the trauma account element consisting of two sessions that include writing about the worst traumatic event, reading it back to the therapist, and processing emotions. Clients were also asked to read the account at home between sessions on a daily basis. The therapist then used Socratic questioning to challenge the clients' erroneous conclusions about the event. CPT-C had cognitive therapy only (CPT-C), with a greater focus on Socratic questioning. In the WA condition the participants wrote their accounts during part of the session and had the reading of accounts and support work during the other half. PE was a guide to the therapy structure and WAs implemented faithfully to CPT but also as close as possible to PE was implementation from Resick et al., (2002)
Talbot et al. (2017) Canada	Non clinical	Self-help. Although no clinical or therapeutic guidance was offered during the treatment phase, participants received weekly e-mails reminding them to complete outcome measures and measures of adherence.	5 weeks	Self-reported total time spent on the website, excluding P6 and P8, averaged 199 minutes (SD =135; range 60 to 480 minutes).	**Self-compassion website.** The website based on Neff, (2016) included seven self-compassion exercises: 1) How self-compassionate are you?; 2) Exploring self-compassion through writing; 3) The criticizer, the criticized, and the compassionate observer; 4) Changing your critical self-talk; 5) Self-compassion journal; 6) Identifying what we really want; and 7) Taking care of the caregiver. Video and Audio clips, including six guided meditation exercises, were also available to be downloaded and a workbook could be purchased.
Talbot et al. (2011) USA	Clinical	CMHC staff clinicians (ten master's level, three doctorate level) delivered the treatments.	36 weeks	Interpersonal psychotherapy participants attended approximately twice as many sessions (12.9±6.5) as those in usual care (6.3±4.2),	**Interpersonal psychotherapy** manualised treatment. Three problem foci (grief and loss, role transitions, and interpersonal conflict) emphasize current interpersonal problems, and a fourth reflects an enduring interpersonal style. The therapist and patient together select the problem focus. The fourth interpersonal problem area was recast as "interpersonal patterns" to reflect the persistent interpersonal difficulties often associated with interpersonal trauma.

Appendix L. Intervention examples from REA2 papers

CT, Morrison et al.
Working on core beliefs:
Advantages and disadvantages of core beliefs, rules or assumptions
New or 'alternative' core belief:
Write any evidence that suggests that this new belief is true. Has someone said or done something that fits with this new belief or shows they agree with it? Is there anyone that would point out things that fit with your new core belief? What would they point out?

Normalising – research and read other personal recovery stories (to feel that I am not alone)

Imagery modification techniques (for recurrent, distressing images) – treat image as a video, introduce a rescuer or alternative image, and introduce humour

DBT, Harned et al. (with interventions taken from Van Dijk, 2012)
Being human & genuine
Van Dijk, (2012) p.43 'If you've messed up, apologise to the client. Admit it when you've made a mistake. Acknowledge that your feelings are hurt or that you felt disappointed when the client blamed you for something or when he didn't complete his homework for the third week in a row. Remember that you're human too and that this is a human relationship'.

Disclosure by the therapist:
Share a similar situation in which you felt the same way
Disclose solutions you've used to handle a similar problem
Model how to engage in self-disclosure, teaching sharing appropriately

Facial expressions
They tell a sad story, you (therapist) reflect this in your facial expression
Half-smile – client practices half-smiling, as this can alter felt affect

Emotions
Opposite action to urges:
Shame: withdraw/hide. Opposite: approach others, & when shame/guilt not justified, continue with activity

Acceptance practice:
Build this up over time (might just accept for 30 seconds a day at first)
1) decide if it's a situation they want to accept
2) Make a commitment to self to accept reality he's fighting
3) Notice when he starts fighting reality again
4) Turn the mind back to acceptance, and remind self of the commitment you made

Validating emotions:
1) acknowledge the presence of emotion rather than judging it
2) give yourself permission to feel the emotion
3) have an understanding of the emotion, e.g. *'it makes sense that I feel unhappy, given the difficulties I have in managing my emotions and the chaos this causes in my relationships and my life'*

Dialectical strategies:
Devils advocate – by arguing against something, the therapist helps the client to argue for it (e.g. commitment to change)

Use of metaphor – they can be less threatening as they are less direct ways of making suggestions. Use to communicate acceptance and understanding of where the client is at, and at the same time present an alternative that will assist with moving towards change

Mindfulness practice:
The mind is a muscle that needs to be exercised. Mindfulness can strengthen the mind – memory & concentration

Coping ahead – practice for a difficult situation, rehearse your plan with the therapist

Written accounts (from CPT) Resick et al.
Working with trauma & fear
Write about your worst trauma, & give SUDS rating (subjective units of distress) before & after writing. Read the trauma account to the therapist. After this is completed, the therapist elicits the client's responses regarding emotions, reviews what she has learnt from the assignment, and discusses which details have been added or overlooked. The therapist can make nondirective, supportive comments and occasional educational statements only. They can direct the clients to write specific portions of the account in more detail over the sessions (focusing in on "hotspots") or move to other traumatic events if they had made good progress with the worst traumatic event. Clients are asked to read their account to themselves everyday between sessions and to record their SUDS ratings. The SUDS ratings were used to identify hotspots and areas that needed further attention or to determine when to go on to other traumas.

Interpersonal therapy, Talbot et al.
Role transitions (such as new identity):
Focus on the ambivalent/anxious feelings they are experiencing about change, bringing attention to both positive and negative reactions to the change –
1) understand nature of transition from the client's perspective, & its meaning in their life
2) empathise with the loss experience, validate loss, anxiety &/or ambivalence about new role
3) use sadness at loss, & anxiety about the new role as motivating factors
4) explore and articulate positives and negative of old and new roles
5) help develop new social supports

Learning to communicate experience:
How well do you think others understand your experience?
What can you do to help others to understand your experience more fully?

Trouble experiencing emotion in therapy:
Identify and examine an interpersonal incident in which they have experienced distress or other relevant affect. This should bring some level of affective shift

Interpersonal conflict:
Role play:
The therapist might play the role of the significant other. In IPT the therapist gives feedback on the client's communication style. If dealing with early abuse, this would need to be handled extremely sensitively. However, this could be an opportunity to express hurt and anger (transformation of experience) that is outward rather than inward directed. Or this could focus on a current interpersonal problem, and use assertiveness skills. This could also be used as a way to access the inner child, if the client plays the role of their younger self.

Working with communication (non-verbal):
Using role play, the therapist can comment on non-verbal communication such as posture, tone, eye contact, and practice using these differently. For example, the therapist may comment on how difficulties with eye contact may make it difficult for other to fully connect with the client

Positive reinforcement of attempts at disclosure (secrets)

Use of affect:
1) recognise immediate affect when client is retelling about a situation/conflict
2) assist them to communicate affect more effectively to others
3) facilitate recognition of suppressed affect.

Process affect is that which is experienced in the retelling. Content affect is that which they report experiencing in the situation they are discussing. If these are dissimilar, the therapist can explore this and point out the incongruence.

Compassion – Albertson et al.
Compassionate body scan
Lie down and rest a hand on your heart as a reminder to be kind to yourself. Starting with the feet and working up to the head, notice the sensations of the various body parts. If judgmental thoughts arise, place a hand on your heart, breath deeply, and return to feeling simple sensations.

Affectionate Breathing
Get in touch with your body by doing a quick body scan and noticing any sensations. Take three deep breaths to let out any tension and then allow breathing to return to normal. Notice where the breath is felt most strongly without trying to control the breath. Adopt a little half smile and observe how she feels. Set an intention to breathe in affection and kindness for yourself and with each out breath, breathe out affection and kindness towards others who are suffering just like you. Try not to judge your mind when it wanders. Appreciate each breath and allow the breath to comfort and soothe, and finally rest in the feelings of kindness you are generating.

Loving- kindness meditation
Have self-compassion for a personal experience of suffering. First, be present in the moment; notice any sounds that are arising, and then focus on the breath. Bring attention to a trait or behavior that has generated negative emotions and allow whatever feelings are connected with this perceived inadequacy to arise. Locate the physical sensation of these emotions in your body and allow them to be there. Place both hands over your heart, to soothe and comfort yourself for the difficult thoughts and emotions you are experiencing. Silently repeat the following phrases to yourself: *May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am.*

Appendix M. Suggested Wise interventions for consultation

Cognitive therapy

Working on core beliefs*: (discuss/write about a new belief about you, or write about your old shaming belief about the self – to revise)* Prompting new meanings? **Need to understand**, selves (my own and others)

> *Direct labelling. Ask 3 people close to you what 3 positive qualities they assign to you. The therapist then also gives 3 positive qualities. Discuss the list and decide what this says about who you are*

> *Increasing commitment through action. How do you like to see yourself and your actions? What are the advantages and disadvantages of being this way, versus the pros and cons of being worthless/unloveable? What would you suggest to someone else in your predicament?*

Normalising: Social belonging intervention. Increased commitment through action – saying-is-believing – Murphy et al., read stories describing how it's normal to…then write about how experience reflects process described. **Need to belong**, remedy threats to belonging that undermine functioning, facilitating beliefs that sustain belonging in the face of challenges, ***can people 'like me' come to belong?***
Or, **Need to understand**, selves, changing beliefs about ability or potential, ***can people change? (Implicit theories of personality)***

> *Increasing commitment through action. Give the client some stories of people like them, describing how they have had similar emotions and experiences and how they got through it with therapy. Get the client to write about how their experience reflects the process described.*

Imagery modification techniques*:* Self-distancing perspective (Kross and Ayduk, 2008). Well-being/Active reflection on negative experience. **Need to Understand**, Selves (my own and others), Changing beliefs about emotions, states and valences, ***Are negative past emotions, states and experiences on going and undermining?***

> *Active reflection exercise. Visualise your distressing image and imaging you are watching it on a television screen. Practice visualising this image.*

> *Active reflection exercise. Visualise your distressing image and imaging you are watching it on a television screen. Bring in a compassionate rescuer who takes you out of the scene and offers you kindness. Practice this visualising this image.*

Written accounts (CPT)

Working with trauma & fear: Active reflection on negative experiences intervention. Write about a traumatic experience. **Need to understand**, selves, changing beliefs about emotions, ***Are negative past emotions, states and experiences ongoing and undermining?***
- Kross & Ayduk (2008) self-distanced perspective when recalling experience reduced depressed affect and recurring thoughts

- Park et al. (2015) write about most distressing event increased self-distancing (active reflection on negative experience)

> *Prompting new meanings. Write about a traumatic event (either worst trauma or one that is slightly easier, and work towards the worst trauma). Write how you feel before and after. Read your account to me (therapist). Therapist will elicit responses regarding emotions, review learning, and discuss any details to add. Client is to read every day between sessions and record feelings before and after. Consider 'hotspots' and then*

Interpersonal therapy

Role transitions (such as new identity): empathise with the loss experience, validate loss, anxiety &/or ambivalence about new role; use sadness at loss, & anxiety about the new role as motivating factors; explore and articulate positives and negative of old and new roles; help develop new social supports

Need to understand, selves, changing beliefs about self-identity, *who could I become? (Prospective or potential self-identity)/ who do I not want to be, become, or be confused with?*

> *Active reflection exercise. Write about what your future, compassionate self might look like, and who you are now. Consider the pros and cons of both the old and new identities, and what you need to put in place to achieve the new identity.*

Learning to communicate experience: **Need to belong**, the nature and extent of one's social connections, remedy threats to belonging that undermine functioning, bolstering beliefs about social connectedness, *am I connected to others?/does this experience mean I don't belong?*

> *Write a letter as if they were a neutral other. What would a compassionate observer say about your experience? What do they need to know to understand your experience more fully (relate to relationship intervention)?*

> *Prompting new meanings. Write about how someone close to you has understood your experience and the significance this has had for you in moving forwards.*

Trouble experiencing emotion in therapy: **Need to understand**, selves, changing beliefs about ability or potential, *can emotions change? (Implicit theories of emotion)*

> *Active reflection exercise. Discuss an incident where you have experienced distress/fear/sadness/anger (whatever emotion you are trying to get to). Intent- to bring up the emotion*

Interpersonal conflict: Role-play where the client plays their younger self talking to the person who is the source of their shame (or a significant other in recent conflict). Give feedback on their communication. **Need to understand**, personal and social experiences, changing beliefs in and about interpersonal conflicts and interactions, *how can I better manage this conflict?*

> *Increasing commitment through action. Saying-is-believing. Imagine you are the young child and I am the (significant other). Say to me the things you would like to have said as a small child about how the situation has made you feel. Afterwards, what would you like to say to your younger self now, that you wish they had known then?*

Working with communication (non-verbal): Role-play recent/upcoming situation, such as job interview. Feedback on non-verbal communication. **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*

> *Active reflection exercise. Imagine you are giving a presentation/at an interview/having a difficult conversation. I will play the role of the audience. Afterwards, I (therapist) will comment on non-verbal communication. We will then re-run using different non-verbal communication*

Positive reinforcement of attempts at disclosure (secrets):

> *Prompting new meaning. Write about the meaning of a time you have disclosed something difficult and how it improved felt experience (like Marigold et al.'s self-esteem intervention, 2007; 2010)*

DBT

Being human & genuine: Disclosure by the therapist: Share a similar situation in which you felt the same way; Disclose solutions you've used to handle a similar problem
Need to belong. As in, social group (not just 'the shamed') *can people like me come to belong?*

> *Prompting new meanings. When a client is struggling with a problem, disclose how you have solved a similar problem. Work through the problem together. Ask them how you are similar and to share how it feels to have similar problems.*

Facial expressions: Get them to write a story about their desired identity, therapist reads the story back to them as they adopt a half-smile and nod their head – induce greater conviction in the story. **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*

> *Get the client to write a story about how others would see their trauma (not their fault). Or write a story around forgiveness. Read the story to the client whilst they practice a half-smile and nodding their head, to encourage conviction.*

Emotions: **Need for self-integrity** (self-integrity to behaviour to motivate positive change). Counter attitudinal behaviour – Festinger & Carlsmith, 1959 – inducing people to freely act in ways that contradict a problematic attitude can motivate change in that attitude) Opposite action. Shame – withdraw/hide. Instead, look up approach person

> *Prompting new meanings. When you feel you want to withdraw/hide, write about how someone who didn't feel shame would act. What would they do in this situation?*

Validating emotions: **Need to understand**, selves, changing beliefs about emotions, ***are negative past emotions, states, and experiences ongoing and undermining?*** [Active reflection on negative experiences]

> *Prompting new meanings. When a difficult emotion arises, acknowledge but don't judge it. Tell yourself you have permission to feel the emotion. Try to understand the emotion (without judgement).*

Coping ahead: **Need to understand**, personal & social experiences, changing beliefs in and about interpersonal conflicts and interactions, ***how can I better manage this conflict?***

> *Increasing commitment through action. Saying-is-believing. Role-play the difficult interpersonal situation that may occur in future. Use assertive language to get your point across whilst considering the other persons feelings.*

Self-compassion

Compassionate body scan: **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, ***how does my body interact with the external world?***

> *Lie down and rest a hand on your heart as a reminder to be kind to yourself. Starting with the feet and working up to the head, notice the sensations of the various body parts. If judgmental thoughts arise, place a hand on your heart, breath deeply, and return to feeling simple sensations.*

Affectionate Breathing: **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, ***how does my body interact with the external world?***

> *Get in touch with your body by doing a quick body scan and noticing any sensations. Take three deep breaths to let out any tension and then allow breathing to return to normal. Notice where the breath is felt most strongly without trying to control the breath. Adopt a little half smile and observe how she feels. Set an intention to breathe in affection and kindness for yourself and with each out breath, breathe out affection and kindness towards others who are suffering just like you. Try not to judge your mind when it wanders. Appreciate each breath and allow the breath to comfort and soothe, and finally rest in the feelings of kindness you are generating.*

Loving- kindness meditation: Health/well-being, active reflection on positive aspect of the self. **Need to belong**, remedy threats to belonging that undermine functioning, bolstering beliefs about social connectedness, ***am I connected to others?*** (Frederickson et al., 2008)

> *Have self-compassion for a personal experience of suffering. First, be present in the moment, notice any sounds that are arising, and then focus on the breath. Bring attention to a trait or behaviour that has generated negative emotions and allow whatever feelings are connected with this perceived inadequacy to arise. Locate the physical sensation of these emotions in your body and allow them to be there. Place both hands over your heart, to soothe and comfort yourself for the difficult thoughts and emotions you are experiencing. Silently repeat the following phrases to yourself: 'May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am'.*

Handle with care. Working wisely with the shamed client

Information for consultation
interviews. July 2018

Jess Haskins, UWE

A synopsis of my thesis.
Handle with care: Working 'wisely' with the shamed client.

Aim: To consider how to integrate working 'wisely' with therapeutic work focused on reducing shame in the counselling room.

1. Consider the evidence on how shame is activated and experienced between client and therapist.
2. Consider the evidence for what works in reducing shame in therapy.
3. Explore how methods from the 'Wise' literature can be incorporated therapeutically to positively transform shame-based interactions.
4. Consult counselling psychologists on the efficacy and usefulness of intended wise interventions, based on data from 1, 2 and 3 above.

Toxic shame

- Shame can be seen as the 'master emotion' that underpins and acts on many other emotions
- It is a 'social emotion' in that it is produced through how we think others view us, which in turn affects our self-view (I am worthless, unloveable)
- Shame is toxic when it affects our day to day functioning and becomes a large part of our identity, overshadowing our true selves. Shame becomes maladaptive, and problematic. This is often characterized by a desire to hide/withdraw

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What is working 'wisely'?

Wise interventions seek to **make new meanings** for people in a range of areas. In each area, *'the key actor…has developed maladaptive views of themselves and/or their circumstances. Understanding the nature of these views, how they arise, and how they can be changed, can change peoples behaviour and improve outcomes'* (Walton and Wise, in press, p.4)

This research study aimed to consider how to integrate working 'wisely' through precise interventions into therapy, to alter meanings around the experience of toxic shame. The research considers **how shame is activated and experienced relationally** between client and therapist (the nature of maladaptive views and how they arise), and considers the evidence base for **what works in reducing shame in therapy** (how they can be changed). These findings are used to inform **ideas for wise interventions that might alter client's shame based experiences** (change behaviour and improve outcomes).

Wise principles:

1) Alter specific meanings to promote change

2) Meanings operate within complex systems

3) New meanings can stimulate recursive change in people and situations

4) Methodological rigor and process

5) Ethical considerations

## Motivations underlying meaning making

There are 3 basic motivations:

- **A need to understand** (selves, other people and groups, personal and social experiences)
- **A need for self-integrity** (adequacy of the self)
- **A need to belong** (nature and extent of one's social connections)

Intervention Techniques

- **Direct labeling** (provide with a positive label, and motivate to behave in accordance with the label)
- **Prompting new meanings** (leading questions can assume an idea and encourage elaboration of its' significance)
- **Increasing commitment through action** (creating situations that inspire people to freely act in line with a new idea, to cement psychological change)
- **Active reflection exercises** (help reframe experiences. Either cutivating positive qualities, or using negative experiences to think more clearly, find a resolution, or find positive meaning to improve functioning. Also value-affirmation exercises)

Example wise interventions

2
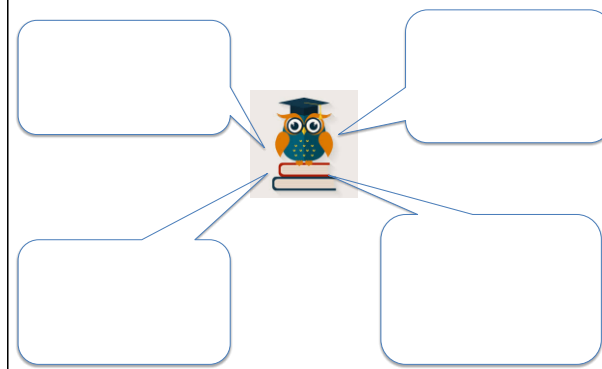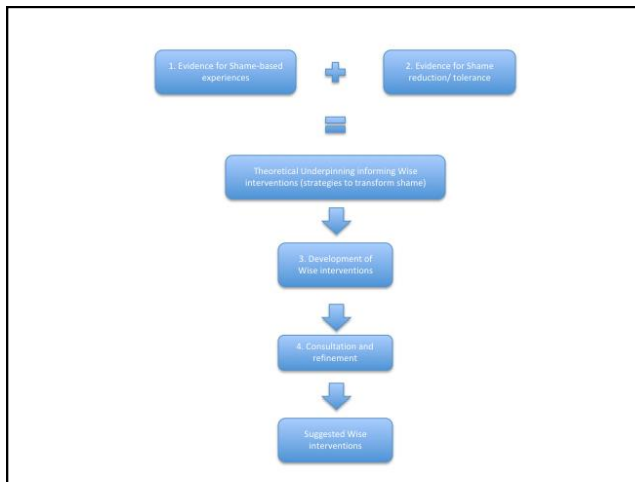
Research questions

4 parts to the research

Parts 1 and 2 enable consideration of a broad question, which is, '*How is shame experienced in a relational context, and how is this dealt with in the therapy room?*'

- **Part 1** answers the sub question:
  How is shame experienced in the therapy room?
- **Part 2** answers the sub question:
  What works in reducing (or increasing tolerance to) shame in individual therapy?

Parts 3 and 4 consider how to transform findings from 1 and 2 into wise interventions, and how counselling psychologists might integrate these in to active therapy, to answer the question, *'How can we transform the meaning of shame through wise interventions?'*

- **Part 3** answers the sub question:
  What might Wise interventions for working with shame look like?
- **Part 4** answers the sub question:
  Do practitioners see value in using therapeutic strategies as Wise interventions to transform shame-based experiences?

REA1: *How is shame experienced in the therapy room?*

Themes from 7 studies:

- Finding the toxic part(s) of me (IDENTITY).
- Your shame is my shame. The relational experience (BETWEEN CLIENT & THERAPIST);
- I live in fear. I need to feel angry (EMOTIONS);
- Secrets, ghosts and psychic retreat (HIDING);
- The child within (INNER CHILD);
- A bodily experience (PHYSICAL)
- Out of the darkness, comes light (COMPASSION AND TRANSFORMATION).

REA1 findings

Taken as a whole, I have interpreted the findings as a challenge between exposing the haunting, ghostly past and finding new ways of relating and believing in oneself, through the power of the relationship between therapist and client. There is a clash of needs that the client battles – both the need to hide their shame, and the need to hide from it. There is something important about the interaction between therapist and client in transforming shame. The client has a dark secret they wish to share, but they are too ashamed to. To let anyone in is to expose the very deepest parts of the soul, laying bare their identity as someone too disgusting to love. The therapist feels this palpable shame in the air in the room, in their body and in their own reactions. Perhaps they react by over-sharing, trying to be freer to meet the clients' need to know that sharing their secrets and being vulnerable is okay. Perhaps they react by feeling powerless, exposing their own feelings of shame and helplessness, forcing the client to retreat to the depths of their soul once again.

The client battles their inner critic to release the shame within, the ghost of the past that haunts their soul. The suicide voice tries to protect them from feelings of worthlessness, by suggesting that they end it all rather than expose themselves for who they really are. The therapist becomes the ghost hunter trying to lure the ghost out. Perhaps they use imagery, or access the client's dreams, finding ways to relive the past in the safety of the therapy room. Perhaps they try to speak to different parts of the client, seeking the inner child who is being protected by the shaming part of the self, the suicide voice.

REA1 findings cont.

Sometimes the shame is so strong that the fragile relationship between client and therapist might falter, shatter. Shame can be so intense that it permeates the air in the room. It can be difficult not just for the client to bear but also for the therapist. One or other might withdraw, hide or avoid it, employing their defence mechanisms to keep the ghosts at bay. If the therapist cannot model effective ways of processing their own shame in the therapy room, then they may diminish the ability of the client to do so.

Once the ghost is located and brought into the light, the client can begin to use methods such as self-compassion, kindness and forgiveness to diminish its' negative impact. However, this in itself is fraught with danger. Stripping away their identity and their only known coping strategies leaves them with a void to be filled. The client may wonder 'what if there is nothing left, when you take all of this away?', 'How will I protect myself?' But slowly and gently, facing the ghost and learning that these experiences are 'not-me' allows the client to forge new ways of understanding their past and their identity. The safety and power of the therapeutic alliance allows them to understand love and kindness, and start to apply these concepts to the self. As they become able to believe in their own worth, they learn to forgive and move on from the past. They learn that bad things happened to them, but this doesn't mean they are bad. They are no longer toxic, and so they can start to look up and out, enjoying the world without a sense of fear that they will be found out. The client moves from the dark in to the light, and in doing so, become lighter themselves.

REA2: *What works in reducing shame in therapeutic interventions?*

15 studies were mapped. Only interventions from those studies that were rated as medium or low risk of bias were considered, as the findings from these can be considered the most robust. Interventions included those from cognitive therapy (Morrison et al., 2016), Cognitive processing therapy/written accounts (Resick et al. 2008), Dialectical Behaviour Therapy and prolonged exposure (Harned et al., 2012, 2014), interpersonal psychotherapy (IPT) (Talbot et al., 2011) and self-compassion meditation training (Albertson et al., 2015).

Possible interventions from REA2
Self-Compassion
Compassionate body scan
Affectionate breathing
Loving kindness meditation
CT/CPT/WA
Psychoeducation
Guided discovery for stigma
Normalising
belief change through behavioural experiments
exploration of meaning of diagnosis
validation of experience of stigma and discrimination
Considering the pros and cons of responses
Written account of trauma with processing
Interpersonal Psychotherapy
Grief and loss
Role transitions
Interpersonal conflict
Interpersonal patterns
DBT & PE
In vivo and imaginal exposure
Monitoring of potential negative reactions to exposure, and targeting of problems that may occur
Dialectics
Irreverence
validation

How to make these wise?

- Consider which experiential themes meet particular motivations and questions from figure 1.
- Consider which possible interventions might meet the wise motivations (need to understand, need for self-integrity, need to belong)
- Consider if they are wise (subjective meaning making), and what intervention category they fall into
- Consider any adjustments needed to make them wise interventions

4

Cognitive therapy

Working on core beliefs: *(discuss/write about a new belief about you, or write about your old shaming belief about the self – to revise)* Prompting new meanings? **Need to understand**, selves (my own and others)

Wise version: (when they have a new possible core belief/self-view). Direct labelling. Ask 3 people close to you what 3 positive qualities they assign to you. The therapist then also gives 3 positive qualities. Discuss the list and decide what this says about who you are

Increasing commitment through action. How do you like to see yourself and your actions? What are the advantages and disadvantages of being this way, versus the pros and cons of being worthless/unloveable? What would you suggest to someone else in your predicament?

Normalising : Social belonging intervention. Increased commitment through action – saying-is-believing – Murphy et al., read stories describing how it's normal to...then write about how experience reflects process described. **Need to belong**, remedy threats to belonging that undermine functioning, facilitating beliefs that sustain belonging in the face of challenges, *can people 'like me' come to belong?*
Or, **Need to understand**, selves, changing beliefs about ability or potential, *can people change? (implicit theories of personality)*

Wise version. Increasing commitment through action. Give the client some stories of people like them, describing how they have had similar emotions and experiences and how they got through it with therapy. Get the client to write about how their experience reflects the process described.

Imagery modification techniques: Link to Kross and Ayduk, (2008), self-distancing perspective. Well-being/Active reflection on negative experience. Processes: **Need to Understand**, Selves (my own and others), Changing beliefs about emotions, states and valences, *Are negative past emotions, states and experiences on going and undermining?*
Wise version: Active reflection exercise. Visualise your distressing image and imaging you are watching it on a television screen. Practice visualising this image.

Visualise your distressing image and imaging you are watching it on a television screen. Bring in a compassionate rescuer who takes you out of the scene and offers you kindness. Practice this visualising this image.

Written accounts (CPT)

Working with trauma & fear:
Active reflection on negative experiences intervention. Write about a traumatic experience, read the account to therapist, who elicits responses regarding emotions. Hotspots pinpointed and revised. Client to read account between sessions. **Need to understand**, selves, changing beliefs about emotions, *Are negative past emotions, states and experiences ongoing and undermining?*

- Kross & Ayduk (2008) self-distanced perspective when recalling experience reduced depressed affect and recurring thoughts
- Park et al. (2015) write about most distressing event increased self-distancing (active reflection on negative experience)

Wise version: Prompting new meanings. Write about a traumatic event (either worst trauma or one that is slightly easier, and work towards the worst trauma). Write how you feel before and after. Read your account to me (therapist). Therapist will elicit responses regarding emotions, review learning, and discuss any details to add. Client is to read every day between sessions and record feelings before and after. Consider 'hotspots' and then move to next trauma when ready.

Interpersonal therapy

Role transitions (such as new identity): empathise with the loss experience, validate loss, anxiety &/or ambivalence about new role; use sadness at loss, & anxiety about the new role as motivating factors; explore and articulate positives and negative of old and new roles; help develop new social supports
Need to understand, selves, changing beliefs about self-identity, *who could I become? (prospective or potential self-identity)/ who do I not want to be, become, or be confused with?*

Wise version: Active reflection exercise. Write about what your future, compassionate self might look like, and who you are now. Consider the pros and cons of both the old and new identities, and what you need to put in place to achieve the new identity.

Learning to communicate experience: **Need to belong**, the nature and extent of one's social connections, remedy threats to belonging that undermine functioning, bolstering beliefs about social connectedness, *am I connected to others?/does this experience mean I don't belong?*
write a letter as if they were a neutral other. What would a compassionate observer say about your experience? What do they need to know to understand your experience more fully (relate to relationship intervention)

Wise version: Prompting new meanings. Write about how someone close to you has understood your experience and the significance this has had for you in moving forwards.

Trouble experiencing emotion in therapy: **Need to understand**, selves, changing beliefs about ability or potential, *can emotions change? (implicit theories of emotion)*
Wise version: Active reflection exercise. Discuss an incident where you have experienced distress/fear/sadness/anger (whatever emotion you are trying to get to). Intent- to bring up the emotion

Interpersonal therapy cont.

Interpersonal conflict: Role play where the client plays their younger self talking to the person who is the source of their shame (or a significant other in recent conflict). Give feedback on their communication. **Need to understand**, personal and social experiences, changing beliefs in and about interpersonal conflicts and interactions, *how can I better manage this conflict?*
Wise version: Increasing commitment through action. Saying-is-believing. Imagine you are the young child and I am the (significant other). Say to me the things you would like to have said as a small child about how the situation has made you feel. Afterwards, what would you like to say to your younger self now, that you wish they had known then?

Working with communication (non-verbal): Role play recent/upcoming situation, such as job interview. Feedback on non-verbal communication. **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*
 Wise version: Active reflection exercise. Imagine you are giving a presentation/at an interview/ having a difficult conversation. I will play the role of the audience. Afterwards, I (therapist) will comment on non-verbal communication. We will then re-run using different non-verbal communication

Positive reinforcement of attempts at disclosure (secrets): **Possibly write about the meaning of disclosing and how it improved felt experience (like Marigold's self-esteem intervention)**

DBT

Being human & genuine: Disclosure by the therapist: Share a similar situation in which you felt the same way; Disclose solutions you've used to handle a similar problem

Need to belong. As in, social group (not just 'the shamed') *can people like me come to belong?*

Wise version: Prompting new meanings. When a client is struggling with a problem, disclose how you have solved a similar problem. Work through the problem together. Ask them how you are similar and to share how it feels to have similar problems.

Facial expressions: Get them to write a story about their desired identity, therapist reads the story back to them as they adopt a half-smile and nod their head – induce greater conviction in the story. **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*

Wise version: Get the client to write a story about how others would see their trauma (not their fault). Or write a story around forgiveness. Read the story to the client whilst they practice a half-smile and nodding their head, to encourage conviction.

Emotions: **Need for self-integrity** (self-integrity to behaviour to motivate positive change). Counter attitudinal behaviour – Festinger & Carlsmith, 1959 – inducing people to freely act in ways that contradict a problematic attitude can motivate change in that attitude) Opposite action. Shame – withdraw/hide. Instead, look up approach person

Wise version: Prompting new meanings. When you feel you want to withdraw/hide, write about how someone who didn't feel shame would act. What would they do in this situation?

DBT cont.

Validating emotions: **Need to understand**, selves, changing beliefs about emotions, *are negative past emotions, states, and experiences ongoing and undermining?* [Active reflection on negative experiences]

Wise version: Prompting new meanings. When a difficult emotion arises, acknowledge but don't judge it. Tell yourself you have permission to feel the emotion. Try to understand the emotion (without judgement).

Mindfulness practice: Growth mindsets. **Need to Understand**, selves, changing beliefs about goals, *How will I accomplish my goals?* Eskreis-Winkler et al (2016) deliberate practice improved performance [saying-is-believing]

Wise version. Use deliberate practice, psychoeducation about neuroplasticity of the brain/mind is a muscle. Include motivation and information aspects. Then introduce mindfulness (see compassion interventions)

Coping ahead: **Need to understand**, personal & social experiences, changing beliefs in and about interpersonal conflicts and interactions, *how can I better manage this conflict?*

Wise version: Increasing commitment through action. Saying-is-believing. Role play the difficult interpersonal situation that may occur in future. Use assertive language to get your point across whilst considering the other persons feelings.

Self-Compassion

Compassionate body scan: **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*

Wise: Lie down and rest a hand on your heart as a reminder to be kind to yourself. Starting with the feet and working up to the head, notice the sensations of the various body parts. If judgmental thoughts arise, place a hand on your heart, breath deeply, and return to feeling simple sensations.

Affectionate Breathing: **Need to understand**, personal and social experiences, changing beliefs about how experiences with the physical world affect the body, *how does my body interact with the external world?*

Wise: Get in touch with your body by doing a quick body scan and noticing any sensations. Take three deep breaths to let out any tension and then allow breathing to return to normal. Notice where the breath is felt most strongly without trying to control the breath. Adopt a little half smile and observe how she feels. Set an intention to breath in affection and kindness for yourself and with each out breath, breathe out affection and kindness towards others who are suffering just like you. Try not to judge your mind when it wanders. Appreciate each breath and allow the breath to comfort and soothe, and finally rest in the feelings of kindness you are generating.

Loving- kindness meditation: Health/well-being, active reflection on positive aspect of the self. **Need to belong**, remedy threats to belonging that undermine functioning, bolstering beliefs about social connectedness, *am I connected to others?* (Frederickson et al., 2008)

Wise: Have self-compassion for a personal experience of suffering. First, be present in the moment, notice any sounds that are arising, and then focus on the breath. Bring attention to a trait or behavior that has generated negative emotions and allow whatever feelings are connected with this perceived inadequacy to arise. Locate the physical sensation of these emotions in your body and allow them to be there. Place both hands over your heart, to soothe and comfort yourself for the difficult thoughts and emotions you are experiencing. Silently repeat the following phrases to yourself: *May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am.*