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When Shame Becomes Part of the Self: How Chronic Shame Shapes Personality

Nadia Kruszyńska, Ph.D. Pysch.[1], Alicja Dominiak, M.Sc.[2]

[1] Centre for Support and Psychotraumatology Karol Marcinkowski University of Medical Sciences in Poznań
ORCID: 0000-0002-8860-1139

[2] Centre for Support and Psychotraumatology Karol Marcinkowski University of Medical Sciences in Poznań
ORCID: 0009-0003-8358-5189

Abstract

This article explores the origins and significance of shame from both developmental and relational perspectives within medical and psychotherapeutic contexts. Shame deeply embeds itself in one's personality and can influence various aspects of human behavior. Approaches to tackling and managing a patient's shame differ based on their background and specific issues. A doctor's strategy in a single patient encounter will differ significantly from the long-term approach taken in psychotherapy. The authors highlight the psychological intricacies of shame and present various methods for addressing it in therapeutic settings.

Keywords: shame, doctor-patient relationship, psychotherapy, personality psychology

Introduction

In an interview for the book *Czując* [Feeling] by Agnieszka Jucewicz (2019), Anna Król-Kuczkowska recounts a story about a lecturer who, after delivering one of his early talks on shame, was advised by a colleague to change his focus. The colleague said, "That's all well and good, but why not choose another topic? Shame won't advance your academic career" (Jucewicz, 2019). Lewis offers further insight into the discomfort of experiencing shame. She suggests that shame is contagious and that, just as those who experience shame are inclined to conceal it, observers of shame often have a natural tendency to turn away from it (Lewis, 1971). Interestingly, this creates an opportunity to research this emotion, its significance, and its impact on all of us. Although experiencing shame

is common, its effects on human health and well-being have only recently begun to be explored in depth by scientists.

Mentions of shame appear in the diagnostic criteria for post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) in the American Psychiatric Association's DSM-V, classified under persistent negative emotional states, and in the ICD-11 classification (Taylor, 2015, as cited in Dolezal & Gibson, 2022). This recognition highlights the role of shame among the emotions (such as fear, terror, anger, and guilt) that individuals experience due to trauma. Its significance has become a key factor in the success of treatment and has extended beyond theoretical discussions in psychotherapy to being included in medical diagnostic manuals (Dolezal & Gibson, 2022).

A review of the literature and empirical research on shame indicates that this emotion is often considered a co-occurring or mediating factor in the development of psychological difficulties. For instance, studies have explored shame in relation to attitudes toward sexual identity, internalized homophobia, and membership in marginalized sexual minority groups (McDermott, Roen, & Scourfield, 2008; Singer, 2013; Brown & Trevethan, 2010). Other research has examined the link between shame and eating disorders (Keith & Gillanders, 2009; O'Loghlen, Grant, & Galligan, 2022; Wong & Qian, 2016), self-harming behaviors (McDonald, O'Brien, & Jackson, 2007; Sheehy et al., 2019), and PTSD or complex PTSD (Lee, Scragg, & Turner, 2001; Saraiya & Lopez-Castro, 2016; Wong & Cook, 1992).

These examples demonstrate that shame frequently appears in psychopathology studies as a co-occurring or mediating factor. However, investigating shame as a variable that influences the structure of human personality remains challenging, likely due to the difficulties in methodologically defining and measuring shame.

Shame in a developmental perspective

Erik Erikson (1950), a pioneering psychologist in human development, identified the genesis of shame in the second of his eight stages of psychosocial development, occurring around age 2. After resolving the initial crisis of developing basic trust in themselves and others, children encounter the next developmental challenge centered on autonomy versus shame and doubt.

During this phase, children begin to develop self-awareness and navigate issues related to boundaries, differentiation, and early mastery of their bodily functions, including physiological needs. This stage is marked by a fascination with self-discovery and bodily control, alongside a heightened sensitivity to unclear boundaries, confusion, and setbacks. The way caregivers and the community respond to a child's assertions of independence and the challenges of toilet training plays a crucial role in shaping their sense of autonomy and potential feelings of shame.

Using a developmental perspective, Erikson highlighted the crucial role of parents in shaping their children's sense of self-worth. Parents who use control, punishment, and shaming can inadvertently instill feelings of worthlessness and submissiveness in their children. As these children grow into adulthood, they are likely to perpetuate this cycle of shame with their own offspring. By inducing feelings of guilt and contempt in their children, they attempt to avoid the sense of failure they associate with parenting and protect themselves from re-experiencing the shame rooted in their own childhoods. Thus, the cycle of shame continues, now repeated by the former children in their new role as parents.

Erikson's theory sheds light on how negative experiences of shame in early childhood can have long-lasting effects. He links feelings of shame and doubt with struggles for autonomy – like the "terrible twos," where toddlers push for independence and express their separateness. According to Erikson, these early experiences of shame are ingrained in the very pre-verbal stages of self-formation. When children successfully navigate these early struggles for autonomy, they develop a strong and coherent sense of self. However, if they face intrusive parenting and shaming as a means of control, they might grow up feeling deeply insecure, inadequate, or defective, which can then interfere with their ability to take initiative, feel competent, or build healthy relationships in later stages of development.

The significance of shame

Shame is a ubiquitous human experience that affects interpersonal relationships. It shapes our self-perception, self-esteem, identity, ability to form and sustain relationships, and social standing. Concurrently, shame is intricately linked to mechanisms of social control and power dynamics, delineating the boundaries of what is deemed normative and acceptable within a society and culture versus what is not (Dolezal & Gibson, 2022). Generally understood as an aversive emotion, shame emerges from concerns regarding others' perceptions and judgments. Individuals experience shame when they perceive themselves as being seen by others – whether those others are physically present, imagined, or internalized – as flawed, or when aspects of their self are viewed as inadequate, inappropriate, or immoral.

Shame overlaps with other emotions like embarrassment, bitterness, excessive worry, and humiliation. It often serves as an umbrella term that encompasses a variety of feelings, including "feelings of being slighted, insulted, disrespected, dishonored, disgraced, disdained, demeaned, slandered, treated with contempt, ridiculed, teased, taunted, mocked, rejected, defeated, subjected to indignity or ignominy; feelings of inferiority, inadequacy, incompetence; feelings of being weak, ugly, ignorant, or poor; of being a failure, 'losing face,' and being treated as if you were insignificant, unimportant, or worthless" (Gilligan, 2003). Fossum and Mason describe shame as "an inner sense

of being completely diminished or insufficient as a person. It is the self, judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being" (Cornell, 1994). What all these experiences have in common is the feeling of being negatively judged by others and the sense of being of less worth than others.

On the other hand, while shame is an unpleasant experience, it is also an inevitable and necessary part of human life. Shame can foster adaptive and desirable qualities such as modesty, humility, gratitude, and respect for oneself and others. Anna Król Kuczkowska (as cited in Jucewicz, 2019) refers to this as healthy shame, explaining that "some degree of susceptibility to feeling shame indicates our maturity, sense of responsibility, boundaries, and intimacy. If you were changing your clothes in the bathroom and a stranger walked in, you would be embarrassed rather than say: Please come in. Perhaps you would like to watch?"

This healthy, adaptive shame can drive personal growth and change, and help individuals form harmonious and meaningful relationships with others (Dolezal, Gibson, 2022). It plays an adaptive role by protecting against the overexposure of certain aspects of the self. In a medical context, a patient's shame is understandable because they reveal to a doctor or psychotherapist parts of themselves that they do not show to others, even in intimate relationships.

According to the *Dictionary of the Polish Language* (2024), shame is defined as "an unpleasant feeling caused by awareness of wrongdoing, … usually combined with fear of losing one's good reputation." Interestingly, the Polish word *srom* [vulva], aside from its anatomical meaning (referring to the external genital organs of women and female mammals), was once used as a synonym for shame, disgrace, and failure. This linguistic connection adds a layer of negativity to nudity and carnality, especially in a sexual context. For example, a nurse in a gynecology ward might tell a patient to "please cover your shame." In this context, the protective aspect of shame becomes blurred.

The significance of chronic shame

"Healthy shame," which has the potential to protect relationships and support personal growth, can easily become distorted and turn into "unhealthy," "toxic," or "destructive" shame (Sanderson, 2015). Toxic shame, according to Sanderson, "paradoxically severs connections, destroys social bonds and can lead to antisocial behaviour." John Bradshaw adds that "shame as a healthy human emotion can be transformed into shame as a state of being … [which] is to believe that one's being is flawed, that one is defective as a human being. [Shame] becomes toxic and dehumanizing" (Bradshaw, 2005).

This kind of shame evolves into a deep-seated sense of inferiority, inadequacy, and defectiveness, coupled with the belief that one does not deserve love or relationships. It becomes a chronic experience that distorts one's sense of self, life, the world, and others, profoundly affecting the individual's life chances. This is consistent with Goldberg's (1991) distinction, which clearly separates guilt ("How could I have done **THAT**?") from shame ("How could I have done that?"). This shift focuses on the person rather than the act, effectively preventing the reparative and restorative measures typically involved with guilt.

Patricia DeYoung (2015) offers another definition of "chronic shame" as the "an experience of one's felt sense of self disintegrating in relation to a dysregulating other." This perspective centers on the relational aspect of shame, emphasizing that shame requires a spectator (whether real, imagined, or internalized) who fails to emotionally mirror the person in an attuned way, instead intensifying the shame with their reaction. This often leads to a desire to hide, disappear, or psychologically "sink into the ground."

This understanding of chronic shame is in keeping with the psychoanalytic view that links early failures in primary relationships – specifically, a lack of parental mirroring and empathic attunement – with present experiences of shame, often marked by a sense of "ruptures in interpersonal bridges" (Lewis, 1971; Kaufman, 1988).

Where does shame hide?

In English-language literature, shame is often described as "hiding in plain sight," which seems to perfectly capture its essence. Patients who seek help from specialists, like psychotherapists, rarely discuss overwhelming shame during initial consultations. Instead, they talk about issues related to self-esteem, low self-worth, and a persistent sense of being damaged or defective. Others focus on relationship difficulties, such as dissatisfaction, unfulfillment in romantic relationships, a lack of respect from their partner, or embarrassment in situations involving sexual intimacy. Some patients also report experiences of abuse and exploitation.

What these various stories and reasons for seeking therapy have in common is the unspoken shame that hides within them, manifesting as symptoms that cause discomfort and distress. As patients build a therapeutic relationship and develop trust and a sense of security, they often gain a deeper understanding of the meaning and function of their symptoms and realize that their past relational experiences share common themes.

Cornell (1994) describes shame as fundamentally feeling invisible. This extends beyond a lack of empathy or parental mirroring to a point where the child feels they hold no real meaning or interest to the parent, except in fulfilling the parent's own desires and fantasies. Many clients express a deep-seated belief that there is something inherently wrong with them, with one client notably stating that they never felt a sense of belonging.

For these individuals, their childhood and adolescence seems irrelevant to one or both parents, resulting in a lack of any external validation of their internal experiences. These people often retreat into fantasies, books, and isolated thought processes. They maintain a sense of internal coherence and security only through isolation, internalizing a belief that they are uninteresting to others. Despite being deeply interested in the world and other people, they do not expect their interest to be reciprocated. Over time, this accumulated lack of validation erodes their sense of self and leaves them with a persistent feeling of inadequacy (Cornell, 1994, p. 8).

As mentioned earlier, shame is often a pre-verbal experience that does not initially lend itself to verbal labeling (Park & Shields, 2023; Hill, 2015). In psychotherapy, especially in the early stages, shame often manifests as a bodily experience triggered by the autonomic nervous system. During these moments, patients may blush, sweat, and feel agitated, expressing their discomfort through actions like wriggling, squirming in their chairs, fidgeting, or having a distracted gaze. Their body language often includes a bowed head, closed eyes, and a body collapsed inward, as if trying to become as small and invisible as possible (Lewis, 1971). At these stages, it is crucial to connect this bodily experience with feelings, thoughts, and behaviors with due sensitivity. This helps to bring the "spilled" bodily experience into states of consciousness where it can be operationalized, labeled, and experienced differently from the initial context.

Shame often hides behind silence. These are the moments in therapy when patients become silent, avoid eye contact, lower their voice, do not respond, or try to change the subject. Silence then becomes a moment in the therapeutic relationship where the patient recreates the experience of not being accepted, feeling scorned, and reliving their past interactions with others. As Cornell (1994) mentioned in a conversation with Lynn Hawker, "I don't think you emphasized enough the silence of shame. The silence keeps the person from telling anyone that they feel shamed, or why and when one feels shamed or embarrassed … one becomes more careful, withdrawn, and covered. You would think that with growing trust, communication, and closeness between therapist and client, some of these issues would finally surface. Not so" (Lynn Hawker, Personal Communication, December 1989).

Psychotherapy has the privilege of allowing ample time and space to work on shame. In a medical context, however, it is vital to sensitize doctors to the multidimensional and deeply destructive nature of chronic shame, as well as the vulnerability to re-traumatization in patients who have experienced humiliation in close relationships. The doctor's role is not to analyze the causes of the patient's shame but to understand its complexity and empathetically acknowledge the patient's difficulty in opening up. For example, a doctor might say to a patient with a ruptured hemorrhoid, "I understand that this is not easy for you to talk about. I respect your willingness to share your concerns, and I will do my best to make you comfortable during the examination."

Recommendations for therapy

In the doctor–patient relationship, it is crucial to develop empathetic understanding, engage in self-reflection on shame, and use language that facilitates communication and eases patients' feelings of shame. In turn, psychotherapists must carefully and consistently engage with patients, providing time, attention, sympathetic interest, and a safe environment. This support helps patients gradually stop trying to prove their worth and avoid experiencing shame. Instead, they can find their voice, recognize their value, and gain a clearer perspective on themselves, which will allow them to create meaning in a narrative that is free of "shaming others." As Cornell (1994, p. 10) notes, "This is quiet work, more often marked by depth of understanding than intensity of expression."

Including group therapy alongside individual treatment can be particularly valuable. Group therapy provides a sense of belonging and a space to talk about oneself, breaking the common rule from shame-based homes that forbids discussing shame. Being listened to, noticed accepted with respect, and made to feel important in a group setting can offer a powerful corrective emotional experience in healing chronic shame.

Kaufman (1988) emphasizes that it is essential for the therapist to genuinely care about the client. For effective restoration to take place, the therapist–client relationship must be authentic, honest, and mutually desired. A secure relationship fosters growth. The increased anxiety that comes with self-exploration and facing dynamic conflicts can only be effectively experienced, understood, and managed within a secure relationship. The therapist and client's joint approach to these conflicts creates this anxiety, and their mutual confrontation of conflict deepens their relationship further. Dependency on the therapist often develops, and this dependency can be permitted without being encouraged. Allowing this dependency and identification, when needed by the client, provides the necessary support, strength, and healing for the wounded or insecure aspects of the self (1998, pp. 120–121).

Conclusion

Given the sensitivity and complexity of how shame affects patients' functioning, along with the societal taboo against discussing it, the authors believe that it is important to discuss the practical approach to chronic shame in doctors' daily interactions with patients. They also aim to demonstrate the potential for deep psychotherapeutic work in treating this condition.

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