Shame Regulation Therapy for Families

Uri Weinblatt

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A Systemic Mirroring Approach

Springer

Uri Weinblatt
Systemic Mirroring Family Therapy Institute
Modi'in, Israel

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Introduction

What is common to all of the following experiences?

- A child plays a game with a friend and loses. He explodes, aggressively throwing the game board to the ground.
- An adolescent girl wants to be friends with two other girls. When they reject her, she goes and cuts her arms.
- An adolescent boy who has been asked by his parents to stay home, rather than go out, curses at them and yells "I'll do what I want!"
- A mother requests that her son clean up his room. When she enters his room for the third time, she screams and yells and tells him that he is a terrible son.
- A father decides to stop talking to his daughter because she is disrespectful.
- A wife requests that her husband arrive home earlier. When he arrives late, she yells "you never cared for me! You only care about yourself!"
- A student is requested to make a presentation in class. On the day of the presentation, he stays at home.
- A teacher tells a student to open his book. He refuses and says, "Who are you to tell me what to do?" The teacher reacts by sending him out of the classroom.
- In a teacher–parent conference, the teacher tells the parents about their child's low grades. Soon both sides start blaming each other for the child's situation.

While we usually do not understand these diverse life events to be representing a common experience, they can all be viewed as expressions of shame. Indeed, the word shame does not capture the many human experiences that are fueled by the emotion of shame. Instead, we use other words (such as: aggression, hurt, pain, acting out, disrespect, humiliation, uncaring, shyness, power struggles, and low self-esteem) to describe them. Yet, all these words are either triggers for or behavioral consequences of the experience of shame. They are all connected with a disruption in the ability to collaborate, an experience of being exposed as inferior, not worthy or uncared for, and they all lead to predictable reactions – blaming the other, blaming ourselves, or withdrawing.

Shame, more than any other emotion gives us the answer to the following question:

> *"Am I important to you?"* (Do I have value? Do you care about me? Do you see me? Do you like what you see?)

When the answer is yes, we experience a range of feelings which contradict, prevent, and oppose shame – a sense of worth, a sense of being loved, a sense of pride, a sense of belonging, and a sense of closeness. When the answer is no, we experience shame – we feel unappreciated, worthless, insignificant, humiliated, and alone.

As adults, we are not supposed to be dependent on the evaluation of others. We are expected to be self-sufficient creatures that can provide for ourselves the approval, admiration, and respect we need. Admitting how important it is for us to be appreciated by others is shameful and often evaluated as childish and needy. Dependence has become a negative word, a pathology, something we fear. Yet, for shame to be regulated, we need others. Tragically, the more shame we have, the more we need others, but are less able to admit it.

Mark Twain has remarked that "In his heart no man respects himself."[1] Occasionally, we all experience shame which leads us to blame, criticize, and dislike ourselves. At such moments, we need others to free us from the shaming process in which we are both perpetrator and victim. We need others to remind us that we are not so awful or complete failures. We need others to reassure us that even if we made a mistake we are still decent human beings and that even if we are not perfect we are still loved.

A Different Kind of Empathy

Carl Rogers was the first great therapist to tackle shame. Although he did not relate to shame directly, it is he, more than any therapist before him, who understood the significance of enabling clients to have a voice – that is, to be able to relate to their experience and to communicate it fully to another person, without being judged. Roger's focus on the self, and on its relationship to itself and others, has led him to develop a radical new model for the therapeutic relationship. In this encounter, the traditional shaming practices of psychoanalysis which were common at the time, namely, the structure of wise Doctor – ignorant patient, blaming patients for not agreeing with the doctor, and basing therapy on interpretations, were revised. Patients became clients, the therapeutic relationship became more equal, the therapist adopted a position of not knowing more than the client and instead of blaming (or interpreting) client's behaviors, clients received empathetic reflections. Since then, empathy became the great antidote for shame, and the empathic climate was shown to be the best environment for exposing the fragile self to the beneficial warmth of others.

[1] *Following the Equator*, Pudd'nhead Wilson's New Calendar.

Indeed, empathy is a powerful force in the amelioration of shame, and yet, it has limits. The leading two are:

- Empathy can increase shame.
- Empathy has little influence on people who are highly avoidant and uncooperative (as a result of too much shame).

Therapists of all orientations discover that approaching high shamed (shame prone) individuals, couples, families, and organizations with classical empathy as a primary tool can lead to failures which intensify the shame in the system. Ironically, empathy can make the shamed person feel worse about himself – his defensive reactions to others' positive and kind gestures only make him look (in his own eyes and in the eyes of others) bad, ungrateful, and mean. In addition, the empathetic attitude also demands exposing one's self, which can easily lead to an intense shame reaction.

Let's look, for example, at a short transcript taken from the first moments of the first session with Mia, an 18-year-old adolescent girl who was referred to our therapy center after two unsuccessful psychotherapies. This is a part of the conversation she had with one of our therapists who is known for her openness and warmth:

Therapist: (warmly, starting with small talk) "Did it take you a long time to get here today with all this rain?"
Mia: "Why do you want to know?"
Therapist: (still pleasantly) "I just hope it didn't take too long, anyway I am glad you are here."
Mia: (silent)
Therapist: (trying to connect) "I heard you have tried therapy twice. Was it hard to come in again?"
Mia: "No."
Therapist: (gives compliment) "I think that coming in again demands courage, I respect that."
Mia: (becoming withdrawn, looking away)
Therapist: (puzzled) "Did I say anything that upset you?"
Mia: (more withdrawn)
Therapist: "We don't need to talk about that."
(Uncomfortable silence)
Therapist: (trying again) "So tell me, how would you like therapy to look this time?"
Mia: (getting angry) "Like nothing."
Therapist: "Nothing?"
Mia: "Yes, is there a problem with that?"
Therapist: "I was just interested in understanding what your expectations…"
Mia: (interrupting) "I have no expectations!"
Therapist: (trying to show empathy) "O.k., that is fair. If I were you, I would probably have no expectations either."
Mia: "Stop thinking you know how I think!"
Therapist: "I am sorry if I offended you…"
Mia: "You didn't offend me. You see? You are doing it again; you think you know who I am!"

The simple empathy-joining strategies failed and the effort to connect with Mia led to more impasse. The same held true for the compliments that caused her to become withdrawn and disconnected. It seems like the process of trying to understand and show compassion toward Mia lead to distress and interruptions in the process of developing a relationship with her. This progression is typical for people referred to as "shame prone," meaning that they can easily experience shame in a very intense and painful way. With such individuals "trying to understand" can generate frustration for all people involved. This, however, does not mean that communication is impossible. Let's look at what happens in the conversation with Mia once the therapist does something else –

Therapist: "You are right, I can see that I was talking as if I know you."
Mia: "So why did you do that???"
Therapist: "I don't know, I guess that sometimes it's helpful."
Mia: "Well it's not helpful for me!"
Therapist: "I get it. Thanks for letting me know; I will try not to do it again."
Mia: "o.k."
Therapist: "o.k."
Mia: (looking for a moment at the therapist, cautiously smiling) "What else did you want us to talk about?"

While the shift the therapist made does not seem dramatic, it leads to a conversation which is of a different quality. What did the therapist change? She stopped interacting in ways which elicit shame and instead acted in ways which reduce shame, in this case admitting her mistakes, admitting her misunderstandings, and giving up the position of being above Mia. The therapist shifted her orientation from what I call a "low shame state" in which shame is regulated, to a "high shame state" in which shame is under regulated. How did she know she had entered into a high shame state? By observing Mia's reactions. In high shame states, questions, reflections, and expectations not only fail to develop a positive rapport (where they would have succeeded in low shame states) but actually promote and propagate an adversarial climate. Once the therapist identified that she had entered into a high shame state dynamic, she did something different. It is empathy, but of a different kind.

The Power of the System

As the example shows, the limits of classical empathy interventions are evident with highly avoidant individuals. For example, children and adolescents who experience high levels of shame and exhibit a range of problems – aggressive behaviors, school refusal, academic failures, and various social problems – are notorious for not responding well to therapy. Actually, many of them will never step into a counseling room, and even when they do, the results are typically counterproductive. They will often be diagnosed as either depressed or as having different oppositional/behavioral problems. The main under-regulated emotion – shame – will not

be addressed directly, and its impact on the child's life will remain misunderstood. With such kids, empathy alone will not help them to escape the shame-avoidance loop that they got caught in. What such kids need is a system to heal their pain. They need others to mirror their abilities, strengths, and hope, and they need the power of their social network (family, community) to shift them from their avoidant position.

Shame is the most public emotion. It is in the presence of other people (real or imagined) that we experience the most shame, and it is with the help of others that we can alleviate our shame. The most important of these others are our family members. Unfortunately, it is often in the family that we do the most shaming and are most often shamed.

In families and other systems (such as school), shame will frequently be addressed under the disguise of disrespect. The more disrespected we feel, the more shame we feel. Actually, many power struggles in families are hidden efforts to regulate shame:

Mother: "David, can you please clean your room."
David: (playing on the computer) "Just a second."
Mother: (5 minutes later, starting to feel disrespected) "I told you to clean your room three times. Can you just go and do it?!"
David: (feeling disrespected) "I told you I will do it. Why do you always have to interrupt me?!"
Mother: "Because you never do anything when you are asked to do it!"
David: "If I never do anything anyway, then I won't do it now either!"

The conversation can continue and escalate in different directions, leading to name calling, punishments, and alienation – actions which will only intensify shame in the system.

Similar dynamics often occur in schools. Teachers and students engage in various power struggles which are fueled by shame, but are viewed as conflicts stemming from disrespect:

Teacher: "Open your notebook please, and copy what I wrote on the blackboard."
Student: (ignores)
Teacher: "Can you please write like the rest of the class?"
Student: "No I can't."
Teacher: "Open your notebook, NOW!"
Student: "You open your notebook!" (Class laughs, teacher feels shame).

While the two examples can be viewed as displays of disrespectful behavior, they can also be seen as efforts to regulate shame. When children experience a demand or command, it immediately makes them feel inferior. Both are unaware of their shame, and do what most of us do when we are shamed – we make the other feel shame. However, in the second example, we see an additional shaming factor. The presence of other students in the class amplifies the shame of the teacher, and it is what makes the student's remark so devastating. The system has the power to reduce shame, and it can also become the leading agent in a shaming process.

The Emotion of Intimacy

Just as shame is the most public emotion, it is also the most private and hidden emotion. When we feel shame, we wish to hide and not be seen. We wish to prevent anyone (including ourselves) from exposing that which is hidden. Yet, the more we try to maintain secrets from ourselves and others – the more we experience shame.

For shame to be regulated, it needs to be exposed. We cannot break out of our shame without allowing ourselves and others to see who we are.

Client: "I need to tell you something, but I also can't tell you."
Therapist: "What will happen if I find out?"

Such discussions are common with people who experience shame. The dilemma of exposing one's self is ever present and needs to be managed constantly.

For relationships to become close, people need to uncover their shame. Confiding feelings of inferiority, failure, unattractiveness, stupidity, or of being "bad" create potentials for successful shame management. When this potential is actualized we experience intimacy. When communicating shame is done in a nonconstructive way – we find ourselves in a fight.

Mirroring All Realities

This book is intended for therapists, counselors, and educators who are involved in regulating the shame of children, parents, couples, and teachers. The importance for addressing shame rests on two basic assumptions: the first is that at the heart of many problems that brought the client/clients to therapy (child acting aggressively, heated escalations between couples, communication problems between parents and teens or between partners, school problems, etc.) lies unregulated shame which leads to intense suffering for the individual and his or her environment. The second assumption holds that most of the disruptions in the therapeutic relationship are shame related. Thus, just as shame plays a dominant role in regulating relationships in the client's life outside therapy it also regulates the quality of the therapeutic relationship. As a result, without the continual regulation of shame in the therapeutic encounter, the most sophisticated and good willed interventions offered to clients are at best used minimally and at worst intensify shame, thus leading to rejection of the interventions and to conflict and resistance in the therapeutic relationship. Interestingly, it is often after shame has been regulated that clients suddenly do not need specific interventions to solve their problems, and rather, without the paralyzing presence of shame, can use their own resources, knowledge, and abilities to find practical solutions to their problems.

In the book, I deal with relationships in different contexts: parents and children, teachers and students, therapists and children or adolescents, and others. Moreover, I often switch from talking about one type of relationship (for example, parent–child) to another (therapist–parents) – this, in order to emphasize the common

processes that shame gives rise to in a variety of relationships. Some chapters, however, focus on the distinctive aspects of regulating shame in specific contexts.

The aim of the approach presented in this book is to provide a therapeutic framework that deals with the two major challenges of shame regulation:

- The challenge of addressing both the individual and relational aspects of shame: while shame is commonly perceived as an extremely private emotion, it is in fact also very public, in that it strongly influences, and is influenced by, the reactions of others. Thus, an effective therapeutic approach needs to combine individual and systemic/relational interventions in a way that both makes sense and feels safe to the client.
- The challenge of adjusting to states of shamelessness and shamefulness: different levels of shame call for different relational strategies. An effective shame-regulation approach needs to respond flexibly to the varying intensities of shame, while maintaining therapeutic integrity and cohesion. This means that, in some cases, the therapist's goal is to reduce shame while in others to increase it.

To meet these challenges, I have integrated and further expanded two highly effective therapeutic models: a parent training model and a couple therapy model – namely, Nonviolent Resistance (NVR) and Collaborative Couple Therapy (CCT), respectively. These I tailored to working with children and adolescents. While neither approach puts shame at the center of attention, both contain powerful interventions for the regulation of this emotion.

NVR (Omer 2004) is a parent-training approach originally developed by Haim Omer for empowering parents and reducing acting-out behaviors in children. One of Omer's great achievements was constructing a powerful therapeutic model that is not dependent on the child's collaboration for success and which leads ultimately to much more cooperative and respectful family dynamics. I have been implementing this model in therapy from its inception and found that its various interventions are effective in regulating shame in both parents and their children. Instead of escalating nonconstructive behaviors when experiencing disappointment, disrespect, and disconnection (all triggers of shame), family members showed higher levels of self-control and an improved ability to communicate with each other – even though they were not coached in communication strategies! Even more fascinating were my experiences with what are called "public opinion" interventions. In these interventions, the child's or adolescent's aggressive behaviors are publicized and lead to the involvement of other people from the social network. Colleagues hearing about these interventions would often protest "but you are shaming the child!" At first I didn't know how to respond to their objections. Yet now, after 15 years of practicing this type of therapy, I understand that the critics were right in addressing the presence of shame in the intervention, but had got it all wrong regarding the effects of the intervention. As a result of experiencing the interventions, the children's shame did not increase; it had actually become regulated: they became more willing to accept criticism and admit to their mistakes, they became closer to their families and were willing to do things which they had avoided earlier such as school work, household chores, and spending time with their families to name a few.

My approach to regulating shame is also inspired and deeply influenced by Dan Wile's Collaborative Couples Therapy (Wile 1993, 2008). Whereas Wile's therapeutic model addresses the entire spectrum of emotions, one can treat his books as manuals for shame regulation in working with couples. From the CCT model, I have adopted the principle that assigns great importance to fostering a collaborative attitude as the main vehicle for regulating shame reactions. I have also followed Wile's unique style of regulating communication in the therapy room and have tried to emulate his way of simultaneously addressing private, interpersonal, and systemic aspects of emotional dysregulation. I have worked intensively with the CCT model in the last 10 years and expanded it to assist children and their families. My experience has convinced me that the most efficacious format for conducting shame regulation therapy is the "triangle," that is, the presence of three people in the therapy room: therapist, parent, and child; therapist and two siblings or therapist with two parents.

The Structure of the Book

The book comprises two parts. The first, "Understanding Shame," describes some of the major dynamics of shame. I do not intend this part to provide a comprehensive overview of shame experiences, as many other books have done this sufficiently. Rather, I focus on the practical aspects related to the process of shame regulation in therapy.

Chapter 1, "Opening our Eyes," describes some of the basic shame experiences in children and their families. Using the biblical story of the Garden of Eden as a background, I present an introduction to the emotion of shame, elaborating when and why people experience shame and how it affects them.

Chapter 2, "Fighting with Shame," describes the main ways in which shame influences and is influenced by relationships. In this chapter, I focus on two predominant effects of shame on relationships – attacking and withdrawing. I show how easy it is to succumb to these dynamics and suggest practical means of extricating oneself from them.

Chapter 3, "Communicating with Shame: Monitoring the Presence of Shame in Conversations," discusses how shame disrupts interpersonal communication and how it can provide clues about important (unresolved) issues in a relationship.

The Second part of the book, "Regulating Shame," details specific interventions for regulating shame in individuals, as well as within families and schools.

In Chapter 4, "Systemic Mirroring: A Model for Shame Regulation," I describe my main intervention for shame management – the Systemic Mirroring intervention.

In Chapter 5, "Regulating the Shame of Parents: Helping Them to Become the Best Team They Can Be," I present an integrated parent–couple approach aimed at transforming parental fights fueled by shame into constructive and intimate conversations, thus helping both parents to become a highly effective shame-regulating team.

Chapter 6, "Regulating Intense Shame of Non-Cooperative Adolescents: When Dialogue Breaks Down," focuses on interventions for shame management when the main shame-afflicted person is unwilling (or unable) to cooperate. In this chapter, I present interventions for dealing with the state of shamelessness.

Chapter 7, "Regulating Shame in Schools: All You Need Is Respect," is the last chapter in the book. Here I address the dynamics of shame regulation between teachers and students, and between teachers and parents in the school environment.

The basic tenet of the approach presented in this book is that shame is best regulated through specialized conversations that elicit openness, vulnerability, and ultimately intimacy. Accordingly, throughout the book, I present short verbal exchanges to model "how it is done." At the same time, I also address the limitations of regulating others' and our own shame. I believe that understanding these limitations (instead of trying to be perfect/god like) allows us to accept our and others' imperfections.

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