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**Shame in therapy: The perceptions of trainees, counsellors, and  
early career psychologists concerning the identification and  
amelioration of shame.**

*A thesis presented in partial fulfilment of the requirements for the degree of  
Master of Arts in Psychology*

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*2024*

## Abstract

Shame has many facets that make it difficult to be defined (Bradshaw, 1988). The complexity of defining shame extends to the difficulty in identifying it in therapy. Research has indicated that shame can have overlapping symptoms in client presentations with that of depression as well as social anxiety, and this could hinder the treatment of shame (Swee, Hudson, & Heimberg, 2021; Kim, Thibodeau, & Jorgensen, 2011). This study aimed to explore how students in their final year of psychology, counsellors, and early-career psychologists perceive shame as a distinct construct in client case scenarios. The study also sought to determine whether introducing a prime would influence case conceptualisation. Recognizing that these emotional states, depression, feeling ashamed and socially anxious can influence each other during therapy sessions, and might hinder the identification of shame, this study intended to shed light on the potential implications this may have on effective treatment. A total of 18 participants who met the criteria were recruited. Six distinct online questionnaires were developed, each presenting the same two client case scenarios and questions but employing different primes related to the three emotional states under investigation. Each participant completed one online questionnaire. Data were analysed using descriptive statistics indicating the frequency of the affective terms before and after the prime effect as well as Thematic Analysis to identify the prominent themes otherwise mentioned in the case conceptualisation. The findings of the study highlighted the complex relationship between shame, depression, and social anxiety and how shame can be masked in client presentations. Social Anxiety was the most prominent affective term that was identified by the participants. Although shame was only identified twice, self-

compassion was recommended 42% of the time as the most suitable treatment option across all affective states identified. This study highlighted the need for improved understanding of shame and how it can present as different affective states in therapy and the effective identification and treatment of it.

**Keywords:** depression, self-compassion, shame, social anxiety disorder, therapists, therapy

## **Acknowledgments**

I would like to thank all the extraordinary people who have supported me throughout my academic journey and made the completion of this research project possible.

I would like to firstly thank the Lord for giving me the ability and the opportunity to have been able to learn more in a field that I am passionate about and to be able to use the knowledge and the learned skills to support others.

I want to thank my academic supervisor, Professor Ian Evans. He has been pivotal in supporting me in creating this research project. His exceptional guidance, support, knowledge, and mentorship throughout this research process will leave a mark on my future in Psychology for many more years to come. His expertise in the area of psychology, and insightful feedback have been invaluable in shaping my work and pushing me to achieve my best. Thank you for the countless hours of researching and discussing the concept of shame. I will miss our meetings and laughs about life's moments in between.

I would also like to thank the late Professor James Liu, who was instrumental in my research project. His sudden passing left a big void. His presence in conversations always felt assuring and filled with compassion and support. Thank you for all you have meant in the time that you have supported me. May this piece of research also add to the legacy you are leaving, in academia.

I am also deeply grateful to Professor Armon Tamatea for his contribution to support me in understanding the cultural sensitivity that was needed to embark on

this research study. Your thoughtful suggestions have greatly enhanced the quality of my research about shame across cultures.

A big thank you to Associate Professor Heather Kempton for her insightful contributions to my Master's thesis. Your expertise, even during a brief period, significantly enhanced the quality of my research. I appreciate your willingness to provide feedback and guidance, and I am thankful for your support.

To Kyle Smith, Gail DaBinett and Chellie Keenan, where do I begin to say thank you for all you have done to support me in recruiting participants for this study. Your support has been vital to reach the needed participants.

A very special thank you to the participants in my study, who generously shared their time and experiences with me. Your contributions are the foundation of this research, and I am deeply appreciative of your willingness to engage in this process.

To Rose-Hannah Brown, my clinical supervisor, thank you for all your support, encouragement, an exceptional amount of knowledge, and compassion throughout the years. You believed in me and taught me to also believe in myself. Thank you for your continued contribution to shaping me in this field of Psychology.

Then, I would like to thank my husband. You have been my anchor throughout this journey. Thank you for believing in me, encouraging me, and keeping me steady. This has allowed me to venture into the deep and unknown, always feeling safe, loved, and supported.

To my three precious children (who might not be able to read this yet) thank you for being my greatest gifts in this world, I love you so much.

I would also like to thank my family and friends, I extend my deepest appreciation for your unwavering support, love, prayers, and encouragement. Your encouragement has been a source of strength throughout my studies.

Thank you to Massey University Human Ethics (Ohu Matatika 1, Application OM1 24/25) who has reviewed and approved this research project.

Finally, I dedicate this thesis to all my clients who have inspired me to want to understand “shame” in all its ways so much better. Thank you for entrusting me with your life stories and for allowing me to be a part of your journey.

Marnell Nortje

2024

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## Introduction

### Overview

Shame is a psychological construct that has been conceptualised in many different ways, including being described as a 'prototypical moral emotion' relating to the way an individual will have a negative perception of themselves due to internalization and externalization problems (Muris, Meesters, Cima, Verhagen, Brochard, Sanders, Kempener, Beurskens, & Meesters, 2013). This affective state has been described as a deep-seated hurt that is experienced where one can feel separate from parts of oneself and others (Bradshaw, 1988). According to Maslow's perspective on 'human belonging', the lack of this important human element can lead to different unwanted conditions that can negatively affect a person's health, emotional wellness, and overall maladjustment (Baumeister & Leary, 1995). Shame can often be hidden beneath a layer of defensive emotions, including social anxiety, self-loathing, anger, despair, contempt, feelings of superiority, envy, destructive impulses, and depression (Greenberg & Paivio, 2017). This affective state also exists on a continuum, ranging from mild embarrassment to intense humiliation (Thomas, Deighton, Mizuno & Fujii, 2019). It is a deeply personal and often stigmatized emotion and can significantly impact an individual's self-worth and overall well-being. Individuals may experience shame related to their physical appearance, their longing for connection and validation, their sexual preferences or identity, their abilities, thoughts, or aspirations (Greenberg, 2024). Culture plays a pivotal role in shaping an individual's perspective, emotional responses, social interactions, and understanding of life experiences. Cultural and social factors often discourage individuals from openly disclosing feelings of shame, especially to mental health professionals (Kroll & Mohamed, 2022).

Despite its significance in therapy, shame is often overlooked or avoided due to factors such as therapists' lack of training, the inherent painfulness of shame, and the difficulty in identifying and addressing it without causing further distress. (Greenberg & Paivio, 2017). Understanding and addressing shame is crucial for effective therapy. Failure to do so can lead to persistent problems or premature termination of therapy and support (Greenberg & Paivio, 2017).

### **Perspectives on Shame**

According to the functionalist view, shame is rooted in Darwin's theory of evolution and the idea that emotions have a purpose in helping us survive (Mills, 2005, p.28). The way the human brain has been hardwired specifically for social interactions and processing makes relationships a critical part of human existence. Some studies have examined the enduring impact of early negative experiences on self-perception and social interaction, focusing on the concept of 'shame memories' as conditioned emotional responses (Pinto-Gouveia & Matos, 2011).

The cognitive attributional perspective of Levinson and Tangney (2002), explains shame as triggered by negative self-beliefs that are internal and all-encompassing. Individuals believe they are inherently bad, rather than simply having done something bad. They see themselves as worthless, undeserving, or flawed. Also adding that shame arises from the discrepancy between personal expectations and one's perceived shortcomings in how others see them (Tangney, Stuewig, & Mashek, 2007; Tangney & Dearing, 2002). A person can make someone else feel ashamed but it may be exaggerated in the individual who feels shame (internalise).

## **Development of Shame**

Shame can develop early in life or can be experienced throughout life in different relationships or experiences.

***Parenting Influences*** Early attachment relationships may be one of the ways that can contribute to the development of shame. According to Bowlby (1973), it is critical for children to form a relationship with a primary caregiver. The quality of these specific attachment relationships forms the basis of how we understand relationships in the world. These can include certain beliefs about the self and others as well as specific expectations of others in relationships. These connections that are grounded in loving and caring for one another offer many benefits (Gilbert, 2014). A substantial amount of research now indicates that the love and support experienced during early life significantly influences the development of genetic, biological, and psychological processes (Belsky & Pluess, 2009; Siegel, 2012; Slavich & Cole, 2013). Caregivers' lack of responsiveness to a child's emotional needs can foster feelings of shame (Schore, 2019; Shabad, 2022) where children are inclined to internalise the caregiver's attitude and actions towards them (Ferguson & Stegge, 1995).

The emergence of shame and the ability to understand other people's minds develop together early in the lives of children, according to Sahi and Elsenberger (2021). Children's ability to understand that they are being observed by others, whom they have no control over, is believed to be a foundation for experiencing shame (Schultz-Venrath, 2021). One example of this will be when a mother shames her daughter by saying that she is overweight and that that is the reason that she will never get a partner, or another example will be when a father makes negative comments about his son to other people while his son is in the conversation to hear.

The child (or person) has no control about what is being said about them. These statements get internalised and then forms part of the individual's representation of themselves.

Bowlby's (1973) attachment theory emphasises the significance of a responsive and empathetic relationship between caregiver and child. The young child then uses this framework and continues to develop their self-concept as it is shaped by their experiences and interactions, leading to the formation of internalised representations of self and others as they grow older. These internalised concepts serve as adaptive strategies that foster autonomy and shape future interpersonal interactions. When caregivers are negative, critical or antagonistic the child may internalise this and in turn become more critical of themselves and evaluate themselves negatively (Tracy, Robins & Tangney, 2007). Children's shame is often linked to parental hostility towards them, inconsistent discipline, and a lack of positive reinforcement (Ferguson & Stegge 1995). According to Bennett, Sullivan and Lewis (2005), abusive parenting can cause children to feel abandoned, rejected, and worthless which can then be felt or experienced as shameful. Disruptions in relationships are inevitable (Fonagy, 2006). It is through these frequent unexplained ruptures that children can blame themselves. Such experiences can contribute to feelings of shame in adulthood (Solomon, 2021).

***Victim of Bullying*** Another way shame can be experienced is through bullying (Castilho, Pinto-Gouveia, & Duarte, 2016). Individuals are naturally inclined to track their sense of belonging and acceptance by others and by doing this it has been proposed by Gilbert (2004) that shame serves as a psychological deterrent, prompting individuals to conform to social norms and avoid ostracism and being

bullied. According to Dearing and Tangney (2011), individuals who frequently experience shame are more likely to be vulnerable, and Lopez, Gover, Leskela, Sauer, Schirmer and Wyssmann (1997) also adds that these individuals may struggle with teamwork and be conflict-avoidant due to the internalised shame perceptions.

When an individual experiences bullying it causes the person to experience exclusion and rejection that leads them to feel that they are not worthy of love or that they are unattractive or unacceptable, thus adding to a negative self-belief that causes shame. Individuals who are prone to shame are more likely to experience hostility, anger, aggression, and a tendency to blame others (Ahmed & Braithwaite, 2004; Bennett, Sullivan, & Lewis, 2005; Harper & Arias, 2004; Levinson & Tangney, 2002). People who become bullies may have also been subjected to domestic violence in their childhood, leading to feelings of shame and a desire to exert power over others (Tangney et al. 2007). Shame can damage the way an individual views relationship and make it difficult to connect with others (Dearing & Tangney, 2011).

***Negative Life Experiences*** Shame that is associated with trauma often stems from societal expectations and the individual's struggle to reconcile their own beliefs with their experiences (Budden, 2009; Øktedalen, Hagtvat, Hoffart, Langkaas, & Smucker, 2014; Wilson, Drozdek, & Turkovic, 2006). For instance, victims of sexual violence may face societal stigma, fearing condemnation, accusation, or isolation, which can intensify feelings of shame and guilt (Bhuptani & Messman-Moore, 2019; Kennedy & Prock, 2018).

Evidence indicates that adverse childhood events are linked to increased shame (McLean & Foa, 2017). Alix et al., (2017), states that self-blame and negative internal attributions are strongly linked to PTSD and suicidal ideation, particularly in

cases of childhood sexual abuse, where societal stigma and feelings of personal failure can exacerbate shame. Research has also shown that women who have experienced interpersonal trauma tend to report higher levels of shame related to their sense of self and body image compared to shame tied to specific actions (Andrews, 1997; Dyer, Feldmann, & Borgmann, 2015; Vidal & Petrak, 2007; Weaver, 2020). It has also been demonstrated that memories associated with shame can exhibit the same characteristics as traumatic memories, including flashbacks, intrusive thoughts, and avoidance behaviours. These memories can become central to individuals' life stories and identities (Shahar, Doron, & Szepeswol, 2015; Pinto-Gouveia & Matos, 2011).

### **The Presentation of Shame**

Evolutionarily, shame has a role in preserving social status. Bradshaw (2005) differentiates between healthy and toxic shame. Healthy shame, similar to our other emotions, serves as a motivational force, prompting us to get our fundamental needs met. It serves as a reminder of our limitations, as exemplified when we acknowledge our mistakes and recognize our human fallibility. Toxic shame, as described by Bradshaw (2005), is a destructive force that leads to self-concealment and a belief in one's inherent defectiveness, often triggered by unexpected exposure.

This affective state could also act as a warning sign that the individual might experience rejection or exclusion in a social setting. This kind of shame would guide behaviour towards safety tactics, such as appeasement, with the goal of shielding oneself from negative judgment by others (Gilbert, 2007). The physical manifestations of shame, including body withdrawal, blushing, avoiding eye contact, and covering the face, can evoke empathy and forgiveness from others

(Asgarizadeh, Sharp, & Ghanbari, 2023). Ironically, these very behaviours that were intended to foster connections can often lead to further rejection and isolation (Hewitt, Flett, Sherry, & Caelian, 2006; Hewitt, Flett, & Mikail, 2014).

Greenberg (2024) classifies shame in five components that all need to be treated in therapy sessions:

1. The Emotional Component: *A bodily felt sinking feeling, shame-anxiety, self-disgust, self-contempt*
2. The Internal Self-Evaluative Component: *I am bad, inadequate, flawed, useless, a failure.*
3. The Social Component: *Others see me as bad, inadequate, useless, a failure and are contemptuous of me.*
4. The Motivational/Behavioural Component: *Desire and tendency to hide or conceal own behaviours, feelings of rage or thoughts about retaliating against shamer.*
5. The Physiological Component: *Increased arousal, sympathetic/parasympathetic autonomic nervous system, stress hormone release.*

Another manifestation of shame can be perfectionism. Socially imposed perfectionism and the need to present oneself perfectly may stem from challenging or traumatic relationships with primary caregivers (Hewitt, Flett, & Mikail, 2014). People who are overly focused on perfection may be driven to meet the high standards set by others or to present a perfect image. Perfectionism, especially in self-presentation, is often seen as a way to gain acceptance and care from others and avoid rejection, failure, shame, and humiliation.

Nathanson's (1992) shame model, that could be seen as a “compass of shame”, outlines four primary ways individuals usually use to cope with shame: self-attack, withdrawal, other-attack, and avoidance. While these styles are typically maladaptive, their effectiveness can be situational. Self-attack involves internalizing shame, leading to self-criticism. Withdrawal involves avoiding the painful experience of shame in a social setting. These styles are categorized as internalizing due to their conscious recognition of shame (Elison, 2019). Other attacks involve externalizing blame, while avoidance involves denying or distancing oneself from shame. These latter two styles are externalizing, reflecting an unconscious denial of shame. Recent research has made us more aware that our adaptive style involves acknowledging shame, compensating for shortcomings, self-assurance, and seeking social support.

Shame can also be described as manifesting as either external or internal. External shame occurs when we believe we are rejected by others, while internal shame is rooted in our own self-criticism (Wood & Irons, 2017). Rather than viewing mistakes or limitations as isolated incidents, individuals with toxic shame often generalize them into a negative self-perception, believing their entire being is fundamentally flawed (Friel, 2016). Shame can also be described as centred around the self and often appears as a broad sense of disapproval directed towards oneself due to perceived failings that arise from engaging in unacceptable actions in social settings (Tangney, 1991). This will then present as an individual who will take another person's perspective and internalise this as the global self through a negative lens. According to Ferguson, Eyre, and Ashbaker (2000), it can be defined as an ‘unwanted identity’; individuals attribute negative characteristics to themselves that conflict with their self-ideal or when they believe others perceive them similarly.

Even in solitude, the self-critical person envisions how they might be perceived negatively by others. Therefore, it is not surprising that the ashamed individual often wishes to hide from others or disappear completely (Tangney, Wagner, & Gramzow, 1992b). This can lead to a struggle to form secure attachments with others, an overwhelming sense of shame, and a strong desire for acceptance and approval that may never be fully satisfied (Banai, Mikulincer, & Shaver, 2005; Hewitt, Flett, & Mikail, 2014; Horney, 1950). Depression and anxiety are issues that can arise should a person experience feelings of rejection or disconnection from others that disrupt the sense of belonging (Cacioppo & Patrick, 2008).

### **Shame vs Guilt**

In the past, psychological research has often treated shame and guilt as synonymous terms (Tomkins, 1962); in more recent studies, a clearer differentiation between shame and guilt has emerged (Gilbert, 2003). The foundational stages of emotional development typically commence within the infancy period, generally spanning from birth to approximately two years of age where young children develop basic emotions like happiness, distress and disgust (Amir, 2017). In comparison to basic emotions, self-conscious emotions like shame and guilt develop later in childhood and require more advanced cognitive abilities. These emotions typically emerge around the age of two or three (Lagattuta & Thompson, 2007).

When experiencing shame, individuals tend to focus on their negative qualities, neglecting the experiences of others (Tangney & Dearing, 2002b). In contrast to shame, guilt involves a focus on one's actions and their negative consequences for others (Lewis, 1971). For example, with shame someone could be enjoying a relationship with a sexual partner but feel shame because of cultural views

even though both partners are consenting, while with guilt someone may be concerned with harming another in the relationship (e.g., not consensual or the harm of people finding out). Guilt and shame have a survival function for humans where they help guide our behaviours in social situations, but it can become malfunctioning and cause dysregulation that can then lead to other psychopathological symptoms (Muris, Meesters, Cima, Verhagen, Brochard, Sanders, Kempener, Beurskens, & Meesters, 2013) like anxiety disorders and depression (Thompson & Berenbaum, 2006). Guilt has shown in recent research to be potentially adaptive in its functioning as a source of motivation. It can cause a person to want to repair a rupture and to actively attempt to make amends when they have done something wrong. It has been regarded as supporting the development of empathy (Baumeister & Leary, 1995; Tangney, 1991). Experiencing guilt often leads to feelings of remorse and actions aimed at rectifying the mistake. Guilt tends to enhance empathy towards others, whereas shame can hinder empathetic responses because it is primarily focused on self-directed distress (Piretti, Pappaianni, Garbin, Rumiati, Job, & Grecucci, 2023).

Recent research has examined the influence of parental socialization on guilt and shame (Meesters, Muris, Dibbets, Maaïke, & Lotte, 2017; Stuewig & McCloskey 2005; Svensson, Weerman, Pauwels, Bruinsma, & Bernasco, 2012) where it demonstrated that children whose parents employ inductive discipline, such as explaining the potential harm to others caused by certain behaviours, exhibit higher levels of guilt (Ferguson & Stegge, 1995; Hoffman, 2000). Research by Dunn, Maguire, & Brown (1995) has shown that inductive parenting has been linked to a more mature moral development, leading children to seek restitution for harm caused to others. A parent saying “You are an idiot” can lead to shameful feelings where “You

made a mistake, but you are still a good person” can lead to more feelings of guilt (Greenberg, 2024).

The Traumatic Stress Institute (2007) has noted that shame is a complex state which affects various bodily systems and operates at a deep, pre-rational level. Shame is therefore a potent force that extends beyond conscious thought. Lewis (1971; 1987b) suggested that individuals prone to shame are particularly susceptible to emotional disorders, especially depression, while those prone to guilt are more vulnerable to cognitive disorders (Tangney, Wagner, & Gramzow, 1992). Recognizing the distinction between shame and guilt is essential, as shame has been implicated in a range of negative mental health conditions, whereas adaptive forms of guilt have not (Muris & Meesters 2014).

### **Shame Overlapping with other Affective States**

Kauffman (1996) stated that shame serves as a foundational factor contributing to a range of psychological disorders, including depression, anxiety, compulsive and impulsive disorders (and addictions), perfectionism, low self-esteem, borderline and narcissistic tendencies (Johnson, 1994).

Shame could possibly be the foundation of many DSM diagnoses (Abe, 2004), but for this research project, the focus is only on the complex relationship between shame and depression, and shame and social anxiety.

### ***Shame and Depression***

As documented thus far, shame is usually marked by a sense of inadequacy and a lack of value. It can be seen how easily these features might overlap with the predominant characteristics of depression (Tracy & Robins, 2004). Research by Kim,

Thibodeau, and Jorgensen (2011a), indicates that it has been associated with a range of other psychological issues such as depression where shame is a significant factor in predicting depression and poorer health outcomes in various situations and health conditions. A significant association has also been found between bodily shame and chronic or recurrent depression, even when controlling for current depressive symptoms (Andrews & Hunter, 1997). Those struggling with depression frequently report feelings of inadequacy, sadness, difficulty in attending to basic needs, challenges in-role performance, and heightened physical pain (Clayton & Burlingame, 2024). There are overlapping symptoms that may mask shame as individuals who are prone to shame may also be susceptible to feelings of hopelessness, which have been identified as a direct cause of depressive symptoms and potentially other types of disorders (Abramson, Metalsky, & Alloy, 1989).

Abramson, Metalsky, and Alloy (1989) identified internal, stable, and global attributions for negative events, in combination with negative self-perceptions, as key contributing factors to hopelessness and depressive symptoms. In a study done by McCleary-Sills, Namy, Nyoni, Rweyemamu, Salvatory, and Steven (2015), women who have experienced intimate partner violence have described how they have lost their sense of self together with the feeling of powerlessness. This led to them withdrawing socially as well as experiencing feelings of worthlessness and a feeling of personal failure. These symptoms could present as depression and mask the hidden struggles with shame that were identified in the study. Persistent negative self-focus can also contribute to the development and maintenance of depression (Orth, Berking, & Burkhardt, 2006).

Initial research suggests that the high rate of shame among individuals with depression may be primarily driven by the association between depression and social anxiety. Two studies have demonstrated that shame and social anxiety remain significantly related, even when controlling for the effects of depression (Gilbert, 2000; Hedman, Strom, Stünkel & Mortberg, 2013). Conversely, Gilbert (2000) discovered that when social anxiety was accounted for, the connection between shame and depression became insignificant. These findings suggest that shame and social anxiety have a relationship that is independent of depression and that social anxiety may partially explain the relationship between shame and depression.

Shame, if not identified as a root of the depressive symptoms, may hinder recovery from depression and increase the risk of future episodes. Conversely, shame could also be a result of persistent depression, as individuals may develop feelings of shame about their personal qualities and behaviours over time (Andrews & Hunter, 1997).

### ***Shame and Social Anxiety***

Social Anxiety Disorder and shame can also often coexist due to several overlapping factors. Both conditions involve social withdrawal, avoidance, impaired relationships, and negative self-thoughts (Clark, 2001; Tangney, & Dearing, 2002b; Taylor & Alden, 2006). The American Psychiatric Association (2013) defines social anxiety disorder, also known as social phobia, as a persistent mental health condition characterized by a fear of negative judgment, significant apprehension, and avoidance in various social or performance settings, leading to noticeable distress or impairment in multiple areas of life. According to the American Psychological

Association (2009), shame can cause individuals to avoid social contact, which can have a detrimental effect on their mental health and relationships.

Various researchers (Buss, 1980; Cox, Fleet, & Stein, 2004; Gilbert, 2000; Gilbert & Procter, 2006; Harder, Rockart, & Cutler, 1993; Lutwak & Ferrari, 1997; Moscovitch, 2009) have suggested that shame may be connected to several key aspects of social anxiety, such as self-critical thoughts, social avoidance, anxiety in social situations, and distress. People with Social Anxiety Disorder frequently have a strong need to be perceived positively by others, but they also anticipate being rejected or even humiliated (Clark, & Wells, 1995). Similar to shame, people who have experienced adverse environmental conditions may become more focused on identifying threats, making them more susceptible to Social Anxiety Disorder (Swee et al., 2021).

The notion that shame may be intertwined with the development and persistence of Social Anxiety Disorder is not new. Moscovitch (2009) proposed that Social Anxiety Disorder is rooted in a pervasive "distorted, negative self-image" (p. 125). Moscovitch states that self-attributes perceived as inadequate or unacceptable by others are the primary feared stimuli in social anxiety disorder. Self-attributes deemed as shameful vary from person to person and may include perceived deficiencies in social skills and abilities, one's physical appearance, one's character, or one's experience of anxiety and a perceived inability to conceal it.

Research by Swee, Hudson and Heimberg, (2021) suggests that social anxiety and shame are closely connected, and it seems highly improbable, if not impossible, to experience significant social anxiety, and certainly a diagnosis of Social Anxiety Disorder, without experiencing some degree of shame. The findings

from work by Shahar, Doron, and Szepeswol (2014) indicate that addressing shame and self-criticism may be crucial in treating social anxiety.

Shame has also been found to play a role in maintaining Social Anxiety Disorder, particularly in the rumination that often follows social interactions (“post-event processing”). This supports both theoretical and empirical evidence of a connection between shame and Social Anxiety Disorder (Candea & Szentagotai-Tatar, 2017). Due to this, individuals may feel ashamed in both real and imagined social situations, leading them to avoid potentially stressful social interactions (Gabbard, 1992).

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Overall, current research indicates that while shame is not exclusive to social anxiety, social anxiety may be a contributing factor to the presence of shame in certain clinical conditions (e.g., depression, eating disorders, psychosis) more than others (e.g., Borderline Personality Disorder, Obsessive-Compulsive Disorder, Body

Dysmorphic Disorder, Generalized Anxiety Disorder) (Swee et al., 2021a). This then adds to the understanding that one cannot treat some individuals with social anxiety without assessing and identifying if there is a shame layer contributing to maintaining it. This highlights the importance of being able to identify shame when it can mask as social anxiety.

### **Treatment Implications due to Overlaps**

When shame is masked by either depression or social anxiety, then treatment may only be focused on improving the client's depressive state or the social anxiety without the focus on acknowledging shame as the root issue.

Acknowledging the presence of shame is a crucial initial step in addressing and managing it (Moursund & Erskine, 2004). Marrone (2014) emphasizes the importance of how a therapist's approach can inadvertently exacerbate a client's feelings of shame by employing minimizing language or offering interpretations that do not fully resonate with the client's subjective experience.

John Bradshaw (1988) in his book, *'Healing the shame that binds you'*, states that due to the lack of studies on shame, it has caused therapists to neglect treating shame and this has affected the success of psychotherapy. Lewis, a psychologist at Yale University has studied shame more extensively. In one of the studies, the transcripts of 180 psychotherapy sessions were studied, with the conclusion that when a therapist failed to identify shame in the patient's narrative their problems got worse and when they did manage to treat the shame the treatment journey got shorter Lewis (1971).

Participants in these studies reported that the therapist's reassurance about the isolating and distressing nature of shame, as well as the tendency to avoid others during experiences of toxic shame, can be healing (Friel, 2016). Research findings align with the perspective within integrative (relational and developmental) psychotherapy that individuals experiencing a lack of security in their relationships will often seek to establish a relationship with others that are safe and secure for them as a way of validating their self-worth and mitigating shame (Bowlby, 2005).

Research on negative therapeutic reactions, particularly in the context of clients with a history of affective dysregulation has indicated that such individuals may be more prone to experiencing intense feelings of shame during therapy. This can present as a belief that a person is defective in a way and that the person has a way of evaluating themselves as negative. This aligns with the attribution theory of emotions which maintains that through specific judgments and beliefs, emotions are obtained and experienced (Swee et al., 2021b). These disapproving beliefs cause the individual to struggle with disentangling the bad experience from being labelled as a bad person and this leads them to want to avoid others to avoid feeling 'exposed' and vulnerable (Tangney et al., 1992).

According to Friel (2016), providing clients with psychoeducation about toxic shame helps them understand and cope with their experiences, reducing feelings of shame and the need to hide. While understanding shame helps to normalize and reduce its harmful effects, a therapeutic relationship characterized by empathy, validation, and atonement creates a trusting and safe environment, which also contributes to reducing shame. A therapeutic relationship can help clients develop secure attachments, let go of unhealthy ones, and fulfil their emotional needs,

fostering a sense of self-worth. It will be important for the therapist to focus on being responsive to the participant's emotions and maintaining a consistent, secure, and connected therapeutic relationship.

To normalize certain beliefs or experiences that the patient feels shameful about helps to break down real or imagined obstacles to a person's desires, it reduces the power of shame to affect their feelings. Normalisation becomes a strong antidote to shame (Greenberg, 2024).

Another way to explain shame in regard to the effect on the nervous system is through research that has indicated that we use the threat response system as our primary system and that this creates within us a 'negativity bias'. This causes us to identify and recall negative events or experiences more easily than positive ones (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001). Shame is linked to stimulating the threat system. The 'threat-protection system' is a system that supports humans with emotion regulation and is functional in helping with identifying and reacting to threats fittingly (Ledoux, 1998). Threat emotions will often cause individuals to seek therapeutic support, and clinicians will then work to manage the threat system. Multiple studies have found a correlation between compassion training and activation of the parasympathetic nervous system (our soothing system) (Matos & Steindl, 2020).

### ***Self-Compassion***

Self-compassion is understood as a complex concept made up of six interconnected elements that work together to respond to suffering. These elements

include increased self-kindness, a sense of common humanity, mindfulness, and decreased self-judgment, isolation, and over-identification (Miyagawa & Neff, 2023)

Compassion-focused therapy (CFT) was developed to support individuals with persistent and difficult mental health challenges, particularly those involving deep-rooted shame and harsh self-judgment. Heriot-Maitland, Gumley, Wykes, Longden, Irons, Gilbert, & Peters (2023) state that CFT helps individuals transition from a mindset that focuses on social rank and power dynamics towards one that emphasizes cooperation, care, and connection with oneself and others.

Individuals with mental health difficulties often face challenges in competitive and status-conscious environments. They may be preoccupied with threats, sensitive to social conflict, prone to shame and rejection, engage in self-criticism, and find it difficult to be caring and supportive of themselves (Heriot-Maitland et al., 2023).

The research indicates that openly discussing shame and sharing personal experiences in a supportive environment can contribute to overcoming shame and building resilience. Clinically, this suggests that seeking help from a compassionate and non-judgmental therapist can be beneficial in fostering individual resilience (Brennan, Robertson, & Curtis (2017).

Since many people seek therapy to address anxiety and fear, therapeutic interventions often concentrate on understanding and modifying these emotions. These interventions typically involve exploring the origins of these emotions and utilizing techniques such as cognitive restructuring, exposure therapy, and skills training, which primarily target the threat response system. To effectively address emotional distress, compassion-focused therapy often involves being able to work

with the positive' affect systems to manage the threat system (Gilbert, 1993). Self-compassion can activate the body's relaxation response, fostering feelings of safety, kindness, and care by engaging the parasympathetic nervous system (Gilbert, 2009, 2014; Gilbert & Irons, 2005).

While self-compassion may vary across cultures, its positive impact on well-being seems to be consistent worldwide (Neff, Pisitsungkagarn and Hsieh, 2008).

### ***Self-forgiveness***

Self-forgiveness can be defined as the inclination to respond to one's own mistakes with compassion and understanding (Thompson, Snyder, Hoffman, Michael, Rasmussen, Billings and Roberts, 2005). Incorporating self-forgiveness into the treatment of shame is important as it has been predicted to decrease depression and feelings of shame and has increased empathy, increased internal acceptance as well as a growth morally (Hall & Fincham, 2005; Enright, 1996; Holmgren, 1998).

Forgiving oneself can help individuals recover from moral failures and reduce associated emotional distress (Griffin, Worthington, Danish, Donovan, Lavelock, Shaler and Davis, 2017; Purcell, Griffin, Burkman, and Maguen, 2018).

A therapist must maintain a heightened awareness of their emotional state, including any personal feelings of shame, and recognize the significance of ongoing supervision and personal therapy in their professional development (Friel, 2016).

A growing body of research highlights the importance of recognizing shame in psychotherapy. Understanding shame can lead to more effective treatments for a

range of psychological disorders that were previously considered difficult to manage (MacBeth and Gumley 2012; Orsillo 2005).

### **Shame and Culture**

There are complex cultural variations in the degree to which shame is typically identified by ordinary people within a cultural or social group. To effectively address shame, therapists must comprehend individuals' belief systems and cultural understandings of shame (Greenberg, 2024). The word 'shame' has different meanings in different languages and cultures. In the Mandarin language, shame has four different meanings (Bedford, 2004). In Chinese, the symbol for shame comprises of two parts, "ear" and "stop" – thus indicating that a person needs to stop their wrong behaviour when they hear other people criticising them about their behaviour. Therapists should explore clients' religious, spiritual, or cultural beliefs and their worldview to understand their practices for coping with shame. They must ensure that clients comprehend the reasons for working on emotions and recognize that confronting and understanding shame is more beneficial than suppressing it (Greenberg, 2024).

In the Māori language, Sachdev (1990) explains, "Whakama" can be described as closest to the word "shame" and its meaning "shy or ashamed" but that there are no exact equivalents to shame in the Māori language. "Whakama" can represent two inherent feelings; the state when a person feels that they have dishonoured, which leans more into the feeling of guilt where the person feels that they have dishonoured others as well as a feeling of a sense of "self-doubt" or that a person feels "inadequate" in different social situations, which leans more into the feeling of shame that is more internalised by the person as a way they see

themselves. Sachdev (1990) goes further to explain five ways in which shame can manifest for people from a Māori cultural background. He states them as: “*blocking*” (when a person tries to ‘go quiet’), “*withdrawal*” (when the person removes themselves from social contacts), “*dark intestines*” (depressed or low moods), “*flight*” (a person that feels that they have dishonoured the people close to them will feel like they want to run away), “*suicide*” (not a common outcome but one that can occur due to overwhelming feelings of shame). From this we can draw similarities to how Nathanson's (1992) shame model explains how shame can present in individuals.

Research reveals the significant impact of shame on the disclosure of intimate partner violence in South Asian cultures. It underscores how shame is not only a personal burden but also a familial, social, and communal concern, as women may hesitate to disclose due to fears of shaming themselves and their loved ones (McCleary-Sills et al., 2015). The treatment of “whakama” (shame) and mental health in the Māori culture also includes different ways that includes self-compassion (Serlachius et al., 2021) and self-forgiveness. Studies have shown that working with individuals from non-Western cultures, it has been observed that they often possess intricate life stories to recount. It is essential to allocate sufficient time and exhibit genuine interest in their narratives to avoid conveying disinterest or disrespect. Therefore, it is important for therapists to endeavour to adopt the frame of reference of the person struggling with shame and to consider them within their sociocultural context (Kroll & Mohamed, 2022).

When working with clients from collectivist cultures, therapists could explain that expressing negative emotions to the therapist is not only permitted but also encouraged to address emotional issues (Greenberg, 2024). This could be further

explored under the cultural understanding of shame across cultures and how to treat it effectively in therapy.

### **Previous Studies**

Research has been limited regarding the role of the therapist in identifying shame. A study done by Kroll and Mohamed, (2004), focused on a group of 225 outpatients at a clinic for patients struggling with depression and anxiety where they were questioned about moral issues in their life. The focus of the study was to understand if patients do worry about moral issues, when presenting with other affective states like depression and anxiety. The findings indicated that moral concerns constitute a unique category of worry, distinct from practical matters. This suggests that many individuals spend significant time contemplating their moral identity and striving to live in accordance with their personal values (Kroll, Egan, Erickson, Carey, and Johnson (2004). More research on the topic was done in 2022 on how well medical professionals are able to identify shame hidden below presenting issues (like depression and anxiety), Kroll and Mohamed, (2022) came to the conclusion that there is not enough focus in treatment to identify and treat shame hidden below other affective states.

Another study by Verynska (2020) delved into verbal responses to shame in the therapeutic setting. Eighty five university students were recruited for the study in which participants were required to disclose a shameful experience to a therapist. The therapist response was recorded. The findings revealed that the students found the therapist that was more willing to explore shame themes more helpful than the therapists that wanted to avoid talking about the shameful content. This study

focused more on the comfortability of the therapist working with shame than the therapist having to identify shame.

### **The Aim of the Present Study**

The aim of this research study was to explore the multifaceted construct of shame, particularly its manifestations, underlying psychological mechanisms, and the implications for therapeutic practices by examining the continuum of shame and its associations with various emotional states, such as social anxiety and depression. Furthermore, it aimed to highlight the prevalent challenges therapists face in addressing shame effectively, the painful nature of the emotion, and the gaps in therapist training. Through a comprehensive analysis of existing literature and qualitative investigations, this thesis set out to contribute to a deeper understanding of shame in the therapeutic context, thereby informing more effective intervention strategies that promote emotional wellness and foster human belonging.

The research study aimed to answer if a therapist will be able to (a) identify shame as part of the client's presenting problems that may look like depression and or social anxiety; (b) to see if a prime will direct their thoughts to a different understanding of the client's presenting problems; and (c) to see if the therapist will consider treating shame with self-compassion and self-forgiveness as a treatment option and or goal.

## **Method**

### **Participants**

The participants in this research were a sample of 18 individuals who responded to a participant's request that was sent out to the Massey Post Graduate Diploma in Psychological Practice students as well as the University of Waikato Clinical Psychology students. Some additional participants responded to a participant invitation on a Facebook community group for Counsellors and Psychologists in private practice. The participants had to have had a basis of training in psychology and some client case experience. Participants received the research study information sheet prior to accessing the questionnaires to enable them to understand the aim of the study, without explicitly stating that the research was about identifying shame. This was done to prevent the participants being primed beforehand about the possibly of shame being present in the content of the study.

Confidentiality and implied consent were explained, prior to the completion of the questionnaires, in the information sheet.

### **Demographics**

The participants completed an optional brief demographic part of the questionnaire to provide information about their gender, age, experience level, and ethnicity.

### **Participant Information**

This part of the questionnaire was optional, and participants could choose if they wanted to answer the demographical questions.

**Participant 1** was a female aged 34. She identified with Pakeha as her ethnicity. She has 1 year of psychological practice experience. She filled out the questionnaire with the depression prime.

**Participant 2** was a female aged 48. She identified with European as her ethnicity. She has 12 years of counselling experience. She filled out the questionnaire with the depression prime.

**Participant 3** was a male aged 36. He identified with Southeast Asian as his ethnicity. He has 10 years of psychological practice experience. He filled out the questionnaire with the depression prime.

**Participant 4** did not include any personal information. They filled out the questionnaire with the depression prime.

**Participant 5** was a female aged 48. She identified with Māori as her ethnicity. She has 6 years of psychological practice experience. She filled out the questionnaire with the depression prime.

**Participant 6** was a female aged 34. She identified with NZ Māori/NZ European as her ethnicity. She has 4 years of psychological practice experience. She filled out the questionnaire with the depression prime.

**Participant 7** was a female aged 42. She identified with NZ Māori as her ethnicity. She has 14 years of psychological practice experience. She filled out the questionnaire with the shame prime.

**Participant 8** was a female aged 51. She identified with Pakeha as her ethnicity. She has 6 years of psychological practice experience. She filled out the questionnaire with the shame prime.

**Participant 9** was a female aged 57. She identified with Samoan as her ethnicity. She has 10 years of counselling experience. She filled out the questionnaire with the shame prime.

**Participant 10** was a female aged 34. She identified with NZ European as her ethnicity. She has 6 months years of psychological practice experience. She filled out the questionnaire with the shame prime.

**Participant 11** was a female aged 34. She identified with European as her ethnicity. She has 3.5 years of psychological practice experience. She filled out the questionnaire with the shame prime.

**Participant 12** was a female aged 44. She identified with European as her ethnicity. She has 3 years of counselling experience. She filled out the questionnaire with the shame prime.

**Participant 13** was a female with no information included about her age. She identified with European as her ethnicity. She did not include the amount of psychological practice experience she has. She filled out the questionnaire with the social anxiety prime.

**Participant 14** was a male aged 33. He did not state his ethnicity. He has 8 years of psychological practice experience. He filled out the questionnaire with the social anxiety prime.

**Participant 15** was a female aged 62. She did not state his ethnicity. She has 5 months years of psychological practice experience. She filled out the questionnaire with the social anxiety prime.

**Participant 16** was a female aged 30. She identified with Indian as her ethnicity. She has 2 years of psychological practice experience. She filled out the questionnaire with the social anxiety prime.

**Participant 17** was a female aged 33. She identified with Pakeha as her ethnicity. She has 5 years of psychological practice experience. She filled out the questionnaire with the social anxiety prime.

**Participant 18** was a female aged 47. She identified with Pakeha and Ngai Tahu as her ethnicity. She has 5 years of psychological practice experience. She filled out the questionnaire with the social anxiety prime.

**Table 1.1**

*Participant Demographics*

<b>Category</b>	<b>Measure</b>
Total Sample size	18
Gender Identification	<i>Female: 14</i> <i>Male: 3</i> <i>Not specified: 1</i>
Age range and mean:	33 – 62 years  <i>Mean: 47.5</i>
Range of years of psychological practice	<i>&lt;6 months to 14 years</i>
Ethnicities Represented	<i>Southeast Asian, NZ European, NZ</i> <i>Māori, Samoan, Indian</i>

## **Ethics**

Each participant was informed about the aim of the study, consent, confidentiality as well as the data collection process through the information sheet that was sent prior to the questionnaire completion.

Participants were also informed about their rights when participating in the study. For this study implied consent was used as advised by the ethics committee as most appropriate for this study. Implied consent was explained, and no consent forms were needed to be signed prior to participation. The safeguarding and data storage process were also explained to the participants. Due to the nature of qualitative studies not relying on statistics or numbers but rather on interpretations and observations requires the researcher to take on an ethical responsibility (Sanjari et al., 2014).

Terre Blanche et al., 2006 explains that there are four philosophical principles that guides ethical research. The first one being 'autonomy and respect for the dignity of people. Under this principle it was to ensure that voluntary informed consent was obtained from the participants and that they were made fully aware of the confidentiality agreement. The information sheet explained what the participant consents to when they choose to take part in the study and that implied consent was used for this study. The participants were informed of their right to withdraw from the study if and when they desire to do so without any undesirable consequences. Each participant was also made fully aware of the confidentiality agreement at the start of each questionnaire.

Terre Blanche et al., (2006) explains the second principle as to do no harm to the participants. To ensure that the research avoids doing any harm or wrong to any of the participants involved. Caution was taken to ensure that there was no

physical or psychological harm done to any of the participants. Participants were assured that there was no identifiable information collected from them when they submitted their questionnaires making use of Microsoft Forms online survey tool. Due to the different nuances and understandings of shame across cultures, the expertise of Dr Armon Tamatea (from the University of Waikato) was included when the questionnaires were developed to ensure cultural sensitivity.

Thirdly, the researcher needs to consider ways on how to maximise the benefits of the research to the participants. The benefits of the research should outweigh the possible risks of the research study. The benefit of the study outweighed the risks of the research study. The benefits are focused on effective treatment of shame in therapy and the acknowledgement of the complexity how to identify and treat shame in therapy. Equipping therapists with the needed skills and strategies to be able treat shame in therapy.

And lastly, Terre Blanche et al., (2006) states the final principle to be an ethical consideration. Here it is to ensure that the researcher treats the participants fairly, and equally and to ensure that the researcher takes responsibility in the care and support of participants during the research process. Ethics were obtained prior to the commencing of the start of the research. Ethics were approved by Massey University Human Ethics (Ohu Matatika 1, Application OM1 24/25) who reviewed and approved this research project before data collection commenced. Data collection was completed over two months. All data have been stored on a OneDrive storage space on a personal computer. Both the computer as well as the OneDrive folder are password protected and secure. There is also not any identifiable information stored of the participants - only the results and thesis information.

## Measures

For the purposes of this study, 6 different questionnaires were developed. Each questionnaire included two client case scenarios (scenario A and scenario B), a personality questionnaire (that was included as the prime) as well as demographical questions at the end of the questionnaire.

The client case scenarios were created to include the exact amount of cues to lead it to either social anxiety, shame or depression depending on the perspective of the participant. These were fictional characters with no link to any real clients in therapy. The type of brief client case scenarios is widely used in training and examinations, and are by nature ambiguous, with no right or wrong answers, and is designed to look at participants' reasoning and judgment processes.

**Scenario A** *Olivia, a 40-year-old, single woman, is a bookkeeper for a small construction company. She experienced a turbulent childhood marked by neglect and abuse. Raised in an unstable environment, Olivia often felt unseen and unheard by her parents, leading to chronic feelings of isolation and insecurity. These early experiences have left her with deep emotional scars that continue to affect her mental well-being. Olivia reports struggling with overwhelming feelings of sadness and hopelessness, finding it difficult to engage in everyday activities or connect with others on a meaningful level. She experiences frequent bouts of self-doubt and inadequacy, questioning her worth and value in social interactions. Olivia's inner struggles manifest as a constant sense of fear and unease, causing her to avoid social situations and isolate herself from others out of fear of judgment and rejection. Olivia reports feeling mental and emotional exhaustion after social interactions.*

**Scenario B** *Emily, a 26-year-old, single woman, who is the owner of a small, online business developing marketing campaigns for producers of organic food. Coming from a childhood marked by being bullied in school as well as critical father, she has a history of failed relationships and struggles to establish meaningful connections with others. Emily often withdraws from social gatherings and avoids intimate relationships, feeling a deep-seated fear of vulnerability and rejection. She exhibits persistent feelings of inadequacy, constantly striving for perfection and feeling like she will never measure up. Emily reports that she struggles to accept compliments or praise, often deflecting or downplaying her accomplishments. She will often make self-critical statements. Emily also reports experiencing mood swings, alternating between periods of intense self-criticism and emotional numbness. She has difficulty trusting others and often second-guesses her social interactions, fearing judgment and disapproval.*

Following the two case scenarios the participants had to answer four questions for each:

1. *From reading the above case description of (Olivia/Emily), please give a brief description of your understanding of what (Olivia/Emily) might be struggling with?*
2. *Given what you explained in question 1, what would likely be the goals that you and (Olivia/Emily) will be working towards in therapy?*
3. *Given what you explained in question 2, what would likely be included in your intervention as a treatment plan for (Olivia/Emily)?*
4. *In your professional opinion, would you assign an initial diagnosis, and if yes, what will this most likely be?*

## Procedure

The questionnaires were divided into three groups (AAB, ABA/ DAB, DBA/ SAB, SBA). One group was aimed at priming for **depression** (DAB, DBA), another group was focused on priming for **shame** (SAB, SBA) and the final group focused on priming for **social anxiety** (AAB, ABA). All three groups had the same client case scenarios but divided them into two different questionnaires with the only difference being the client case scenarios that the order of presentation was changed to see if it would influence the prime.

The short abbreviation of the questionnaires represents the specific content of the question paper for example:

**(AAB, ABA)**

A, at the start indicates that the questionnaire has the Social Anxiety (A) prime.

**(DAB, DBA)**

D, at the start indicates that the questionnaire has the Depression (D) prime.

**(SAB, SBA)**

S, at the start indicates that the questionnaire has the Shame (S) prime.

The AB or BA, after the first letter, will indicate if the case scenarios were first the case scenario A and then the prime and then case scenario B or if it first was case scenario B, then the prime and then case scenario A as the second part. Table 1.2 indicates the layout of the different questionnaires.

**Table 1.2**

*Questionnaire change in layout from AB to BA for all three groups*

<b>Questionnaire AB</b>	<b>Questionnaire BA</b>
<i>Scenario A</i>  <i>Answer the four questions pertaining to the case scenario.</i>	<i>Scenario B</i>  <i>Answer the four questions pertaining to the case scenario.</i>
<i>Prime (Personal Questionnaire)</i>  <i>10 Questions drawn from psychometrics linked to the prime.</i>	<i>Prime (Personal Questionnaire)</i>  <i>10 Questions drawn from psychometrics linked to the prime.</i>
<i>Scenario B</i>  <i>Answer the four questions pertaining to the case scenario.</i>	<i>Scenario A</i>  <i>Answer the four questions pertaining to the case scenario.</i>

The participants had to read the first case scenario and then answer four questions using their own clinical judgement and experience regarding the presentation of the client in the client case scenario. Then they had to complete ten questions from the personality questionnaire that were included to act as a prime. Depending on the specific questionnaire that they received that will either be the depression, social anxiety or shame questions. The three personality questionnaires that was used to act as a prime were the Beck Depression Inventory (BDI) (Beck, Steer and Brown, 1996), Internalized Shame Scale (ISS) (Cook, 1987) and the Social Anxiety Questionnaire for Adults (SAQ-A30) (Caballo, V. E., Salazar, I. C., Iurrtia, M.

J., Arias, B., and CISO-A Research Team. (2012). There were ten questions extracted from the psychometric questionnaires to use that was to act as the prime before continuing to the second case scenario and questions.

The second case scenario had the exact same format as the first case scenario where the participant had to read the case scenario and then answer the four questions that followed. Our aim was to see if the prime made any difference to the way the participants conceptualised the second case scenario and if it affected their answers to the questions.

There were six questionnaires from which each participant received one questionnaire to complete. Answering all questions pertaining to the client case scenarios was mandatory, therefore there was no missing or incomplete data. Participants had the choice if they wanted to fill out the demographic information at the back of the questionnaire.

**Table 1.3**

*Questionnaires Layout*

<p align="center"><b>Questionnaire 1: Depression Prime DAB</b></p>	<p align="center"><b>Questionnaire 2: Depression Prime DBA</b></p>
<ul style="list-style-type: none"> <li>* Client Case Scenario A</li> </ul>	<ul style="list-style-type: none"> <li>* Client Case Scenario B</li> </ul>
<ul style="list-style-type: none"> <li>* Prime (10 questions from the Beck Depression Inventory (BDI))</li> </ul>	<ul style="list-style-type: none"> <li>* Prime (10 questions from the Beck Depression Inventory (BDI))</li> </ul>
<ul style="list-style-type: none"> <li>* Client Case Scenario B</li> </ul>	<ul style="list-style-type: none"> <li>* Client Case Scenario A</li> </ul>
<ul style="list-style-type: none"> <li>* Demographic Questions</li> </ul>	<ul style="list-style-type: none"> <li>* Demographic Questions</li> </ul>

<p style="text-align: center;"><b>Questionnaire 3: Shame Prime SAB</b></p> <ul style="list-style-type: none"> <li>* Client Case Scenario A</li> <li>* Prime (10 questions from the Internalized Shame Scale (ISS))</li> <li>* Client Case Scenario B</li> <li>* Demographic Questions</li> </ul>	<p style="text-align: center;"><b>Questionnaire 4: Shame Prime SBA</b></p> <ul style="list-style-type: none"> <li>* Client Case Scenario B</li> <li>* Prime (10 questions from the Internalized Shame Scale (ISS))</li> <li>* Client Case Scenario A</li> <li>* Demographic Questions</li> </ul>
<p style="text-align: center;"><b>Questionnaire 5: Social Anxiety Prime AAB</b></p> <ul style="list-style-type: none"> <li>* Client Case Scenario A</li> <li>* Prime (10 questions from the Severity Measure for Social Anxiety Disorder (Social Phobia))</li> <li>* Client Case Scenario B</li> <li>* Demographic Questions</li> </ul>	<p style="text-align: center;"><b>Questionnaire 6: Social Anxiety Prime ABA</b></p> <ul style="list-style-type: none"> <li>* Client Case Scenario B</li> <li>* Prime (10 questions from the Severity Measure for Social Anxiety Disorder (Social Phobia))</li> <li>* Client Case Scenario A</li> <li>* Demographic Questions</li> </ul>

## **Data Analysis**

### **Approach to Data Analysis**

The original design of the study was grounded in two research tactics. My interest was in whether, when formulating ideas about a client's needs based on minimal but typical basic information about a new client, trainees would be influenced by a prime. The initial idea was that words used in the participants' case conceptualisation could be counted, and changes in frequency of relevant symptom words could be assessed from Time 1 to Time 2. Change scores could reveal the effect, if any, of a prime, which was in this case completing a questionnaire that asked about one of three possible personality characteristics—social anxiety, depression, or feelings of shame. Changes in frequency of mentions would then be subjected to a statistical test of significance. In the end, however, the small number of available participants made that tactic untenable. Instead, it was decided that only descriptive statistics summarising terms used would be reported, and the findings could indicate—in a sort of “test of concept” manner—whether the method used had any future value for exploring trainees' judgments and decision making, and the extent to which their own needs might influence that.

Furthermore, it was expected that the participants might not use specific symptom terminology. Thus the original goal was to use a qualitative approach to the narratives the participants gave in response to each scenario. To conduct this type of analysis thematic analysis was chosen and the findings from this analysis are reported. In addition to this more formal analysis, a general description could be provided regarding the conceptualisations given, and these somewhat subjective judgments are also provided.

## Thematic Analysis

In this study, a qualitative thematic data analysis approach was used. In the data, themes were identified by looking at patterns. These specific patterns narrated and compartmentalized the data in detail (Braun & Clarke 2006:83–84). The patterns can also be observed as 'common threads' (Morse & Field 1995:139–140; Willig 2013:58) that were identified from the questionnaires and directed to the research question. This supported the interpretation of the data according to concepts that will be recognised in the study. According to Braun & Clarke, (2006), a theme is what can be seen as something in the data that is important and has a relation to the research question and represents some patterns that can be identified. The themes start to be identified when the researcher sees patterns in the data (Braun & Clarke, 2006).

The use of thematic analysis was relevant to use for this study because it helped to confine the meanings that was conveyed through the individuals taking part in the research (Holloway & Todres 2003:347).

There are 6 phases of thematic analysis identified by Braun & Clarke, (2006):

1. *Familiarizing yourself with the data*

Transcribing data (if necessary), reading and re-reading the data, noting down ideas.

In this study all the data was gathered through Microsoft Forms. All the data was then read through, and notes were made on possible themes.

## 2. *Generating initial codes*

Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

The data was then used to identify some of the key themes that would be mentioned more than once throughout the questionnaires.

## 3. *Searching for themes*

Collating codes into potential themes gathering all data relevant to each potential theme.

Once the key themes were identified, they were then put into order to see if there are some that could be grouped together to share an umbrella theme.

## 4. *Reviewing themes*

Checking if the themes work in relation to the coded extracts and the entire data set, generating a 'thematic map' of the analysis.

The themes were analysed again to see if they correlated with the theoretical evidence found in the literature.

## 5. *Defining and naming themes*

Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.

The themes then guided the information that was needed to show how it linked to the research study. Then, further refinement of the themes and the adding of information from the available literature.

## 6. *Producing the report*

The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected themes.

Key words/phrases from the participants were used as extract examples. All the themes were refined again to ensure the quality of the data collected.

There are some advantages to making use of this method according to Braun & Clarke, (2006). This being the flexibility it has to include a wide amount of data. The results are usually quite easily accessible to educated populations. It is also a useful way to collaborate with participants. It is also an effective way to summarize large amounts of information and can bring about the similarities and the differences that can be found in the data. It can also help to gain insights that are not usually anticipated. It also allows for different ways of interpreting the data that could be social and or psychological and lastly it can also be a useful method to use to create informed policy development (Braun & Clarke, 2006).

Thie themes will be further discussed under the results and discussion part of this paper.

## Results

### Themes Identified

**Table 1.4**

*Initial Themes Identified*

<b>Theme:</b>	<b>Number of times mentioned:</b>
<i>Attachment Issues/ Critical parents/ voices of parents/ Difficult upbringing</i>	9*
<i>Low Self-Esteem</i>	9*
<i>Fear of Judgment/ Fear of Rejection/Abandonment</i>	12*
<i>Trust Issues</i>	3
<i>Perfectionistic Tendencies</i>	4
<i>Self-doubt</i>	2
<i>Self-worth Issues</i>	6
<i>Trauma</i>	11*
<i>Aware of Insecurities</i>	4
<i>Loss of Sense of Self/ Loss of Identity</i>	3
<i>Hopelessness</i>	3
<i>Bullying</i>	2
<i>Lack of Self-Acceptance</i>	2
<i>Validation</i>	2
<i>Self-criticism /Negative Self Beliefs</i>	9*
<i>Struggle with Vulnerability</i>	2
<i>Sadness</i>	2

\* *Core themes with the highest amounts mentioned*

There were 17 themes identified in the data through the process of thematic analysis.

These were then compounded to form four core themes:

### ***Theme 1: Attachment Issues***

*Sub themes: Critical parents/ Voices of parents/ Difficult upbringing*

Participants identified attachment issues as some of the core issues that both scenarios presented with. They linked the client's difficult upbringing to how they learned to attach and how they viewed and understood their relationships.

- **In Scenario A participants used phrases like:**

“Attachment Disorder”, “insecure attachment”, “attachment issues” and “attachment issues with her parental relationships”

- **In Scenario B participants used phrases like:**

“Attachment related issues”, “insecure attachment”, “internalized critical parent”, “father wound” and “her father's critical voice has become her own inner voice”.

### ***Theme 2: Identity Concerns***

*Sub themes: Loss of Sense of Self/ Loss of Identity/ Low Self-Esteem/ Self-doubt/ Self-worth Issues/ Aware of Insecurities/ Self-criticism/ Lack of self-acceptance/ Negative Self Beliefs*

Concerns around the identity of the clients in the case scenarios also featured a few times. Participants connected the presenting problems with a negative understanding of the self.

- **In Scenario A participants used phrases like:**

“Low self-esteem”, “internalized negative belief about herself”, “worthlessness”, “being unloved”, “insecurity” and “the maladaptive belief impacts her sense of self and identity”, “self-doubt, and feeling inadequate”, “she feels that she is not good enough”, “aware of her insecurities”, “loss of identify”, “strong self-beliefs of worthlessness and a lack of motivation” and “insecurity”

- **In Scenario B participants used phrases like:**

“High levels of self-criticism”, “low self-esteem”, “low self-worth”, “negative self-talk”, “feeling unworthy or of little value”, “negative self-evaluations”, “self-beliefs around inadequacy”, “struggling with self-acceptance and self-esteem” and “several core insecurities”.

### ***Theme 3: Trauma***

*Sub themes: Fear of Judgment/ Fear of Rejection/Abandonment/Trust Issues/ Perfectionistic Tendencies/ Bullying/ Validation/ Vulnerability*

A large number of participants identified trauma as a core issue in both case scenarios. The trauma was also linked to a fear of being judged or criticized by others. The trauma also manifested into perfectionism that the participants identified as a presenting problem. This could also be linked to being bullied as well as not being validated. All these problems form a web that interlinks with one another and affects how the person functions.

- **In Scenario A participants used phrases like:**

“Trauma”, “trust issues”, “fear”, “trauma from early neglect and abuse”, “fear of rejection”, “vulnerability”, “fear and unease”, “CPTSD”, “perfectionism and rejection

of compliments”, “past traumatic experiences”, “childhood abuse” and “aversive childhood experiences (abuse and neglect)”.

- **In Scenario B participants used phrases like:**

“Hypersensitivity to rejection resulting in instability”, Maladaptive processing of distressing or traumatic events”, “trauma”, “difficulty trusting others”, “perfectionism”, “trauma of being a bully target”, “internally striving for perfection”, “fear of criticism/rejection, judgment, disapproval”, “high expectations of self”, “bullying at school”, “has perfectionistic traits that suggest she is fear driven and is dismissive of her accomplishments”, “past trauma”, “difficulty to show her vulnerable side”, “fear of being judged or not accepted”, “invalidation”, “lack of acceptance and/or validation from her”, “received little validation” , “history of traumatic invalidation” , “fear of rejection” and “fear of being hurt and abandoned”

#### ***Theme 4: Emotional States***

##### *Sub themes: Hopelessness/ Sadness*

The emotional state of the client, specifically in Scenario B was identified as them feeling sad and hopeless.

- **In Scenario A participants used phrases like:**

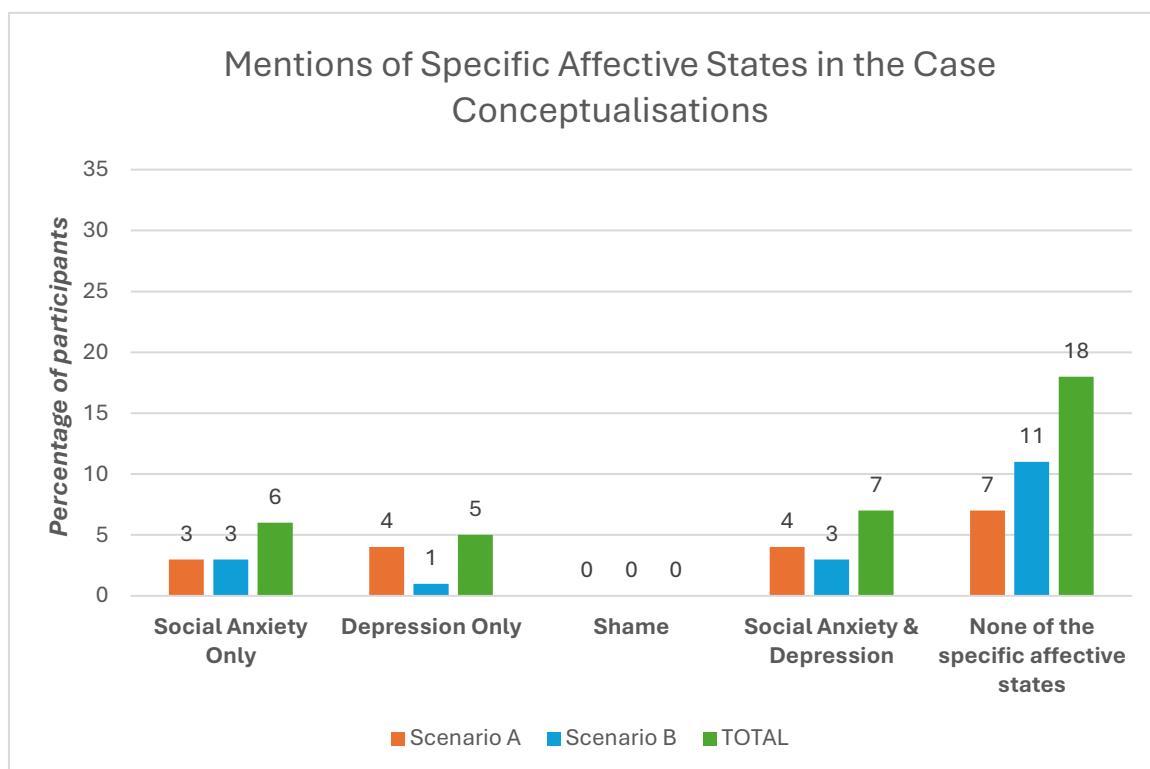
“Hopelessness” and “sadness”.

- **In Scenario B participants used phrases like:**

No mention in scenario B.

## Statistical data

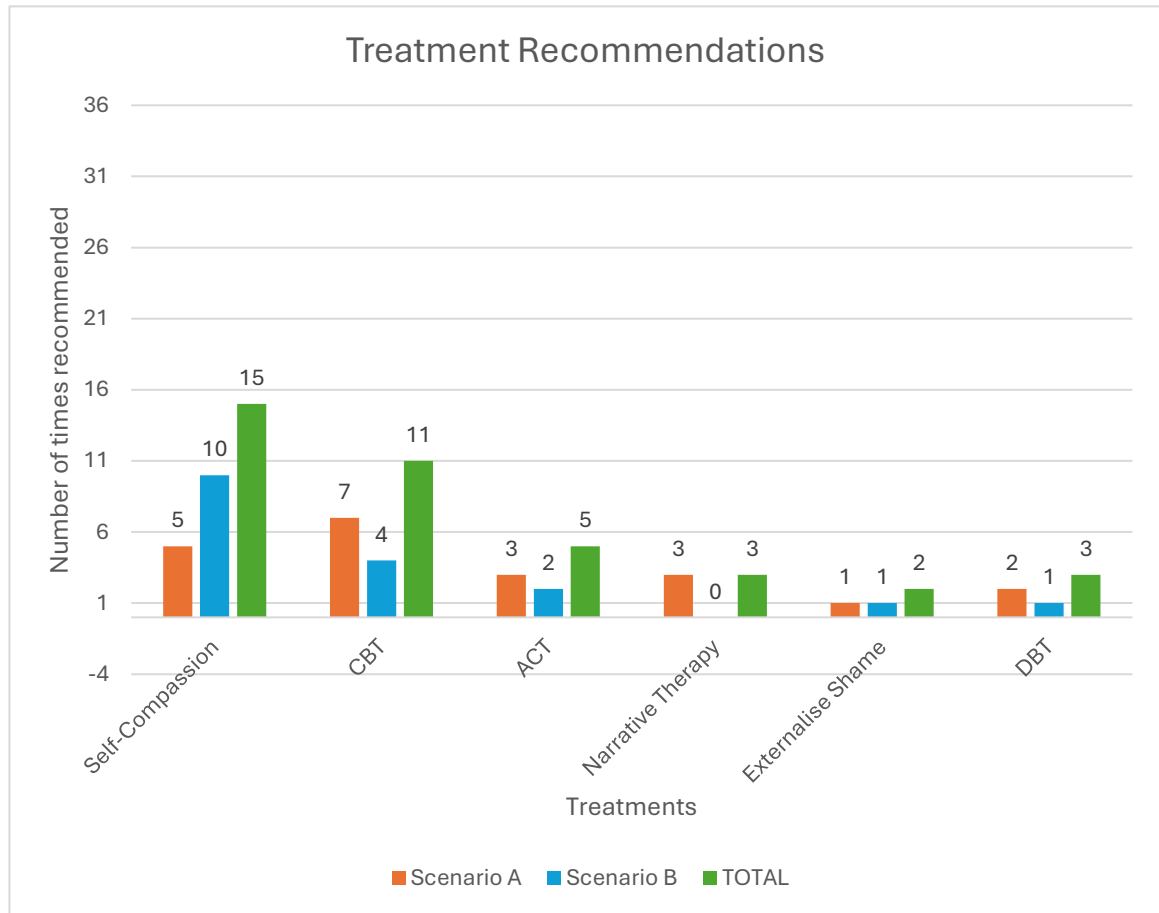
### Affective States Identified



*Figure 1.* This figure shows the percentage of participants that identified either Social Anxiety, Depression or Shame in the case conceptualization part of the questionnaire for both client case scenario A, and B, and in total.

Most of the participants identified *Social Anxiety and Depression* as the most fitting way to explain what the client scenarios presented. *Social Anxiety Only* was the second most used affective state identified in the client presentations overall. *Shame* had no mentions in either client case scenario A or B. Half of the participants did not identify any of the three affective states but rather focused their conceptualization on explaining other ways these clients' struggles are presenting as.

## Treatment Recommendation



*Figure 2.* This figure shows the number of times the specific treatment options were mentioned out of the 36 case scenarios across all 6 questionnaires.

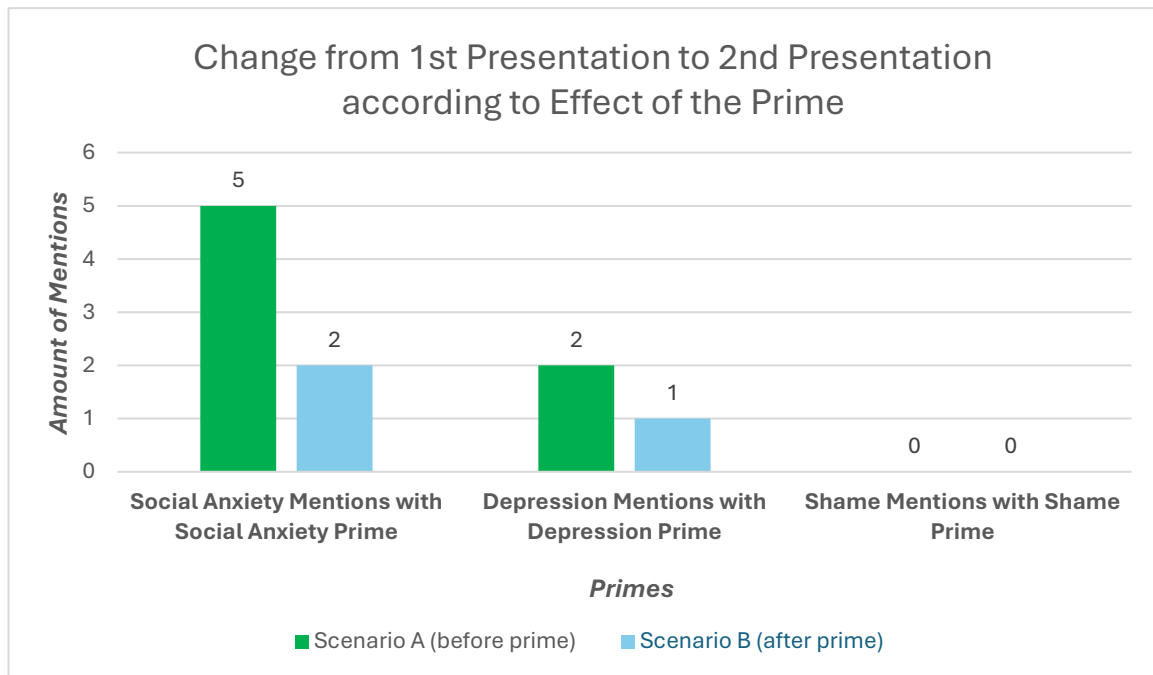
All 18 participants identified what the most fitting treatment will be for the clients in the case scenarios. For Scenario A, the most recommended treatment option was Cognitive Behavioural Therapy (CBT). Scenario B had more participants leaning toward recommending Self-Compassion as the most suitable treatment. In total, Self-Compassion was the most recommended form of treatment across both scenarios. It was in the treatment recommendation section that shame was mentioned for the first time in the response of the participants. Two participants that

formed part of two different prime groups, one from the depression prime group and one from the social anxiety prime, mentioned externalizing shame, as a treatment option. This indicating that even though they did not identify shame initially in the conceptualization part of the questionnaire, they did feel it appropriate to mention as a treatment option to explore externalization of possible shame feelings.

### **Function of Prime**

The priming element is an important aspect of the research study, as it allows investigation of how participants' initial conceptualizations of a client's issue are influenced by their pre-existing beliefs, biases, and training. By priming participants with specific affective states, can help them consider alternative perspectives and diagnoses that may not be immediately apparent. By priming them with shame-related concepts, can help them become more attuned to the subtle signs and symptoms of shame that may be present in the client's scenario. The priming element can increase the ecological validity of the study by simulating real-world scenarios where practitioners are often exposed to complex client issues and may need to consider multiple diagnoses and treatment approaches. The priming element can also contribute to a deeper understanding of the psychological processes involved in diagnosis and treatment.

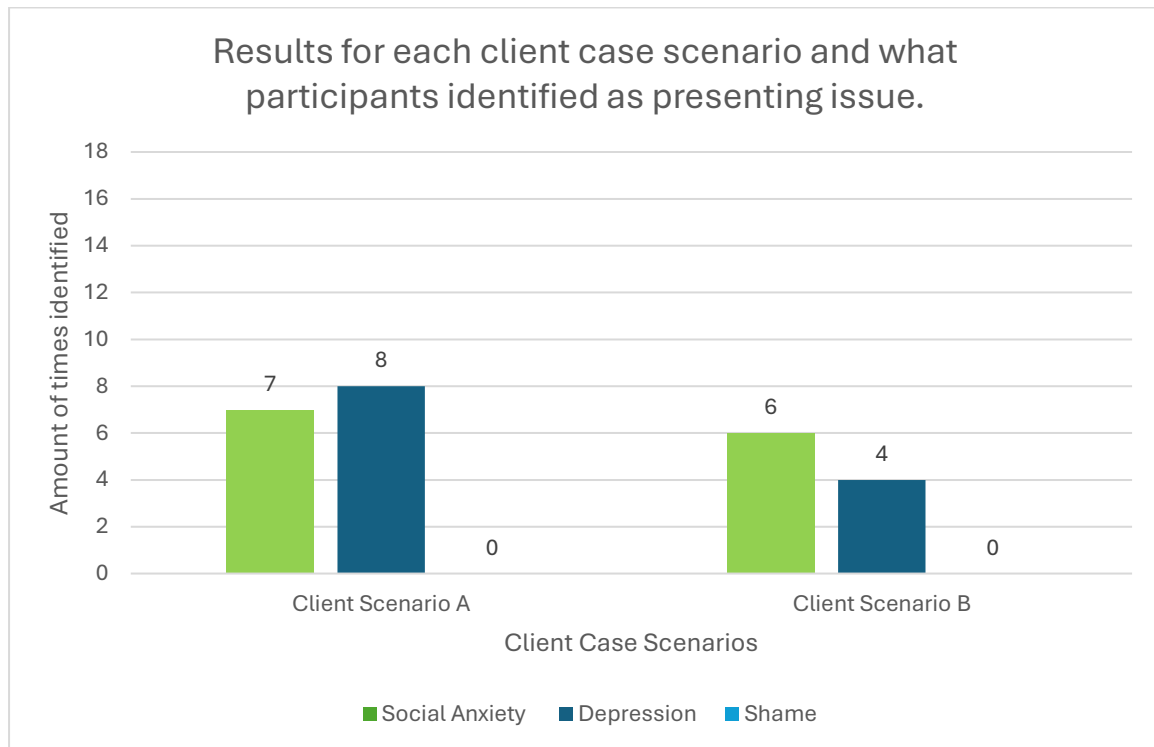
## Effect of priming



*Figure 3.* This figure shows the specific prime effect on the specific groups. The number of times the specific affective states were mentioned in the case conceptualisation part of the questionnaires, comparing scenario A (no prime) with the amount of mentions in scenario B (with the specific prime) for Social Anxiety (6 participants), Depression (6 participants) and Shame (6 participants).

The aim of this study was to see if the prime will be effective in affecting the clinical judgement of the participants in how they conceptualized the two different case scenarios. The findings showed that the prime was not effective in its functioning role to affect the judgement toward the prime used (depression, social anxiety and shame). I found a reverse effect where the participants were more reluctant to mention the specific affective states.

## Results for Client Case Scenarios A & B



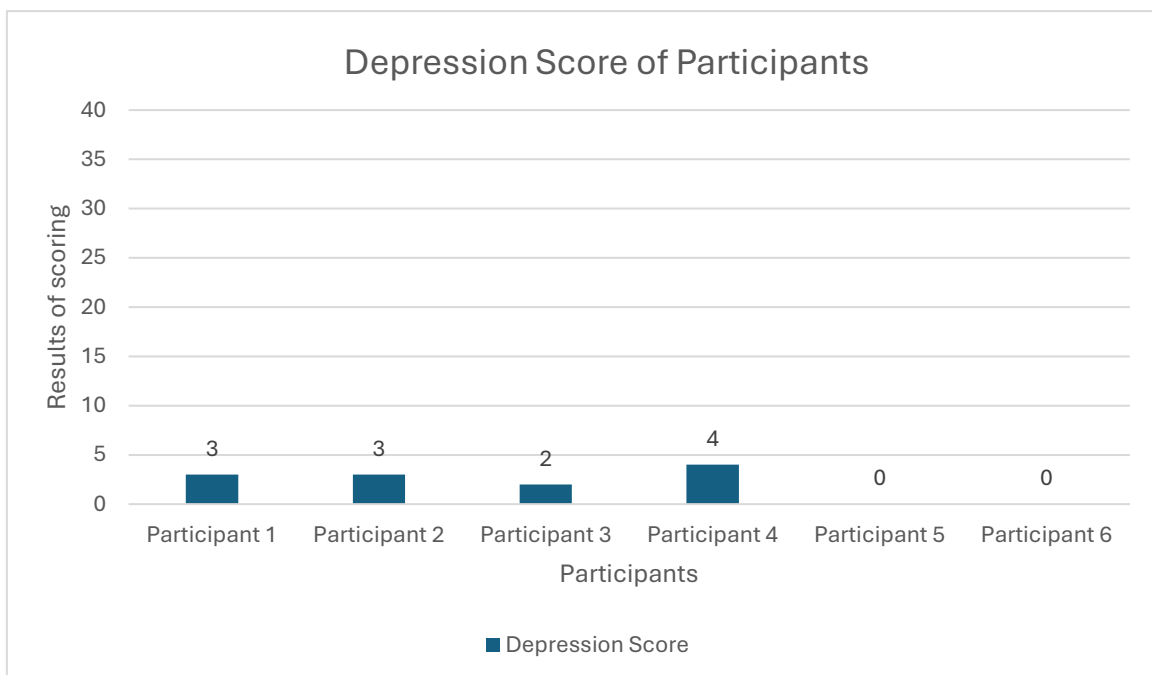
*Figure 4.* This figure shows the prime effect on the two case scenarios. The number of times the specific affective states were mentioned in the case conceptualisation part of the questionnaires, comparing Scenario A (no prime) with the amount of mentions in Scenario B (with the specific prime).

The participants identified depression and social anxiety as the presenting issues for the client in case scenario A and case scenario B. There was no mention of the client presenting with shame. The prime had no significant effect on the results of client case scenario B. The data shows the reverse effect. Results showed a decrease in the number of times the participants identified social anxiety and depression. Shame was also not mentioned as a presenting issue in client case scenario B. The difference could possibly be slight differences in how the cases were presented and if the clients in the case scenarios evoked different

responses due to other “noise” that could indicate other presenting issues that does not include depression or social anxiety.

## Personality Questionnaire results

### Depression Prime



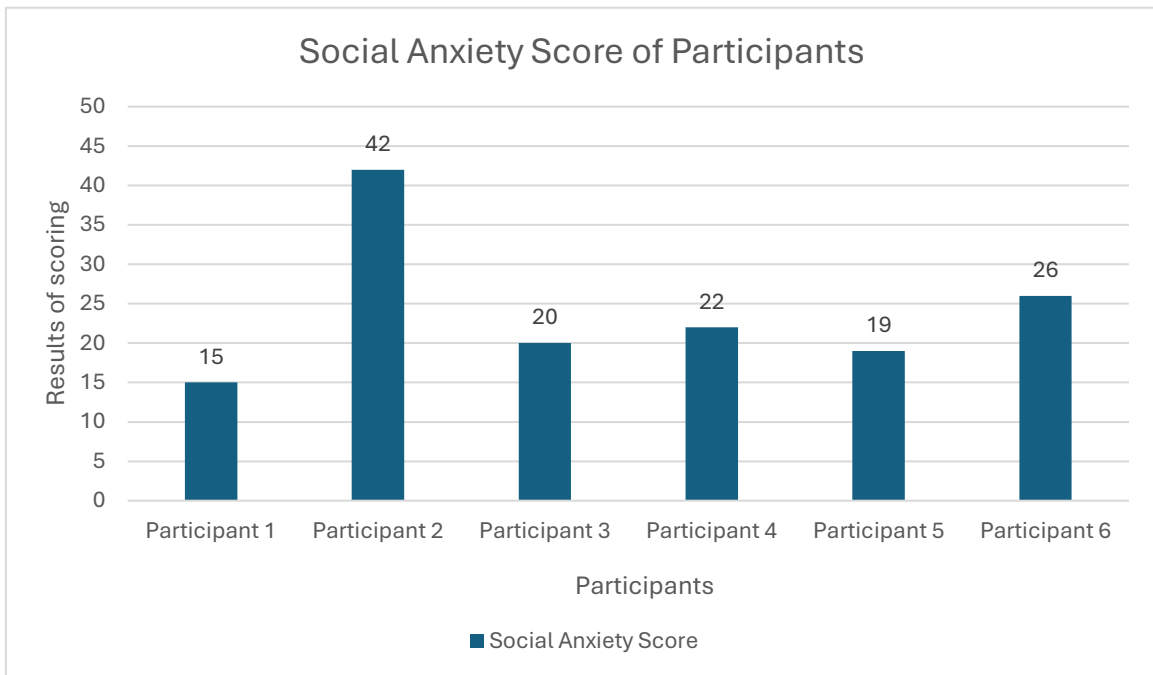
*Figure 5.* This figure shows the scores of each participant on the Depression Prime Personality Questionnaire that was extracted from the Beck Depression Inventory.

The prime used for this group of 6 participants were 10 questions extracted from the Beck Depression Inventory. The goal was to see if the questions would prime the participants to identify depressive states after answering these questions and proceeding to analysing client case scenario B. The results of the questions were analysed, and no significant concern was raised as to the affective state of the participants and how they identified on the day of the questionnaire. The Beck

Depression Inventory scoring categorises the results into 4 groups; (1-10) These ups and downs are considered normal, (11-16) Mild mood disturbance, (17-20) Borderline clinical depression, (21-30) Moderate depression, (31-40) Severe depression, (Over 40) Extreme depression. All participants fell under the (1-10) These ups and downs are considered normal, category.

The prime used for this group of 6 participants were 10 questions extracted from the Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996). The goal was to see if the questions would prime the participants to identify depressive states after answering these questions and proceeding to analysing client case scenario B. The results of the questions were analysed and no significant concern was raised as to the affective state of the participants and how they identified on the day of the questionnaire. The Beck Depression Inventory scoring categorises the results into 4 groups; (1-10) These ups and downs are considered normal, (11-16) Mild mood disturbance, (17-20) Borderline clinical depression, (21-30) Moderate depression, (31-40) Severe depression, (Over 40) Extreme depression. All participants fell under the, (1-10) These ups and downs are considered normal, category.

## Social Anxiety Prime



*Figure 6.* This figure shows the scores of each participant on the Social Anxiety Prime Personality Questionnaire that was extracted from Social Anxiety Questionnaire for Adults.

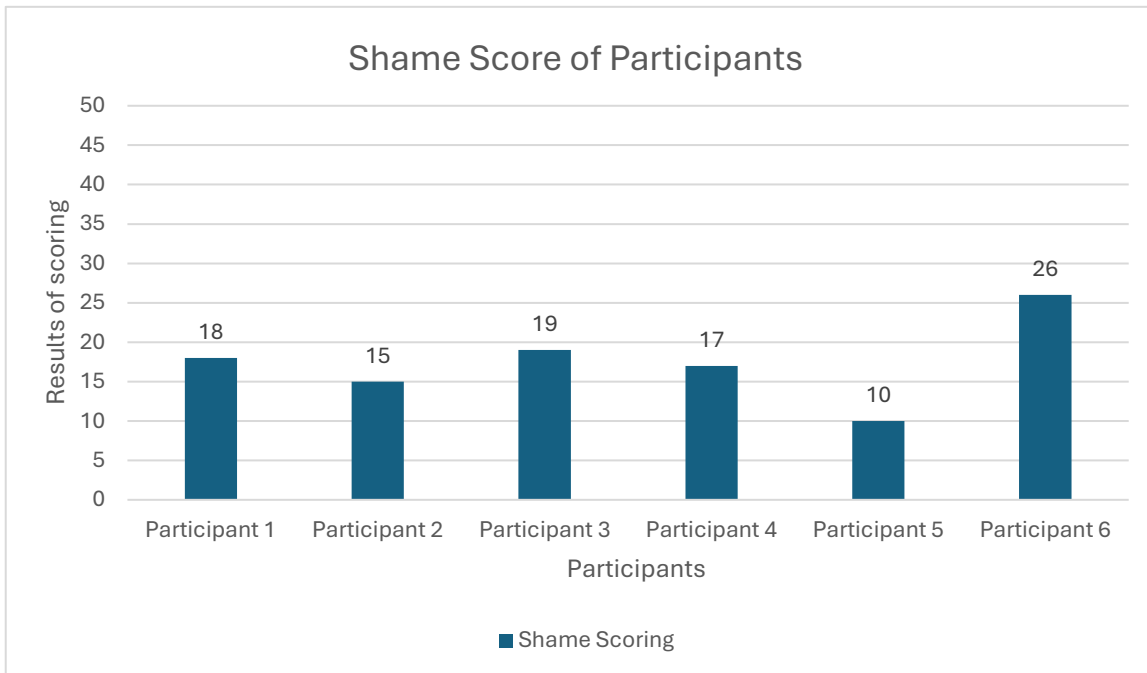
The prime used for this group of 6 participants were 10 questions extracted from Social Anxiety Questionnaire for Adults. The goal was to see if the questions would prime the participants to identify social anxiety after answering these questions and proceeding to analysing client case scenario B. The results of the questions were analysed and some significant concern was raised as to the emotional state of the participants and how they identified on the day of the questionnaire. The Social Anxiety Questionnaire for Adults scoring categorises the results into 5 groups; (1-10) No feelings of unease, stress or nervousness, (11-20) Slight level of unease, stress or nervousness, (21-30) Moderate level of unease, stress or nervousness, (31-40)

High levels of unease, stress or nervousness (41-50) Extremely high levels of unease, stress or nervousness.

Two of the participants fell into the *Slight level of unease, stress or nervousness* category. Three of the participants fell into the *Moderate level of unease, stress or nervousness* category. One person fell into the *High levels of unease, stress or nervousness* category.

Thus, making the prime for social anxiety something these participants could associate more with. The fact that more participants had higher levels of social anxiety related feelings did not affect the effectiveness of the prime when they had to conceptualise client case scenario B. The results indicated that the reverse happened to this group where with client case scenario A (before prime) the participants more easily mentioned social anxiety as a presenting issue, where with client case scenario B (after the prime) they did not – they were less likely to choose social anxiety as part of the client presenting issues.

## Shame Prime



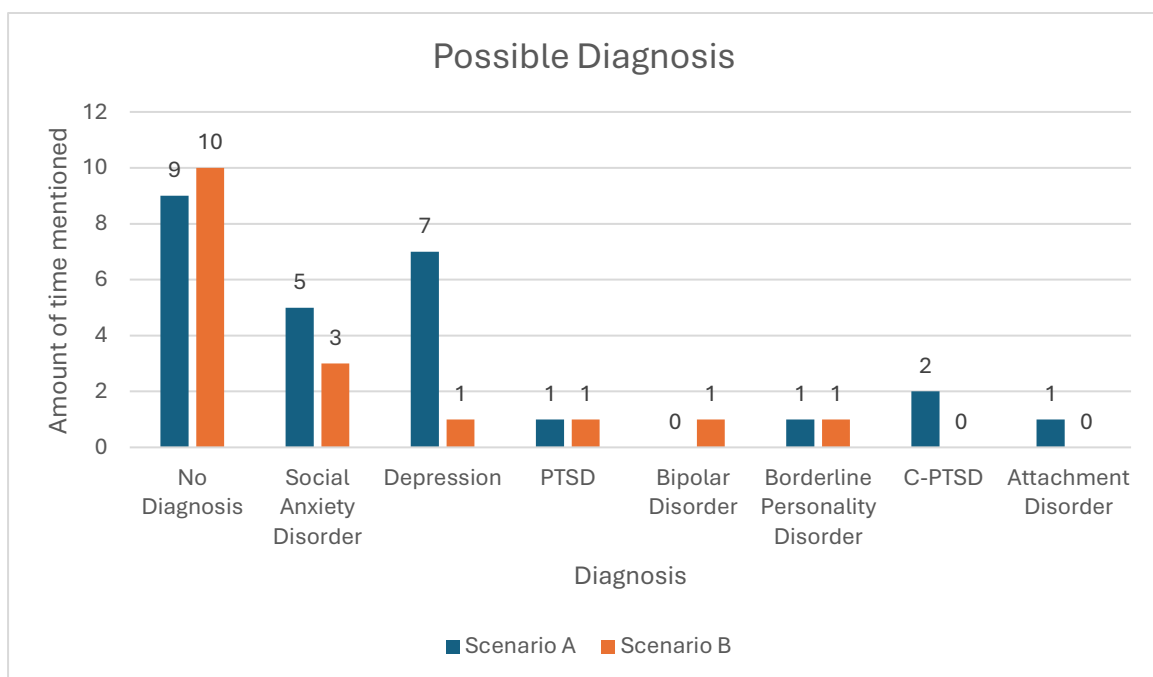
*Figure 7.* This figure shows the scores of each participant on the Shame Prime Personality Questionnaire that was extracted from Internalized Shame Scale.

The prime used for this group of 6 participants were 10 questions extracted from the Internalized Shame Scale . The goal was to see if the questions would prime the participants to identify shame states after answering these questions and proceeding to analysing client case scenario B. The results of the questions were analysed, and no significant concern was raised as to the affective state of the participants and how they identified on the day of the questionnaire. The Internalized Shame Scale scoring categorises the results into 5 groups; (1-10) Do not relate to shame statements (11-20) Relate to shame statements a little (21-30) Relate to shame statements somewhat (31-40) Relate to shame statements very much (41-50) Extremely relatable to shame statements.

This group had 1 participant scoring in the, *Do not relate to shame statements*, category. There were four participants scoring in the, *Relate to shame statements a*

little, category. Only one participant scored in the, *Relate to shame statements somewhat*, category. These scores indicate that most of the participants did relate to shame in some ways in their personal capacity on the day they completed the questionnaires. The scores did not affect the effectiveness of the prime as no one identified shame as a presenting issue in client case scenario B.

## Diagnosis



*Figure 8.* This figure shows the different diagnosis that were mentioned by the participants for each case scenario.

One of the questions in the questionnaires asked the participants if they would, in their professional opinion, assign a diagnosis to the clients in the case scenarios. The majority of the participants were less likely to assign a diagnosis and more hesitant to mention what it will be, should they need to. For client case scenario A the diagnosis of Depression was predominant, with Social Anxiety

Disorder being the second most recommended diagnosis. For Scenario B, Social Anxiety Disorder rated higher as the most recommended diagnosis and Depression was recommended the same number of times as PTSD, Bipolar Disorder and Borderline Personality Disorder.

## Discussion

Shame may be a hidden factor in mental health conditions like depression, addiction, or other psychological disorders, especially in cultures that don't openly discuss it. If the presentation of a problem is focused on a global sense of one's badness rather than feeling bad about a specific action, then shame is likely to be the central emotion (Sinha, 2017).

The aim of this research study was to determine if a therapist will be able to (a) identify shame as part of the client's presenting problems that may look like depression and or social anxiety; (b) to see if a prime will direct their thoughts to a different understanding of the client's presenting problems; and (c) to see if the therapist will consider treating shame with self-compassion and self-forgiveness as a treatment option and or goal.

The findings of this study have shed light on the complex interplay between shame, depression, and social anxiety, as well as the challenges therapists face in identifying and addressing shame in clinical practice.

### Identifying Shame in Clinical Practice

The results suggest that shame can often be masked by other presenting problems, such as depression and social anxiety. In 50% of the case scenarios the participants *did not mention any of the specific affective states* as the presenting problem. *Social Anxiety Disorder and Depression* was the most identified presenting issue with *Social Anxiety* the third most mentioned affective state that was identified. Shame was not identified at all in the case conceptualization part of the questionnaires. Thus, answering our first aim of this study, therapists were not able to identify shame due to it presenting similar to social anxiety and depression. The

tendency to overlook shame could have far-reaching implications, as this foundational emotion can significantly exacerbate symptoms of depression and anxiety (Brown, 2006; Gilbert, 2007).

The participants' focus on social anxiety as the primary affective state may indicate a reliance on observable behaviours—such as avoidance or fear of judgment—in place of deeper emotional processes.

This finding emphasizes the need for therapists to be attuned to the subtle manifestations of shame, which may not be explicitly articulated by clients. The difficulty in identifying shame in this study highlights the importance of careful clinical assessment and a nuanced understanding of the emotional landscape of clients.

### **The Impact of Priming on Clinical Judgment**

The priming intervention, designed to direct therapists' attention toward the specific affective states, did not significantly influence their clinical judgments. The results showed that the prime had the reverse effect where the participants were less eager to identify the presenting issues as that of depression, social anxiety or shame (depending on the prime). The prime did not have any specific words in that implicitly stated depression, social anxiety or shame and therefore leaves room for consideration that if the prime was more specific and included the specific affective terms, would this have delivered different findings and would there have been a more significant change in the results.

This suggests that while therapists may be aware of the concept of shame, it may not automatically be considered as a primary factor in the assessment and treatment of clients.

## **The Role of Self-Compassion in Treatment**

Despite the limitations in identifying shame, the study revealed that many therapists recognized the potential benefits of self-compassion as a therapeutic intervention. This suggests that therapists are increasingly aware of the importance of self-compassion in promoting mental health and well-being. However, the connection between self-compassion and shame was not explicitly made by most participants. Self-forgiveness was also not mentioned as a treatment option by any of the participants.

### **Key themes identified**

The thematic analysis conducted in this study successfully identified and synthesized the complexities of individuals' psychological experiences as represented in the case scenarios. Through the elaboration of 17 initial themes, four core themes emerged: *Attachment Issues*, *Identity Concerns*, *Trauma*, and *Emotional States*. The analysis not only highlights the multifaceted perspectives provided by participants but also connects these issues to existing literature, particularly concerning shame. Each theme offers profound insights into the conditions affecting the clients, underscoring the interplay of psychological principles affecting mental health and well-being.

### ***Attachment Issues***

The significant presence of attachment issues in both case scenarios emerges as a common element influencing the participants' relationships with themselves and others. Findings indicate that a difficult upbringing, characterized by critical parenting and insecure attachments, deeply impacts self-perception and relationships.

Participants noted terms such as "insecure attachment" and "attachment disorder," emphasizing the enduring effects of early relationships on individual development.

These insights resonate with existing literature that state that insecure attachments lead to diminished self-worth and an increased propensity to experience shame (Mikulincer & Shaver, 2004, 2005). This study's connections between attachment styles and feelings of unsafety and untrustworthiness further illustrate how early familial dynamics shape emotional responses in adulthood. As many participants articulated, the internalization of a critical parental voice directly influences the way clients engage with their self-image and social relationships. This finding suggests that therapeutic interventions targeting attachment-related issues may be essential in addressing the root causes of distress experienced by individuals in both case scenarios.

### ***Identity Concerns***

Concerns regarding identity emerged as prominent themes, indicating that participants associated the clients' struggles with deeply ingrained negative self-concepts. Frequent references to "low self-esteem," "self-doubt," and "feeling unworthy" suggest that clients are entangled in a cycle of self-criticism and negative self-beliefs. This aligns with findings in shame literature that assert the debilitating effects of shame on self-identity (Kim et al., 2011).

The participants' observations on the connection between identity and shame provide crucial insights into how the perception of self can solidify when intertwined with experiences of worthlessness. Perceiving oneself as "defective" not only reinforces negative beliefs but also contributes to a shame-based identity, suggesting a pathway for therapeutic focus on reshaping self-concept through compassion and

acceptance. The implications of these findings necessitate that future therapeutic approaches include strategies to foster a more secure and positive self-identity, which could mitigate risks associated with pervasive shame.

### ***Trauma***

Traumatic experiences, including bullying, neglect, and emotional abuse, were frequently mentioned by participants as underlying factors influencing the clients' mental states and behaviours. The recurring themes of "fear of rejection," "trust issues," and "perfectionistic tendencies" highlight the far-reaching effects of trauma on individual functioning. The participants noted how trauma manifests into social and behavioural anxieties, resulting in a web of emotional distress.

This study commensurate with recent literature that unresolved trauma exacerbates feelings of shame and can trap individuals in a cycle of avoidance and perfectionism (Brennan et al., 2017). Participants described how perfectionism often arises from a fear of criticism and rejection, demonstrating a correlation between trauma experiences and avoidance strategies. Collectively, these findings emphasize the importance of validating experiences and working on client's comfortability with being vulnerable and open to talk about their shame experiences.

### ***Emotional States***

Lastly, the significant feelings of hopelessness and sadness, particularly identified in case scenario A, lead to critical questions regarding the emotional well-being of individuals struggling with shame and attachment-related issues. The implications of prolonged feelings of shame, as well as their potential to foster hopelessness, are significant and warrant greater attention (Orth et al., 2006).

The thematic analysis yielded valuable insights into the psychological challenges facing clients through the lens of attachment theory, identity development, trauma experiences, and emotional states. Each core theme emphasizes the intricate interplay of factors contributing to the distress observed in the case scenarios—this adding to significant implications for psychological practice. The links established with existing shame literature provide a foundation for developing more targeted therapeutic interventions aimed at fostering secure attachments, enhancing self-worth, addressing trauma, and improving emotional regulation.

### **Limitations and Future Directions**

It is important to acknowledge that this study has limitations. The sample size was small, and in the end they all came from somewhat different training backgrounds. Another limitation could be the use of hypothetical case scenarios that may not fully capture the complexities of real-world clinical practice. It also limits the study to know if the participants were recently primed with workshops on depression or social anxiety recently that could have affected the way they interpreted the client cases. The participants did not mention anything about the possible cultural aspect and how this might affect the way they conceptualise the cases. Future research could include more cultural understandings of shame and the importance of being able to understand a client's background and how they experience shame through a cultural lens. Future research could also focus on a larger sample size and explore the impact of shame on a wider range of mental health conditions and investigate the effectiveness of specific therapeutic interventions targeting shame.

These initial insights could prove beneficial for clinicians addressing issues related to shame in their clients. The importance of a therapeutic relationship characterized by

consistent emotional attunement, which also includes comprising inquiry, validation, and normalisation, can effectively address the early relational experiences that contributed to the development of toxic shame (Erskine, 2011).

### **Conclusions**

In conclusion, this study highlights the need for further research to explore the role of shame in clinical practice and to develop effective strategies for identifying, addressing and treating shame in therapy. By increasing awareness of shame and its impact on mental health, therapists can provide more comprehensive and compassionate care to their clients and more important conversations can be initiated to inspire change. By promoting empathy, challenging harmful norms, and creating supportive spaces, we can empower individuals to build resilience and overcome shame (Brennan, Robertson and Curtis (2017).

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## **Appendix A**

**MASSEY UNIVERSITY**  
**COLLEGE OF HUMANTIES AND SOCIAL SERVICES**  
**TE KURA PŪKENGĀ TANGATA**

*Title: A study of clinical judgment in trainees and early career psychologists in professional practice: Perceptions concerning the identification and amelioration of distressing affective states.*

### **INFORMATION SHEET**

#### **Introduction:**

Kia ora, my name is Marnell Nortje and I am a Psychology Masters student at Massey University. I am working under the supervision of Prof Ian Evans. As a part of the requirement for my degree I am conducting a research project that aims to understand the knowledge student cohorts in their final year of psychology studies have on affective reaction.

An affective reaction is a psychological response that is characterized by an emotional or feeling-based response to a stimulus or event. In other words, it refers to the emotional or affective aspect of a person's reaction to a situation. Affective reactions are often automatic and instinctive, meaning that they occur quickly and without conscious thought or deliberation. They can be influenced by a person's personality, past experiences, and current emotional state.

Affective reactions can be difficult to identify in therapy. We are interested in exploring the clinical judgement of students in psychology in their final year of studies. How much information do they identify and what would be their recommended treatment options.

Participants will be asked to answer a three-part questionnaire that includes 2 case vignettes and a personal affect questionnaire. There are no right or wrong answers, and the answers should be based on the personal clinical judgement of the participant. The participants will be anonymous to ensure complete confidentiality. Please take note that by completing the questionnaire consent is implied.

There is no risk of harm to yourself should you choose to take part. Whether you choose to participate or not will not affect your course, status, or role as a student. Your data may be used in presentations, and other research reports, but it will be anonymized, and no personal identifying information will be shared. Individual data will be stored in secure locked files for 1 calendar year after the research has been completed and marked. Only the researcher and the supervisors will have access to the information. The data will be destroyed at the end of this time period using methods approved by Massey University.

Once the research study has been completed a full debrief will be presented to participants that includes the results, findings, more information as well as additional readings. This will be done in a voluntary class discussion session together with Professor Evans and myself.

### **What are your rights as a participant?**

As a participant in this study:

- You have the right to withdraw from the study without penalty before the questionnaire has been submitted. Once the questionnaire has been submitted the data will not be able to be retracted due to it being sent as '*anonymous*', with no identifiable information from the participant.
- You have the right to ask questions about the study and its procedures.
- You have the right to refuse to answer any questions or complete any tasks that cause you discomfort.

### **Implied consent:**

By completing the questionnaire and participating in this study, you are giving informed consent to participate in this research. This means that you understand the purpose, procedures, and potential risks of the study, and you are willing to participate.

### **Who can I contact for more information?**

If you have any questions or concerns about this study, please contact:

Marnell Nortje

Mobile: [REDACTED]

Email: [marnell.nortje.1@uni.massey.ac.nz](mailto:marnell.nortje.1@uni.massey.ac.nz)

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 24/25. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email [humanethics1@massey.ac.nz](mailto:humanethics1@massey.ac.nz).

May thanks in advance. Your participation is greatly appreciated.

### **Researcher:**

Marnell Nortje

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**Appendix B** Participant Response in Identifying the Specific Affective States

Name of Questionnaire:	Participant:	RESULTS OF RESPONSES BEFORE SHAME PRIME: Case Scenario A	Treatment Recommendation:	RESULTS OF RESPONSES AFTER SHAME PRIME: Case Scenario B	Treatment Recommendation:
<b>SAB (Shame Prime)</b>	<i>Participant 1</i> (Case Conceptualisation)	Social Anxiety Disorder	*	Social Anxiety Disorder & Depression	Self-Compassion
	<i>Participant 1</i> (Diagnosis)	Social Anxiety Disorder & Depression		*	
	<i>Participant 2</i> (Case Conceptualisation)	Depression	CBT & DBT	*	CBT & DBT
	<i>Participant 2</i> (Diagnosis)	Major Depressive Disorder		*	
	<i>Participant 3</i> (Case Conceptualisation)	*	Narrative Therapy & ACT	*	Self-Compassion
	<i>Participant 3</i> (Diagnosis)	*		*	
Name of Questionnaire:	Participant:	RESULTS OF RESPONSES BEFORE SHAME PRIME: Case Scenario B	Treatment Recommendation:	RESULTS OF RESPONSES AFTER SHAME PRIME: Case Scenario A	Treatment Recommendation:
<b>SBA (Shame Prime)</b>	<i>Participant 1</i> (Case Conceptualisation)	*	Self-Compassion	*	Self-Compassion
	<i>Participant 1</i> (Diagnosis)	*		*	
	<i>Participant 2</i> (Case Conceptualisation)	*	Self-Compassion	Depression	CBT
	<i>Participant 2</i> (Diagnosis)	*		*	
	<i>Participant 3</i> (Case Conceptualisation)	Depression	*	Depression	CBT & Narrative Therapy
	<i>Participant 3</i> (Diagnosis)	Depression		Depression	

Name of Questionnaire:	Participant:	RESULTS OF RESPONSES <b>BEFORE SOCIAL ANXIETY</b> PRIME: Case Scenario A	Treatment Recommendation:	RESULTS OF RESPONSES <b>AFTER SOCIAL ANXIETY</b> PRIME: Case Scenario B	Treatment Recommendation:
<b>AAB (Social Anxiety Prime)</b>	<i>Participant 1</i> (Case Conceptualisation)	Depression & Social Anxiety	*	*	Self-Compassion
	<i>Participant 1</i> (Diagnosis)	Social Anxiety & Depression		*	
	<i>Participant 2</i> (Case Conceptualisation)	*	CBT	*	CBT
	<i>Participant 2</i> (Diagnosis)	*		*	
	<i>Participant 3</i> (Case Conceptualisation)	Social Anxiety	Self-Compassion	*	Self-Compassion & “externalise bullying and associated shame”
	<i>Participant 3</i> (Diagnosis)	*		*	
Name of Questionnaire:	Participant:	RESULTS OF RESPONSES <b>BEFORE SOCIAL ANXIETY</b> PRIME: Case Scenario B	Treatment Recommendation:	RESULTS OF RESPONSES <b>AFTER SOCIAL ANXIETY</b> PRIME: Case Scenario A	Treatment Recommendation:
<b>ABA (Social Anxiety Prime)</b>	<i>Participant 1</i> (Case Conceptualisation)	Depression & Social Anxiety	CBT & DBT	Social Anxiety	CBT & ACT
	<i>Participant 1</i> (Diagnosis)	Social Anxiety		Social Anxiety	
	<i>Participant 2</i> (Case Conceptualisation)	Social Anxiety	Self-Compassion	Depression & Social Anxiety	Self-Compassion & CBT
	<i>Participant 2</i> (Diagnosis)	Social Anxiety Disorder		Depression & Social Anxiety	
	<i>Participant 3</i> (Case Conceptualisation)	Social Anxiety	CBT	Depression	*
	<i>Participant 3</i> (Diagnosis)	*		*	

Name of Questionnaire:	Participant:	RESULTS OF RESPONSES <b>BEFORE DEPRESSION</b> PRIME: Case Scenario A	Treatment Recommendation:	RESULTS OF RESPONSES <b>AFTER DEPRESSION</b> PRIME: Case Scenario B	Treatment Recommendation:
<b>DAB (Depression Prime)</b>	Participant 1 (Case Conceptualisation)	*	CBT	*	Self-Compassion
	Participant 1 (Diagnosis)	Social Anxiety & Depression		*	
	Participant 2 (Case Conceptualisation)	Social Anxiety & Depression	*	Social Anxiety	*
	Participant 2 (Diagnosis)	Social Anxiety & Depression		*	
	Participant 3 (Case Conceptualisation)	*	ACT, DBT & Narrative Therapy	*	Self-Compassion
	Participant 3 (Diagnosis)	*		*	
Name of Questionnaire:	Participant:	RESULTS OF RESPONSES <b>BEFORE DEPRESSION</b> PRIME: Case Scenario B	Treatment Recommendation:	RESULTS OF RESPONSES <b>AFTER DEPRESSION</b> PRIME: Case Scenario A	Treatment Recommendation:
<b>DAB (Depression Prime)</b>	Participant 1 (Case Conceptualisation)	Social Anxiety Disorder & Clinical Depression	ACT	*	“Explore any specific past instances of emotional trauma, including things she's ashamed of.”
	Participant 1 (Diagnosis)	Social Anxiety Disorder		*	
	Participant 2 (Case Conceptualisation)	*	Self-Compassion	*	Self-Compassion
	Participant 2 (Diagnosis)	*		Depression	
	Participant 3 (Case Conceptualisation)	*	ACT	Depression & Social Anxiety	Self-Compassion
	Participant 3 (Diagnosis)	*		Depression & Social Anxiety	

