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An Investigation of Shame's Influence in Psychotherapeutic Delivery

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Abstract: **Despite the many years in development of a broad set of psychotherapies for change, the social service professions counseling, psychology, and social work have continued to be thwarted by stigma and shame that keep clients, particularly minorities away. In our own daily routines we also have felt victim to shame's influence. In a fresh look, this study will investigate the obstacles and influences that have added timidity to our a full dialogue of the problem. This is perhaps because the problem *IS* shame, and we are to fearful to have the conversation, and to consider our alternatives. Perhaps we cannot give our client's power, until we, ourselves, learn how to be empowered? I think investigation and analysis is a journey we need to take.**

Keywords: **Psychotherapy, Shame, Stigma, Oppression, Discrimination, Systems.**

I. INTRODUCTION

The ethic of those who serve the disempowered is to commit energy to reinstate persons to wholeness, mental health, or to a quality of function that allows for productive daily living [22]. To accomplish this task, theory and intervention are applied as part of comprehensive psychotherapeutic practice [7]. A service delivery system has evolved around applying psychotherapy that is an evidence-based collection of knowledge, value, and skill that is proven to impact client integration [21]. Despite the presence of a well-established therapeutic social structure, the social permission to use these structures remains in question. Evidence of client healing is clear; and yet, social reticence to openly embrace therapeutic healing remains [9][25]. Factors of shame, stigma, institutional discrimination, and social oppression corrosively influence access to quality of living society so desperately needs [2][5][8][29][30].

In investigation and evaluation of the influences on individual and social shames that make clients fearful of therapeutic healing, all areas of resistance will be fully explored. Foundationally, the origins for shame adhesion that impedes receptiveness to services will be identified for understanding [7][14]. Introducing system theory, rational explanation will be uncovered that tie individual shame to institutional oppressions and thwarting those who might otherwise access the mental health system. Once these stigmatizing blockages are uncovered, they will be analyzed into a collective of insights about the ubiquitous predispositions that keep individuals, and the greater society, separated from transformation living and social transcendence. In integration of factors of resistance, origin and theory identification, the patterns of resistance, analysis for insight, the outcome of study evaluation, will present a framework for change that will incorporate study discoveries to supplant the shames and stigma systems that are hampering client access to the healing services of psychotherapy [11][21][30].

II. THE ORIGINS OF SHAME AND HOW IT DIMIISHES INDIVIDUALS AND SYSTMS

As an intimate emotion, shame develops in the toddler years [23]. Shame is suspected to be the last emotion to develop and has relational qualities [13]. The function of relationships is shaped and changed by shame [26]. Relationships can be healthy and reinforced by emotions that attract one to the other. Shame can be healthy and reinforcing to keep the individual operating within norms of social acceptance. Ideally, social service professionals are collectively able to practice from a healthy shame-base position [12].

As a healthy reinforcement, the individual can feel shame as a positive attribution. Healthy shame may operate as a guilt or embarrassment—and is only experienced for a brief interval [13][28]. These emotions can actually help us refrain from conducting ourselves in a socially unacceptable way. Normal shame presents from time-to-time when people feel judgment, teasing, or admonishment [13]. However, shame does not simply act with positive attribution. There is also no larger negative attribution than shame.

Negative shame is toxic to the individual; it will likely present as humiliation or mortification. In a toxic state, shame produces fear and judgment--a feeling of being inferior--of being a mistake. Shame, appeared to be shaped further by influences from reinforcing relationships with others—either through mocking, sarcasm, judgments—in early repeated exposures [16][22]. These periods of shame, cause more prolonged periods of dis-ease, stress, and uncertainty. Toxic shame from individuals and institutions may seek to control and immobilize through threat and intimidation, which leads to negative, toxic results. This approach leads to a generalized toxicity, or dysfunction, within the institutional system.

Fear and insecurity as a part of individual and a more universal shame is a feeling of being devalued and cutoff from known associations. Think of it like being removed from what has been known and trusted. For the individual, toxic shame decreases the sense of safety, causes a feeling of pain, and promotes depersonalization that separates and feels like a dream-like experience. For an oppressed group, it can lead to apathy, powerlessness, and uncertainty [14].

The feeling of oppression, and the resulting malaise, burnout, and powerlessness can transfer from the oppressed group to those responsible for their betterment and wellbeing [12][16]. For example, it is well documented that those who treat traumatized individuals are highly susceptible to secondary or vicarious trauma as a result of exposure. Then, imagine a similar impact that occurs when the social service community is serving groups needing consistent and dedicated empowerments. Feelings of disempowerment may be an unintended consequence to the social service professional [18]. It is suspected that this may be a factor in social service agencies experiencing low salaries and high turnover.

The shame response has multiple places of entry into an individual's life experience. Scheff speculated that shame appeared at different intensities, in different people [16] [26]. Those individuals who experience lower esteem are likely to have greater shame/pain response. The pain can be experienced as a physical pain, but it is connected to an unwanted or difficult feeling of being inadequate or incompetent. There is a feeling of not being respected and trusted which separates the person from others and generates a lack of trust. When in a shame spiral, it brings acute awareness of one's unworthy self [13]. Shame, is the product of being in relationship, but the feelings of shame typically occurs alone. Shame occurs internally, out of the awareness of others [26].

III. INDIVIDUAL AND GROUP RESPONSES TO SHAME ARE THE SAME

In social services, it is unlikely to find the clinician directly addressing issues of shame [14]. This seems incredible given its pervasive role in interaction. In seminal research, Lewis found in analysis of 170 client sessions, shame and embarrassment were the most reoccurring emotions [17][23]. There is an indication that shame can separate the client from the therapist due to transference and countertransference fostering defensiveness and cutting off empathy [16]. The therapist may be unwilling to consider shame, as bringing up shame tends to pass on shame feelings to others. Facing the shame feelings may mean the therapist will have to come face-to-face with their own feelings of shame.

It would be a logical conclusion that everyone (client and therapist) could be overwhelmed by shame when defensiveness causes reflectiveness and a turning inward. The tendency is to want to withdraw and hide the shame from others. In fact, it is in hiding the same that shame gains strength. According to Brere, it is when shame is openly discussed that it diminishes its capacity to gain control [6]. According to Scheff, repressing shame gives it more power [26]. Shame is an emotional state that grows in strength when hidden and spreads to others when practiced as transference [26]. It can only dispelled when calling it my name, when responding to the self in true affection, and when sharing the shame story with another. Despite this discovery, shame intervention work is not widely occurring in session work. When it comes to institutional shame, the instruction to confront the shamer/bully, is often coupled with a proviso that not much can be done to stop the shamer, giving them permission to continue shaming. In trauma work, the strategy to confront the shamer/penetrator is typically through court action or separation from the shamer.

We have seen the results of shame-based costs to society. Oppression is typically ascribed toward a non-dominant group and can provided restricted access to fair pay, restrictions in social ways of living, and limitations to aspects of human

rights. There is some indication, under system theory application, that like issues have a greater propensity to attract--meaning that institutional restrictions to a socially oppressed group (like, voting by minorities) can tend to have similar socially oppressed issues within an organizations (like, court restriction prohibiting organizations from taking minorities to register). At the individual level, this would present as a shame-based action (turning away a minority person to presents to vote). Therefore, social oppression would an established outcome reducing one's trust and comfort in utilizing a system. The social services delivery system has limited avenues for access, is restrictive about the kinds of services that will be offered, has confusion about therapy processes, and typically operates as a time-limited service.

IV. SHAME-BASED FACTORS CAUSING RESISTENCE TO THERAPY

Shame would be most influential at the individual level. There is a tendency for individuals to adhere to institutional norms that promote an internalized sense of pride while diminishing the shame of going against institutional norms [8]. Institutions regulate individual support through group allegiance by the pride-and-shame [23]. There is support within social stigmas that discourages or rejects therapeutic supports for certain social issues, after all other informal supports that been exhausted [2][13]. Socially, families, friends, and church institutions are viewed as the only safe avenue for individual needs. Stigma is strong conveyed among minority consumers [2][30]. The sense of humiliation and embarrassment (shame) can translate, not only on consumers, but on their families as well. Mexican-Americans and African-Americans find familial connection to be the more accepted group for advice giving and problem-solving. The feeling is that private matters are best handled within the family domain [2]. It may be difficult to accept that a therapist from a different cultural group has any identification with daily lives and trials of an African American life. The mindset is not without validity. White psychiatrists evaluated African Americans as twice as likely to need psychiatric hospital stays over cultural groups [3].

Additionally, the inherent stigma of a mental health diagnosis often can often create anxiety and avoidance issues for session work [6][7][25][29][30]. Men appear to avoid counseling if their problems are not at crisis levels. The stigma by society calls upon men to suppress and control their issues and feelings. Admitting to sadness, grief, and vulnerability is socially taboo, even in contemporary times. By the time males feel compelled to go to a session, they are assessing their level of distress as "severe" [25]. In crisis, the client is without reserve and tends to be focused on nothing but immediate relief.

Communities can be ostracizing and oppressing when they learn that someone may be "crazy" enough to see therapeutic intervention—thus creating a social taboo [12]. The ostracization is real. Oppressed groups are subject to more limitations in finding housing, jobs, financial assistance, and unbiased police support [10][21]. This stigma limits social interactions, exposes the recipient to dealing for themselves with depressions, anxieties, loneliness, and stressors [29][30]. Communities may have a service to meet the need, but social stigmas will be a high hurdle when looking for recourse or solution [13][29]. In this cycle, the oppressed individual is left without support, remediation, or rescue other than continue to rely on self-will to maintain against alienation, anxiety, depression, loneliness, and repressed anger. There has been speculation that the high number of male suicides in the United States is predicated on this allusion that sessions are ineffective or a less preferable strategy for relief and resolution. In a time when there is more observed violence and political division, contemporary society's collective denial has been more willing placed its citizenry into peril than to explore for causation for lack of therapeutic follow-through.

Systems in this country have become oppressed organizations—meaning they have been ridiculed as the problem for decreased health care, for insufficient mental health options, for poor education systems, for lack of infrastructure, etc. [12][14]. Institutional denial, in general, has grossly impaired society's corrective plan for healing [7]. The institutions are woefully impaired. Health care services, as another example, are not affordable and without broad wraparounds for sufficient and high-quality care. Health care is an oppressed profession in that health care professionals cannot live up to the high-quality of care that is required for anxiety-free modalities of care [14]. Physicians are suspicioned of driving up costs, of providing unnecessary services, and have diagnostic competency questioned by those not in direct contact with the patient. As a result of physician shame, there is a developing a shortage of doctors because of the demands and challenges and financial burden of dealing with a repressive bureaucratic structure. Therefore, when we are considering the challenge of stigma within mental health offerings, we must understand that system repression is universal [7]. When speaking of corrective strategies for mental health, it is better to consider the problem as correctly a societal dysfunction.

The mental health system is not a chaotic, vague offering of service. In that regard, much has been gleaned in how to offer qualified, evidence-based protocols. There is literature affirming quality-of-care protocols for effective mental health services. Residential living continuums have provided some very developed multi-level, step-down strategies--ranging from hospitalization to independent living components, with effective case management and wrap-around services. There is a broad range of outpatient services for a myriad of issues, considering: addiction, mental health illness, and problems of living issues. As medical coverage is now open to consider preventive services, there has been a growing sense of responsibility of insurance to allow for extended mental health issues, and preventive mental health care (e.g., insurance provisions covering for athletic trainers for issues of obesity). The need and the strategy is well understood by service professionals, with many being competently trained in the execution of therapeutic services. Knowledge is not the area of concern or deficit—what is not yet known about mental health is being progressively uncovered.

As with other systems, like the health care industry mentioned earlier, social service work has degenerated into an oppressed profession [12][14]. That oppression, as something toxic, has come through as malignant, discounting, and suppression. Therapy has been discounted as being less preferable, and secondary to medication [18][21][24]. Therapy's proven effectiveness has been doubted. There have been suppressive trends within communities to marginalize social work, psychology, and counseling's professional standing [10]. The broader community is not even clear on the role of each profession, what services and interventions are provided, and what skill is even involved in clinical therapy. Salaries and hourly rates within social service professionals have suffered reductions within insurance provisions. Social work is the only profession that is shamed for suggesting the right to higher salaries [19]. However, shame's influence effects multiple professions, not simply the social services—any profession that utilizes relationships will understand the debilitating potential of shame. Further, society has inadvertently pitted systems of counseling against one another through confusing licensing, state restrictions on credential and covered services, and a systems that should be working compatibly and cooperatively are being incentivized to shame strategies for self-preservation.

For the larger society, individuals and groups who have experienced chronic rejection, persecution, and alienation, are more likely to experience chronic shame. This is particularly significant when encountering those from suppressed socioeconomic groups and those who experience high stress from daily living. Culturally diverse groups could be more susceptible to this type of shame. Additionally, there seems to be a correlation between psychological problems and those who are shame-prone [11][26][24]. Studies confirm that those who have been victims of childhood abuse, or who have had shame-prone experiences in childhood, were more likely to be shame-prone as adults [4][5][6]. In shame-based institutions, oppressed professionals are likely to be more susceptible to shame, or throwing shame onto another, given professional ethics which challenges the social service worker to be authentic, vulnerable, and to meet challenge with self-control and suppression of ego-states [12][14].

The permutations of shame flows across a psychosocial continuum and is experienced as a social emotion with, cognitive and emotional response, cultural reaction, and spiritual integrity. Those permutations of process can catalyze humiliation, stigma, and past shame experience [15][29]. It is necessary to be mindful in a reflexive way (talking to one's self) and in a reflective way (self-regulation based upon awareness, value and emotional regulation, and in a fully conscious manner). Part of reaching a balanced perspective expects that social service applies empathic accuracy in identifying the psychosocial elements of the misrecognized shame. If shame predominates the entire process, the worker may miss identify the shame and invest in defensive responses. Those defensive responses could be shields against depersonalization, exposure for being imperfect, self-deprecation, and reticence. In the repression of shame, defensive anger can emerge in its place (. Persistent displays of anger can be a sign that the anger is actually covering as a shame defence.

V. ANALYSIS OF SHAME FOR SOLUTIONS TO UNDER-UTILIZATION OF THERAPY

A. Perspective-Taking: A Management Viewpoint:

Those who are well-versed in throwing off shame do so because they cannot tolerate even the mildest forms of reject, embarrassment, or humiliation. Their protection is in being able to find a willing vestal that will accept their shame—meaning, "If you are the embarrassed or mortified one, then I do not have to be." Shame is so repugnant to them that it cannot be allowed. The shamer, to throw shame, must be in a position to have sufficient authority over an individual or a system.

Shame statements or actions start to befall the victim that wear down the self-esteem. It is not unusual for levels violence to become a part of the escalating actions [10]. Typically, secrecy, things said in innuendo, or slurs/threats, which could be interpreted in several ways, make up part of this barrage. If the client is a subordinate, the cascade of abuses may be for purposes of assault, exploitation, or departure/termination. The fear of the unexpressed/veiled threat is always present in the relational exchanges. Remember that while intermittent shaming is embarrassing, shame as a part of a toxic mix has prolonged influence. The shamer is speaking from his/her perspective, but the client has a valid perspective also. A perspective is not a truth but is merely an opinion. Everyone has equal right to their own opinion.

A strategy to confront an individual shame would indicate confrontation. Confrontation, without emotion but objectively stated, with a solution, is effective if the shamer has a healthy sense of shame. If not, the best instruction is to deliver this non-defensive confrontation, but expect it not to have long-term impact on stopping shaming attacks. Many human services offices have codes of conduct. If a resolve is agreeable to an agency, it typically requires a written set of consequences to restrain a toxic shamer or the consequences will have no long-lasting effect. The presence of leadership with the clout to discipline a shamer, and the ability and willingness to follow-through is the best recourse. The difficulty with long-lasting relief for the client/employee is that many institutions do not have strategies in place for employee shame resolutions at the management level.

B. Perspective-Taking: A Therapeutic Viewpoint:

The experts acknowledge that shame intervention requires the clinician to have the appropriate training in order to be able nondefensively go with the client to explore the shame [6][25][26]. If a clinician has not done their own work, there is a danger of inadvertently shaming the client by controlling how much of the story the therapist is willing to hear. With the training, the therapist can assess the level of client and places where education of shame and its nature can be explored. It is necessary to help the client develop full awareness of the complexity of shame exposure and how childhood shames contribution to current circumstances. In this way there is a full disclosure of the client's sources of shame and a way for the client to begin to contextualize shame. In course of owning shame, the client needs a new framework for self-esteem—recognizes strengths, forgiveness, self-power, and a healthy internal locus of control. The presence of shame diminishes empathy in the clinician's response and diminishes trust within relationships [16][125]. The therapist then is able to hear the client's narrative of shame, and then reconstruct that narrative to develop the new, and more resilient self-esteem. Included in this strategy would be for the client to develop action steps to deal with shame-based reactions, in the future. The purpose would be to move toward more healthy shame integration.

C. Perspective-Taking: A Systems Viewpoint of the Oppressed Service Provider Dilemma:

Within the mental health industry, the service provider is responsible for the wellbeing of the client but is also subject to the discretion of agency dictates, professional licensing restrictions, legal standards, social norms, and ethical considerations. This is not an option for the clinician, but it is to be considered a set of givens that are sometimes compatible and sometimes contradictory to one another. In social work, the two confounds are referred to as dilemmas because there are to two competing perspectives that the clinician has to take into full consideration, to reconcile, and then to act from the reconciliation. If the service provider accepts the working social service system as oppressed, this means that all responses from all systems related to counseling will be regarded as having ulterior motives and are to be judged with suspicious. Trust in all systems (individual, agencies, institutions) will be regarded as part of a conspiracy to thwart outcomes and progress. If trust is impacted by these suspicions, the ability to advocate and provide meaningful authentic therapeutic intervention will be undermined because self-doubts will rise up (lowering self-esteem). The therapist's submission to an absolute supremacy of oppression by the larger system will make the clinician impotent, and ultimately ineffective as a competent clinician.

An alternative view of working within oppressed system is to recognize and be reconciled to the presence of alternative perspectives. Those perspectives would be the recognition of a systems imperfection but also recognizing advocacy is the strategy for resolution. It is a perspective of critical oppression understanding (e.g., critical social work), that all social problems arise from social oppression [1][4]. This view is that clinicians are obligated to use critical thinking to comprehend and address problems that are moral and ethical in nature. This theory ascribes the clinical responsibility to respond where individuals are disadvantaged. A part of that perspective, begins with advocacy for one's self and one's profession. If social services are oppressed, then clinicians have a profound responsibility to respond and not succumb to threats to integrity. Social services execution of services not only require this but demand it.

Critical practice applications systematically involve critical thinking, critical applications, and reflexivity [1][27]. Critical thinking embodies the mechanisms employed in this study—the use of application, analysis, altering viewpoint to come to a logical and reasoned conclusion about problems and their resulting strategies for change. The application is the written process of plans for action, and how those actions would be carried out. Reflexivity would involve considered process and thought to make sound decisions with fully consider on available information, process, and disciplines/theories. Part of this critical understanding theory is the expectations of self-emancipation and progression to steps and actions for change [27]. Therefore, strategies for change, if social service professions have been relegated to an oppressive group social service providers is not to accept the shame but to embrace anti-oppressive strategies

VI. ANTI-OPPRESSION SOLUTION STRATEGIES FOR SOCIAL SERVICE DISEMPOWERMENTS

A. Major Tenets of Anti-Oppression Solutions:

Anti-Oppression strategies challenge social work and all social services to be cognizant that open-mindedness is essential in the establishment of oppression repelling strategies. It is foolish to assume that a sole advocate is keeper of all that is correct—when we know from the earlier discussion of perspective-taking that multiple sources will have multiple opinions. and no one opinion is necessarily more correct, or just, than another. What may appear to be humanizing to one group may actually be experienced as dehumanizing by another—or what advantages one group may have may inadvertent disadvantage another. Therefore, all words and actions should be viewed through a critical filter to check for bias before strategies are implemented. In the examination of oppression, a better approach is to collectively consider how all are hurt by oppression and how all can be benefited by anti-oppression actions.

A target strategy should begin with a collective dialogue among social services practitioners about oppressions affecting social service systems that would benefit from anti-oppression changes. Coming together in coalescence as a group empowers and provides opportunities for collective and consensual change strategies [18]. The changes will be more harmonious, tend to have longer-term advantages, and lead to the potential of additional anti-oppression changes for other systems. The additional advocacy resulting from larger associations, rather than individual effort, will provide benefits of shared tasks, greater group esteem, and modeled examples for other systems and organizations.

For issues impacting larger social oppressions, such as oppression to religious groups or oppression to migrants, larger coalitions would be necessary. From an ethical and moral perspective, once anti-oppression resolutions becomes the mission of individual pursuit, it should never cease or be supplanted. Part of larger coalition development would necessitate continuing research and discovery to understand the history, nature and extent of other oppressive experiences through critical thinking approaches [1][27].

B. Solution Strategies for Specific to Social Service Feeling of Institutional Shaming:

To address shame-prone social services concerns, it is important not to project shame, which will only elicit defensive-shaming in response. It is also important to address concerns with leadership/administrators within organizations where the shame-projection appears to be occurring. Open the dialog in more intimate, one-on-one settings will help reduce shame spiral potential. If responses initially appear shame-based, gentle acknowledge what you are hearing and help re-state concerns in a manner that opens up dialog. Again, resist the temptation to respond from shame, even if initially the leadership is not practiced in responding authentically [15]. It will be harder for leaders/administrative groups to respond defensively if you are open and continuously genuine in your model of communication.

If multi-systems/organizations/departments are involved in social service shaming, look for opportunities to promote the positive aspects of the discipline. Gathering in social settings is less confrontational and may offer opportunities to provide friendly and productive collaborations. Demonstrating opportunities for shared benefit is a good way to develop network and connection. A good way to show respect and shared goals is to provide experiences that allow potential partners to see you in action. Just like developing cohesions with clients, you want potential adversaries to trust you as allies and partners. Developing that kind of relationship may allow you to educational opportunities on the costs of oppression to an organization or institution.

C. Solution Strategies for Affirmation of Therapeutic Integrity:

Much of the process information applied today as part of psychotherapeutic technique is now being affirmed in science. Empathy's connection with intelligence and compassion, the value to quality of living through relationship bonds, and the

benefits of stress reduction to mental health and longevity have now been proven to be physiologically correct [7]. Additionally, the intensive history of meta-analysis discovery has provided empirical weight that psychotherapy is an efficient and effective method of intervention, with proven efficacy above select medications in remediation of mental health issues [21]. These outcomes need to be more widely disseminated to affirm consumers of the successes in mental health care. Additionally: 1) the promotion of social service can be more widely promoted in the media, in films, and in commercially accessible literature. 2) Culturally-sensitive trainers need to develop protocols for therapy training techniques that are particularly culturally-salient [21]. 3) Client satisfaction surveys need to have a cultural assessment component so that therapies and therapists can be better assessed for cultural applicability. 4) Concerted efforts need to demystify therapy and promote session work as a collaboration and not a construct under the therapist's control. This information could easily be established as a web-link developed as a national initiative, or as the result of individual agencies providing public services messages that promote their services on-line. 5) The consumer needs education that therapy is a service and that consumers have a right to ask questions and have expectations about the services they receive; and adopt an anti-oppressing therapeutic approach [4][21][26]. 6) Finally, the therapist needs to be bold and empowered—confidently addressing and facing shame issues. This empowered approach will model shame-reducing responses in the client [18][24].

D. Solutions Strategies for Personal Esteem and Shame-Reduction:

It is challenging, but no change is sown more deeply than the changes that can be adapted to the self. This change will not come without some discomfort, but practice will build competency. To reduce the oppression and shaming, takes the courage to be painstakingly honest, to walk through some discomfort, and to remain positive in an expectation for change. To be open to change will mean not to over-interpret the motivations of others but to give others permission to be human as work can progress toward mutually beneficial goals. Most importantly, as it relates to critical practice, is to confidently lean on the knowledge, values, and experience acquired in professional groups. Looking for opportunities to promote practice, to practice consistently connecting theory to practice, and confidently strive to maintain the highest therapeutic integrity will, over time, undergird therapeutic legitimacy [27].

VII. CONCLUSIONS

The study explored how perception of therapy may be fueling the stigma, bias, and profession shaming that has resulted in reliance in the medical model over trust in the psychosocial system of mental health. Some of the confusion and mistrust in clinical system has been fueled by control, misconception, and negative attributes ascribed to oppressive groups. This control has compounded the lack of trust in session work, by implying the mental health care system has been incapable, intolerant, and impotent. In a sense, psychotherapy has falsely been portrayed as inferior, insignificant, and illegitimate—as part of a shame-based system. The study exploration produced elements for analysis, leading to discovery of anti-oppressive measures that could revitalize mental health delivery, empower the therapist, and confront oppression-based shame. From a shame-reduced platform, proactive solutions would be able to more freely emerge.

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