Laurentian University

Advanced Practicum Thesis

presented at

Laurentian University

as a partial requirement of the Master of Social Work Program

By

Wendy L. Plante

The Role of Shame in Interpersonal Violence

July 30, 2020

Laurentian University/Université Laurentienne
School of Graduate Studies/École des études supérieures

Title of Thesis/Advanced Practicum Project Report Titre de la thèse / stage spécialisé	The Role of Shame in Interpersonal Violence
Name of Candidate Nom du candidat	Wendy L. Plante
Degree Diplôme	Master of Social Work
Department/Program/Département	Social Work
Date of Approval / Date de la soutenance	July 30, 2020

APPROVED/APPROUVÉ

Examiners/Examinateurs:

(First Reader/Supervisor/Directeur(trice) de thèse / stage spécialisé) Dr. Tanya Shute

(Second Reader/Co-supervisor/Co-directeur(trice) de thèse / stage spécialisé) Dr. Lea Tufford

(Committee member/Membre du comité / stage spécialisé)

Approved for the Faculty of Graduate Studies
Approuvé pour l'École des études supérieures
Dean, Faculty of Graduate Studies

Abstract

This practicum thesis explores the role that shame plays in healing from interpersonal violence. The practicum took place at Health Sciences North (Violence Intervention and Protection Program) and at the Voices for Women Sexual Assault Centre. This culmination of the learning experience describes the practicum environment, work experience, learning goals, academic and clinical supervision process, and activities involved in the learning process. It considers the empirical research on the relationship between shame and trauma and provides a theoretical framework that includes both psychological and meta-theories related to social work practice, through which the learning process was informed. This thesis considers the relationship between shame and healing from interpersonal trauma in three work environments: in the direct support of clients accessing the treatment facilities, in group therapy work with survivors, and in one-to-one trauma counselling sessions with sexual assault survivors. It considers the importance of addressing shame and shame triggers by social workers in the course of their reflexive practice. Additionally, it examines valuable methods for addressing shame within the practice environment, including the important role social connection plays in the healing process, the significance of depathologizing traumatic responses, strategies for increasing survivor empowerment and the importance of addressing shame within the therapeutic relationship. Finally, it explores the course of disclosure and the value and risks involved in the disclosure of interpersonal trauma in both group and individual therapeutic session environments.

Résumé

Cette thèse de stage explore le rôle que joue la honte dans la guérison de la violence interpersonnelle. Le stage s'est déroulé au Health Sciences North (Programme d'intervention et de protection contre la violence) et au centre de lutte contre les agressions sexuelles Voices for Women. Ce point culminant de l'expérience d'apprentissage décrit l'environnement du stage, l'expérience professionnelle, les objectifs d'apprentissage, le processus de supervision académique et clinique, et les activités impliquées dans le processus d'apprentissage. Il prend en compte les recherches empiriques sur la relation entre la honte et le traumatisme et fournit un cadre théorique qui inclut à la fois des méta-théories et des aspects psychologiques liés à la pratique du travail social, grâce auxquels le processus d'apprentissage a été éclairé. Cette thèse examine la relation entre la honte et la guérison d'un traumatisme interpersonnel dans trois environnements de travail : dans le soutien direct des clients qui accèdent aux structures de traitement, dans le travail de thérapie de groupe avec les survivants et dans les séances de conseil en traumatisme individuel avec les survivants d'agressions sexuelles. Il considère l'importance de traiter la honte et les déclencheurs de la honte par les travailleurs sociaux dans le cadre de leur pratique réflexive. En outre, il examine les méthodes utiles pour traiter la honte dans l'environnement de la pratique, y compris le rôle important du lien social dans le processus de guérison, l'importance de la dépathologisation des réponses traumatiques, les stratégies pour accroître l'autonomisation des survivants et l'importance de traiter la honte dans la relation thérapeutique. Enfin, il explore le déroulement de la révélation, ainsi que la valeur et les risques liés à la révélation d'un traumatisme interpersonnel dans le cadre de séances thérapeutiques de groupe et individuelles.

Acknowledgements

Throughout the writing of this practicum thesis I have received a great deal of support and assistance.

I would like to warmly thank my First Reader, Dr. Tanya Shute (RSW, MSW, PhD), for your kind support and guidance throughout my graduate studies. Thank you, also, for your encouragement both personal and professional.

A heartfelt thanks to my Second Reader, Dr. Lea Tufford (BA, MA, BEd, MA, PhD.), who helped me to grow both as a researcher and as a writer. My deepest gratitude for your expertise.

A special thanks to my clinical supervisor, Mrs. Paulette MaCrae (MA) for her invaluable knowledge, guidance, and support during my work term. Your confidence in my abilities and the time you took in developing my clinical skills were so important to my learning journey.

I would like to thank Ms. Jennifer Giroux-McKetchnie (MSW) who was always available to answer my questions from a social work perspective and who provided valuable resources to expand my learning.

I would like to acknowledge the clinical practitioners at the VOICES Center and at VIPP who supported my work and provided valuable advice on my clinical challenges. I would also like to thank Nancy Horan (RN) for the opportunity to work with your organization. It was very much appreciated.

On a personal note, I would like to thank my husband Alain Plante who has been in my corner since the day I suggested that I wanted to take on a social work degree. I could not have done this without you.

To my parents, Linda and Arthur Sadites, with deepest gratitude for all that you have given me from love, to the benefit of your wisdom, to your belief in my abilities to take this on—thank you both.

To my two amazing children of whom I am so proud, Amelia and Noah Plante, who were always there for me in their patience and support. Thank you both. It is your turn now.

Table of Contents

Table of Figures

Introduction

> "There was only one emotion which in recollection, was capable of resurrecting the full immediacy and power of the original moment—one emotion that time could never fade, and that would draw you back any number of years into the pure, undiluted feeling, as if you were living it anew. It wasn't love…and it wasn't hate or anger, or happiness, or even grief. It was shame. Shame never fades."
>
> —Laini Taylor, Author—

The potency of shame is a ubiquitous experience, universally endured and lamented—a common thread among humanity. Going back in time to our earliest stories of the birth of society, the Hebrew Tanakh and Christian Bible open with two accounts that set the stage for the unfolding of the human condition. First, the fall of Adam and Eve. Despite God's warning that they were not to eat the fruit of the tree of knowledge of good and bad, they disobey. In that instant unfolds the beginning of the shamed state. God looks for Adam after his transgression; Adam responds, "I heard you in the garden, and I was afraid because I was naked; so, I hid" (Genesis 3:10, New International Version). To this God replies, "Who told you that you were naked? Have you eaten from the tree that I commanded you not to eat from?" (Genesis 3:11, New International Version). At this point in the drama, Adam and Eve are exiled from Eden, forced to live out the remainder of their days in hardship—separated from the approval of God. This story is followed immediately by the narrative of Cain and Abel. God disapproves of Cain's offering but approves of Abel's because God finds in him an unworthy quality (Genesis 4:4, New International Version). In his anger, Cain murders his brother Abel and is exiled from the rest of human society (Genesis 4:12, New International Version).

I include these two ancient accounts because they embody many of the primary aspects of shame that research, in recent years, has gathered on the formation, effects, and consequences of shame and its relationship to violence. As will be discussed later in my consideration of research on the topic, the shame state arises from a place of self-conscious judgment—the knowledge of good and bad (Trumbull, 2003). It then manifests in a need to conceal the self from others—even from the scrutiny of

one's self. It results in an exiled condition, where the experiencer believes themself defeated and then responds by retreating into isolation (Harman & Lee, 2010). The story of Cain poignantly shows how the evaluation of one's self as unworthy can turn to aggression—a mechanism identified in research as underlying the perpetration of many forms of interpersonal violence (Schoenleber et al., 2015).

In 2018, 423,767 violent crimes were reported in Canada. While this is down from 458,559 in the year 2000, there has been a significant increase in violent crime statistics since hitting a low point in 2014 at 370,050 ("Canada: Number of Violent Crimes", 2018). While men are the victims of more violent crime than women, women experience more incidents of sexual assault (70% of all reported incidents are from female victims) (Government of Canada, 2017). Victimization through domestic violence does not different greatly between men (17%) and women (18%); however, women suffer more severe injuries as a result of domestic violence then do men ("Intimate Partner Violence", 2008). Healing from interpersonal violence is often a complicated and difficult journey for many survivors. Reporting to authorities, the subsequent investigation (Herman, 2011), the possibility of court proceedings (C. Lee et al., 2002), the need to seek help during the healing process (Hahn, 2004), interactions with practitioners in the course of healing (Hahn, 2004), and the social stigma attached to being a survivor of interpersonal violence (Aakvaag et al., 2016) all represent significant triggers for the shame state. While some survivors are able to navigate the treacherous waters of healing with fewer long-term consequences, many survivors develop distressing effects that require compassionate, effective, and therapeutic intervention (Andrews et al., 2000).

In discussing the process of healing from trauma—particularly trauma that results from interpersonal violence—it is important to differentiate between the traumatic event or events and the posttraumatic state because the traumatic event requires a social response while the posttraumatic state requires a therapeutic response. A traumatic event(s) is something that has occurred in the past. As such, it cannot be undone. The posttraumatic state that results, is what faces the survivor in the present and is, therefore, the focus of individual interventions under consideration within this thesis. In looking at it as a past event, it is important to draw attention to the social and structural forces that perpetuates and accepts violence within culture. These forces need to be addressed so that such events

do not reoccur (Lundy, 2011). While this thesis focuses on interventions with individual survivors of interpersonal trauma, it is impossible to move forward without pointing out the need for wide-scale social reform. In looking into the mechanisms underlying shame, it is possible to see how acts of aggression and violence themselves, are the product of shame (Mills, 2008); this mechanism will be explored later in this thesis. As shame can be responsible for the perpetration of violence there is a need to work toward social work principles and values (Canadian Association of Social Work [CASW], 2005) that intervene with individuals and groups, in the throes of shame-based dysfunction, so that shame does not manifest in the outpouring of violence is a necessary pursuit and should underlie all social work that is done with survivors.

As will be discussed in the review of literature, shame has emerged in research as a significant contributor to prolonged distress associated with interpersonal trauma (Andrews et al., 2000; J. G. Beck et al., 2011; Bockers et al., 2016; Budden, 2009). While originally focused on interventions to address trauma-related fear, the recognition of the shame state as representing the primary impedance to healing has now been supported in empirical research (Badour et al., 2017). Brené Brown, a leading social work researcher examining the effects of shame on experiencing a meaningful life, describes it as "the master emotion" (B. Brown, 2006). Lansky (2000), suggests that the impact of shame that results from trauma is so great that it likely forms the basis for dissociative disorders in the extreme case, and the subdivide of ego states in its less intense forms. This makes it imperative that social work practitioners, working with survivors of trauma, understand the mechanisms underlying the formation of shame, its impact on a trauma survivor's sense of self, and effective methods for working with shame within the therapeutic relationship.

This thesis is presented in four chapters—the culmination of my learning through the practicum experience. Chapter 1 describes the focus of my practicum, the environment in which it took place, the requirements that were agreed to and met within the process, the initial training received, the process of supervision (both clinically and academically), the major practicum activities that took place, and my goals for learning. The chapter continues with a theoretical framework that describes important knowledge that has informed my learning and the construction of this thesis. It concludes with a

discussion of my personal and professional perspectives on practice. Chapter 2 provides a review of literature related to the concept of shame, its formation, its definition, its role in trauma, and its implications in clinical practice in working with survivors of interpersonal violence. In Chapter 3, I will examine the relationship between shame and trauma in the therapeutic environments in which I practiced. Included in this section is a discussion about how shame can operate in practitioners in their interactions with clients and the value of coming to understand my own shame triggers as part of reflexive social work. This chapter will consider the importance of social connections in healing and various strategies for addressing shame in the course of social work interventions with survivors and it will address the pathologizing of trauma during empirically supported methods of intervention. In Chapter 4, I will describe how I met my learning goals and I will also discuss the process of clinical supervision and the impact of the COVID-19 pandemic on the supervision process. I will also discuss the implications of the role of shame in trauma care as it applies to social work practice. Finally, I will outline considerations for non-pathologizing trauma care and some potential considerations for social workers looking to begin practice as trauma care clinicians.

Chapter 1 – The Practicum

Focus of Practicum

The primary focus of my practicum experience was to develop knowledge and skills towards competent practice with adult survivors of interpersonal violence. Since my preliminary research suggested that shame plays a pivotal role in recovering from violence-related trauma (Saraiya & Lopez-Castro, 2016), I became interested in exploring this topic as part my learning experience. Survivors in this practice setting include adult victims of crime, sexual assault, physical assault, intimate partner violence, childhood sexual assault, or workplace violence. My practice experience took place within two organizations—the Violence Intervention and Prevention Program (VIPP) at Health Sciences North (HSN) and at the Voices for Women Sexual Assault Centre, in Sudbury. During the second half of my practicum experience, Canada and the world began to feel the effects of the spread of COVID-19. While it was necessary to modify my learning plan due to practice restrictions, it was possible to meet my learning goals through a modified work plan.

The Practicum Environment

VIPP is an outpatient, hospital-based program that provides therapeutic interventions to survivors of violence who have recently been assaulted (usually within three months). While referrals to this program are often made through HSN's urgent care facilities, through Employee Assistance Programs (EAP), and through contact with law enforcement, self-referrals are also accepted. It is common for clients attending VIPP counselling to present in crisis and requiring assistance with painful flashbacks, disturbing nightmares, dissociative states, and intrusive and distressing cognitions. VIPP counsellors take a client-centered approach to interventions, applying evidenced-based practices to reduce distress and improve emotional regulation. Eye Movement Desensitization and Reprocessing (EMDR) is regularly practiced at VIPP by certified practitioners, due to its empirically demonstrated success in treating a variety of trauma-related symptoms (Högberg et al., 2008). VIPP is an active

member in regional and provincial trauma networks that regularly provide training opportunities and research on trauma-related topics for the benefit of network members and the clients they serve. In addition to counselling services, VIPP staff assist with safety planning for survivors of domestic abuse, forensic documentation and photography following assault, court testimony, public education and advocacy, and sexually transmitted disease and pregnancy testing. VIPP staff include registered counsellors, nurses, practical nurses, and social workers.

The majority of my practicum took place at the Voices for Women Sexual Assault Centre (VOICES). While the original intention was for my work to be split evenly between the two sites, it was necessary at the mid-point of the practicum to confine my practice to VOICES due to safety concerns resulting from the commencement of the COVID-19 pandemic. While the pandemic did create the need for revisions to my practicum plan, it is my assessment and that of my clinical and academic supervisors that I learned a great deal from working within the confines of the pandemic and that it offered professional learning opportunities that would not otherwise have taken place—such as participating in phone counselling and crisis support and in assisting clients to cope with extreme environmental stressors. While crisis support is offered by VOICES, they are primarily involved in counselling women who have experienced historic sexual assault. Psycho-educational group workshops on safety and stabilization, therapeutic groups, and individual counselling are provided. VOICES is open to drop-in visits and clients are encouraged to attend the space as needed; crisis walk-in support is offered when required. Referrals to the program come from a variety of community groups and agencies, and women may self-refer. While VOICES is a distinct organization from VIPP, it is currently managed by HSN staff, receives some HSN funding, and shares a senior counsellor who practices in both agencies.

The waitlist for individual counselling is approximately 14-months long and although clients can take both psychoeducational group programs and attend group therapy while waiting for individual counselling, it is evident that the program is in need of more resources if clients are to receive timely

services. Individual counselling with survivors of sexual assault is often a lengthy process—particularly since many of the women seeking therapeutic services have comorbid mental health challenges or have experienced multiple instances of or ongoing sexual violence. Members of the VOICES team include registered counsellors, social workers, and child and youth workers.

My practicum experience involved work with drop-in clients, the co-facilitation of group therapy sessions with sexual assault survivors and individual counselling with trauma survivors. I was also involved in the co-facilitation of psychoeducation groups for trauma clients and conducted research into brief session interventions with recent survivors of interpersonal violence. Supervision was provided both on a daily basis and following intervention sessions, and my site location and schedule shadowed that of my clinical supervisor.

Requirements of the Practicum

My practicum experience was scheduled to begin January 6, 2020 and to conclude April 30, 2020. A scope of practice, applicable to the Master of Social Work program, was defined; It was understood that at the time of my placement, that I already held the credentials as a registered member of the Ontario College of Social Workers and Social Services Workers—in good standing. Prior to beginning my practicum I completed a series of 12 modules of training necessary to work within the HSN environment including courses focused on working with clients with disabilities, workplace violence, health and safety, emergency preparedness, health care hygiene, confidential records handling, and caring for the needs of sexual assault survivors. All necessary health status assessments and vulnerable records checks were completed as per HSN student placement protocols and I received security clearances necessary to access both HSN and the VOICES Sexual Assault Centre. Formal placement documentation was completed by Francine Boudreau—Placement Coordinator for the Master of Social Work program and was accepted by Crystal Lawerence—HSN's Advisor on Leadership and Learning.

Initial Training

During my first weeks of practicum I received training on the use of MEDITech (HSN's patient management software), and the VOICES client database systems. I was provided with access to medical health information and was actively involved in the mechanics of maintaining a confidential record workflow in both practicum locations. Additionally, I was provided with training in case management software and became familiar with the administrative processes of both organizations. While I benefited from working within two different organizations by acquiring training in two case management systems, and in working alongside a wide variety of counsellors, moving between the two locations required that I develop a greater degree of flexibility in my practice. It represented a larger initial learning curve than if I was working in a single environment. This created some challenges but was more than compensated for by the additional learning opportunities the arrangement provided.

Academic Supervision

In preparation for my practicum experience I approached Dr. Tanya Shute and Dr. Lea Tufford to arrange academic supervision throughout my learning experience. Dr. Shute agreed to act in the capacity as my first reader and Dr. Tufford accepted the role of second reader. My practicum committee and myself corresponded prior to and during my practicum experience and met in person to coordinate the production and review of my Practicum Proposal, the completion of the Post-Practicum Evaluation and throughout the preparation of my Advanced Practicum Thesis. Meetings moved to an online format with the commencement of the COVID-19 pandemic, which did not represent a barrier to the academic supervision process. While academic supervision did take place according to the plan outlined in my Practicum Proposal, both academic supervisors assisted in revisions to my practicum plan to accommodate issues presented by the COVID-19 pandemic.

Clinical Supervision and Learning Activities

Following my initial training in administrative processes I began to first attend and then co-facilitate various education and treatment groups at the VOICES site. During this time, I learned how to

effectively teach safety and stabilization skills to clients and to actively engage in the psychoeducational component of therapeutic interventions. I developed skills in facilitating workshops involving sensitive and emotionally intense topics and discovered how to redirect conversation when emotions within the therapy group were running high. I came to understand how delicate a balance must be maintained between supporting clients in expressing their experiences and their emotions while at the same time, ensuring that they left the group therapy session in a safe state of mind. In addition to the co-facilitation of therapy groups, I was responsible for providing crisis support for group members who felt the need to leave sessions prematurely, while in a state of distress. This process often involved providing support and active listening to clients while they expressed their emotional reactions to the group activity or discussion and offering safety and stabilization direction to regain emotional regulation. It was common for clients to experience shame following the intensity of their reactions, at which point I acknowledged and addressed shame-based responses directly before supporting the client to reenter the group—if they felt they were capable of doing so.

Part of my work at VOICES involved providing supportive counselling to drop-in clients. This offered me the opportunity to practice crisis trauma intervention skills that I had learned prior to my practicum and which were expanded upon though shadowing my clinical supervisor, Paulette McCrae. Paulette McCrae (MA) is the senior counsellor at both VIPP and VOICES, possesses over 20 years of counselling experience and is a skilled trauma care practitioner. She specializes in the use of EMDR in working with trauma and inspired me to expand my working knowledge of the mechanics and techniques involved in EMDR therapy. She also provided guidance in the use of Internal Family Systems (IFS) therapy—an ego state therapy that can be applied in conjunction with EMDR or can be implemented independently when working with survivors of trauma and complex trauma. My secondary supervisor, Jennifer Giroux-McKetchnie (MSW) was available to answer my questions related to trauma treatment from a social work perspective and to assist with any issues related to the application of

social work ethics that arose during my practicum. Additionally, Ms. Giroux-McKetchnie offered invaluable resources related to social work trauma practice and shared important insights into how trauma treatment can be adapted when working with children. Since Ms. Giroux-McKetchnie is a graduate of the Laurentian University Master of Social Work program, she understood the process and requirements of the practicum experience and shared her insights on the connection between Master-level theory and trauma practice.

Following my training in group therapy work and supervisor shadowing activities, I was assigned clients for whom I provided weekly, individual trauma counselling sessions. Clients were selected based on their need for immediate support. Normally, clients in this category would have to wait for an extended period before counsellors were available to begin individual sessions; however, my practicum offered the opportunity to provide counselling for those in greatest need in a timely manner. Each session was debriefed in follow-up sessions with my clinical supervisor. Mrs. McCrae provided guidance around challenges that arose during my sessions, role-played any issues that came up for which I believed I required more practice, and used our supervision interactions as learning opportunities for engaging with difficult client-counsellor events. For example, my supervisor provided guidance on how to handle ruptures that may occur in the therapeutic relationship, due to misunderstandings or miscommunication, and how to turn this into an opportunity to model behaviours for clients. Mrs. McCrae used these regular supervision sessions to share important breakthroughs that she had witnessed in her own sessions and asked questions about how I would approach a similar experience had I been the therapist. These sessions were critical to my development as a counsellor, and the time Mrs. McCrae spent in supervision with me resulted in the most important learning opportunities of my practicum, aside from those lessons I learned from my clients themselves. While I was able to apply many of the techniques I had learned in observing my clinical supervisor early in the practicum, I was encouraged to make use of my past training in Cognitive Behavioural Therapy (CBT-level one and level

two), when I felt that a client would benefit from this form of intervention.

Towards the end of my practicum, the COVID-19 pandemic required that we discontinue face-to-face counselling sessions and switch to phone-based support for those who needed immediate assistance. Clients often presented in a state of crisis and experienced extreme trauma-related stress reactions in response to the mandatory quarantine sanctions. During this time, I was able to gain valuable crisis intervention skills that could be administered remotely. My clinical supervisor provided guidance on helping clients to tune in to their immediate environments—becoming present and disengaging those areas of the brain heightened by trauma but triggered by the stress of the pandemic. While I had initially thought that counselling by phone might be a frustrating endeavour, I quickly learned that by achieving a state of presence myself and by decreasing the client's arousal through slow, soothing dialogue, it was quite possible to help clients manage their worst moments and regain internal emotional regulation. This often led to basic instruction in mindfulness exercises that could be practiced at later moments when they may feel intense emotions resurfacing.

During the practicum experience, students are given the opportunity to prepare a project that can benefit the sponsoring organization. I chose to undertake a research project on the benefits and risks involved in undertaking brief EMDR symptom reduction interventions for those clients who are on a waitlist for services. The research project was completed on behalf of VIPP in the form of a literature review that was then presented to the Ontario Trauma Network. The completion of this formal review became a component of my work experience when my work plan was modified due to the COVID-19 virus. The Ontario Trauma Network has received the research project and it will be used to advise them in their deliberations in the implementation of short-term interventions across the Network.

Learning Goals

By the conclusion of my practicum I planned to achieve five primary learning objectives. Firstly, I wanted to better understand the role shame plays in post-violence responses in adult survivors.

Secondly, it was my intention to develop a better understanding of the course of disclosure, as it relates to interventions with survivors of violence. While the COVID-19 pandemic did cut short the disclosure process that normally takes place in the concluding sessions of group therapy with sexual assault survivors, I was able to identify challenges that arise during the disclosure process and delineate the role shame can play during these delicate therapeutic interventions; this was accomplished as it was my observation that disclosures, while scheduled to occur at the conclusion of the group therapy work, took place on a micro scale throughout the entirety of the group sessions. Thirdly, I intended to identify ways of empowering service users in their healing process. I also set out to develop tangible, evidence-based practice skills in working with trauma—both in a one-on-one intervention setting and in the group therapy environment. Finally, it was my intention in the course of this practicum to learn to become an effective ally to service users in healing shame and in cultivating therapeutic relationships. It was in the course of pursuing this goal that some of my most important client-counsellor engagements occurred and it became evident just how important the process of healing shame is to the overall success of interventions with survivors. It was agreed in consultation with my academic and clinical supervisors that my learning goals had been met during the course of my practicum experience and positive feedback from my clinical supervisor relayed approval of my level of accomplishment in the development of clinical social work skills with trauma survivors.

Theories in Practice

In informing my analysis of the relationship between shame and trauma during my practicum, it was beneficial to consider various theoretical perspectives that could contribute to my understanding of shame, its formation, and methods of healing shame that can be used in interventions following experiences of violence.

Psychological Theories on Shame

Interest in the formation of shame first appeared in empirical literature in the early 1970s with

the seminal work of Helen Lewis (H. Lewis, 1971), followed by a period where little research was conducted on shame in the 1980s and 1990s, followed by a resurgence beginning in 2010 (Harman & Lee, 2010). There are a core group of psychological theories that have addressed shame, however loosely, in their perspectives on human development. Among the more valuable perspectives that choose to delineate shame in their models are psychodynamic theory, object relations theory, and emotion-based theories.

Psychodynamic Theories. From the psychodynamic perspective, shame represents the subjective evaluation of the self as imperfect, defective, flawed, weak, or insignificant (Morrison, 2011). It is, perhaps, straightforward to envision how these negative self-evaluations would be increased by experiences of violence. Sandler et al. (1963) theorized that difficulties are created in the contrast between the ideal-self (the internal perception of the ideal) and the actual-self (the evaluation of the self as it is perceived to be). The psychodynamic formulation of shame relies heavily on the conceptualization of narcissism—the need to be considered special or unique in the eyes of others (Morrison, 2011). In healthy individuals, it is theorized that early connections with primary caregivers create a model of the self that is stable, consistent, and adequate in perceptions of self-esteem (Morrison, 2011). Conversely, in situations of narcissistic vulnerability—inclusive of times of stress or trauma—the perception of the self can become chaotic and fragmented (Morrison, 2011). While psychodynamic theory does provide valuable insights into the formation of shame—particularly later branches of psychodynamic theory such as ego state therapy with its model of the formation of distinct 'parts' within the human psyche—its tendency to pathologize these mechanisms without recognition of their universal nature and functional purpose places limitations on its usefulness in working within precepts of social work values.

Object Relations Theory. It is worth considering the object relations theory perspective of shame, as shame has been identified as being both a personal and relational affect. Of founding

importance in object relations theory is the premise that humans are social by nature and depend on and related to, other humans as a necessary component of overall health and wellbeing (Stadter, 2011). Object relations, like psychodynamic theories, contends that the development of shame occurs primary within the functional or dysfunctional relationships with primary attachment figures. Within this framework, consideration of shame is based on three concepts. Firstly, that each individual is unique and that their uniqueness may have been a source of shame for them in the past (May, 2017). Secondly, shame may create a closed system of interaction between the client, themselves, and others—re-enacting familiar yet dysfunctional patterns they have experienced in the past (Stadter, 2011). Finally, the practitioner—once aware of the reoccurring pattern—uses transference and countertransference to better understand the client's inner shame state and behaves with new responses that can reorganize the established pattern (Sandler, 1990). Object relations theory, while similarly not addressing the importance of wider social issues on the formation of shame, is valuable in its recognition of shame as being both created and healed through interpersonal relationships.

Emotion-Based Theories. Emotion-focused therapy (EFT) is foundationally premised on the role of emotions in functional or dysfunctional psychological processes (Greenberg & Iwakabe, 2011). From this theoretical perspective, emotions are seen as an important information processing mechanism that helps people to pay attention to their environment and to prepare them for action in response to environment cues (Greenberg & Iwakabe, 2011). EFT suggests that shame is created in response to traumatic or injurious emotional experiences. It uses four primary modalities for working with shame: relational validation (using the therapeutic relationship to work through shaming experiences to acknowledge and fully experience the shame response in an affirming and empathetic environment); accessing and acknowledging shame (helping clients to recognize when they are avoiding potentially shaming experiences and aids them to articulate the shame they are experiencing); regulating shame (to decrease arousal to the shaming experiences, while creating meaning around uncomfortable events);

and transforming shame (generating new emotional responses to shaming experiences that lead to resilience) (Gilbert, 2011). In a similar way as object relations theory, emotion-based theories generate the hope that shame can be addressed through the therapeutic relationship. However, like cognitive behavioural theories, emotion-based theories tend to treat emotional responses from a pathological perspective.

Meta-Theories Related to Social Work Practice

While there is a great deal of important learning that can be acquired on the formation of shame through psychological theories, social work theories help to tie the nature of shame to social, cultural, and structural issues. For this reason, I find it valuable to include the use of feminist, structural, and relational-cultural theories in informing my learning and practice related to the formation of shame and its connection with violence.

Feminist Theory. In relation to the concept of trauma, feminist theory led the way for the inclusion of interpersonal violence to be listed amongst traumatic stressors in the DSM-III (Herman, 1992). Of primary concern through the lens of feminist practice, is for the survivor of interpersonal violence to comprehend that their state of suffering was not caused by some personal deficit or weakness, but instead by the action of being oppressed by a system that holds inappropriate power over their lives and perceptions of being in the world (L. Brown, 2004). As a consequence, feminist practice attempts to help the client find "strategies and solutions advancing feminist resistance, transformation, and social change in daily personal life, and in relationships with the social, emotional, and political environment" (L. Brown, 1994, pp. 21–22). In working with shame, this offers the practitioner the opportunity to put traumatic experiences inside the framework of oppressive systems, which has the potential to diminish the stigma of personal unworthiness and move violence and its associated shame, into the domain of the social and political. Belonging to a non-dominate group may have put the client at greater risk for externally referenced shaming experiences, in part, because of their special vulnerability as a marginalized member of society (L. Brown, 2004). Feminist theory is

valuable in working with both shame and violence as it addresses the social issues that a) apply pressure to individuals to repress aspects of the self that make them vulnerable within dominant social systems and norms (Ferguson et al., 2000) b) points out social inequities that place individuals at greater risk of experiencing both shame and violence (L. Brown, 2004), and c) addresses issues of power that allow dominant members and groups within society to dictate what is acceptable, valuable, advantageous and for whom (Fischer, 2018).

Structural Theory. Of particular interest in the treatment of shame, related to interpersonal violence, is the concept of trauma disclosure—an evidenced-based and common practice in individual counselling and group work with trauma survivors (Ullman, 2011). The process of disclosure is one that is generally facilitated with care; however, it may arise prematurely before the client has built adequate trust within the therapeutic relationship (Kunz & Stoltys, 2007). While it is hard to argue that there is no necessity to discuss traumatic events in the course of trauma treatment, the way in which this is orchestrated can be reflected on from a structural theoretical perspective. Firstly, the position of the practitioner as the 'professional' from which the client seeks 'help', creates an inherent power imbalance where the professional requests of the client that they disclose traumatic events, and to benefit from the trauma counselling, the client must comply (Finn, 2016). This may occur prematurely, before the practitioner has adequately constructed a trusting and empathic relationship with the client and may be hurried due to limited treatment durations or resources. Secondly, the requirement to disclose within the group environment, due to the prescribed arrangement of the therapeutic plan, can result in shame when a client does not feel capable of the vulnerability required to share their story with others (Ware & Dillman Taylor, 2014). The pressure to make the private 'public' can cause the client to feel revictimized—particularly if the response is not sufficiently empathetic (Ullman, 2011). While great effort is taken to build adequate empathy within the trauma treatment group, it is not possible to control all the interrelational factors that may be responsible for worsening trauma symptoms (Ullman,

2011). In addition to the nature of the therapeutic structure, some clients may be at risk of experiencing multiple intersecting traumas, due to their non-dominant status within society. Their matrix of shame is likely to be quite complex and will require that the practitioner be cognizant of the various sources of structurally induced shame, which may complicate the assessment of shame triggers that are related directly to their experiences of interpersonal violence (B. Brown, 2006). In working with clients from non-dominant groups, it may be useful to explore systemic sources of shame as part of the process of working through experiences of interpersonal violence. Since shame has a silencing affect, structural theory suggest that it can be useful to help clients to explore the possibility of and the need for social change (Lundy, 2011), beyond the scope of trauma treatment.

Relational-Cultural Theory. Since shame is constructed within both personal and social spheres, a theoretical framework that does not consider human development in interrelation terms, would result in an incomplete picture of the creation and treatment of shame—particularly shame that occurs as a consequence of interpersonal violence. Relational-cultural theory (RCT) suggests that human psychological and emotional development is a movement through and toward relationships with others, over a lifespan (Comstock et al., 2008). Mutual empathy, empowerment, and authenticity are viewed as forming the basis for healthy relationships that lead to psychological stability and wellbeing (S. Brown et al., 2018). As a consequence, RCT requires that the practitioner consider how these social relationships have been impacted by oppression, discrimination, shame, and marginalization (Comstock et al., 2008). Additionally, sources of shame can be culturally dependent, with the dominate forces within each culture defining what is considered shameful and for whom (Comstock et al., 2008). Practitioners should recognize the importance of cultural differences around the construction of shame triggers, if they are to work effectively with survivors of interpersonal violence (Budden, 2009). While early caregivers provide the first relationships in which people grow, RCT would suggest that these relationships are only the beginning and that they do not determine the outcome of psychological and emotional growth

(Comstock et al., 2008). This concept allows for the intervention by practitioners who can act as surrogates in nourishing relational growth. Indeed, Brown (2006) suggests that shame cannot exist when exposed to empathy within caring relationships, particularly if this empathy helps survivors to feel empowered to act within their lives and to avoid the strong temptation, implicit in shame, to isolate themselves as a protective measure. Since shame brings with it deep feelings of unworthiness of connection and acceptance and because many survivors of interpersonal violence have developed strong defenses against vulnerability, it can be more challenging for the practitioner to encourage survivors that further vulnerability is required in the form of engagement in healthy relationships—relationships that may help them in their healing journey (Hartling & Walker, 2000). People who have endured extended periods of domestic violence experience a gradual and insidious increase in their shame states, as they are manipulated through the effects of bullying, to accept that they are deserving of the treatment that they now experience (Buchbinder & Eisikovits, 2003). Additionally, sexual assault can leave survivors permanently threatened within benign environments, and they are more likely to experience shame as a direct result of the sexual nature of the trauma (Van Vliet, 2008).

Personal Approach to Practice and Worldview

In determining an approach to understanding shame and its relationship to violence from a theoretical perspective I have distilled important knowledge, postulated within these afore considered theories, and developed my own perspectives, as a practitioner, on how I will use them in understanding shame and violence in working with survivors. What I choose to take away from each theoretical perspective, it must be acknowledged, is in part a function of my worldview and life experiences. For example, it is my perspective that there is a critical need for dramatic change both within social systems and within individuals before the effects of shame and violence can be adequately addressed. I believe that an evolutionary-biology theoretical approach to shame—one that admonishes shame as pro-social in nature and positive in the development of a unified and stable society, is simplistic. Such a theoretical

view, to my mind, does not take into consideration arguably higher and potentially more spiritual perspectives that perceive humans as being in possession of a core self, capable of great empathy, wisdom, compassion, and acceptance, but that has been inhibited through the suppression of its more vulnerable qualities in response to an inhospitable environment. A prosocial view of shame, one that sees shame as adaptive within the context of social structures, reinforces the idea that those placed in positions of authority or power and who determine what constitutes a violation of social norms and thus reinforces external sources of shame, are correct in their values and in their assertions of what is shameful.

It has been my observation during the course of my research, in the preparation of this practicum thesis, that the majority of the studies taking place on the connection between shame and trauma are primarily focused on physical acts of violence (sexual assault, domestic violence, workplace violence, etc.). I would like to emphasize that my professional perspectives on violence are that it occurs much more commonly and in many subtle forms. For example, psychological and emotional violence can play a significant role in the development of shame and the unfortunate reality is that such forms of violence go largely unrecognized (Outlaw, 2009). These subtleties do appear in research studies that discuss precursors to physical violence where grooming, threats, manipulation, intimidation, and control are recognized but not acknowledged as fully formed acts of violence (J. G. Beck et al., 2011) Therefore, these forms of violence are included amongst acts of interpersonal violence and are applicable to the formation of shame and to this thesis.

VIPP and the VOICES Sexual Assault Center both approach practice with trauma survivors from a client-centered framework. As such, it was essential to my practice within these organizations to develop skills and models of intervention that were in line with organizational principles. The client-centered framework is founded on the principle that the client is the expert on their own lives and issues. First introduced by Carl Rogers in the 1950s, Rogers suggested that humans are essentially good

and search out purpose and meaning as a course toward fulfillment (Joseph, 2004). Starting with this principle, practitioners use a non-judgmental and non-directive approach to working with clients—while supporting them in recognizing and enhancing their sense of personal power to create change (Joseph, 2004).

In response to my sponsoring organization's focus on client-centered work with survivors of violence and in support of ethical social work principles, I explored several models that would help me to better reach my practice goals (CASW, 2005). In the course of my practicum, I was introduced to Internal Family Systems (IFS) therapy through my clinical supervisor. IFS came out of early work into ego state theories that suggest that the mind is universally composed of distinct 'parts', each filling an important role within an individual (Schwartz, 2001). This model also suggests that there exists a 'self'—a compassionate, accepting, and wise core that is present within each of us. In contrast to models that suggest that multiplicity of the mind (many 'parts') is representative of pathology and dysfunction, IFS views this non-singular composition of mind to be the rule instead of the exception (Schwartz, 2013). Additionally, IFS views each 'part' as important to the functioning of the overall mind system and instead of cultivating an adversarial response to a 'part's' sometimes challenging behaviours, it attempts to develop a compassionate and understanding relationship with each 'part', facilitated by the core 'self' (Schwartz, 2013). The use of IFS in working with trauma has drawn considerable attention in recent years—particularly among practitioners who specialize in EMDR or trauma-based cognitive therapy (t-CBT) when working with clients who do not respond in positive ways to EMDR or t-CBT practice techniques (Forgash & Knipe, 2012).

Since the founding principles of IFS focus on the idea that the client already has all the tools necessary to work through their trauma-related issues and that the role of the practitioner is to act as a guide in the process of reintegrating 'parts' IFS offers an excellent entry point to working within a client-centered framework (Courtois & Ford, 2009). I mention the use of the IFS model here in my discussion

of my theoretical approaches to practice with survivors of trauma because it has become, to me, such a valuable form of practice that I found myself calling on its tenets throughout the entirety of my practicum. In considering the literature on the use of IFS in the treatment of trauma, it asserts that IFS is a) non-pathologizing in nature (Frederick, 2005); b) represents a collaborative intervention process that is in support of social work principles (Lucero et al., 2018); and c) recognizes that each client has resources, strengths, and sources of resilience that are ultimately responsible for their past ability to cope and their future ability to heal from the effects of trauma (Schwartz, 2013). As a consequence, IFS represents an effective intervention for practitioners looking for a client-centered approach, particularly for those who are committed to a non-medical model approach to mental health interventions.

From There to Here

I have considered, throughout my social work education, how my life experiences and perspectives were likely to play a role in my approach to practice. In preparation for my work with trauma survivors—specifically sexual assault survivors—I considered the fact that I have not experienced this form of interpersonal violence in my personal life and I wondered if I would be able to truly understand the experiences of the clients with whom I was to work. My approach going forward was twofold. Firstly, I decided that while my research into the experiences of survivors of interpersonal trauma was extremely useful and my education extensive, I could not fully experience what they had gone through. As a consequence, I committed myself to the client-centered approach of recognizing the client as the expert on their own lives and I openly acknowledged this during interventions (Larson, 2008). Secondly, I recognized—to a certain extent—that if I continued as I had as a student—learning, listening and gathering as much information as I could, I would begin to form an understanding of my clients and their particular needs. I believe that this is what is referred to in eastern philosophy as adopting a 'beginner's mind' (Childs, 2007).

It is extremely tempting as a new practitioner to cover one's shame in 'not knowing' with a

manufactured confidence. While I lacked a personal connection with sexual violence, I was able to draw on other forms of interpersonal violence that I had experienced or had witnessed over the course of my lifetime. At one point in my practicum I had to stop and reflect critically on some of the privileges that I would have if I had experienced traumatizing episodes of interpersonal violence. For example, many of my clients wait at least 14 months before they can access counselling services. I reflected on the fact that my stage of life, the resources I have at my disposal, and the privileges associated with being a mature student all mean that I would be able to access services in a much more timely manner. Access to private insurance would mean that I could choose which facility and counsellor I would seek services from and I would also have the ability to change counsellors or clinics if I found that the current intervention was not effective.

At an earlier point in my practicum I remember mentioning to my supervisor that I was concerned that as a new practitioner, my clients may not be getting the full range of interventions that a more experienced counsellor may provide. In response she commented on the fact that these same clients may not be able to access services for months, but with my presence they could receive services sooner. I realized in the moment that while she was correct, the options for interventions with survivors were few and limited in the variety of the help they could receive in comparison to those services I could access if I was need. This realization made me extremely vigilant in my efforts to provide the best services possible, but it was clear in that moment how big a gap exists between individuals with access to resources in comparison with those without.

According to Faver (2004), our sources of meaning as practitioners are worth scrutiny in the process of learning because it helps practitioners to be aware of their own worldviews and how these views may impact their work with service users. For example, if I make the decision to take up the profession of social work because I find meaning in helping others, I must be aware (constantly reflexive) that my pursuit of meaning comes with it an unspoken goal that could ultimately prove

counterproductive to the wellbeing of clients with whom I work. How could this be the case? It is possible that my measurement of whether I have achieved something meaningful is limited by my perspectives on the therapeutic progress of the clients with whom I work—my professional worldview on what constitutes helping. For some clients the pressures of 'fixing the problem' or 'feeling better' may in themselves create barriers to long-term mental health (Schwartz, 2013). In some cases, what constitutes a valuable therapeutic invention may simply involve the relief service users experience in being seen, heard, and accepted—the importance placed on 'fixing', 'healing' or 'repairing' may not represent what they truly need. In such a case the need to 'help' becomes about the goals of the practitioner and not necessarily the 'client'. I am focusing on this particular aspect of reflexivity because it is so easy to overlook when working with survivors of trauma that, as a practitioner, we already carry with us preconceptions around what it means to 'help' in our movement toward professional satisfaction. Regardless of one's evidence-based practice framework, research shows that the most important component of successful interventions is the relationship between the service user and the practitioner (Bachelor & Horvath, 1999; Lambert & Barley, 2001). This, perhaps, is representative of a critical yet difficult to achieve aspect of practice—to be fully present in an aware state unburdened by our ego 'part's—so that in those moments the client experiences safety and a role model to work from, in doing the same. The findings that are presented in this practicum thesis will rest solidly on this one social work practice principle, and as such, I feel it important to present this professional worldview at the onset as it will heavily inform the content of its pages.

Chapter 2 – A Review of Literature

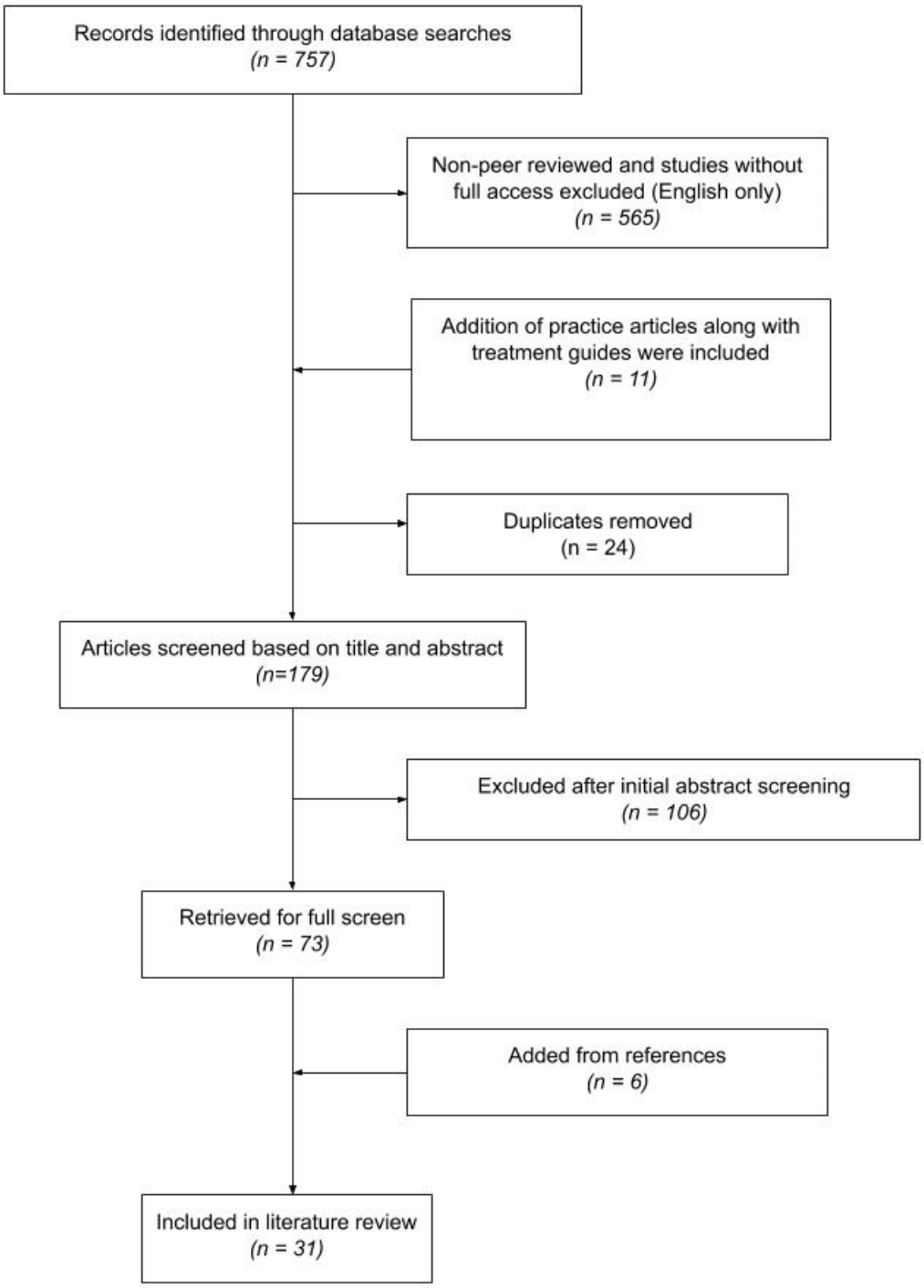
As with many topics, when a careful and in-depth analysis takes place of something universal and seemingly self-explanatory, the topic often ends up being far more complex and nuanced than first anticipated. Shame is no exception. While it is often described as an emotion, it is also considered a state—a way of being in the world (Lansky, 2000). There is great variety in its definition, in the perception of its relationship to other self-conscious emotions or states, the understanding of its formation, perspectives on its relationship to trauma, and its role in recovery is difficult to delineate. Additionally, perspectives on the meaning of shame, models that predict its triggers, and theories about its role in the human condition are often conflicting. Adding to this complexity is a discussion around what constitutes effective interventions to mitigate its disabling effects. As a result, it is appropriate to consider the empirical evidence on the topic and a literature review is an effective tool in this undertaking. This literature review will analyze empirical research on shame and will consider the question: what role does shame play in healing from experiences of interpersonal violence by adult survivors and how can an understanding of its construction and maintenance provide tangible methods for working with shame?

Methods

A literature search was conducted in the EBSCOHost, ProQuest, PubMed, and Elsevier databases. Search criteria took the form of the following search string: ab(shame) AND (violent OR violence) AND (ptsd OR "post traumatic stress disorder" OR "post-traumatic stress disorder" OR "post-traumatic stress disorder" OR trauma OR CPTSD OR "complex PTSD"). The initial collection resulted in 757 sources. Non-peer reviewed literature, studies to which full access was not available, and non-English research was excluded (*n=565*) (see Figure 1). Additional seminal practice, model, and theoretical articles on the topics of violence and shame were added to the unscreened collection (*n=11*).

Figure 1

Methodology Workflow



Note: This figure shows the literature search methodology used in this review

Duplicates were then removed (*n=24*). The remaining body of literature (*n=179*) was screened for topic and population applicability as found in the title and abstract. After title and abstract screening, *n=106* articles were excluded using Rayyan QCRI—an online screening support tool. The remaining body of literature (*n=73*) were retrieved for full text screening. In considering the content of the full text articles, the literature under review was expanded to include valuable references articles found within the contents of the remaining collection (n=6). After the final screening based on full text content, articles (n=31) were included for consideration within this review.

While this thesis will comment on the pathologizing nature of the clinical diagnosis, associated with the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), it was necessary to include post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (C-PTSD) in the search criteria, in order to address important information resulting from research undertaken using a medical model perspective. Literature was evaluated based on a clear conceptualization of shame, its relationship to experiences of violence, its role in forming barriers to recovery, a model for its formation or maintenance, and the inclusion of tangible, evidenced-based practice theories for interventions with survivors of trauma.

Cross-sectional, randomized control trials (RCTs), longitudinal, phenomenological, grounded theory, scoping reviews, clinical models, and practice articles were included in this review. Cross-sectional, RCTs, and longitudinal studies were useful in summarizing key concepts and providing correlational connections between shame, violence and the symptoms of PTSD (Aakvaag et al., 2016; Anderson et al., 2010; Andrews et al., 2000; Au et al., 2017; Badour et al., 2017; J. G. Beck et al., 2011; Bockers et al., 2016; DeCou et al., 2019; Goldsmith et al., 2014; Harman & Lee, 2010; La Bash & Papa, 2014; Leskela et al., 2002; Schoenleber et al., 2015; Wong & Cook, 1992). Phenomenological and grounded theory studies provided insight into the lived experience of violence and the gap shame creates between the survivor and the outside world (B. Brown, 2006; Buchbinder & Eisikovits, 2003; Dorahy & Clearwater, 2012; Talbot, 1996; Van Vliet, 2008). Practice and clinical model articles featured options for working with shame in both groups and with individuals (C. Lee et al., 2002; M. Lewis, 2003; Trumbull, 2003; Wilson et al., 2006). Finally, other literature and scoping reviews summarized key

concepts and pointed to important sources that may not have been encountered through the search methodology (Hahn, 2004; MacGinley et al., 2019; Mills, 2008; Saraiya & Lopez-Castro, 2016; Ullman, 2011).

Findings

The included literature was analyzed, and several themes emerged through its consideration from both social work and psychological perspectives. To clearly conceptualize shame and its relationship to violence, it was first necessary to settle on a definition to be used throughout the remainder of this thesis (see Appendix A). The definition was identified through the careful evaluation of the various conceptualizations of shame included in the empirical research and by extracting the essence of important variations found in the analysis. Five key themes emerged in the analysis. Firstly, most authors attempted to address the formation of shame from their theoretical perspectives. Two relationships surfaced from an analysis of shame's formation—its relationship to other self-conscious emotions or states and its relationship to the concept of the self. The second theme to emerge was the connection between shame and the medical model diagnosis for posttraumatic stress disorder (PTSD). Thirdly, many of the research articles under consideration attempted to identify barriers that shame created to the healing process. The fourth theme involved the consideration of methods of healing shame in an interpersonal-trauma context. The final theme gathered together important concepts around working with shame within the therapeutic relationship.

Defining Shame

While the majority of the studies included in this review provided a definition of shame as a component of their analysis, the definitions were wide-ranging and varied in their composition. At this point in the discussion, I will consider the collective concept of shame as represented in the literature under review. Several included studies identified shame as a painful (Aakvaag et al., 2016; Brown, 2006; Budden, 2009; La Bash & Papa, 2014; Leskela et al., 2002; Mills, 2008; Saraiya & Lopez-Castro, 2016) self-conscious (Bockers et al., 2016; Budden, 2009; DeCou et al., 2019; Harman & Lee, 2010; Lewis, 2003; Trumbull, 2003) emotion or state that encourages the experiencer to conceal themselves from

others (Andrews et al., 2000; Budden, 2009; Harman & Lee, 2010; Schoenleber et al., 2015). While some studies hinted at the idea that shame may take more than one form, Lee, Scragg and Turner (2001) and Budden (2009) were the only articles that clearly articulated the idea that shame can be internally or externally referenced (See Figure #2). External shame represents the assessment that one's self does not adequately measure up to real or perceived dominant social ideals, while internal shame was described as the belief that one's core self is unacceptable when compared to one's own internalized assessment (Harman & Lee, 2010). This concept of internalized shame will be scrutinized further in Chapter 2. Characteristics identified as being externally referenced sources of shame include the belief that the self is: unattractive to others, incapable or incompetent, damaged, inferior, disgusting or dishonoured. Internally referenced shame characteristics include the belief that the self is: flawed, unworthy, powerless or weak, inadequate, tiny or insignificant or that the self is a 'bad person'. A sense of powerlessness was identified as emanating from the belief in being utterly defeated—unable to find a course of action that would mitigate the feelings of shame (Budden, 2009). In turn, the sense of powerless along with the need to conceal oneself and to avoid further shame, results in both perceived and actual isolation (Brown, 2006; Harman & Lee, 2010; Schoenleber et al., 2015; Wong & Cook, 1992). In looking at the concepts presented in empirical research, this thesis will define shame as a painful self-conscious state where the experiencer perceives their self as being unworthy of survival within their social environment and, as a consequence, exists in a state of constant threat from which they need to conceal themself.

The Formation of Shame

Two sub-themes appeared in the literature related to the formation of shame—shame as a separate and distinct concept from guilt or humiliation, and shame and its relationship to the self. These two themes are important and provide insight into the mechanisms that underlie shame.

Table 1

Self Characteristics Associated with Internal and External Shame

Self Characteristics Associated with Internal and External Shame						
	Self Characteristic	**Literature Review - Included Authors**				
External Shame (Budden,2009; Lee, Scragg & Turner, 2001)	Not Attractive to Others	Aakvaag, 2016	Andrews, 2000	Harman & Lee, 2019	Van Vliet, 2000	
	Incapable/Incompetent	Au et al., 2017	Lee, Scragg & Turner, 2001	Lewis, 2003		
	Damaged	Au et al., 2017				
	Inferior	Budden, 2009	DeCou, 2017	Harman & Lee, 2019	Lee, Scragg & Turner, 2001)	Wong & Cook, 1992
	Disgusting	Lee, Scragg & Turner, 2001				
	Dishonoured	Wilson, 2006				
Internal Shame (Budden,2009; Lee, Scragg & Turner, 2001)	A Bad Person	Beck, 2015	MacGinley, 2019			
	Flawed	Brown, 2006	Schoenleber, 2015			
	Unworthy	Brown, 2006	Leskela et al. 2002			
	Powerless/Weak	Harman & Lee, 2010	Lee, Scragg & Turner, 2001	Leskela et al., 2002		
	Inadequate	Au et al. 2017	Lee, Scragg & Turner, 2001	Lewis, 2003		
	Tiny/Insignificant	Buchbinder, 2003				

Note: This figure provides an overview of the definition of shame as included in the literature under review within this thesis.

Shame, Guilt and Humiliation. Many studies under consideration identified shame as a strictly negative emotion afflicting the self (Aakvaag et al., 2016; Brown, 2006; La Bash & Papa, 2014; Schoenleber et al., 2015; Wilson et al., 2006). In contrast, some studies presented shame as an adaptive emotion, with its origin primarily pro-social in function (MacGinley et al., 2019; Trumbull, 2003; Van Vliet, 2008). Trumbull (2003) and Van Vliet (2008) suggest that shame evolved as a determination of social status, where behavioural deviance from the dominant standard resulted in social ostracization and increased vulnerability for those not modifying their behaviour in line with group norms. Trumbull (2003) suggests that shame provides important feedback to the experiencer about the threat of losing social status within a hierarchy and as such, results in physical manifestations such downcast eyes, the turning away of the face, and a posture that reflects an attitude of submission.

Van Vliet (2008) suggests that "the pain and adversity associated with shame motivates individuals to increase their intellectual, physical, and social competencies" (p. 233). Thus, from Van Vliet's perspective shame plays a vital role in learning and in the advancement of society as a whole. Despite these theoretically pro-social functions, Van Vliet concedes that since so many psychiatric disorders appear to have shame as an agonist, the pro-social effects of shame were likely to be short-lived (Van Vliet, 2008). It would then be necessary, in Van Vliet's view, for shame to be reduced in order to restore healthy functioning in an affected individual. Studies that presented shame as pro-social in origin often did not adequately address the difference between guilt (well established as an unpleasant, yet pro-social emotion that motivates behavioural change) and shame, which results in a destructive turning against the self and is isolating and disempowering. As Brown (2006) suggested, guilt says 'I have done something bad' while shame says, 'I am bad'. While shame is strongly implicated as a causal factor in the medical model's formation of violence-related PTSD and C-PTSD and guilt is not (La Bash & Papa, 2014; Wilson et al., 2006), the differentiation between guilt and shame is an important distinction; however, guilt in the wake of violence can also be present but does not necessarily interfere with efforts

to heal.

To further differentiate the state of shame from the emotion of guilt, it is useful to identify the object on which they act and the response that each elicits. Guilt is a self-conscious emotion that acts on the assessment of personal behaviours (M. Lewis, 2003). It warns the actor that their behaviour will likely result in damage either to another or to one's social relationships (Aakvaag et al., 2016). As a consequence, guilt inspires change—either a change in behaviour or a move toward the repair of the affected relationship. In contrast, shame acts as an evaluation of the core self—one's essence or state of being in the world. The negative evaluation of the self that follows, produces a sense of defeat or powerlessness as the self is faced with the inadequacy of something it feels is beyond its ability to change (Saraiya & Lopez-Castro, 2016).

Humiliation, while rendering the experiencer initially powerless to defend themselves in a similar way to shame, diverges from shame in a few key areas. Firstly, social rejection is perceived, during episodes of humiliation, as unjust (D. A. Lee et al., 2001). As a consequence, blame for the humiliating event is placed on the other as the source—not the self. Humiliation requires an observer to be experienced. In this situation, the self perceives the other as bad (Andrews et al., 2000). This is in contrast to the shame state where judgment is by the self and of the self. For example, a victim of sexual assault may experience the event as humiliating but may not feel shame when she does not perceive the event with self-condemnation; the blame lies elsewhere. Unlike shame, experiencers of humiliation are more likely to ruminate about humiliating events and imagine new courses of action to alleviate their social discomfort (D. A. Lee et al., 2001); this may include some form of angry retaliation or revenge. During the shame state, the experiencer has the urge to hide and cover over their sense of defeat, powerlessness, and badness (MacGinley et al., 2019).

Shame and the Self. External shame is formed within the context of cultural norms and standards of behaviour. Gilbert (Gilbert, 2011) describes external shame as arising "when we perceive

our self as creating negative emotions (angry, disgust, contempt, ridicule) in the mind of the other" (p. 327). Expectations, both real and perceived, about appropriate gender roles, dress, interests, parenting, physical attractiveness, power, and morals communicate strong shaming messages to members who do not conform. When the inability to conform is pervasive, shame becomes an entrenched view of a defective self (B. Brown, 2006). In a recent study by Robertson et al. (2018), the authors attempted to establish that it was possible to elicit shame responses in individuals who have done nothing wrong but perceived that they were about to experience social devaluation. The authors suggest that this finding refutes the idea that shame is an internal phenomenon. However, if it is recognized that shame occurs from more than one source—externally as a sign of impending social devaluation and internally, as an assessment of one's state of being against an internal reference, the Robertson et al. study makes sense; If both external and internal facets of shame are considered, these finding do not pose a significant conflict with current models.

Internal shame relates to evaluations of the self as insufficient in one's own eyes, in a way that poses a threat to one's internal continuity (D. A. Lee et al., 2001). Described by Gilbert (2011) as the "dark mirror within" (p. 328), the internal assessment of one's self can generate feelings of frustration, anger, disappointment, contempt or disgust. An individual can, therefore, possess a high level of internal shame and perceive elements of themselves as threatening or undesirable even if others are unlikely to evaluate them in the same unforgiving way (D. A. Lee et al., 2001). From this perspective, how an individual responds to traumatic events will likely be a combination of internal and external sources of shame. For example, a survivor of domestic abuse may carry internal shame associated with the perception that there is something about them that is fundamentally flawed and, therefore, deserving of abuse. External shame related to their abuse can come from their reluctance/inability to leave the perpetrator and the stigma associated with appearing weak and unwilling or unable to stand up for themselves.

Incidents of violence—whether physical, emotional, or psychological—involve an acting subject and an affected object. Trumbell (2003) suggests that a violent encounter transforms the survivor from subject to object. The shared transformation, "disrupted in the moments of shame, leaving alienated and objectified the one who has been shamed" (p. 54). Wilson (2006) suggests that suicidal ideation, associated with shame, may represent a desire to destroy the self as an object; if the self is obliterated, so is the shame. This metamorphosis from subject to object severs the connection between the survivor's sense of self and the rest of humanity. Herman (1992) expands on this disconnect stating, "the traumatic event thus destroys the belief that one can be oneself in relation to others" (p. 53). This conceptualization is consistent with critical and relational social work theories that suggest that the pathologizing of the survivor's state of being should be deconstructed and better understood as the internalization by the survivor of a social construct, one of otherness (Morley, 2003). Additionally, greater shame will be experienced by survivors of a violent act that is socially stigmatized, such as sexual abuse (Aakvaag et al., 2016). This is likely the effect of externally sourced shame.

Shame and Posttraumatic Stress

Posttraumatic Stress Disorder (PTSD) is included in the DSM-V as a Trauma and Stressor-Related Disorder. An individual meeting the diagnostic criteria for PTSD will have directly experienced, indirectly experienced, or witnessed a traumatic event and, as a consequence, may experience nightmares, flashbacks, unwanted or upsetting memories, some form of emotional distress, or physical symptoms when exposed to triggers (American Psychiatric Association, 2017). Additionally, those meeting the criteria for PTSD may experience problems related to self and others including: negative self-evaluation, exaggerated blame of themselves or others in causing the trauma, a negative mood, decreased interest in daily activities, feelings of isolation, and difficulty in experiencing a positive mood (American Psychiatric Association, 2017). It is straightforward to see how these criteria would be met by everyone having experienced interpersonal trauma; while the DSM-V only classifies individuals having experienced one or more of these criteria as having PTSD, they specify that these symptoms must persist for more

than one month (American Psychiatric Association, 2017).

Several research articles, under consideration, demonstrated a correlational relationship between shame and those individuals meeting the criteria for PTSD (Andrews et al., 2000; Badour et al., 2017; Beck et al., 2011; Budden, 2009; Dorahy & Clearwater, 2012; Harman & Lee, 2010; Wong & Cook, 1992). While fear has traditionally been the focus of interventions to treat PTSD, it has been established that the presence of shame is a better predictor for the development of PTSD than fear (Badour et al., 2017). Since the completion of studies looking at the role of shame in the development of PTSD, there has been a significant movement to revise the DSM-5 to include shame as a recognized component (Weathers et al., 2014). Additionally, gold-standard approaches to working with PTSD in the form of exposure or desensitization therapy—such as Eye Movement Desensitization and Reprocessing (EMDR)—have recognized that such approaches, while reducing fear-related responses can be blocked by the activation of shame (Forgash & Knipe, 2012). As a consequence, EMDR researchers are investigating alternative therapies that can be paired with EMDR—such as Internal Family Systems (IFS) Therapy—to work through shame-based issues that may block the healing process (Forgash & Knipe, 2012).

Shame-Created Barriers to Healing

Brown (2006) found that shame results in three primary experiences: the survivor feels trapped, powerless, and isolated. Feeling trapped or defeated was associated with the belief that there were few options for action that did not result in further exposure to shame (Harman & Lee, 2010). This may contribute to the reluctance some survivors feel in sharing their experiences with others and may prevent survivors from reaching out for support in their healing process. If the survivor's story is not positively received and empathy is not extended, the effects of shame may increase (DeCou et al., 2019). Powerlessness is the result of believing that in the middle of a shaming experience it is difficult to find an action that could counter the effects of shame (B. Brown, 2006). Powerlessness can be amplified through feelings of hopelessness in creating change. One of the attributes of violence-related shame,

that women involved in the Buchbinder and Eisikovits (2003) study pointed out, is that it "traps the individual in a feeling of irreversible failure and worthlessness" (p. 356). Feelings of isolation were attributed to the effects of feeling both trapped and powerless (B. Brown, 2006). Shame generates an urgent need to hide and conceal the defective self from exposure (MacGinley et al., 2019; Wilson et al., 2006). This can involve avoiding interpersonal relationships, social engagements, or opportunities to experience interactions that may be healing. Social workers, working with survivors of violence, may note safety behaviours such as avoiding contact (either physical or eye), downcast eyes, turning away of the face, blushing, inhibited behaviour, a slumped posture, and an inability to find their words (Wilson et al., 2006).

Healing Shame

Brown (2006) determined that shamed individuals, who receive an empathetic response, experience an increase in their sense of power and connection. While this empathy is strongest when coming from another person, study participants noted that self-empathy also reduced feelings of shame (Au et al., 2017). Additionally, participants felt less socially/culturally trapped when they worked with others to reassess what was important in life (B. Brown, 2006). Anderson (2010) proposed that group work with violence-related shame provides a structured opportunity for empathy and connection, while Ullman (2011) cautioned that the value of group disclosure lies in the survivor receiving an adequately empathetic response. If a positive response is not received, group disclosure can result in a worsening of violence-related effects (Ullman, 2011). Because shame is psycho-social-cultural in formation, Hernandez and Mendoza (2011) suggested that shame is intersectional and working through the 'web' of shame that has been adopted into the self, may be necessary in understanding a survivor's shame triggers. Brown (2006) concludes that education can help through learning to identifying shame triggers, seeking empathic support, and embracing a state of vulnerability. Hahn (2004) cautions practitioners that the accidental triggering of a survivor's shame may result in negative therapeutic reactions that

may not be easily rectified. It may be necessary to work through the shaming experience directly so that progress in supporting the survivor can continue (Hahn, 2004).

Shame in Social Work Interventions

Van Vliet (2008) indicates that shame recovery can take the form of five processes: connecting with others; refocusing on positive action; accepting vulnerable feelings; understanding shame triggers; and resisting through the rejections of negative judgements, asserting one's self, and challenging others where appropriate. Brown (2006) postulates that it may be useful for social workers to help survivors identify larger structural and systemic issues that may be responsible for triggering shame; this prevents pathologizing shame-related thoughts such as 'there is something wrong with me'. This same study also recognized that the thoughts that make individuals feel most alone and isolated, are often the most common (B. Brown, 2006). Hernandez and Mendoza (2011) determined that shame triggers are not universal and places them within a context and person-specific framework. While it may be possible to hypothesize about various shame triggers a survivor is likely to possess it is important, in using a critical theory approach, that the worker does not develop preconceived ideas about what a survivor experiences as shameful. An exploration of cultural norms, socially constructed gender expectations, unspoken rules within the family of origin, religious affiliation, or incidents of violence (particularly those incidents that carry social stigma, such as sexual assault) may help the practitioner to assist survivors with making conscious their personal shame triggers (B. Brown, 2006).

Brison (1999) states "trauma undoes the self by breaking the ongoing narrative, severing the connection among remembered past, lived present, and anticipated future" (p. 41). The author goes on to suggest that the act of sharing one's narrative of violence allows the survivor to again become a person—the subject of their own story instead of the object of the perpetrator's (Brison, 1999). Brown (2006) also concluded that the sharing of narratives—with recipients who have earned the survivor's trust and respect—can reduce shame and offer sharers the opportunity to feel empowered through

connection. While it is clear that care must be taken to ensure that a safe and empathetic environment is available to survivors during the sharing of their lived experience, practitioners may provide an important 'other' with whom they may regain their subjective self.

The findings of this review point to the importance of addressing shame, in all its manifestations, as a component of effective interventions with trauma survivors; however, of additional importance are the effects of shame on practitioners. Practitioners, like all other humans, carry their own burdens of shame. Due to the intensity of the therapeutic relationship it is possible, and in many cases quite likely, that the practitioner's own shame will be triggered in the course of their work. While it would be a superhuman feat to completely harness one's shame in preparation for clinical work, it can be valuable for practitioners to develop a practice of identifying their own shame triggers, so that they can be reflexive in their interactions with clients (Hahn, 2004). Like clients, shame for practitioners arrives as a combination of internal shame (ex. being suddenly aware of their own limitations or inadequacies) and external shame (ex. worrying about the negative assessments of their abilities by clients and other professionals) (Gilbert, 2011). Additionally, practitioner shame may erupt when a client confronts or provokes the practitioner in an attempt to bypass their own shame (Schwartz, 2013). While it would be most advantageous for the practitioner to work through issues of shame through their supervision and through personal therapy, it can also be useful to use shaming experiences to create an opportunity to model healthy responses to shame in the therapeutic relationship (B. Brown, 2006). Practitioners can demonstrate how self-awareness and self-compassion can be used to acknowledge, accept, and release shame in a heathy way when it occurs during therapeutic intervention (Hahn, 2004).

While this thesis focuses on shame as experienced by survivors of interpersonal trauma, it is useful to take a brief look at the effects of shame on perpetrators, if only to frame discussions with survivors if they are to enquire about the underlying mechanisms involved and in addressing wider social issues that underlie violence. Schoenleber et al. (2015) and Mills (2008) both commented on

mechanisms of shame in perpetrators of violence. Schoenleber (2015) concluded that men with a history of interpersonal violence exposure as survivors who also met the criteria for PTSD, were significantly more likely to use aggression in their interactions with intimate partners. They theorized that aggression may be a regulatory strategy in coping with shame. Additionally, PTSD is associated with higher levels of experiential avoidance and perpetrators may be more prone to using aggression to suppress shaming experiences (Schoenleber et al., 2015). However, since humiliation has been shown to be more correlated with retaliatory aggressive responses (D. A. Lee et al., 2001) than shame, which is associated with the tendency to hide (MacGinley et al., 2019), this theory may require further scrutiny or at the very least, the conceptual difference between shame and humiliation should be better delineated in studies examining these effects. Likewise, Mills (2008) concludes that exerting power over an intimate partner is the perpetrator's response to feelings of extreme vulnerability. Mills (2008) suggests that perpetrators come to believe that the use of violence can mitigate feelings of a loss of their own control and power. It is also postulated by both Mill (2008) and Schoenleber (2015) that interventions with perpetrators fail because they do not address issues of hidden shame.

The findings of this review show the important role that shame plays in recovering from experiences of violence. It should be noted that the majority of the literature focusses on women's experiences of shame. Little research has explored the differences in the experience of shame among men, women, and transgendered persons. This gap may lead to the conclusion that all genders experience shame in the same way. It will be necessary to consider this gap when observing and participating in interactions with service users. The literature within this review did identify the need for larger sample sizes (Anderson et al., 2010; Andrews et al., 2000; Beck et al., 2011; Goldsmith et al., 2014; Harman & Lee, 2010; D. A. Lee et al., 2001; Wong & Cook, 1992) and more controlled intervention processes (Au et al., 2017; B. Brown, 2006; Dorahy & Clearwater, 2012) in evaluating treatment that address shame related to trauma (see Appendix A). Many studies used a cross-sectional structure

(Aakvaag et al., 2016; Badour et al., 2017; Beck et al., 2011, 2015; Bockers et al., 2016; Goldsmith et al., 2014; Harman & Lee, 2010; La Bash & Papa, 2014; Schoenleber et al., 2015; Wong & Cook, 1992) and as such were not able to establish a causal relationship in many of their findings. Almost all empirical studies under consideration were limited by self-reported data.

Chapter 3

During my practicum there were three primary environments in which I could investigate the relationship between shame and trauma, and in which I developed skills relate to my goals. My goals were: 1) to better understand the role shame plays in post-violence responses in adult survivors; 2) to develop a better understanding of the course of disclosure, as it relates to interventions with survivors of violence; 3) to identify ways of empowering service users in their healing process; 4) to develop tangible, evidence-based practice skills in working with trauma—both in a one-to-one intervention setting and in the group therapy environment; 5) and to learn to become an effective ally to service users in healing shame and in cultivating therapeutic relationships. Firstly, I had the opportunity to work with clients during their regular attendance at VOICES—whether the purpose of their visit was to seek support or to simply drop-in and utilize the space. Secondly, I learned about the role of shame in the recovery from interpersonal trauma while working with clients within the group therapy environment. Group therapy can elicit shame (Hakimi et al., 2018) and also help to heal shame-related trauma during interactions between clients, during interventions by facilitators, and in the process of trauma disclosure (B. Brown, 2006). Finally, I had the opportunity to learn from my clients about the operation of shame and its role in trauma intervention methods during one-to-one trauma therapy sessions. This learning was reinforced through the supervision process.

In Chapter 3, I will explore what I learned about the relationship between shame and trauma in the therapeutic environments in which I practiced. Included in this section is a discussion of the generation of shame in accessing services. I also discuss how shame can operate in practitioners in their interactions with clients and the value of coming to understand my own shame triggers as part of reflexive social work. Additionally, I consider the importance of social connections in healing and various strategies for addressing shame in the course of social work interventions with survivors. Finally, I discuss the pathologizing of trauma during empirically supported methods of intervention.

Shame and Accessing Services

While therapeutic interventions with survivors can be extremely useful in the course of their recovery, the process of seeking services can induce shame (Tangney & Dearing, 2004). As was

described in Chapter 2, shame manifests from two sources—externally, as a comparison of one's self with others and internally, as judgement of the self. As a consequence, survivors can be exposed to multiple sources of shame when they access services.

Just prior to beginning my placement at VOICES the facility moved from an office building that housed a mixture of commercial businesses and medical services to a building closer to the downtown core that contained other HSN hospital-sponsored outpatient services—including addictions treatment and crisis intervention programs. Sharing close quarters with addiction-related and crisis services appeared to trigger external shame for some clients in that they felt that there was strong negative social evaluation associated with accessing services within the outpatient facility. This demonstrated to me that there remains a large gap in addressing the stigma connected with treatment and that there continues to be a hierarchy of stigma associated with seeking mental health services (Huggett et al., 2018). Angermeyer and Dietrich (2006) determined that there exists a hierarchy of stigma associated with mental health diagnosis. Individuals who are symptomatic for schizophrenia and those with substance use issues experience the most severe stigma associated with their mental distress, while those with problems related to mood such as depression and anxiety, experience the least stigma. It was the conclusion of the Angermeyer and Dietrick (2006) study that the stigma associated with mental illness was related to two factors—namely, the perceived level of potentially unpredictable or violent behaviour associated with the condition and the amount of culpability connected with a given mental health challenge. For example, the general public perception that individuals with substance use issues somehow had control over their illnesses (the perceived choice to use illegal substances) resulted in greater stigmatization when compared to the public view of sexual assault survivors who are perceived as being victimized due to no fault of their own, plays a role in the hierarchy of stigma (Huggett et al., 2018). Additionally, individuals with substance use issues are perceived as being more unpredictable or potentially violent than do sexual assault survivors (Huggett et al., 2018). It was clear from my experiences in working at VOICES that some clients did perceive the location of sexual assault services alongside services for addiction treatment and crisis intervention, as externally shaming.

It was my observation, as a student professional, that the same level of external shame did not

appear in clients accessing services directly at VIPP (located in Health Sciences North). Clients accessing services at VIPP have experienced recent interpersonal trauma and as such, attending services at the hospital may have better matched their perception of their state of being 'injured' and in need of 'treatment'. This may have resulted in less external shame than for those survivors seeking services for historic sexual assault through VOICES. Huggett et al. (2018) identified that individuals with mental health challenges experience less externally sourced shame when the source of their distress was described as a brain function issue (biological) or when the clinician discussed their mental health issue in terms of a chemical imbalance. This is likely due to the fact that physical illness is less stigmatized than mental illness (Angermeyer & Dietrich, 2006). It was interesting to see how the use of terminology and the presence of a medical model diagnosis plays a significant role in how clients frame their experiences of seeking help and how this can affect their level of externally referenced shame. The medical model represents mental distress as a pathology—in a similar manner as physical disease—it can be assessed by signs and symptoms, and subsequently treated (Casstevens, 2010). Diagnostic labels have been shown in empirical literature to have both positive and negative consequence. Perry (2011) asserts that a mental illness labels can have some positive consequences, such as the survivor experiencing a degree of freedom from culpability for their 'illness', along with a greater likelihood of being granted release from obligations in fulfilling everyday social roles. Conversely, negative consequences can include increased stigma and discrimination associated with a specific mental illness diagnosis and less empowering messages associated with their stress responses being labeled abnormal or disordered (Perry, 2011).

I noticed during psychoeducational workshops and group therapy sessions that the effects of trauma were often described by senior facilitators in terms of its impact on physical brain structures. Often trauma was expressed, using a neuroscience perspective, as a brain injury that needed to heal. It was unclear if this approach was an aspect of the practice model on which the group therapy program was based. During one specific group therapy session the facilitator led a discussion that included the latest research on epigenetics and included information about how trauma experienced by past generations can alter the genetic composition of the brains of the current generation. I noticed that this

form of psychoeducation can be very useful in reducing the shame survivors feel toward their trauma symptoms; however, I also noticed that caution needed to be exercised in taking these connections between trauma and brain injury too far. In one workshop it was clear that some of the participants were somewhat alarmed by the idea that past trauma could alter their brain structure and were concerned that this might represent an alteration from which they could not recover. Sensing some general disturbance in the group over this concept, the facilitator switched into a discussion of neuroplasticity that suggested that these sorts of changes could be reversed through effective trauma treatment. Taken from this perspective, the inference is that participants were not viewed as possessing the attributes—the wisdom, resilience, and insight necessary to heal themselves, with support from the practitioner. I see this as a disempowering message that tends to place the responsibility and control of recovery in the hands of the practitioner instead of within the reach of the client. Outside of a possible decrease in shame due to reduced stigma connected with a physiological explanation for trauma, I do not necessarily endorse a presentation on the effects of trauma from a neurological perspective, in the course of trauma care. I suggest that there is a risk of disempowering client's in their recovery journey if they believe themselves at the mercy of a physical ailment over which they may feel they have no influence.

Seeking therapeutic services in itself can and often does, induce shame (Tangney & Dearing, 2004). The recognition that one's mind is not fully under one's control and one requires assistance, carries a strong stigma and can compound already present feelings of powerlessness and isolation. Further adding to the burden of shame are the assessments and diagnostic processes that categorize normal yet ongoing emotional, physical, and psychological impacts resulting from interpersonal trauma as a 'disorder'. The meaning implicit in this categorization is that carrying the burden of trauma for longer than appropriate (as determined by a group who has the power of oversight over such decisions), represents pathology. It is interesting to note that other life experiences—such as grief—are not evaluated in the same way; instead it is recognized that grief following loss is a very individual process and cannot and should not be viewed as pathological (Wakefield, 2012). The consequence of arbitrary diagnostic criteria can add to an already significant burden of shame. It was my observation, that this

aspect of the diagnostic criteria for PTSD and complex PTSD is often compounded by well-meaning, yet ill-informed friends or loved ones that come to believe that the survivor should have 'gotten over it by now'. Making the situation more intolerable is the shame response experienced by many survivors when they believe that they are not worthy of connection. The desire to isolate themselves from the effects of further unempathetic or judgmental treatment and the subsequent shame it creates can cut survivors off from the social relationships critical to the healing process. I noticed this response in group therapy participants who elected to venture out of their home only for group sessions and who expressed no desire to interact with others in their family or community. For some, this state was described as being somewhere between life and death—still breathing but not living.

As was noted earlier, there still exists significant stigma along with the shame it triggers, by both service users and society in general, when it comes to mental distress and its underlying causes. While there has been improvement in recent years in educating the public about mental health challenges and correcting misinformation using various social media campaigns and curriculum inclusions in all levels of the education system, there is still much work to be done by social workers in reducing the external shame associated to accessing services.

Disclosure

Survivors of sexual assault carry a large burden of shame due to the sexual nature of the violence perpetrated against them (Van Vliet, 2008). As a consequence, survivors of childhood sexual abuse or survivors of adult sexual assault may not receive an adequately empathetic response to their disclosure and may, instead, have their suffering go unacknowledged or even suppressed. This may minimize the impact of the trauma they have suffered and increases the shame they experience (Hakimi et al., 2018). Survivors may not be believed after disclosure to appropriate authorities—whether these authorities are governmental or social (as in the case of family members, religious authorities, education authorities, or authorities associated with other social institutions) (Dorahy & Clearwater, 2012). The literature is mixed on the value of disclosure as a therapeutic tool. As was noted in the review of literature, an unempathetic or, simply, an inadequately empathic response to disclosure is likely to

reinforce internal shame (Ullman, 2011). However, group therapy that involves a disclosure component can decrease negative mood and trauma responses, and increase self-esteem (Nisbet, 2002). Ullman (2011) also suggests that one of the most valuable aspects of disclosure can be an increase in social support. Regardless of the conflicting support for disclosure as a therapeutic tool, it is a component of many group and individual treatment programs (Follette et al., 2010), including the program used at the VOICES Sexual Assault Centre. A study by Lubin et al. (1998), which involved group therapy for trauma treatment that included a short psychoeducational session, followed by a discussion that included an opportunity for the survivors to share their experiences of trauma—a very similar format as that undertaken during the VOICE group therapy program—resulted in a significant decrease to PTSD responses in the participants. A second study by Classen et al. (2011), following a similar format, also yielded decreased trauma responses and decreased dissociative symptoms. Where the VOICES process diverged from those used in the previously cited studies, was in the structure of the disclosure process in its postponement and containment within the final two sessions of the program. While I was not informed as to the basis for the use of this particular model of disclosure, underlying their choice in approach to group therapy, it was the structure of group therapy process under which I completed my practicum. It was evident that the structure of these sessions followed a prescribed format as dictated in their approved outline.

Before beginning my practicum, I had some serious concerns about trauma disclosure in the course of social work interventions with clients. Firstly, my recent educational experience had emphasized the need to be aware of the vulnerable and often fragile state of clients seeking trauma services. For this reason, I was apprehensive about the process of disclosure as I realized that there was a distinct possibility that a client could be revictimized through their interactions with well-meaning yet careless practitioners and therapeutic groups. Adding to my concern was substantive research that suggested that more harm than good can come from trauma disclosure in an unempathetic environment and that great care is needed in the handling of client disclosure (Anderson et al., 2010). With this in mind I was interested in witnessing the process of trauma disclosure, as it took place within the group therapy environment, and how disclosure within one-to-one counselling could be handled in a

safe and supportive manner. As a new practitioner, I had concerns about facilitating this process. I expressed my concerns to my supervisor who provided guidance and training for using safety and stabilization methods during disclosure events.

Disclosure within the group therapy environment at VOICES is extremely structured and controlled. While clients are advised that they will have the opportunity to share their stories near the completion of the group intervention sessions, they are not required to do so. Before I began my practicum, I wondered if clients may feel a certain degree of social pressure to disclose due to the relationships they had cultivated within the group and with the facilitators, and whether this pressure would result in disclosure before they were psychologically and emotionally ready to do so; however, it was my experience during my practicum that quite the opposite was true. The facilitators chose to steer participants away from disclosure—until such time as they felt it safe for the group to endure the process and for individual clients to stabilize themselves before exiting the session. Through discussion with my supervisor, I was educated about some of the key components she was assessing prior to the disclosure process. These included the development of safety and stabilization skills (such as deep breathing for emotional regulation, the use of mindfulness to attune to the present moment, basic grounding skills, knowledge of five-sense focus control) through the group's psychoeducation process and the ability to create distance between emotions, thoughts and the status of their current reality. The facilitator was also looking for indicators that the group had cultivated the ability to provide mutual emotional support, empathy, and connection. The assessment of the presence of these components, from my observation, was based on the lead facilitators assessment of individual group members' behaviours during session and the status of the group's dynamics. After the initial few sessions, when clients had come to know each other and the facilitator, I witnessed an urgent need by many participants to share their stories with the others in their group. I realized that the survivors were among people, perhaps for the first time, who could truly understand what they had gone through and the opportunity to unburden themselves, to be recognized, and to have their feelings acknowledged and supported, resulted in many attempts to share their narratives before the facilitators felt it was safe to do so. The facilitators response to these events was an extremely delicate one. The senior facilitator

would acknowledge what the client was trying to say, fully recognize the significance of their experience, and then would ask a question of the other group members that was related but that steered the conversation towards a less emotionally charged topic. Additionally, the facilitators recognized that a premature disclosure by clients—before the group had cultivated safety and stabilization skills—could trigger reactions throughout the group. While the group members did not appear to react negatively to the process of being steering away from 'premature' disclosure, I was not able to determine with certainty, what their perceptions of these diversions were or how it affected them on an emotional level. It was also not possible to evaluate, from my observations, what effects these controlled approaches may have had on the group's sense of power in directing their own therapeutic process. Additionally, I was not able to experience all aspects of the disclosure process because I was required to vacate my practicum, prior to the final disclosure sessions, as a result of the COVID-19 pandemic. This placed limitations on my ability to assess the approach to disclosure, as prescribed through the VOICES group therapy program, and to determine its effect on clients. It may, in fact, be useful to assess this outcome through future research.

Safety within the disclosure process was of the highest priority to the facilitators working with groups. Facilitators worked in teams of two (I worked in tandem with my clinical supervisor during these sessions). The senior facilitator would lead the group, artfully responding to the interactions within the group and holding space for participants who wanted to share their thoughts and feelings. It was the senior facilitator's task to lead the content and direct the group if the conversation became too intense. The co-facilitator's task was to augment the content provided by the lead facilitator and to attend to clients who needed to the leave the session due to emotional dysregulation. The co-facilitator would attend to the affected group member, providing safety and stabilization until they recovered emotional regulation. They were then helped by the co-facilitator to reenter the group. This process of working in teams allowed the facilitators to ensure the safety of the group and help clients to recover from the process of disclosure. I learned a great deal about the skill involved in leading group therapy work during the course of my practicum. In my view, it was a far more challenging task than working with individual clients. The facilitators needed to constantly monitor the emotional states of each participant, help

them to be empowered in finding their voice within the group while ensuring their emotional safety. Working as a co-facilitator during these sessions greatly contributed to my developing skill as a practitioner and I am deeply grateful for the opportunity to have worked with and learned from my clinical supervisor who acted as the lead facilitator.

While I had educated myself about safety and trauma disclosure and its use within the therapeutic relationship prior to beginning my practicum, I admit that I expected the disclosure process to make up a significant portion of individual therapy interactions. What I found was that disclosure seemed to occur naturally during periods, throughout the course of intervention. I chose not to directly solicit disclosure in working with individual clients. This was a conscious choice on my part based on my favoured client-centred therapeutic approaches—such as IFS. Additionally, I chose to address the incidents of assault in a more organic and less structured way. Taking what I learned from my involvement in the group therapy session work, I was open to disclosure as it occurred naturally in the course my conversations with clients. Since my methods of working with trauma were not based on a desensitization and reprocessing approach, I did not see the value in requesting the disclosure around traumatic events until such time as my clients expressed the need to do so. It became my experience that the majority of my clients' difficulties were sustained, not by the details around their experience of violence, but on their internal relationship to the meaning of those events. From my perspective, the details of the event seem only necessary to discuss when working with somatic aftereffects related to their traumatic experiences.

Social workers are trained to be compassionate caregivers (Senreich et al., 2020). While compassionate and empathetic responses to the disclosure of self-harm, related to trauma, are to be expected, it was my observation that impassioned responses that are overly reactive and emotional can be shame-inducing for clients. For example, it would not be beneficial, upon the disclosure of self-harm, for the worker to assume that their client is at imminent risk for committing suicide. Self-harming behaviours are used by some trauma survivors as a method of emotional pain management (Phanichrat & Townshend, 2010). Separate from suicidal behaviour and not at all part of suicidal ideation, self-harm is a distinct phenomenon with a myriad rationales and mechanisms, and that can be used as a coping

behaviour (albeit an unhealthy one) to replace emotional pain with physically pain—temporarily relieving survivors of a focus on their internal state (Brown & Kimball, 2013). It is important that practitioners, when faced with the disclosure of self-harming behaviours, take appropriate steps to evaluate the motivations behind self-harm and assess when it represents a life-threatening situation or, conversely, when it is used by the client to distance themselves from intense levels of emotional and psychological distress. These are important distinctions and it was my experience during my practicum that a failure to meet these disclosures in a calm, compassionate, yet under-reactive manner was critical to maintaining trust within the therapeutic relationship and in avoiding the creation of further shame. This can be challenging to do when a new practitioner is confronted in their practice with these behaviours—particularly for the first time. I found it beneficial to work backwards from the disclosure of self-harm through the thoughts and feelings that led the client to those behaviours. This tended to expose a harsh or judgmental evaluation by the client toward themself—lacking in self-compassion and creating a spiral of shame from which the survivor was unable to escape. In the systematic review undertaken by Cleare, Gumley, and O'Connor (2019) the authors state that the majority of studies under their review demonstrated that increasing self-compassion weakens the relationship between self-harm and negative life events and all studies proved the connection between increased self-compassion and decreased self-harm. Learning to respond with self-compassion in those first moments of self-judgement, before the shame spiral began, became a primary focus of my practice with survivors with self-harming behaviours. For example, the client can be encouraged to consider how they would respond to a close friend who had experienced what the client had just gone through. Additionally, I learned to model self-compassion in my interactions with clients whenever the opportunity arose, so that they were prepared to do the same when needed. For example, after a particularly anxious client had spilled her coffee over an art table, something I knew would be extremely hard on her, I took ownership of the accident and demonstrated how to make light of it and how to commiserate with others nearby about having 'one of those days'. We were both able to laugh about it afterward and the event allowed me to model self-compassion by placing the accident in a healthier context. This approach was approved by my clinical supervisor and all disclosures of self-harm were reviewed and monitored

during the supervision process. My clinical supervisor provided valuable insight into the evaluation of self-harming behaviours—something which I had hoped to learn in the course of my practicum.

Shame and the Practitioner

Lewis (1971) determined that shame can be contagious. Not only does the person who experiences shame feel the need to hide and conceal themselves from others, the observer in witnessing shame often feels compelled to turn away from the one who has been shamed (Welten et al., 2012). It would appear that witnessing shame invokes a reference to the witness's own past experiences of shame and to avoid the discomfort this creates, the witness attempts to decrease their distress by avoidance of the one being shamed (Morrison, 2008). Morrison (2008) goes so far as to suggest that the reason client shame has gone unaddressed until recent years is due to the excruciating effects it can have on practitioners. If a practitioner is attempting to work through shame responses with a survivor who is already in a shamed state, this mechanism can be problematic. Without a clear understanding of their own shame responses, the practitioner may inadvertently find themselves communicating rejection instead of acceptance or fail to acknowledge the significance of the experience at all (Tangney & Dearing, 2004).

In those moments of feeling unhelpful or ineffective in our work with service users, there exists the potential to feel shame and withdraw ourselves emotionally from our clients. It is my view that this can be particularly problematic for new practitioners who may be more susceptible to feelings of inadequacy in their practice. While supervision offers new practitioners the opportunity to work through shame that they experience in the course of their practice, Yourman (2003) suggests that supervisees tend to conceal negative client interactions from their supervisors in response to shame. In turn, supervisors may feel shame if they believe they have inadequately supported or guided their students (Yourman, 2003) thus leading to feelings of shame in both practitioner and supervisor. This mechanism is counterproductive in the supervision process as the concealment of negative therapeutic interactions by students, prevents them from gaining important knowledge about alternative approaches to interventions that may a) reduce the probability of creating ruptures to the therapeutic relationship,

and b) be more effective in supporting clients (Yourman, 2003).

With these principles in mind, I attempted to keep track of my own shame triggers and responses during the course of my practicum. Each day I journaled about my experiences and kept an updated list of those situations that formed my distinct set of shame triggers; I then explored how these triggers were invoked during my work with clients. After a few weeks, I found myself getting better at spotting my own shame in both my professional and personal life. This process generated curiosity about how shame was triggered, how I reacted to it, and what seemed to take away its sting. For example, during a lunch break, I was asked about my work experience prior to my placement by some members the social work staff. I responded by describing my work experience from my undergraduate placement—which I found very rewarding. I was then asked about work outside of my practicum and, in that moment, I experienced an intense negative emotion as I sensed that, in their estimation, my practicum experience was somehow not what they had in mind when they inquired about my work experience. I felt defeated for the remainder of the day and my confidence suffered. Later in the evening when completing my journal entries, I reflected on this exchange and realized that I had experienced a strong shame response as a result of their questions. I noticed that I was experiencing feelings of incompetence and I began to question my worthiness to undertake my current practicum assignment. Unlike some Master of Social Work students, who had begun their graduate work after completing a number of years of 'in the field' experience, I had moved directly from my undergraduate studies and into my graduate studies. As a result, my work experience 'in the field' felt very limited in comparison with the path others took in their careers. I decided to apply self-compassion to my feelings, which included recognizing how hard I had worked to get to this point in my education and that I was worthy of the opportunity to learn and grow as a social worker—despite embarking on a different path from that of others. Had I not spent time to reflect on my feelings of shame and to be self-compassionate with my feelings, the feelings of shame I had experienced could have affected my work performance—undermining my confidence and creating avoidance in the face of future challenges. As a consequence of this form of reflective awareness, I became more sensitive to spotting shame reactions in my clients, in holding space for them in full acknowledgement of the shaming experiences they

related, and then responding with empathy and compassion for their distress. If I found that I was experiencing a shame trigger during the course of my session that was proving to be a distraction, I chose to disclose this in my interactions with clients and then I modeled self-compassion in my response to the event. Ladany, Klinger, and Kulp (2011) suggest that a therapist's shame event can be "used therapeutically and may actually have been beneficial to the therapeutic work" (p. 309). It was my experience, and that of my clients through their provision of feedback, that this process resulted in a state of mutual empathy and connection and it was my observation that clients were more open to sharing their shaming experiences as a consequence.

Due to Yourman's (2003) assertion that new practitioners have a tendency to conceal events in their practice which the student perceives their clinical supervisor would not approve, I chose to be fully open about my practice experiences in supervision ahead of time. While it was difficult to disclose situations in which I did not feel fully confident in my abilities to my supervisor, it was my experience that this disclosure was often met with stories about her own uncomfortable exchanges with clients. Along with empathetic support came important sources of learning about how to handle a similar situation in the future. Had I withheld shame-inducing events in the course of my supervision, I would have missed out on valuable learning opportunities that arose from this form of exchange. For example, in the process of contacting clients on the waiting list to offer individual counselling sessions, I had been instructed to make three contacts in order to arrange an appointment. If the client avoided setting an appointment or had missed three scheduled appointment, it was the policy of the Center to indicate to the client that their file would be closed until such time as they felt they were able to attend. This was done so that the next client on the waiting list could be approached to begin individual sessions. A client with whom I was trying to arrange an individual counselling session, became very alarmed when I informed her that her file would be closed, as she had not attended any of the three scheduled appointments (which the client, herself, had scheduled). It was evident that this had made her angry—despite my assurances that she could reopen her file when she felt it was possible for her to attend. I felt that I may have created a breach in our developing relationship by informing her, in a direct manner, about the status of her file. I discussed this with my supervisor despite the fact that I was concerned that

I had communicated ineffectively and damaged the relationship with the way I handled the event with the client. My supervisor listened to my account and reassured me that some clients had a very difficult time coming in for their first appointments, despite feeling the need to begin counselling, and that the client's response was likely the conflict she was experiencing in her ability to commit to the session. Had I simply closed the file and moved on to the next client without reviewing the event with my supervisor, I may not have fully come to understand the internal struggles that many clients feel in the process of beginning therapy.

Practitioner Assumptions and Shame. During our social work education, we are reminded that our experiences frame our perceptions of the world. As such, we need to be aware that what we may perceive we have in common with clients may be an inaccurate assumption. I was never more aware of this divide than when I was co-facilitating a group therapy session with survivors on the use of self-compassion. During this discussion, some group members expressed frustration because they could not really grasp what being self-compassionate entailed. In an attempt to help them understand, I chose to use an illustration. I began to explain how self-compassion could be viewed as the actions of a loving caregiver toward a small child who had made a mistake. I suggested how they could think back to how a caregiver had treated them kindly—how they did not blame or judge the client but had been accepting, open, empathetic, and reassured them that everyone makes mistakes. After asking them to reflect on this memory, I noticed that while some clients seemed to understand this example, others first appeared to look non-responsive or blank; then, after catching themselves, appeared to nod in agreement but their face still wore a confused expression. I realized in that moment that some of my clients—individuals who experienced neglectful or abusive parenting as children but were also survivors of sexual assault—had never experienced a caregiver responding to them in the way I described—with kindness and empathy. Instead, it appeared to me that they had experienced a moment of shame as they realized they could not relate to my example but felt obligated to do so. As a result, they nodded and tried to respond in the same way as other group members.

This event reminded me that our assumptions about the experiences of others—in this case because my childhood experiences had differed from theirs—can be misinformed and become a source

of shame for my clients. It also reinforced the understanding that what we take for granted as being a common experience can be very uncommon for others. While it is unadvisable to avoid all use of illustrations in psychoeducation, as such tools can be very useful in helping clients to grasp key concepts, I learned that I need to be sensitive to shame responses that I may inadvertently trigger when working with survivors—and indeed, all clients. After noticing the blank stares I received from some of the group, I became aware of my incorrect assumption and offered a second illustration. I added that one could also imagine, instead, how they would treat a close friend who had made a mistake and needed support. By choosing this alternative example, one where the clients could reference their own active attempts to be empathetic with others instead of referencing a past experience that I had wrongly assumed they possessed, the illustration changed into something they could relate to and it helped to decrease the shame they experienced after the first illustration.

Working with Shame

In therapy groups, I noticed that a discussion around 'why me' arose from time to time, as survivors tried to make sense of their experiences. Since all members present were survivors of sexual assault and in many cases, additional forms of interpersonal violence, they seemed to have this question in common. Along with this form of inquiry came releases of deep and intense emotion, which often included sadness and anger. Shame was clearly playing a role as there seemed to be an underlying belief that some characteristic they possessed, had brought violence into their lives—a sign of internal shame triggering. Additionally, after voicing their anger, several members seemed to feel shame over the presence of the anger they felt—a sign of external shame triggering. It was then necessary for the facilitators to point out that anger was a signal that something bad had happened to them and that it was a natural and useful response—helping them to identify when they were experiencing treatment from others that had violated their boundaries. It was interesting to note how many members, after expressing anger, then expressed frustration at their lack of ability to control their angry feelings. This inability to accept anger as useful or informative also arose when I worked with clients in individual counselling. It would seem that for many of these women, the presence of anger had become a shame

trigger. Whatever the mechanism underlying the shame associated with what they perceived as inappropriate anger, there was definitely the need to question the validity of these beliefs in working through survivors' shame responses. I found that at such times, feminist theories were very useful in helping to reframe distorted perceptions of appropriate anger. It became possible, using this framework, to help clients observe how many women repress their anger but that it was very appropriate to feel given their experiences of violence and oppression (Bell, 2009). This could then be followed by a discussion of useful ways of expressing their anger and how this could generate a sense of empowerment in critically examining the underlying social messages that women should not feel or carry anger.

As described in Chapter 2, the scholarly literature points to the fact that working with shame related to interpersonal trauma varies with the type of shame with which the client presents. External shame may be more accessible to cognitive therapies that help clients to question the validity of beliefs around their value in relation to others (Saraiya & Lopez-Castro, 2016). Additionally, feminist-based or structural interventions may be useful in drawing attention to dominant social constructs of worthiness or value that can call into question perceived shame-generating ideals along with their sources (Rennison, 2014). Studies on social ostracism have concluded that social networks, particularly those identity groups that share non-dominant characteristics in common, can help ostracized individuals to reassess sources of shame and to question their validity (Williams, 2009). This may offer survivors the ability to place the shaming source outside themselves. If this was successful, it may be possible that survivors would have feelings more in line with humiliation instead of shame, where blame is externalized.

Some studies suggest that this may help to heal shame that occurs as a result of a failure to meet external social standards or may aid in preventing the internalization of a shaming social message (Hartling & Walker, 2000). Unfortunately, the techniques that are useful in working with externally referenced shame do not appear to be effective in working with internally referenced shame. While cognitive therapies may help clients to question dysfunction schema and to logically frame how their external sources of shame do not match reality, cognitive approaches do not allow the client to connect

with parts of themselves that embody shame responses, often frozen at the developmental stage at which they were formed (Au et al., 2017). For the survivor, a battle between parts of the client whose function it is to block shame triggers or whose job it is to suppress, distract, sooth, cope, or dissociate do not seem, based on my experience, to respond to feminist or structural interventions. For this reason, non-pathologizing ego state therapies, such as IFS, offer clinicians tools for working in often deeper and more entrenched waters (Hodgdon et al., 2017).

Social Connection and the Therapeutic Environment

During my practicum I had the opportunity to participate in social events hosted by VOICES for clients currently receiving services for individual counselling, group therapy, and psychoeducation. For example, on International Women's Day, VOICES hosted their annual 'Purple Party' that offers clients an opportunity to gather in recognition of this important event. These events provided important opportunities for service users to meet with each other and to connect outside of the therapeutic environment. Some new clients, in attending these events for the first time, expressed surprise at the number of women at the event who had also experienced sexual assault and were at various stages of their healing process. The opportunity to connect with others who shared their experiences seemed to reduce feelings of isolation and helped clients understand that they were not alone. It also reinforced that what had happened to them was not shameful but needed to be addressed at a wider societal level. A sense of empowerment was evident as they supported each other by normalizing each other's reactions to challenging experiences.

A similar phenomenon of empowerment occurred during group therapy sessions. During my first group therapy session my clinical supervisor encouraged me to leave the group, temporarily, while the clients were involved in creating a weekly, art-based project that occurred for a 20-minute period during each session. Instead of staying and participating, the facilitators left the room and completed other work. The idea was to give clients the opportunity to connect, talk, laugh, and build relationships with each other. It was the intention of these activities to encourage clients to build social connections with each other that could extend outside of the therapeutic environment, if they chose to do so, and

that could continue after group therapy had concluded. Many of the therapy group participants went on to meet regularly outside of VOICES and to offer each other support on a weekly basis. These relationships helped to reduce isolation, increase social support, empower clients to continue their healing processes on their own, and to reduce feelings of shame. For many of the participants, these relationships were often the first to be formed after years of self-isolation.

In working with groups, I learned through my observation of my clinical supervisor that encouraging other group members to respond to the distress experienced by a group member during discussion, was far more valuable than for the facilitator to come to their aid. In those moments, the group often reached within themselves and intuitively provided the affected group member with exactly the sort of empathetic and supportive response that the affected group member needed. By encouraging group members to support each other instead of intervening directly, the group became empowered and build stronger connections. After the affected group member recovered, it was then useful for the facilitator to praise the group for their care of each other and then provide education around any other useful responses that they could use if a similar situation arose again.

The Pathologizing of Trauma

It was my observation that while trauma informed practice has been extremely useful in that it draws attention to the reality that humans exposed to violence—either as witnesses, survivors or perpetrators—are significantly and negatively impacted by these experiences, it has done little to alter the format of trauma therapy that approaches the 'dysfunction' as if it emanates from within the individual. Cognitive and behaviour therapies suggest that this pathology is attached to the theory that the survivor now carries a distorted worldview ('cognitive distortion') or schema following trauma—one where the world is unsafe, people cannot be trusted, and where they will continue to be victimized (Beck & Beck, 2011). As such, these approaches attempt to first question and then reorient the survivor toward a more 'realistic' appraisal of the world so that the survivor can rejoin it in a 'healthy' way. While these are laudable aims, it is my view that the assertion that the world is safe, that people can be trusted, and that the survivor will not be revictimized is an untenable presumption based on a

worldview that is the privilege of very few—but seems to be adopted by many. It was also my perspective that it fails to recognize that the schema the client has adopted, in the aftermath of violence, was highly adaptive and necessary to their survival. In my opinion, the client, in turn, is stripped of all recognition that they possessed strength and resilience in the process of surviving.

It is my perspective that while modern psychological interventions no longer blame the victim for their resulting symptomology, the new terminology that frames the effects of violence as an 'injury' from which the client must now 'heal' and the categorization of those who cannot 'heal' as being under the influence of a 'disorder', continues to pathologize the survivor from an arguably, less obvious yet equally insidious, vantage point. In my view, for the vast majority of humanity, the world is not safe—not physically safe for some, not psychologically safe for many, and not emotionally safe for most. It is neither controllable nor predictable and certainly not just. Faced with this reality, it is much easier to understand the development of shame where the 'self' experiences the regular reinforcement of unworthiness (L. Brown, 2004). But we, as trauma workers, may frame our interventions as if the process will change this unfortunate reality—that once the client 'heals' the fundamental nature of the world will change. I identify this fact not to be macabre, but to point to a reality that is rarely delineated. So, what hope exists for trauma interventions that do not continue to perpetuate this distortion? In my view, any selected course appears to require several important components: a) that it does not pathologize survivors as being the source of the problem; b) it recognizes that all aspects of themselves have been vital to their survival but that some aspects may require guidance in living in a more harmonious and self-lead life; c) that the client, as the expert on their lives, possess the resources to improve—to the extent possible within the confines of the current environment—their relationship with themselves and with others; d) that the process is collaborative and therefore empowering.

As mentioned In Chapter 1, IFS along with my past training in CBT informed a significant portion of my work with individual trauma clients. During the course of my practicum I invested significant time and reading on the use of IFS as a trauma intervention approach. I took an online training program that introduced me to the principles of working with IFS and my clinical supervisor—who already uses IFS for the treatment of trauma—provided guidance on its use with survivors. She also relayed her experience

in using IFS with clients who became blocked during EMDR treatment and required an alternative approach to treatment. IFS has become popular among EMDR therapists when working with clients who do not respond well to standard EMDR treatment protocols (Lobenstine & Courtney, 2013). While my clinical supervisor is a skilled EMDR practitioner and demonstrated significant success in helping survivors during their recovery process, I found that my preferred forms of trauma intervention were more aligned with the principles of IFS. Additionally, IFS dovetailed nicely with principles of modern social work that views the client as the expert on their own lives and the practice tenants on which it is built namely, to empower clients in pursuit of their own healing process. As such, I elected to study IFS methods in more detail instead of a course oriented toward EMDR treatment. I felt that one of the opportunities provided during the practicum experience was exposure to a variety of practice modalities along with the opportunity to explore how each modality fit within the practitioner's favoured approaches. That being said, I investigated the principles of EMDR therapy in detail during the preparation of a research project on brief session EMDR treatment for trauma symptom reduction, which is now being used to inform program development undertaken by the Ontario Trauma Network.

Chapter 4

In Chapter 4, I describe how I met my learning goals, as set out at the beginning of my practicum and I also discuss the process of clinical supervision and the impact of the COVID-19 pandemic on my practice experience. Further, I will discuss the role of shame in trauma care as it applies to social work practice. Finally, I will outline a set of practice principles for non-pathologizing trauma care and some potential considerations for social workers looking to begin practice as trauma care clinicians.

Attainment of Learning Goals

As was described in Chapter 1, I set out to achieve five learning goals related to my practicum. By the conclusion of my practicum I wanted to better understand the role shame plays in the post-violence responses of adult survivors. Part of my motivation for exploring this relationship came from my past experiences in working with female inmates at the Sudbury jail. During my BSW practicum, I provided both group workshops and individual counselling for women in conflict with the law. It became abundantly clear during this experience, that the clients I worked with were the survivors of significant traumatic experiences—many during vulnerable and critical developmental years. Over 80% of my clients were themselves the victims of violence; over 50% of these women had been the victim of sexual assault. These events had significantly altered their sense of self and along with it, the future trajectory of their lives. Some had developed substance use issues while others were in continuous cycles of violence with abusive partners—often driven by deep feelings of unworthiness. Entrenched feelings of shame came up repeatedly in our conversations together. These feelings were more long-standing than their offences and it was evident to me that these women had carried these burdens for most of their lives. The experiences I had in working with these women, after meeting them for the first time years earlier, never really left me. As a consequence, when I was considering options for my Master-level practicum, I was instinctively drawn toward a more in-depth work experience in the trauma intervention field. In the course of my thesis project, I had the opportunity to research the relationship between shame and trauma through the formal preparation of my literature review. I was able to witness many of the concepts, presented in my research, throughout my Master's practicum; As a consequence, I have been able to expand my understanding of the relationship between shame and trauma that built on the

clinical experiences beginning in my undergraduate work.

In preparation for my practicum I began reading a wide range of literature about the process of traumatic disclosure. This topic is complex and the conclusions often conflicting. There is empirical evidence supporting the therapeutic value of disclosure (Masaviru, 2016) yet there is a body of work that questions its effectiveness and raises dire warnings about its potential hazards (Hakimi et al., 2018). As a consequence, a goal of my practicum involved the development of more complete understanding of the course of disclosure and its role and value in clinical social work. I will summarize my conclusions about trauma disclosure later in the section of Chapter 4 entitled, *Implications for Social Work*; I explored this goal thoroughly in the course of my work in co-facilitating group therapy sessions throughout the entity of my practicum and I also analyzed its implications in trauma counselling sessions with my own clients. Additionally, I spoke with other social work practitioners, who worked at VOICES and VIPP, about their experiences with the course of disclosure in their own practice. I used these discussions to help to confirm or negate observations I had made during my own assessments.

My third goal involved developing practice skills that would empower clients in the course of their healing work. While I informed myself through research on various methods of empowering clients during trauma interventions, I received my greatest insight into these methods through the clinical supervision process and during my participation in monthly social work team meetings. A portion of each meeting was allocated to the presentation of a formal case conceptualization to the group, during which time the practitioners could solicit feedback from each other on their approach to intervention with specific clients and gather ideas about how to handle challenging intervention barriers. Rubin and Schwitzer (2014) state that “case conceptualization is a tool for observing, understanding, and conceptually integrating client behaviors, thoughts, feelings, and physiology from a clinical perspective” (p. 31). The authors suggest that the ability to conceptualize a case provides a practitioner with a framework and rationale for her work with clients (Schwitzer & Rubin, 2014). While beneficial for all practitioners, it is particularly useful for new practitioners to conceptualize a client case in preparation for treatment planning (Schwitzer & Rubin, 2014).

I had the opportunity to present a formal case conceptualization to the social work team and I

gained the benefit of their experience in helping me to address barriers I was facing with specific clients. I gathered highly useful practice techniques through this process, several of which were specially aimed at empowering clients in the community and providing resources, activities, and services to help my clients engage with valuable social supports. For example, one of my clients felt that she did not match well with many of the people in her current social group. This mismatch was perceived by my client as social ineptitude in her interactions with others; however, in seeking input from other social workers on my team, I was able to find out about alternative social clubs that supported youth with unique interests and social locations. By attending these clubs, my client was able to expand the diversity of her social group to include others with similarly unique qualities. This diminished her perceptions of social incompetence and offered her the opportunity to reach out to others who found that they were not fitting in with their immediate social circles. This was a very empowering experience for my client, and she gained confidence in her social skills as a result.

Unlike my other goals related to the practicum, the exploring of the relationship between shame and trauma and methods of addressing trauma-related shame was not a goal I could meet through supervision or through my observations of or discussions with other practitioners. While Brené Brown's work on shame was well known to the practitioners with whom I worked (her TED talks were included during several psychoeducational components of group therapy and workshop programming (B. Brown, 2012)) there did not seem to be present the recognition of the strong role—according to empirical research—shame plays in creating and maintaining experiences of distress associated with the medical model criteria for PTSD. Of larger importance to the practitioners I worked with were the somatic memories or somatic effects of trauma and their related interventions. A number of practitioners were pursuing additional training related to the somatic processing of trauma and this work largely influenced their focus. As was mentioned previously, my clinical supervisor specializes in the use of EMDR as her preferred approach to trauma care. Both of these focusses are well supported in empirical research (Högberg et al., 2008; C. Lee et al., 2002; Warner et al., 2014) and given the distress that both traumatic memories and the embodiment of traumatic memories in somatic form cause for clients, it is understandable that these approaches would receive considerable attention and make up a

significant portion of their professional development plans. Additionally, while shame was mentioned from time to time in group work with clients, it was usually framed as a prosocial emotion that was out of balance due to trauma. As was discussed earlier, it is the viewpoint of this thesis that shame is not prosocial and always represents a destructive turning of judgement against the self. Despite the significant empirical evidence that places shame at the forefront of the development and maintenance of trauma—ahead, even, of fear—there was not, in my observation, much focus on addressing shame in the therapeutic modalities commonly practiced. I attribute this absence largely due to the fact that research, identifying shame as pivotal to the development and maintenance of distressing PTSD criteria, is relatively new and poorly disseminated among mainstream trauma treatment modalities. It is my hope that in focusing my thesis on this relationship between trauma and shame that social workers may take up this focus in both research and practice settings. While not directly addressed in my observations of practice during my practicum, it is possible that the principles of applied self-compassion, the IFS framework, and mindfulness that are practiced within the VIPP and VOICES centers, would indirectly address shame through their naturally occurring mechanisms. Despite these limitations, the research compiled during my literature review process along with my work with clients during one-to-one counselling allowed me to develop approaches for addressing trauma-related shame. I will discuss these principles in further detail later in this chapter under, *Implications for Social Work.*

My final learning goal was to become an ally in healing trauma-related shame in the cultivation of the therapeutic relationship. The therapeutic relationship represents one of the most critical factors in the success of client-centered trauma care (Lambert & Barley, 2001). I met this goal through three primary means. Firstly, I learned techniques for enhancing my therapeutic relationship skills through the clinical supervision process. For example, my clinical supervisor often shared with me her negative therapeutic interactions with clients or experiences of negative therapeutic outcomes from her own practice preemptively. She would then share methods to repair these breaches that I could use if I faced similar circumstances. I found this disclosure of her therapeutic missteps both courageous and highly valuable to my learning process. Brown (2006) asserts that a willingness to be vulnerable—as my clinical supervisor had been in her disclosure of negative therapeutic experiences—reduces shame responses

for both the sharer and in the one with whom the disclosure is shared. There was great value in these interchanges, and I hope to emulate her courage in sharing these sorts of experiences if I find myself acting in a supervisory role. In addition to the clinical supervision process, I found that my work with clients in one-to-one trauma counselling helped me to gain experience in cultivating and enhancing my work within the therapeutic relationship. My clients were instrumental in providing feedback that helped me to develop skills and guided my approach as I moved through my practicum. I found that if I felt any undercurrent of discomfort within my client, directly asking them about our interaction helped to identify any subtle breaches that occurred in the course or our sessions. These breaches could be small changes in body language, or even changes in the amount of positive feedback I provided in the course of discussions. By asking the client directly if my behaviour or body language had affected them during the course of our work together, I was able to clarify what was happening or modify my behaviour so that they became less reactive. Due to the nature of the violence they have experienced or the abuse or neglectful experiences they have had in their past, it was my observation that trauma care clients are often extremely sensitive to changes in body language or in my tone of voice. This makes sense if one considers how these cues had played such an important role in keeping them safe in their interactions with others. Survivors of interpersonal trauma often experience a heightened state of environmental arousal and may be more prone to looking for signs within their environment and in their interactions with others, that may represent a threat (McFarlane, 2010). As a result, I tried to determine with each client, what they needed from me in terms of non-verbal communication in order to feel safe in our developing relationship. Additionally, it became evident that my very presence—the way I looked, the words I chose to use, or even the way I laughed or adjusted my glasses—could trigger reminders of their negative experiences with others. While these very subtle mannerism cannot necessarily be consciously modified, I found it important to ask my clients about their reactions to my behaviour on a regular basis so as to gather feedback that I could then use to improve our relationship. I found that if I did invoke a memory of past negative interactions for the client, the act of acknowledging this memory and then working through it with the client, often relieved them of any adverse reactions they were experiencing. For example, in one situation I noticed a definite shift in my client each time I adjusted my

glasses. After I was able to determine what action was causing this shift, I asked my client if they were experiencing any discomfort. At first it was difficult for her to determine what was happening and what she felt. Once we had identified how this mannerism reminded her of the behaviour of a highly critical and demeaning caregiver from her past, we were able to talk about these experiences, identify the shaming memories she was reliving, and she noted that my mannerism was no longer triggering for her.

Clinical Supervision

What is considered clinical supervision varies significantly from one social work practicum to another (Bogo & McKnight, 2006). Largely driven by the expectations of the sponsoring organization or clinical environment, supervision can be arm's length, intensive, or somewhere in between (Bogo & McKnight, 2006). While supervision within the structure of the Laurentian Master of Social Work program can involve as few as three, in-depth sessions between supervisee and supervisor, it was my hope for a more intensive experience where the clinical supervisor provides a certain degree of training along with oversight of client interactions. It was my intention, in approaching clinical supervision, that my experience would involve learning critical trauma care skills. I was very fortunate that I received daily supervision, in the course of my practicum. After my supervisor assessed my current level of practice skill and Mrs. Macrae was confident in my awareness of the safety implications of working with vulnerable clients, I was entrusted with my own clients with whom I performed weekly trauma counselling. As a result of my supervisor's confidence in my abilities and with a careful monitoring process in place, I benefited greatly from the depth of practice experience I received during my practicum and it is my assessment that I developed trauma care skills to a greater degree due to my regular and intensive access to clinical supervision.

One of the barriers I faced during supervision was the opportunity to shadow my clinical supervisor during one-to-one therapy sessions with survivors. Since two-person clinical teams were always present in group therapy, I did not experience the same barriers when working with groups. Approval was always sought from clients before students were permitted to be present. While it was originally planned that I would observe therapeutic sessions, this proved difficult to arrange. Clients

visiting VIPP for services had recently experienced violent trauma and were reluctant to permit observers during their initial sessions. For those clients who had been receiving therapy for several sessions, they often felt that the rapport they had built with my clinical supervisor and the continuity of their treatment would be interrupted by the presence of an observer. Additionally, due to the strong, reactions sexual assault survivors can have during EMDR sessions, my clinical supervisor found it challenging to find clients who were open to student observation. I include this practicum limitation in my discussion to inform future social work students pursuing practicum opportunities in the trauma care field, that this may be a situation they face in their own placements and—out of respect for the risk of this kind of work—students should plan for alternate methods from the onset.

While these barriers did place limitations on my exposure to the work of other clinicians in the course of trauma care, this was more than compensated for by the additional debriefing process undertaken by my clinical supervisor. Where there was an option to do so, my clinical supervisor would share the trajectory of her sessions within the confines of confidentiality and I had the opportunity to discuss with her how she approached each case, often within hours of the session's completion. While this barrier was first perceived by me to be disappointing yet understandable given the vulnerability of our clientele, I found that the debriefing process allowed me to take away important practice techniques while developing my personal style of counselling practice. Since I was not overly exposed to the sessions of other practitioners, I had the opportunity to develop my own approach to working through challenging client trauma responses and I believe I developed more confidence in my abilities than I would have if I were to try to integrate another practitioner's definitive style. As such, any disappointment I had was short-lived and by the end of my practicum I was glad for this opportunity to develop my clinical skills more independently.

Closure

During the final weeks of my practicum, the COVID-19 crisis erupted and in the course of one day, I received notice that students were to leave their placements until the full nature of the virus could be determined. All practicum students were notified by email at 9:00 am with the requirement that we

vacate our placements by noon. In the short span of a few hours I was required to wrap up my work and leave the premises. Due to the fact that my immediate supervisor was working out of the VIPP location on the same day that I was seeing clients in the VOICES location, I did not get to complete my supervision process in person. After communicating by phone, we finalized our work together with the intention of laying out a course for the completion of my practicum work experience. While it was always the plan that my clients would transition into ongoing work with my clinical supervisor at the conclusion of my practicum, and that these arrangements were clearly communicated to my clients at the beginning of my counselling sessions with each one, the abrupt nature of my required departure did little to promote feelings of closure within my practicum experience. It is hard to argue that there was a need to suspend the practicum given the dire situation in which the world found itself, at the time; however, I was left with a rather unsettled feeling around the lack of an opportunity this process provided, to complete my work with my clients. My clinical supervisor offered me the opportunity to communicate in writing with each of my clients and she relayed my notes of support and transition to each one in a secure and confidential manner. This process of advising my clients of a suspension of services to be followed by alternative support services until such time as their sessions could recommence, followed the direction provided by the Ontario College of Social Workers and Social Services Workers in a guidance document posted to college members (Betteridge, 2020). While it must be recognized that Laurentian University provided the best response possible given the available information, with all of their practicum students' safety in mind, it would seem that it might be wise for programs that involve social services, psychological, or health practicums to develop a process to manage the cancelation of practicum work with an eye to fact that a similar future emergency could occur. I did not find that this process represented the best transition possible for my clients and I was initially concerned about the impact this abrupt departure may have on their trauma recovery process. While I know that my clinical supervisor will provide the best possible care for my clients going forward, it would have been my professional preference to have had the opportunity to handle this situation differently. I write about this issue in my practicum report because I believe it is valuable to consider how the therapeutic process and the relationship between the client and the worker can be impacted by

unexpected disruptions in therapeutic interventions.

Implications for Social Work

After considering the scholarly literature on the connection between shame and violence and in reflecting on my practicum experience working with survivors of interpersonal trauma, I considered how this knowledge could inform social workers as they consider practice in the field of trauma intervention. Of interest is the fact (gathered in conversation with my clinical supervisor and in reviewing the membership within the Ontario Trauma Network) that the majority of practitioners working in non-private practice trauma intervention are social workers. This becomes even more apparent when looking at the practitioners providing trauma interventions outside of metropolitan regions of Ontario. Master of Social Work graduates are in high demand within health care and clinical environments, precisely because their backgrounds make them ideally suited to such work. As a consequence, understanding the mechanisms underlying interpersonal trauma and effective interventions for working with it, are useful for practitioners who intend to pursue clinical trauma practice.

The body of empirical research has clearly implicated shame as a major barrier to trauma recovery and a contributing force to the medical model criteria for PTSD and c-PTSD (Andrews et al., 2000). Because shame is multi-sourced—with external shame originating in the perception of one's self as unworthy in the eyes of others and internally, as the judgement of one's self as being defective or deficient (D. A. Lee et al., 2001)—social workers should be aware of the matrix of shame in which their clients exist. Feminist and structural social work theories offer avenues for addressing externally referenced shame by questioning the legitimacy of shaming messages whose only claim to validity is their endorsement by dominant individuals and groups. Cognitive and behavioural therapies have also been demonstrated to be effective in testing the validity of externally sourced shame (Saraiya & Lopez-Castro, 2016). Internally sourced shame, however, may be better addressed through the application of mindfulness, compassion-based therapies (such as ACT) and non-pathologizing ego state therapies such as IFS (Au et al., 2017).

Shame invokes an immediate compulsion to conceal the self from the scrutiny of others and

from one's own process of self-evaluation (Schoenleber et al., 2015). As a result, it compels isolation and the avoidance of relationships that have the potential to act as a catalyst for healing (Hernandez & Mendoza, 2011). Empathy by others and compassion towards one's self, disarms shame (B. Brown, 2006). In the absence of other healing relationships, the skilled practitioner can facilitate the healing process. Shame is not only isolating but also disempowering (B. Brown, 2006). The shame-driven client can lose the power to act on their own behalf for fear of invoking more shame (Morley, 2003). Avoidance of shame-induced pain makes it seem hopeless that they can behave in such a way as to mitigate shame's effects (Aakvaag et al., 2016). Five processes discussed in the literature that have been shown in empirical research to reduce the effects of shame include: connecting with others; refocusing on positive actions; accepting vulnerable feelings; understanding shame triggers; and resisting through the rejection of negative judgments, asserting one's self, and challenging others where appropriate (Van Vliet, 2008).

Survivors of interpersonal violence are exposed to shame triggers as a consequence of the shaming nature of violence and in the process of healing and accessing services (Tangney & Dearing, 2004). Group interventions offer a valuable opportunity to feel validated, acknowledged, and understood; however, there are risks associated with inadequate empathy in relationships with others that can invoke more shame and increase trauma-related distress (Hakimi et al., 2018). As a consequence, social workers involved in group work with survivors must be vigilant in the observation of group dynamics and in being directive at times when group empathy is not optimal. Practitioners working in one-to-one therapeutic interventions with survivors do well to identify non-verbal signs of shame, communicated by their clients, and to take opportunities to identify and address shame triggers that arise during counselling sessions (D. A. Lee et al., 2001). It is also valuable for social workers to identify their own shame triggers through reflexive practice and to model shame resilience in their client interactions (Morrison, 2008). It is useful to develop a client's shame vocabulary through psychoeducation, so that clients have the tools to identify shame triggers and to discuss their shame responses in the course of trauma interventions (B. Brown, 2006). Social workers should also be aware that it is natural for humans to turn away or avoid acknowledging the shame experienced by others

(Welten et al., 2012). If we allow these natural inclinations to influence our behaviour during client interactions, we will likely meet shame with unhelpful responses that avoid or fail to fully acknowledge its significance.

Whenever possible, it is beneficial for social workers to empower their clients to expand and develop their social supports (B. Brown, 2006). This is particularly useful when working with clients who meet the medical model's criteria for c-PTSD, due to their tendency to have difficulty in maintaining interpersonal relationships (La Bash & Papa, 2014). The literature suggests that external shame may be diminished by more accurately identifying the source of shame triggers—namely, the source of externally shaming messages (Williams, 2009). Clients may benefit from joining groups that support their non-dominant identity, which may help to avoid the internalization of external shaming messages. Social workers can also advocate for and support clients in correcting misleading or inaccurate sources of shaming messages—calling into question the validity of these messages within the sphere of wider society. For example, supporting clients in joining an anti-bullying campaign or leading an anti-bullying campaign within the immediate community, may contribute to a sense of empowerment. Other social justice initiatives that may prove empowering for clients may include participating in public education that mitigates shame associated with seeking mental health support and that addresses the hierarchy of stigma.

The human mind is an amazing instrument—something that seems to get ignored by medical model approaches to interpersonal trauma care. According to the IFS model, in the throes of a traumatic event, the mind mobilizes to protect the core self from harm—separating off vulnerable parts and generating new ones whose task it becomes to protect the mind system (Schwartz, 2013). To the outside observer—particularly after the immediate threat has past—the resulting behaviours and emotional reactive patterns can appear dysfunctional. However, to convince the human mind system that there no longer exists the possibility that it will face the threat again, is untenable. The world can be a harsh and threatening place—people and situations unpredictable. In the absence of a guarantee that the same threat, or one of equal or even lessor significance will occur again, the mind's protective mechanisms continue to be vigilant. The ethical practitioner, in the process of trauma care, cannot

suggest that their client will not, again, be threatened or even harmed. Knowledge of the research reveals that clients who are survivors of interpersonal trauma—specifically childhood sexual abuse—are more likely to be victims of further violence than those who have never experienced such (Barnes et al., 2009). It is perhaps for these reasons that CBT, that questions cognitive distortions or schema as a consequence of violence is not effective for a significant portion of the population (Bryant, 2000).

During the traumatic event and more often after the event has past, the survivor is confronted with their valid perception that they are vulnerable, and the world is not such a safe place. It does not take long for the survivor to realize that the pain they are experiencing is not universal—not everyone feels it. What the diagnosis of PTSD or c-PTSD unintentionally manages to reinforce is that on top of the fact that not everyone will experience interpersonal violence, but among those who do, not all survivors experience the same debilitating long-term aftereffects. When a client does have these experiences, the mind can easily conclude that something about them—their sense of self—is to blame for the unbearable emotional pain, which is now theirs to hold alone. It is clear to see how this mechanism is shame inducing. If this state persists, the sense of aloneness, the feelings of isolation in their suffering, endures.

As compassionate social workers we have a natural inclination to relieve pain. We wish to generate hope that the survivor will feel better. We may wish to convince them that they are safe and use techniques that are designed to question their perception of the world as unsafe. Unfortunately, in our focus on pain relief, we can avoid one of the most valuable aspects of trauma care—the need to hold painful feelings in a context of human understanding. Stolorow (2016) suggests that the practitioner can serve as a 'relational home' for unbearable emotional pain and the sense of existential vulnerability that precedes it. Stolorow (2016) states that the language the practitioner uses in acknowledging another's emotional trauma meets the trauma directly, giving language to the indescribable and articulating what is unbearable. It is Stolorow's (2016) assertion that the practitioner needs to avoid mitigating "by any efforts to soothe, comfort, encourage, or reassure" the client's experience, because such efforts are "experienced by the other as a shunning or turning away from his or her traumatized state" (p. 72). What Stolorow (2016) suggests is required of the effective trauma care

practitioner is that:

> We must tolerate, even draw upon, our own existential vulnerabilities so that we can swell unflinchingly with his or her unbearable and recurring emotional pain. When we dwell with other's unendurable pain, their shattered emotional worlds are enabled to shine with a kind of sacredness that calls forth an understanding and caring engagement within which traumatized states can be gradually transformed into bearable painful feelings (p. 73)

Stolorow's (2016) approach to trauma care is certainly not an easy one. There has been much research and discussion of the hazards for social workers in developing what has been termed 'compassion fatigue' (Bride & Figley, 2007). As a consequence, social workers looking to enter the field of trauma care and who intend to practice with the intensity promoted by Stolorow, will inevitably require a well-structured plan of self-care. During the course of my practicum the importance and value of self-care was discussed regularly—both within my clinical supervision process and during regular staff meetings. As I worked in VIPP and VOICES, I noticed how practitioners took the opportunity to get regular physical exercise, to take moments between client appointments to ground themselves and participate in their favoured form of mindfulness practice. Some practitioners described the value they found in working within their own processes of supervision as part of their ongoing professional development and the role this supervision played in their self-care. It was also emphasized how clinicians themselves can benefit from their own personal therapeutic sessions to help them to continue to be self-aware and in regular contact with their current level of stress or compassion fatigue. I found the process of journaling useful as a regular process of self-care. The opportunity to write about my experiences at times when I faced difficult challenges, helped me to put my experiences in perspective and to gain clarity, which may only be possible in reflecting on the day's and week's events.

Conclusion

This practicum thesis represents the culmination of my learning over the course of my graduate work. Looking more broadly, it is also the culmination of my academic journey that began with preparation for my undergraduate degree. While this section marks the conclusion of my study in understanding the relationship between shame and trauma, I have come to the realization that this topic will continue to be an avenue of exploration throughout the remainder of my social work career. In some ways, it has become a part of who I am, as all important learning should be.

In concluding I would like to address the concept of shame as it can apply towards the profession of social work. One of the things that I noticed over the course of my education and during my practicum—related to the role of social workers—is the tension that has transpired between micro and macro practice. In the early years of social work there was a deep and committed focus on acting as allies to clients in addressing their tangible needs and in influencing social structures responsible for both creating and satisfying those needs. As time progressed, a positivist approach to working from a place of evidence-based practice emerged and we, as a profession, took a hard turn toward a focus on clinical practice (Okpych & Yu, 2014), to the detriment (in the view of many social workers) of our role in drawing attention to the tyrannical nature of social hierarchical structures. In recent years, this recognition has swung widely in the other direction—focused strongly toward issues of social justice. These large pendulous swings are common in institutions trying to define themselves and in finding their road moving forward (Rapport, 2005). It has been my observation that such reactive readjustments are common and, to a certain degree, necessary in finding a better path. If this project has taught me anything it is that shame is toxic and we need to confront it at all costs, both in our personal and our professional lives. There is no room for shaming ourselves within our profession with an insistence on one approach to social work (either micro/clinical or macro/social justice oriented) and we should be cautious and vigilant about any need to make our fellow practitioners feel that they have committed some form of violation if they choose to focus on one over the other. Whether our practice is clinical with an eye to social justice or if our focus is social change with the recognition of the valued need for micro interventions—there is the room for and the necessity of, both and either. There can be no room

for shame in it.

I am very grateful for the opportunity provided by both VIPP and VOICES to learn the valuable trauma interventions skills necessary to do good work with survivors. Both my clinical supervisor, along with other clinicians in both facilities who took the time to impart their knowledge, have contributed greatly to my development as a skilled practitioner. It takes time to train a clinician well, and the time the VIPP and VOICES practitioners invested me will never be taken for granted. I would also recognize the clients with whom I worked over the course of my practicum. They were instrumental in my learning process and I am grateful for their willingness to work with a new practitioner at such a vulnerable crossroads in their lives. While I write in general terms about what I learned through this experience, I believe it important to mention here that this thesis represents only the surface of what I took away from this experience—as it is not possible within the confines of confidentiality to share the depth of the experiences and the learning that took place as a result of my work with my clients. It is the most rewarding work I have had the privilege to undertake and it is difficult to express the magnitude of my respect and admiration for these courageous survivors, who work so hard to recover their lives. They are truly heroic.

I remain deeply concerned about what role violence will play in the future unfolding of human history. It is a plague on the world. While the focus of this practicum thesis was on the process of recovery from interpersonal trauma, we would do well—as a profession—to give additional attention to its causes as well as its consequences. As was discussed in Chapter 2, shame is strongly implicated in the construction and perpetration of violence. As with other issues in the human world, it may be in dissecting the intersection and insidiously cyclical nature of violence and shame that we come to identify what must be done to end it.

Appendix A

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Aakvaag et al. (2016)	Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse.	Men (*n=2092*) and women (*n=2437*) experiencing childhood sexual assault, domestic abuse, childhood abuse, adult rape, interpersonal violence	Cross-Sectional	• Women somewhat more prone to shame following violence • All forms of severe violence is associated with shame • The more violence types an individual experience the greater the perception of shame • Shame and guilt were associated with depression and anxiety following violence	• Shame and guilt measures require further validation • Heavily weighted on self-assessment (further research required)	"A painful affect, often associated with perceptions that one has personal attributes, personality characteristics or has engaged in behaviors that others will find unattractive and that will result in rejection or some kind of put-down."
Anderson et al. (2010)	Effects of clinician-assisted emotional disclosure for sexual assault survivors: A pilot study	Female (*n=28*) university students who are survivors of sexual violence	Randomized Control Trial	• Improvements in PTSD after 6 months with emotion-focused therapy and practitioner-assisted disclosure	• Small sample size containing only female participants, therefore, not generalizable • No results at 1 and 3 months as is consistent with other disclosure-based interventions	No definition provided

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Andrews et al. (2000)	Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse	Male (*n=118*) and female (*n=39*) survivors of interpersonal violence	Longitudinal	• No significant gender differences were found for shame following violence • Shame and anger predicted PTSD at 1 month and 2 months post-trauma • Shame was a factor in the relationship between child abuse and adult psychopathy	• Unbalanced and limited sample	"Shame is bound up with such experiences as having concerns about not taking effective action to defend oneself, being humiliated, and looking bad to others (which involves the humiliation of having others actually witness one's defeat)."
Au et al. (2017)	Compassion-based therapy for trauma-related shame and posttraumatic stress: Initial evaluation using a multiple baseline design	Female (n=9) and male (n=1) survivors of interpersonal trauma	Longitudinal	• After intervention of compassion-based therapy 9 out 10 participants had reduction in PTSD symptoms, 8 participants showed decrease in levels of shame • Treatment gains were maintained at 4-week remeasurement point • Majority of improvement seen in first three session	• Lack of controlled therapeutic conditions • Single therapist administered all interventions, possibility of therapist specific influences • Raters were trained in using instruments but lacked expertise in rating treatment quality • Self-reported measures	"Shame can fuel a sense of internal threat (e.g., seeing oneself as damaged, inadequate, incapable)."
Badour et al. (2015)	Associations between specific negative emotions and DSM-5 PTSD among a national sample of interpersonal trauma survivors	Male (n=477) and female (n=1038) survivors of interpersonal violence	Cross-Sectional	• The order of the impact of specific emotions on the development of PTSD are anger, shame, and then fear • Shame was somewhat more associated with the development of PTSD in women than in men	• Study was based on survey data that was self-reported	No definition provided

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Beck et al. (2011)	Exploring negative emotions in women experiencing intimate partner violence: Shame, guilt, and PTSD	Female (*n=63*) survivors of intimate partner violence	Cross-Sectional	• Shame, guilt distress, and guilt cognitions are correlated with the development of PTSD • Shame was more present in situations where higher levels of emotional and verbal abuse occurred • Higher levels of shame were correlated with the development of PTSD, but guilt was not a moderator	• Small sample size • Only female participants • Not generalizable	No definition provided
Beck et al. (2015)	How do negative emotions relate to dysfunctional posttrauma cognitions? An examination of interpersonal trauma survivors	Female (*n=109*) survivors of intimate partner violence	Cross-Sectional	• Higher levels of shame and depression were associated with negative self-appraisals • Negative cognitions about the self were associated with the development of PTSD	• Sample was recruited from among service users with pre-existing mental health challenges	"Shame is the negative evaluation of one's entire self. As such, individuals who feel shame might describe themselves as 'a bad person'."
Bockers et al. (2015)	The role of generalized explicit and implicit guilt and shame in interpersonal traumatization and posttraumatic stress disorder	Female (*n=92*) survivors of interpersonal violence (with diagnosis of PTSD/without diagnosis of PTSD /non-traumatized)	Cross-Sectional	• Explicit guilt and shame were significantly higher in participants with PTSD • Traumatized women without PTSD showed significantly higher levels of explicit guilt and shame than nontraumatized participants • PTSD was associated with implicit guilt but not implicit shame	• Cross-sectional design limits to correlational relationship only • Study results will not necessarily reflect men's experience	"Shame is defined as distinctive self-conscious emotion linked to the self in an interpersonal context and concerns the global self."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Brown (2006)	Shame resilience theory: A grounded theory study on women and shame	Female participants (n=215)	Grounded Theory	• Shame is interpreted in the real or perceived failure of meeting cultural expectations • Shame generates feelings of being trapped, powerless, and isolated • Shame triggers are individual not universal and may include a 'web' of shame • Empathy can heal shame through connection, increasing sense of power, increasing freedom to act, decreasing isolation	• Controlled research is required to test the validity of Shame Resilience Theory • Did not consider the impact of shame on men or triggers that may be unique to men	"An intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging."
Buchbinder & Eisikovits (2003)	Battered women's entrapment in shame: A phenomenological study	Jewish women (*n=20*) who have experience intimate partner violence (IPV)	Phenomenological	• Perpetrators of IPV create and reinforce shame by fostering a women's separation from her core self and increasing low self-esteem along with a sense of helplessness • Negative impact to self is universal, while cultural factors define norms and standards whose violation results in unique shame triggers	• Small sample • Sample lacks diversity	"Shame shrinks the self, making it tiny and insignificant, while others become overly large and gain preponderance in defining and assessing the self."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Budden (2009)	The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V	N/A	Scoping review	Theoretical model suggests that shame: a) Severs bonds with the social world b) Is not personal but occurs in interrelational spaces and is impacted by power dynamic in social institutions c) Regulates a range of core symptoms of PTSD, yet are not included in DSM criteria for such	• Requires additional validation through clinical empirical testing	"It is the painful self-consciousness of or anxiety about negative judgment, unwanted exposure, inferiority, failure, and defeat. As a dimension of the self, shame has both external and internal orientations."
DeCou (2017)	Assault-related shame mediates the association between negative social reactions to disclosure of sexual assault and psychological distress	Female psychology undergraduates (*n=207*) who have experience attempted or completed sexual assault	Cross-Sectional	• Shame mediates the connection between negative reactions to disclosure and symptoms of PTSD	• Self-reported measures • Correlational only due to cross-sectional design • Limited to female survivors	"Shame is a multifaceted experience of negative self-evaluation that occurs in tandem with perceived social threat, including fear of negative judgment from others, and feelings of embarrassment and inferiority"
Dorahy & Clearwater (2012)	Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation	Male (*n=7*) survivors of childhood sexual abuse	Phenomenological	• Survivors experience 'self as shame' perception • Pervasive sense of powerlessness and self-doubt • Sense of self-directed life-flow disrupted due to potential for exposure • Dissociative symptoms result in isolation	• Nature of investigation process is not generalizable • Focus group can result in uncontrollable influences from co-group members	"Shame is linked to how individuals perceive the self and how they believe others perceive them. It is associated with internal, stable, and global attributions about causality of negative events as well as a sense of uncontrollability in making things different."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Goldsmith et al.(2014)	Mindfulness-based stress reduction for posttraumatic stress symptoms: building acceptance and decreasing shame.	Female (*n=9*) and male (*n=1*) survivors of interpersonal trauma (with and without PTSD)	Cross-Sectional Pilot	• Participants experienced a significant drop in the levels of PTSD and depressive symptoms with mindfulness intervention• Greater decrease in PTSD symptoms than depressive symptoms with intervention• Participants reported increases in acceptance of thoughts and emotions and reduction in shame-based trauma appraisals• Most significant improvement occurred in first three sessions	• Small sample size, unbalanced sample by demographic, and lack of a control condition• Cross-sectional design does not permit establishment of a causal relationship	No definition provided
Hahn (2004)	The role of shame in negative therapeutic reactions	N/A	Review of Literature	• Shame underlies negative therapeutic interaction and these need to be addressed when progress is halted • When shame emerges in psychotherapy, it often includes disorganizing physiological and emotional elements that clients find difficult to express • Practitioners must be aware that their own shame responses can become triggered though interactions with clients • Shame may need to be addressed indirectly to avoid further triggering	• Methodology was not identified, and limitations were not delineated, therefore it is difficult to determine the limitations of the review	"Shame is activated when positive emotional states are not matched or when negative emotional states are not soothed."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Harman & Lee (2010)	The role of shame and self-critical thinking in the development and maintenance of current threat in post-traumatic stress disorder	Male (*n=23*) and Female (*n=26*) participants with diagnosed PTSD with interpersonal trauma (43%)	Cross-sectional	• Shame is positively correlated with self-criticism and shows significant negative correlation with self-reassurance • Measures of inadequate self and hated self were positively correlated with shame • Shame was associated with higher levels of depression • Clinicians should view the reduction of shame as a key factor in the treatment of PTSD • Cognitive interventions that address negative self-evaluation should also be considered	• Small sample size • Time lags between some measures • Cross-sectional design does not establish causal relationships	"Shame is a 'self-conscious' emotion relating to feelings of powerlessness, inferiority, a sense of social unattractiveness and a desire to hide or conceal deficiencies."
La Bash & Papa (2014)	Shame and PTSD symptoms	Female (n=99) college students who have experienced interpersonal trauma (with PTSD)	Cross-sectional	• Indirect relationship between number of traumatic incidents on PTSD symptoms through the action of shame • Traumatic incidents negatively bias the survivor's view of the world as safe and predictable • Fear did not show the same relationship to PTSD as did shame	• Cross-sectional design does not establish causal relationships • Retrospective self-reported measures • Non-clinical sample	"Shame suggests that it is a highly aversive negative emotion arising when a part of the self is thought to be corrupted by an irredeemable act or by a contaminating event that evokes the perceived judgment of others"

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Lansky (2000)	Shame dynamics in the psychotherapy of the patient with PTSD: A viewpoint	Theory-based overview	N/A	• Posttraumatic nightmares and flashbacks are psychic struggles that involve shame in the life of the survivor • The focus should be not on the treatment of the trauma itself (a past event) but on intervention with the posttraumatic state • Experiencing of posttraumatic symptoms may be the minds method of screening out awareness of the underlying shaming condition (concealment)	• Theoretical model only - requires further research to establish efficacy	"Shame arises when one sees oneself as failing to conform to one's standards and ideals."
Lee, Scragg & Turner (2001)	The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD	N/A	Clinical Model	• Exposure treatment is most effective with clients experiencing fear-based forms of PTSD but these do not address shame-based forms of PTSD • Clients can be re-shamed during interventions through the assessment process • Shame may be addressed through meaning-making • Two forms of shame are identified: internal and external	• A single case formulation was used to demonstrate the model • Efficacy of the model would need to be proofed in research with a variety of different client types	"External shame is associated with beliefs that others look down on the self and see the self as inferior, inadequate, disgusting, or weak in some way. Internal shame, however, relates to experiences of the self as devalued in one's own eyes in a way that is damaging to the self-identity"

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Leskela, Dieperink & Thuras (2002)	Shame and posttraumatic stress disorder	Male (n=107) war veterans with PTSD	Cross-sectional	• Participants with PTSD had higher shame proneness than those without • Guilt proneness was unrelated to the intensity of PTSD symptoms • An attributional style that is focussed on actions instead of self-evaluation may result in a diminished risk for PTSD	• Non-random sample with self-reported information • Participants were all advanced in age and had carried the trauma for over 50 years • Findings are not generalizable	"An emotion in which the entire self, not just the behavior is negatively evaluated. Shame theoretically involves painful self-scrutiny, and feelings of worthlessness and powerlessness."
Lewis (2003)	The role of the self in shame	N/A	Clinical Model	• Shame disrupts all external activity as the self focuses completely on its internal state - results in the inability to think clearly, to talk, and to act • In a state of shame the client becomes inwardly focused and driven by the need to hide or disappear - as a consequence it increases the risk of suicidal ideation • Increased risk for early shame experiences include harsh socialization experiences, high levels of reward for success versus high levels of punishment for failure	• Theoretical model only - requires further to establish efficacy	"A heightened degree of self-conscious, self-awareness, or self-attention: our consciousness is filled with self and we are aware of some aspect of self we consider innocuous or inadequate."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
MacGinley, Breckenridge & Mowll (2019)	A scoping review of adult survivors' experiences of shame following sexual abuse in childhood.	N/A	Scoping Review	• Shame resulting from childhood sexual abuse has significant negative affects on interpersonal relationships, mental health, willingness to disclose, self concept, and recovery • Provides an overview of current research around the connection between shame and trauma with recommendations for therapeutic approaches and future research	• Identifies need for further qualitative research on lived experience of shame for childhood sexual abuse survivors and its implications for treatment • Absence of second person in search collection of research results • Included studies where shame was not the primary topic under exploration	"Shame involves an assessment or judgement of the self as 'bad' or 'wrong'. Shame is, 'I am wrong'."
Mills (2008)	Shame and intimate abuse: The critical missing link between cause and cure	N/A	Scoping review	• Explorations underlying violence from the perpetrator's perspective indicate that violence may be used to ward off feelings of shame • If perpetrators believe their shame has been triggered by their partner, they may act out their victimization in violent ways • Patterns of emotion leading up to violence include: vulnerability, fear, and then anger	• Research's tendency to focus on victims instead of perpetrators yielding less research into causal factors (small number of studies) • Social barriers involved in attempting to understand violence resulting from shame from the perpetrator's perspective	"A painful feeling of having lost the respect of others because of the improper behavior, incompetence, etc., of oneself or another."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Saraiya & Lopez-Castro(2016)	Ashamed and afraid: A scoping review of the role of shame in post-traumatic stress disorder (PTSD)	N/A	Scoping Review	• The creation of shame related to interpersonal violence is connected with social subordination, powerlessness, and lack of control • Shame appears to be as critical as addressing fear when it comes to recovery from interpersonal violence • Immediate assessment of the experience of interpersonal violence as shameful appear to be correlated with the development of PTSD • All therapeutic interventions tested result in a decrease in shame - therapeutic relationship that reduces shame may be key	• Limited only by the studies available for inclusion • Full methodology available as component of review • Need for further empirical research to confirm self-reported measures identified	"Shame can be briefly defined as a painful set of affective and cognitive states typified by self-judgment stemming from a perceived transgression of social/cultural norms or expectations."
Schoenleber et al. (2015)	Role of trait shame in the association between posttraumatic stress and aggression among men with a history of interpersonal trauma	Male (*n=103*) participants with a history of interpersonal trauma	Cross-Sectional	• Men who have been survivors of interpersonal violence show a correlation between posttraumatic stress and violence • Trait shame accounts for the connection between posttraumatic stress and violence • Results suggest that aggression may function to regulate and cope with shame • Results suggest that that the relationship between aggression and shame may be cyclical	• Cross-sectional design does not establish causal relationships • Reliance on self-report measures of trait shame are open to various bias • Participants recruited from a university campus only - results cannot be generalized • Male participants only	"Shame involves the perception of the self as flawed or defective, and results in urges to withdraw or hide from other."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Talbot (1996)	Women sexually abused as children: The centrality of shame issues and treatment implications	Single female who had experienced childhood sexual abuse	Case Study	• Adult survivors of childhood violence may be particularly susceptible to feelings of powerlessness due to violence that took place at a developmental stage when they were not able to act to protect themselves • Caregivers can intervene with children who have experienced shame so that their system does not become overwhelmed - this can prevent future avoidance behaviours • Practitioners can provide shame-mitigating responses that survivors may not have received as children • Recognize that shame may only be tolerable in small amounts • Practitioners need to be aware of their own shame triggers that activate through countertransference	• Finding not generalizable given the single case design • Results may vary depending on the developmental stage that the survivor was when the interpersonal violence occurred • Aspects of individual temperament were not considered	"An individual experiences shame when he/she recognizes the discrepancy between the grandiose and actual self."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Trumbull (2003)	Shame: An acute stress response to interpersonal traumatization	N/A	Practice Article	• Survivors may experience nightmares and flashbacks as the mind attempt to understand the relationship between the traumatic event and the sense of self • Acceptable interpretations of one's self can result in depression and anger that can be turned inward or outward • Caregivers provide the first models of reacting to shame. These same responses of helplessness can be triggered in later years following trauma	• Author recognizes the need for longitudinal research in clinical and non-clinical samples to fully understand the role of shame in psychological dysfunction	"Shame disrupts ongoing activity as the self focuses completely on itself and the result is confusion: inability to think clearly, inability to talk, and inability to act."
Ullman (2011)	Is disclosure of sexual traumas helpful? Comparing experimental laboratory Versus field study results	N/A	Review of Literature	• A literature review indicated that there is a small positive effect to experimental disclosure of stressful events • Experimental disclosure studies showed that the positive effects were nullified when the response to disclosure was not sufficiently positive • The value of disclosure is associated with a) contextual issues, b) characteristics of the disclosure, c) voluntariness of disclosure, d) disclosure characteristics, e) previous disclosure experiences, and f) history of childhood disclosure and the subsequent response received	• Methodology of data collection not specified	No definition provided

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Van Vliet (2008)	Shame and resilience in adulthood: A grounded theory study	Female (n=9) and male (n=4) survivors of significant shame experiences	Grounded Theory	• There is a contradiction between the concept of shame as adaptive and its indisputable relationship with a wide range of mental health problems • Shame resilience is composed of connecting with others, finding allies, connecting with higher powers, refocusing on the positive, accepting, understanding, and resisting	• More research is needed on different types of shame (social transgressions versus trauma) and between cultural groups	"Shame results from a perceived loss of social attractiveness and serves the adaptive function of alerting individuals to threats to their power and status in society."
Wilson (2006)	Posttraumatic Shame and Guilt	N/A	Practice Article	• Posttraumatic shame should be considered across eight dimensions: self-attribution, emotional states, action appraisal, impact on personal identity, suicidality defensiveness, PTSD proneness, and negative self-structure • Shame can result in loss of self-continuity as it relates to upholding cultural values • Shame-related suicidality is related to the need to escape from haunting, intrusive memories of trauma and the sense of being trapped within a shamed state • Need for practitioners to recognize that posttraumatic shame is associated with reactions to prolonged traumatic stressors • Need to recognize that posttraumatic shame is multidimensional and complex	• Practice article had a shared focus on both shame and guilt in their relationship to posttraumatic stress dysregulation • The article discussed posttraumatic trauma in general terms and did not discuss the implications of the multidimensional aspects of shame as it pertains to different forms of trauma	"Shame is a feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior; dishonor; a person or thing being dishonored; a cause to feel ashamed."

Author (Year)	Title	Sample Type	Design	Finding Summary	Limitations	Shame Definition
Wong & Cook (1992)	Shame and its contribution to PTSD	Male (n=47) combat veterans (PTSD versus substance use diagnosis)	Cross-Sectional	• Patients with a diagnosis of PTSD scored significantly higher on shame and depression than did participants with substance use issues • Shame was more important in results when compared to feelings of alienation or inferiority	• Correlational affect only • Small sample size • Limitations in generalization due to male only participants	"Shames related feelings of alienation and inferiority can be directly attributable to experiences defined as the 'breaking of the interpersonal bridge'"

References

Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Røysamb, E., & Olff, M. (2016). Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse. *Journal of Affective Disorders*, *204*, 16–23. https://doi.org/10.1016/j.jad.2016.06.004

American Psychiatric Association. (2017). *Diagnostic and statistical manual of mental disorders* (5th Ed.). https://doi.org/10.1176/appi.books.9780890425596.

Anderson, T., Fende Guajardo, J., Luthra, R., & Edwards, K. M. (2010). Effects of clinician-assisted emotional disclosure for sexual assault survivors: A pilot study. *Journal of Interpersonal Violence*, *25*(6), 1113–1131. https://doi.org/10.1177/0886260509340542

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology*, *109*(1), 69–73. https://doi.org/10.1037/0021-843X.104.2.277

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163–179. https://doi.org/10.1111/j.1600-0447.2005.00699.x

Au, T. M., Sauer-Zavala, S., King, M. W., Petrocchi, N., Barlow, D. H., & Litz, B. T. (2017). Compassion-based therapy for trauma-related shame and posttraumatic stress: Initial evaluation using a multiple baseline design. *Behavior Therapy*, *48*(2), 207–221. https://doi.org/10.1016/j.beth.2016.11.012

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy.* (pp. 133–178). American Psychological Association. https://doi.org/10.1037/11132-004

Badour, C. L., Resnick, H. S., & Kilpatrick, D. G. (2017). Associations between specific negative emotions and DSM-5 PTSD among a national sample of interpersonal trauma survivors. *Journal of Interpersonal Violence*, *32*(11), 1620–1641.

Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among

victims of severe childhood sexual abuse. *Child Abuse & Neglect*, *33*(7), 412–420. https://doi.org/10.1016/j.chiabu.2008.09.013

Beck, J., & Beck, A. (2011). *Cognitive behavioural therapy: Basics and beyond* (2nd Ed.). The Gilford Press.

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, guilt, and PTSD. *Behavior Therapy*, *42*(4), 740–750.

Bell, M. (2009). Anger, virtue, and oppression. In L. Tessman (Ed.), *Feminist Ethics and Social and Political Philosophy: Theorizing the Non-Ideal* (pp. 165–183). Springer Netherlands. https://doi.org/10.1007/978-1-4020-6841-6_10

Betteridge, L. (2020, March 20). COVID-19 recommendations for social workers and social service workers. *OCSWSSW*. https://www.ocswssw.org/2020/03/20/covid-19-recommendations-for-social-workers-and-social-service-workers/

Bockers, E., Roepke, S., Michael, L., Renneberg, B., & Knaevelsrud, C. (2016). The role of generalized explicit and implicit guilt and shame in interpersonal traumatization and posttraumatic stress disorder. *The Journal of Nervous and Mental Disease*, *204*(2), 95–99. https://doi.org/10.1097/NMD.0000000000000428

Bogo, M., & McKnight, K. (2006). Clinical supervision in social work: A review of the research literature. *The Clinical Supervisor*, *24*(1–2), 49–67. https://doi.org/10.1300/J001v24n01_04

Bride, B. E., & Figley, C. R. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal*, *35*(3), 151–153. https://doi.org/10.1007/s10615-007-0093-5

Brison, S. (1999). Trauma narratives and the remaking of the self. In M. Bal, J. Crewe, & L. Spitzer (Eds.), *Acts of memory: Cultural recall in the present* (p. 250). University Press of New England.

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society: The Journal of Contemporary Social Services*, *87*(1), 43–52. https://doi.org/10.1606/1044-3894.3483

Brown, B. (2012). *Listening to shame*. https://www.ted.com/talks/brene_brown_listening_to_shame

Brown, L. (1994). *Subversive dialogues: Theory in feminist therapy*. Basic Books.

Brown, L. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 464–471. https://doi.org/10.1037/0033-3204.41.4.464

Brown, S., McGriff, K., & Speedlin, S. (2018). Using relational-cultural theory to negotiate relational rebuilding in survivors of intimate partner violence. *Journal of Creativity in Mental Health*, *13*(2), 136–147. https://doi.org/10.1080/15401383.2017.1355289

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy*, *39*(2), 195–208. https://doi.org/10.1111/j.1752-0606.2011.00270.x

Bryant, R. A. (2000). Cognitive behavioral therapy of violence-related posttraumatic stress disorder. *Aggression and Violent Behavior*, *5*(1), 79–97. https://doi.org/10.1016/S1359-1789(98)00021-4

Buchbinder, E., & Eisikovits, Z. (2003). Battered women's entrapment in shame: A phenomenological study. *American Journal of Orthopsychiatry*, *73*(4), 355–366. https://doi.org/10.1037/0002-9432.73.4.355

Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science & Medicine*, *69*(7), 1032–1039. https://doi.org/10.1016/j.socscimed.2009.07.032

Canada: Number of Violent Crimes. (2018). Statista. https://www.statista.com/statistics/525273/canada-number-of-violent-crimes/

Casstevens, W. J. (2010). Social work education on mental health: Postmodern discourse and the medical model. *Journal of Teaching in Social Work*, *30*(4), 385–398. https://doi.org/10.1080/08841233.2010.515920

Childs, D. (2007). Mindfulness and the psychology of presence. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*(3), 367–376. https://doi.org/10.1348/147608306X162600

Classen, C. C., Palesh, O. G., Cavanaugh, C. E., Koopman, C., Kaupp, J. W., Kraemer, H. C., Aggarwal, R., & Spiegel, D. (2011). A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial. *Psychological Trauma:*

Theory, Research, Practice, and Policy, *3*(1), 84–93. https://doi.org/10.1037/a0020096

Cleare, S., Gumley, A., & O'Connor, R. C. (2019). Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. *Clinical Psychology & Psychotherapy*, *26*(5), 511–530. https://doi.org/10.1002/cpp.2372

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Ii, G. S. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development*, *86*(3), 279–287. https://doi.org/10.1002/j.1556-6678.2008.tb00510.x

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.

DeCou, C. R., Mahoney, C. T., Kaplan, S. P., & Lynch, S. M. (2019). Coping self-efficacy and trauma-related shame mediate the association between negative social reactions to sexual assault and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(1), 51–54.

Dorahy, M. J., & Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation. *Journal of Child Sexual Abuse*, *21*(2), 155–175. https://doi.org/10.1080/10538712.2012.659803

Faver, C. A. (2004). Relational spirituality and social caregiving. *Social Work*, *49*(2), 241–249. https://doi.org/10.1093/sw/49.2.241

Ferguson, T. J., Eyre, H. L., & Ashbaker, M. (2000). Unwanted identities: A key variable in shame - anger links and gender differences in shame. *Sex Roles*, *42*(3), 133–157. https://doi.org/10.1080/15299732.2015.1004771

Finn, J. L. (2016). *Just practice: A social justice approach to social work* (3rd. Ed.). Oxford University Press.

Fischer, C. (2018). Gender and the politics of shame: A twenty-first-century feminist shame theory. *Hypatia*, *33*(3), 371–383. https://doi.org/10.1111/hypa.12431

Follette, V., La Bash, H., & Sewell, T. (2010). Adult disclosure of a history of childhood sexual abuse: Implications for behavioral psychotherapy. *Journal of Trauma & Dissociation*, *11*(2), 228–243.

https://doi.org/10.1080/15299730903502953

Forgash, C., & Knipe, J. (2012). Integrating EMDR and ego state treatment for clients with trauma disorders. *Journal of EMDR Practice and Research*, *6*(3), 120–128. https://doi.org/10.1891/1933-3196.6.3.120

Frederick, C. (2005). Selected topics in ego state therapy. *International Journal of Clinical and Experimental Hypnosis*, *53*(4), 339–429. https://doi.org/10.1080/00207140591007518

Gilbert, P. (2011). Shame in psychotherapy and the role of compassion focused therapy. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 325–354). American Psychological Association.

Goldsmith, R. E., Gerhart, J. I., Chesney, S. A., Burns, J. W., Kleinman, B., & Hood, M. M. (2014). Mindfulness-based stress reduction for posttraumatic stress symptoms: Building acceptance and decreasing shame. *Journal of Evidence-Based Complementary & Alternative Medicine*, *19*(4), 227–234. https://doi.org/10.1177/2156587214533703

Government of Canada. (2017). *Sexual assault—JustFacts*. Department of Justice. https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2017/may02.html

Greenberg, L., & Iwakabe, S. (2011). Emotion-focused therapy and shame. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 69–90). American Psychological Association. https://doi.org/10.1037/12326-000

Hahn, W. K. (2004). The role of shame in negative therapeutic reactions. *Psychotherapy*, *41*(1), 3–12.

Hakimi, D., Bryant-Davis, T., Ullman, S. E., & Gobin, R. L. (2018). Relationship between negative social reactions to sexual assault disclosure and mental health outcomes of Black and White female survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(3), 270–275. https://doi.org/10.1037/tra0000245

Harman, R., & Lee, D. (2010). The role of shame and self-critical thinking in the development and maintenance of current threat in post-traumatic stress disorder. *Clinical Psychology & Psychotherapy*, *17*(1), 13–24. https://doi.org/10.1002/cpp.636

Hartling, L. M., & Walker, M. (2000). *Shame and humiliation: From isolation to relational transformation*

(Series No. 88; Work in Progress, p. 16). Wellsley Centers for Women.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence, from domestic abuse to political terror*. Basic Books.

Herman, J. (2011). Posttraumatic stress disorder as a shame disorder. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 261–276). American Psychological Association.

Hernandez, V. r., & Mendoza, C. t. (2011). Shame resilience: A strategy for empowering women in treatment for substance abuse. *Journal of Social Work Practice in the Addictions*, *11*(4), 375–393. https://doi.org/10.1080/1533256X.2011.622193

Hodgdon, H., Anderson, F., Southwell, E., Hrubec, W., & Schwartz, R. (2017). *Internal family systems (IFS) treatment for PTSD and comorbid conditions: A pilot study [PDF]*. The Trauma Center at Justice Resource Institute.

Högberg, G., Pagani, M., Sundin, Ö., Soares, J., Åberg-Wistedt, A., Tärnell, B., & Hällström, T. (2008). Treatment of post-traumatic stress disorder with eye movement desensitization and reprocessing: Outcome is stable in 35-month follow-up. *Psychiatry Research*, *159*(1–2), 101–108. https://doi.org/10.1016/j.psychres.2007.10.019

Huggett, C., Birtel, M. D., Awenat, Y. F., Fleming, P., Wilkes, S., Williams, S., & Haddock, G. (2018). A qualitative study: Experiences of stigma by people with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(3), 380–397. https://doi.org/10.1111/papt.12167

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*(1), 101–119. https://doi.org/10.1348/147608304322874281

Kunz, J., & Stoltys, F. (2007). *Transformational reminiscence: Life story work*. Springer.

La Bash, H., & Papa, A. (2014). Shame and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(2), 159–166. https://doi.org/10.1037/a0032637

Ladany, N., Klinger, R., & Kulp, L. (2011). Therapist shame: Implications for therapy and supervision. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 307–322). American

Psychological Association. https://doi.org/10.1037/12326-000

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy*, *38*(4), 357–361. http://dx.doi.org.librweb.laurentian.ca/10.1037/0033-3204.38.4.357

Lansky, M. R. (2000). Shame dynamics in the psychotherapy of the patient with PTSD: A viewpoint. *Journal of the American Academy of Psychoanalysis*, *28*(1), 133–146. https://doi.org/10.1521/jaap.1.2000.28.1.133

Larson, G. (2008). Anti-oppressive practice in mental health. *Journal of Progressive Human Services*, *19*(1), 39–54. https://doi.org/10.1080/10428230802070223

Lee, C., Gavriel, H., Drummond, P., Richards, J., & Greenwald, R. (2002). Treatment of PTSD: Stress inoculation training with prolonged exposure compared to EMDR. *Journal of Clinical Psychology*, *58*(9), 1071–1089. https://doi.org/10.1002/jclp.10039

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, *74*(4), 451–466. https://doi.org/10.1348/000711201161109

Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress*, *15*(3), 223–226. https://doi.org/10.1023/A:1015255311837

Lewis, H. (1971). *Shame, guilt and neurosis*. International University Press.

Lewis, M. (2003). The role of the self in shame. *Social Research*, *70*(4), 1181–1204.

Lobenstine, F., & Courtney, D. (2013). A case study: The integration of intensive EMDR and ego state therapy to treat comorbid posttraumatic stress disorder, depression, and anxiety. *Journal of EMDR Practice and Research*, *7*(2), 65–80. https://doi.org/10.1891/1933-3196.7.2.65

Lubin, H., Loris, M., Burt, J., & Johnson, D. R. (1998). Efficacy of Psychoeducational Group Therapy in Reducing Symptoms of Posttraumatic Stress Disorder Among Multiply Traumatized Women. *American Journal of Psychiatry*, *155*(9), 1172–1177. https://doi.org/10.1176/ajp.155.9.1172

Lucero, R., Jones, A. C., & Hunsaker, J. C. (2018). Using internal family systems theory in the treatment of combat veterans with post-traumatic stress disorder and their families. *Contemporary Family*

Therapy, *40*(3), 266–275. https://doi.org/10.1007/s10591-017-9424-z

Lundy, C. (2011). *Social work, social justice, human rights: A structural approach to practice* (2nd Ed.). University of Toronto Press.

MacGinley, M., Breckenridge, J., & Mowll, J. (2019). A scoping review of adult survivors' experiences of shame following sexual abuse in childhood. *Health & Social Care in the Community*, *27*(5), 1135–1146. https://doi.org/10.1111/hsc.12771

Masaviru, M. (2016). Self-disclosure: Theories and model review. *Journal of Culture, Society and Development*, *18*, 43–47.

May, M. (2017). Shame! A system psychodynamic perspective. In E. Vanderheiden & C.-H. Mayer (Eds.), *The Value of Shame: Exploring a Health Resource in Cultural Contexts* (pp. 43–59). Springer International Publishing. https://doi.org/10.1007/978-3-319-53100-7_2

McFarlane, A. (2010). The long-term costs of traumatic stress: Intertwined physical and psychological consequences. *World Psychiatry*, *9*(1), 3–10.

Mills, L. G. (2008). Shame and intimate abuse: The critical missing link between cause and cure. *Children and Youth Services Review*, *30*(6), 631–638. https://doi.org/10.1016/j.childyouth.2008.01.010

Morley, C. (2003). Towards critical social work practice in mental health. *Journal of Progressive Human Services*, *14*, 61–84. https://doi.org/10.1300/J059v14n01_05

Morrison, A. (2008). The analyst's shame. *Contemporary Psychoanalysis*, *44*(1), 65–82. https://doi.org/10.1080/00107530.2008.10745951

Morrison, A. (2011). The psychodynamics of shame. In R. L. Dearing & J. Tangney (Eds.), *Shame in the therapy hour* (pp. 23–44). American Psychological Association.

Nisbet, D. (2002). Reduction of trauma symptoms following group therapy. *Australian & New Zealand Journal of Psychiatry*, *36*(1), 67–74. https://doi.org/10.1046/j.1440-1614.2002.00980.x

Okpych, N. J., & Yu, J. L.-H. (2014). A historical analysis of evidence-based practice in social work: The unfinished journey toward an empirically grounded profession. *Social Service Review*, *88*(1), 3–58. JSTOR. https://doi.org/10.1086/674969

Outlaw, M. (2009). No one type of intimate partner abuse: Exploring physical and non-physical abuse

among intimate partners. *Journal of Family Violence*, *24*(4), 263–272. https://doi.org/10.1007/s10896-009-9228-5

Perry, B. L. (2011). The labeling paradox: Stigma, the sick role, and social networks in mental illness. *Journal of Health and Social Behavior*, *52*(4), 460–477. https://doi.org/10.1177/0022146511408913

Phanichrat, T., & Townshend, J. M. (2010). Coping strategies used by survivors of childhood sexual abuse on the journey to recovery. *Journal of Child Sexual Abuse*, *19*(1), 62–78. https://doi.org/10.1080/10538710903485617

Rapport, J. (2005). Policy swings over thirty-five years of mental health social work in England and Wales 1969–2004. *Practice*, *17*(1), 43–56. https://doi.org/10.1080/09503150500058041

Rennison, C. M. (2014). Feminist theory in the context of sexual violence. In G. Bruinsma & D. Weisburd (Eds.), *Encyclopedia of Criminology and Criminal Justice* (pp. 1617–1627). Springer. https://doi.org/10.1007/978-1-4614-5690-2_70

Robertson, T. E., Sznycer, D., Delton, A. W., Tooby, J., & Cosmides, L. (2018). The true trigger of shame: Social devaluation is sufficient, wrongdoing is unnecessary. *Evolution and Human Behavior*, *39*(5), 566–573. https://doi.org/10.1016/j.evolhumbehav.2018.05.010

Sandler, J. (1990). On internal object relations. *Journal of the American Psychoanalytic Association*, *38*(4), 859–880. https://doi.org/10.1177/000306519003800401

Sandler, J., Holder, A., & Meers, D. (1963). The ego ideal and the ideal self. *The Psychoanalytic Study of the Child*, *18*(1), 139–158. https://doi.org/10.1080/00797308.1963.11822927

Saraiya, T., & Lopez-Castro, T. (2016). Ashamed and afraid: A scoping review of the role of shame in post-traumatic stress disorder (PTSD). *Journal of Clinical Medicine*, *5*(11), 94. https://doi.org/10.3390/jcm5110094

Schoenleber, M., Sippel, L. M., Jakupcak, M., & Tull, M. T. (2015). Role of trait shame in the association between posttraumatic stress and aggression among men with a history of interpersonal trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(1), 43–49. https://doi.org/10.1037/a0037434

Schwartz, R. (2001). *Introduction to the internal family systems model*. Trailheads.

Schwartz, R. (2013). Moving from acceptance toward transformation with internal family systems therapy (IFS). *Journal of Clinical Psychology*, *69*(8), 805–816. https://doi.org/10.1002/jclp.22016

Schwitzer, A., & Rubin, L. (2014). Clinical thinking skills: Diagnosis, case conceptualization, and treatment planning. In *Diagnosis and treatment planning skills: A popular culture casebook approach (DSM-5 update)* (2nd Ed., pp. 27–40). Sage Publications.

Senreich, E., Straussner, S. L. A., & Steen, J. (2020). The work experiences of social workers: Factors impacting compassion satisfaction and workplace stress. *Journal of Social Service Research*, *46*(1), 93–109. https://doi.org/10.1080/01488376.2018.1528491

Stadter, M. (2011). The inner world of shaming and ashamed: An object relations perspective. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 261–276). American Psychological Association.

Stolorow, R. (2016). Pain is not pathology. *Existenial Analysis*, *21*(1), 70–74.

Talbot, N. L. (1996). Women sexually abused as children: The centrality of shame issues and treatment implications. *Psychotherapy*, *33*(1), 11–18.

Tangney, J., & Dearing, R. L. (Eds.). (2004). *Shame and guilt in the therapy hour*. Guilford Press.

The Canadian social work code of ethics. (2005). CASW. https://www.casw-acts.ca/sites/casw-acts.ca/files/documents/casw_code_of_ethics.pdf

Trumbull, D. (2003). Shame: An acute stress response to interpersonal traumatization. *Psychiatry*, *66*(1), 53–64. https://doi.org/10.1080/00332747.2020.1717308

Ullman, S. E. (2011). Is disclosure of sexual traumas helpful? Comparing experimental laboratory versus field study results. *Journal of Aggression, Maltreatment & Trauma*, *20*(2), 148–162. https://doi.org/10.1080/10926771.2011.546751

Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology*, *55*(2), 233–245. https://doi.org/10.1037/0022-0167.55.2.233

Wakefield, J. C. (2012). Should prolonged grief be reclassified as a mental disorder in DSM-5?: Reconsidering the empirical and conceptual arguments for complicated grief disorder. *The*

Journal of Nervous and Mental Disease, *200*(6), 499–511. https://doi.org/10.1097/NMD.0b013e3182482155

Ware, J. N., & Dillman Taylor, D. (2014). Concerns about confidentiality: The application of ethical decision-making within group play therapy. *International Journal of Play Therapy*, *23*(3), 173–186. https://doi.org/10.1037/a0036667

Warner, E., Spinazzola, J., Westcott, A., Gunn, C., & Hodgdon, H. (2014). The body can change the score: Empirical support for somatic regulation in the treatment of traumatized adolescents. *Journal of Child & Adolescent Trauma*, *7*(4), 237–246. https://doi.org/10.1007/s40653-014-0030-z

Weathers, F. W., Marx, B. P., Friedman, M. J., & Schnurr, P. P. (2014). Posttraumatic stress disorder in DSM-5: New criteria, new measures, and implications for assessment. *Psychological Injury and Law*, *7*(2), 93–107. https://doi.org/10.1007/s12207-014-9191-1

Welten, S. C. M., Zeelenberg, M., & Breugelmans, S. M. (2012). Vicarious shame. *Cognition & Emotion*, *26*(5), 836–846. https://doi.org/10.1080/02699931.2011.625400

Williams, K. D. (2009). Ostracism: A temporal need-threat model. In *Advances in experimental social psychology* (Vol. 41, pp. 275–314). Academic Press. https://doi.org/10.1016/S0065-2601(08)00406-1

Wilson, J. P., Droždek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence, & Abuse*, *7*(2), 122–141. https://doi.org/10.1177/1524838005285914

Wong, M. R., & Cook, D. (1992). Shame and its contribution to PTSD. *Journal of Traumatic Stress*, *5*(4), 557–562. https://doi.org/10.1002/jts.2490050405

Yourman, D. B. (2003). Trainee disclosure in psychotherapy supervision: The impact of shame. *Journal of Clinical Psychology*, *59*(5), 601–609. https://doi.org/10.1002/jclp.10162