Chronic Shame and Spiritual Care

Exploring the position of *chronic shame* within spiritual care in the Netherlands

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0 Foreword

When I discovered what I wanted to write my master-thesis about, I somewhat understood that having a personal relation to the topic is both a blessing and a curse, both for various reasons. Reflecting on it, this thesis is not just written about shame but also ´by´ it. On the one hand, I felt encouraged enough to share and work on supporting something important, yet on the other, there is the dormant anxiety of underachieving and failing to live up to certain standards. All in all, I did not foresee what this project would reveal about myself, how it exactly would change me, what it has learned me about spiritual care, and what insights it gave me about the human condition. What I especially failed to predict was how the topic would spark the interest of many people around me, and even less so that it would lead to the many profound and insightful conversations I've had ever since.

I am grateful for the contribution of the participants, for besides the admiration I felt when listening to the attention and care with which they handle their clients and students, the participants took the time to tell their stories and share their curiosity, experience, and wisdom. By providing their unique stories, the participants are responsible for the quality and substance of the thesis. Anja Visser couldn't provide a better context to work in, and she helped me to make it to the end. Her enthusiasm and expertise, and her patience, and understanding made the process lighter when it could be deeply distressing. I want to thank Hanneke Muthert as well, for the feedback which not only proved very valuable but also encouraged me to finish the thesis. Last but certainly not least, I want to thank Hanna, Lara, Kevin, and Doris for their help and trust in me and this thesis, and their insightful reflections along the way.

1 Introduction

The study aims to explore the current understanding of chronic shame among spiritual counselors in the Netherlands. Although an understanding of chronic shame has proved highly relevant within psychology concerning different aspects of therapy, therapeutic relationships, the client, and the therapist himself, the relevance of chronic shame within the Dutch field of spiritual care is unclear and therefore exploration of the subject is required. Currently, it is unclear in what way the spiritual counselors themselves and by extension the field of spiritual care benefit from an understanding of chronic shame. Therefore a preliminary literature study was done which shows different relations between chronic shame and spiritual care that may contribute to supporting the relevance of chronic shame in the field.

Reviewing the literature on the understanding of chronic shame within Dutch spiritual care was attempted in several ways. One way was to look for articles or books originating from Dutch spiritual care about chronic shame, and another was to look for any research on the relation between the two within The Netherlands. Despite many attempts, this proved unsuccessful throughout the entire course of the research. Since no direct sources could be found addressing how spiritual counselors in the Netherlands relate to chronic shame, no information was gathered on how they understand or deal with it. So there was a gap in the literature and thus no insight into the relationship between chronic shame and Dutch spiritual care.

By interviewing Dutch spiritual counselors on chronic shame and reviewing it through the theoretical framework, the research attempts to contribute to several debates concerning different aspects of the profession. Through the interdisciplinary exploration of chronic shame and spiritual care, it is probed whether this niche may provide preliminary insight into future opportunities for improving the field of spiritual care in The Netherlands.

The motivation for writing the thesis is most accurately illustrated in the following story. During the internship to become a spiritual counselor, I experienced several long and intense periods of anxiety. Whether during casual coffee breaks in a residential living room, when the supervisor asked about my feelings on what happened between another student and me, or when I was writing something that would be reviewed, anxiety was roaring down almost any other feeling. I was also occasionally shocked when I noticed an extremely punitive, harsh, and demanding tone with which I was talking to myself, sometimes for multiple days. Although I finished my internship, and we addressed social anxiety, low self-esteem, perfectionism, and isolation, it felt as if I was still missing a large piece of the puzzle.

During the summer break, I came across the term existential guilt, which someone feels when '[…] he injures an order of the human world whose foundations he knows and recognizes as those of his own existence and of all common human existence'.[1] I was somehow deeply moved by this description, which made me reflect on it. Shortly thereafter, I read 'Shame is the part of us that feels beaten up by the inner critic, accepting what it says as true and believing that we are unworthy, not enough, too much, fundamentally broken, and maybe better off dead'.[2] Feeling even more understood than before, I continued reading and came across chronic shame. After a while, I started to wonder what would've changed if I had learned about chronic shame earlier, during, or perhaps even before my internship.

[1] Buber, *The Knowledge of Man*, 165.
[2] Fern, *Polysecure: Attachment, Trauma and Consensual Nonmonogamy*.

1.1 Research question

The research question central to this thesis is: "What is the current understanding of chronic shame among spiritual counselors in the Netherlands and to what extend is there a foundation for furthering the understanding of chronic shame and its implications for specific aspects of spiritual care?" To properly answer this question the research question is divided into the following sub-questions:

I. What is chronic shame?
II. What are the prevalent perspectives within the literature on the role of chronic shame in clinical practices?
III. How does chronic shame relate to spiritual care specifically?
IV. What are the experiences and perceptions of Dutch spiritual counselors regarding shame in their practice?

I, II, and III are answered by constructing a theoretical framework through an extensive literature review, and IV is answered by conducting in-depth interviews. The sections '…to what extent there is a foundation for furthering the understanding of chronic shame…' and '…its implications for specific aspects of spiritual care', are both answered by comparing particular aspects within I, II, and III to those within IV, and then documenting the differences between them. By establishing the relevance of answering both I 'What is chronic shame?' and II '…the role of chronic shame in the clinical practice', and III on how does '…chronic shame relate to spiritual care…', as well as IV 'What are the experiences and perceptions of Dutch spiritual counselors regarding shame in their practice', the comparison of I, II, and III taken together and then compared with IV may provide insight in the need for furthering the understanding of chronic shame, as well as insight in what specific aspects of spiritual care are affected by this.

2 Method

2.1 Research design

John Creswell and J. David Creswell write in *Research Design Qualitative, Quantitative, and Mixed Methods Approaches* (2018) that research ought to involve alongside its strategy of inquiry and research methods an intersection with a philosophical worldview as well. This thesis includes a *social constructivist worldview* because the definition of chronic shame and other concepts in this thesis is developed through the subjective meaning of the participants, as well as definitions within the theoretical framework. This research tries to make sense of the meaning that is given by other researchers and by the participants, to develop new and different patterns of meaning about it.[3]

This is qualitative research, with a phenomenological design of inquiry. Qualitative, because to answer the research question an approach is needed that explores the understanding and meaning individual spiritual counselors ascribe to chronic shame which is data that cannot be quantified.

The question of the current understanding of chronic shame is partially answered by defining chronic shame, done so through extensive theoretical research presented in chapters 3 and 4. Chapter 5 presents what spiritual care is and the spiritual counselor does. From the theoretical research, interview questions were devised to frame and analyze the understanding of chronic shame, answered in chapter 6. This was done in such a way that qualitative evidence of all possible outlooks and theoretical frameworks of chronic shame was gathered.

2.2 Data collection

The qualitative data was gathered by conducting in-depth semi-structured interviews (Appendix II: Interview guide). The interview questions were built up in such a way, that first a general idea of the presence of chronic shame was explored. To get an open response to "chronic shame" as a term, a basic outline of the theoretical idea of chronic shame as such and a definition were shared with the participants, before their consent in participating in the study (Appendix III: Additional information). This was done to rule out an initial response of recognition with common notions of regular shame (3.1), or other possibly preconceived notions and interpretations of the words 'chronic' and 'shame' that was not in line with the definition used in this study.

After the broad and open introductory question, questions were asked to the participants which they were free to share their ideas on the topic before further knowledge. Then, more specific questions were asked, to define the level of understanding of chronic shame, the potential overlap of knowledge and understanding of other related phenomena, and possibly related general knowledge that the participant might have in this area. The participant was encouraged to freely elaborate or adapt and frame in their own words what their experience and knowledge in this area entailed.

To find what aspects of spiritual care are related to chronic shame and how the understanding of chronic shame may influence those areas, the participants were asked theory-specific questions about competencies and other aspects of spiritual care possibly affected by chronic shame. Furthermore, they were asked to share additional perspectives they might have

[3] Creswell and Creswell, *Research Design: Qualitative, Quantitative Adn Mixed Methods Approaches*, 53:44.

on aspects of their discipline related to chronic shame and how these are potentially affected by it.

2.3 Data recording and processing

To collect and record the data, six of seven participants were interviewed online and one was interviewed in real-life. All the participants were recorded and the interviews were transcribed afterward, which can be found in 'Appendix I: interviews'. The data was coded using the coding software Atlas.ti. After this, a selection was made using thematic analysis (2.4).

2.4 Data analysis

The data is analyzed inductively, which means patterns, categories, and themes are formed by moving from data to themes and vice versa. The analytical process and its different phases are based on *Thematic Analysis: A Practical Guide* (2021) by Virginia Braun and Victoria Clarke. The data is also analyzed deductively because the data is repeatedly approached through the established themes to further support them.[4] By iteratively moving between the database and the set of themes, a comprehensive set was established regarding the different aspects of spiritual care affected by chronic shame. The data was repeatedly evaluated through those themes attempting to support them with more evidence or to acquire extra information.

2.5 Participants

Spiritual care is an expansive field including many different backgrounds, religions, educations, and life philosophies. To gain insight into the field of spiritual care in the broadest possible way, and research the subject in the best possible manner, a range of participants was selected to cover a large area within each characteristic. This includes topography, years of experience in the field, work field, and university. Spiritual counselors from a large range of denominations were approached, of which Humanists, Buddhists, and one with 'no specified denomination' replied. Exclusion criteria were 'no experience as a spiritual counselor' and 'no experience with teaching spiritual counselors'. Spiritual counselors with different denominations were approached. However, spiritual counselors with a Christian denomination were excluded. After extensive research of theological and Christian perspectives on shame, it was decided that, given the constraints of this project, interviewing spiritual counselors that might already have a specific theological framework or background within which they understand shame, provided too great of a risk in perhaps not serving the purposes of this study.

Due to the limitations of this research, the choice was made to focus on academically affiliated participants. It provided less of a challenge to approach them and helped avoided creating large variables within the educational background of the participants.

Spiritual counselors with a teaching position at university within the field of spiritual care were the preferred candidates for this study because of their presumably closer involvement with (novel) theories, ideas, and educational methods and programs within the field. Although there are probably many valuable sources of new ideas and theories within

[4] Braun and Clarke, *Thematic Analysis: A Practical Guide*.

spiritual care, there is no clear indication as to where theoretical knowledge is more prevalent or further developed somewhere else.

Name	Denomination	Experience (years)	Current occupation
Bas	Buddhist	<5	Spiritual counselor
Kees	Buddhist	>15	Spiritual counselor
Julia	Humanist	>20	Spiritual counselor, supervisor
Linda	Humanist	<5	Spiritual counselor, teacher
Monique	Humanist	>10	Spiritual counselor, teacher
Sandra	Humanist	<5	teacher/educator, supervisor, researcher
Nicole	No denomination	>15	Spiritual counselor, Researcher

Table 2.1

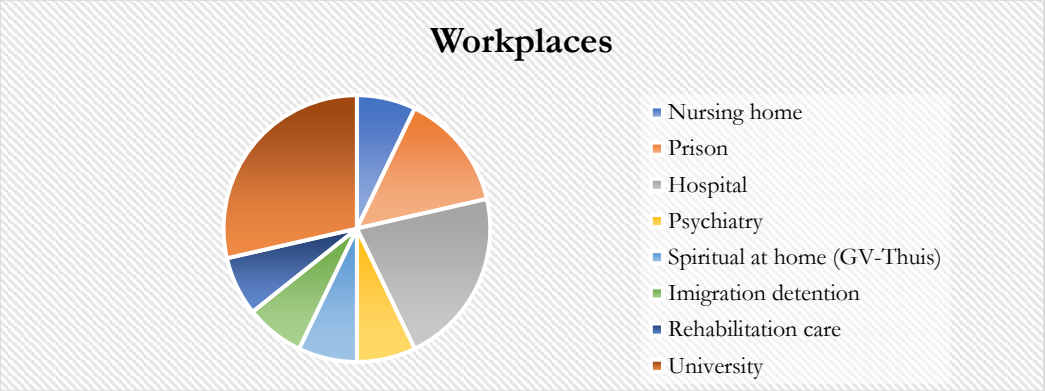

Figure 1

2.6 Ethical considerations

All the participants were informed about the central topic of the study and its purpose. Both on the consent form they were given as well as during the start of the interview, it was explained that the personal information shared about themselves and others was handled, stored, and processed under the scientific RUG GGW guidelines (further explained in on the consent form). They were also informed that talking about shame can cause difficult emotions and feelings to arise, for example, shame itself (4.2.2) and that they are allowed to stop and leave at any time (Appendix IV: Consent-form). The participants were asked to sign the consent form provided they have read it completely as well as the additional information (Appendix III: Additional information), that were informed correctly about their rights, and that they voluntarily agree to be recorded. The participants were told they were not allowed to partake in the interview any further if they didn't sign it immediately.

The interviews started with an additional remark explaining that the information is transcribed and anonymized in several ways (which will not be disclosed here). However, it is not always clear what details of themselves, others, or their stories, are considered sensitive. Therefore, the participants were told about this issue up front and were asked to pay attention to it and warn about this if needed, and that the researcher would do this as well. They were asked about this again at the end of the interview, and also what specific details should be changed and in what way, or to be left out entirely. For some participants, the choice was made to exclude certain information entirely, for it was considered too sensitive.

3 Chronic shame

The purpose of this chapter is to answer the question "What is chronic shame?", which will be used in the following chapter to explore its role within the clinical practice. This question is fundamental to answering all the different aspects of the research question. First, paragraph 3.1 will be used to explain what ordinary shame is and how it develops. Then in 3.2, it will be explained what chronic shame is, and in 3.3 how it develops.

3.1 Shame

3.1.1 Situational shame

Before discussing chronic shame, it is important to shed light on shame in the basic sense. In their book *Shame in the Therapy Hour* (2011), Ronda Dearing and June Tangney introduce shame as a common yet painful emotion that arises when someone experiences that he or she violated a norm or rule, or committed an offense.[5] In his book *The Soul of Shame: Retelling the Stories We Believe About Ourselves* (2015), Curt Thompson draws from the studies of neuropsychology and says shame is activated for example due to a corrective remark of a parent or another authority, activating the *in-the-moment shame* by a series of physiologic events.[6] Jonathan Hooton, In the article 'Shame: An Existential Wound', published in *The Knowing Field* (Volume 1, Number 34, 2019), states that shame is not considered to be merely a cognitive response, but a biologically hardwired experience of the nervous system below conscious awareness, which triggers a range of external and internal effects. Although it doesn't serve the purposes of this thesis to discuss the neurological mechanisms of shame, they do take a dominant role in both Thompson's book and Patricia DeYoung's *Understanding and Treating Chronic Shame* (2015), which is often used in this thesis. The sense of shame causes behaviors such as a slumped posture, a lowered head, the need to cover the face, and blushing.[7] The eyes are closed or averted and the shoulders are rolled forward and inward[8]. Internally, one becomes extremely self-conscious and feels the need to hide, sink through the floor, or disappear.[9] A severe shame response may even lead to a loss of coordination and cognition.[10]

Shame is generally believed to have a social function. Paul Gilbert for example writes in the chapter 'Shame in Psychotherapy and the Role of Compassion-Focussed Therapy,' in *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011) that, from an evolutionary perspective, the shame dynamic can be explained and understood as such because our relationship to others plays a crucial role in survival and reproduction.[11] Expressing and observing emotions is part of our innate tendency to carefully observe how we exist in the minds of others, which is important because it tells us whether we are safe or under threat within our social network.[12] DeYoung says in Understanding and Treating Chronic Shame that, in the case of shame, its visible aspects are linked to communicating a submissive stance that once served social positioning and ideally the safety of the group[13].

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[5] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 4.
[6] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 54.
[7] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 5.
[8] Hooton, Knowing, and June, "Shame: An Existential Wound," 30.
[9] Hooton, Knowing, and June, 30.
[10] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 39.
[11] Gilbert, "Shame in Psychotherapy and the Role of Compassion Focussed Therapy," 327.
[12] Gilbert, 327.
[13] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 5.

In their chapter 'Introduction: Putting Shame in Context', also from *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), Ronda Dearing and June Tangney, claim the social function of shame can further be understood when it is regarded as a moral emotion, due to its power to debilitate someone when they are performing acts that are considered to be socially undesirable.[14] Anthony Friel, in his article 'What detoxifies shame in integrative psychotherapy?', published in the *British Journal of Psychotherapy* (Volume 32, number 4, 2016), concludes from his study that shame is about forming a cognitive structure that functions as a boundary system in which we can operate. When we break a rule or transgress a standard, shame acts as a boundary phenomenon reminding us of our limitations and finiteness.[15] Similarly, John Bradshaw says in his book *Healing the Shame That Binds You* (1988) (which was chosen for this thesis because of its remarkable descriptions), says that healthy shame signals our essential human limitation and can be understood as an emotion that is the foundation of humility; it lets us know that we are not God,[16] but provides us instead with the permission to be human.[17] This adaptive shame goes by many names. In her book *Counseling Skills for Working with Shame* (2015), Christiane Sanderson calls it *conscious* shame, because of the property of shame of being bearable enough to remain in conscious experience.[18] Bradshaw calls it both healthy and nourishing shame because the same phenomena that bounds and limit us, also help us to understand we cannot know everything and therefore motivates us to seek and learn new things.[19] Dearing and Tangney in 'Introduction' add that it is in-the-moment shame,[20] for the same reason it is called situational shame by Norman Epstein and Mariana Falconier in their chapter 'Shame in Couple Therapy: Helping to Heal the Intimacy Bond' from *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), which is that they both point toward shame being a momentary reaction to a problem in the here-and-now, which is how shame is commonly experienced.[21] Although all these properties may appear to point towards different types of shame, the different names mainly signify the focus on a certain aspect of the same phenomenon. Some are genuinely critical if shame is ever truly adaptive, however. To Andrew Morrison for example, in his chapter 'The Psychodynamics of Shame', also from *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), shame is extremely painful, and is only considered helpful or adaptive because it can be resolved. He argues that whatever useful outcome shame may have, is just as well achieved with self-awareness, but then without the painful aspects of it.[22]

3.1.2 Development of situational shame

Alan Schore's *Affect Dysregulation and Disorders of the Self* (2003) is often referred to by shame experts when the developmental origins and underlying mechanisms of shame are addressed. Schore, who is a psychologist and a researcher in neuropsychology, incorporates biological, psychological, and social sciences in his book to present theory rooted in research. He approaches shame from a neuropsychological perspective and describes shame as a neural mechanism that is capable of regulating heightened positive effects to socialize the child. By

[14] Dearing and Tangney, 5.
[15] Anthony Friel, "What Detoxifies Shame in Integrative Psychotherapy? An Interpretative Phenomenological Analysis," 533.
[16] Bradshaw, *Healing the Shame That Binds You*, VII.
[17] Bradshaw, 4.
[18] Sanderson, *Counseling Skills for Working With Shame*, 25.
[19] Bradshaw, *Healing the Shame That Binds You*, 3.
[20] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 5.
[21] Dearing and Tangney, *Shame Ther. Hour*, 4:5; Epstein and Falconier, "Shame in Couple Therapy: Helping to Heal the Intimacy Bond," 169.
[22] Morrison, "The Psychodynamics of Shame," 41.

acting as a powerful inhibitor of certain forms of excitement and affect, shame grinds a person to a halt and stops him from engaging any further in exploration or exposure.[23] Schore describes that for the first year the face of a caregiver typically only elicits joy. However, due to developmental changes, the caregiver's gaze becomes a source of shame somewhere in the second year. Whereas the expectation up until then has been to meet affect and attunement, the child's system is now shocked by encountering a face that is affectively misattuned. Thus, Schore explains, what we call shame is that sudden and rapid shift between expecting a positive interaction with a caregiver, and then unexpectedly encountering the opposite. Thompson, who elaborates on the work of Schore, describes shame in *The Soul of Shame* as a severely disrupting and brutal force, typically when only moments ago we were trustfully and unsuspectingly minding our own business.[24] So, shame is supposedly a powerful mechanism that originally, due to it developing in early childhood, can be considered to exist before any verbal thoughts are formed. Thompson continues that instead of forming a rational explanation of a series of events, we develop what he calls a *felt sense of shame* before anything else.[25] Additionally, from a developmental perspective, this means that we typically do not have any conscious memories of our first encounters with it.[26]

In the chapter 'Shame is relational' of *Understanding and Treating Chronic shame* DeYoung proposes that "The essence of shame is a non-verbal affect […]" referring to shame as a hardwired neurobiological mechanism fundamentally influencing a person. To DeYoung, the external and internal effects (also mentioned in 3.1.1) are that which emanate from the visceral experience of shame, and she captures this by calling it "[…] the self that disintegrates in reaction to a misattuned other".[27] She draws from a *self-psychological* perspective, that speaks of well-being, or a healthy self, if it is capable of being with another person while experiencing a "[…] cohesive, firm, harmonious self". In other words, the self is ideally experienced as integrated and for the self-psychologist shame is thus a dangerous thing for it threatens precisely that. Because shame is tied to the self, it influences how we assume others see us and how we see ourselves.[28] As Schore and DeYoung explain, however, shame is repaired, or the sense of self is restored, by a caregiver that participates in regulating the child.[29]

Gilbert explains in 'Shame in Psychotherapy' that in psychology shame often is regarded as a *secondary or self-conscious emotion*, as opposed to primary emotions. Emotions like anxiety and anger are considered primary because they are alerting and focused, yet shame is part of a family of more complex emotions. It is tied to our sense of self, which is constituted by how we assume others see us and how we see ourselves.[30] Morrison explains in 'The Psychodynamics of Shame' this sense of self requires a certain level of developmental maturity, generally reached somewhere between twelve to eighteen months. Here the toddler starts to differentiate between himself and the environment, accompanied by feelings of independence and autonomy, but also separateness and isolation.[31] This separation is accompanied by realizing it can compare and compete with others. This self-awareness potentially affirms the sensitivity to shame.[32]

From a developmental point of view, provided in the book *The Life Cycle Completed* (1998) by Erik Erikson and Joan Erikson, shame occurs in the stage in which Erikson and Erikson say the central conflict is *autonomy vs. shame and doubt*. In her chapter 'Posttraumatic

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[23] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 52.
[24] Thompson, 54.
[25] Thompson, 54.
[26] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 52.
[27] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 36.
[28] Gilbert, "Shame in Psychotherapy and the Role of Compassion Focussed Therapy," 326.
[29] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 27.
[30] Gilbert, "Shame in Psychotherapy and the Role of Compassion Focussed Therapy," 326.
[31] Morrison, "The Psychodynamics of Shame," 26.
[32] Morrison, 25.

stress disorder as a shame disorder' from *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), Judith Lewis Herman elaborates on the theories of Erikson and Erikson. She argues that when the conflicts of this life stage are positively resolved, this lays the groundwork for healthy pride, relational mutuality, and both respect for others and self-respect[33]. In this period, separations and reunions with the caregiver are central. Separation normally evokes fear and protest in toddlers, but shame occurs during reunions when the excitement of a toddler is met with indifference or disapproval. Shame then reflects "[…] a sense of ineffectiveness in gaining the love or attention of the early caregiver". The child seeks a particular response from the caregiver, but when the caregiver does not respond accordingly, attachment is breached and the child feels shame.[34]

Since no caregiver can at all times be empathically attuned to her child, these kinds of experiences are unavoidable and common. Normally, however, the external effects of shame provoke sympathetic responses in others, which resolves the sense of shame. By repeatedly experiencing this interpersonal dynamic sufficiently a toddler learns both the limits of caregiver and acquires the capacity to soothe himself and regulate shame[35].

3.1.3 Shame and guilt

According to every writer on shame mentioned up until now, it is important to differentiate between shame and guilt. These terms are often used interchangeably, which may (as will become clear in the next chapter) lead to different problems in therapeutic relationships. Although shame and guilt can both be conceptualized as states that make us feel as if something is wrong, they are ultimately different in multiple ways.

A basic, important, and often a repeated distinction is, mentioned by Dearing and Tangney in 'Introduction', made by Helen Block Lewis (1971), who proposed that the difference in shame and guilt depends on the focus of attention. If one is focussed on the attribute or behavior that triggered the response this leads to guilt, and if one is generally focused on the self this leads to shame.[36] Guilt is thus a negative evaluation of someone's behavior or attributes accompanied by the feeling that he or she has done something wrong, and situational shame is a negative evaluation of the self and feeling as if they are exposed as fundamentally defective.[37]

Guilt is generally considered to develop after shame.[38] As stated before, shame developmentally emerges somewhere between twelve to eighteen months, before active memories or words about experiences are formed. According to Thompson in *The Soul Of Shame*, guilt on the other hand emerges somewhere between the age of three and six, preceded by the required capability for empathy. He or she becomes aware of the causal relationship between his or her behavior and the emotional impact it has on others. According to Thompson, shame and guilt are somewhat related because they bestow us with a feeling of having done something wrong because research suggests that "[…] in one sense, neurodevelopmentally guilt stands on shame's shoulders." One way to put it is that shame can be experienced without guilt but it is unlikely to experience guilt without a certain sense of shame.[39]

Although shame and guilt are both linked to moral behavior, each evokes different action tendencies and has different interpersonal consequences. Guilt may be resolved by

[33] Herman, "Posttraumatic Stress Disorder as a Shame Disorder," 263.
[34] Herman, 263.
[35] Herman, 264.
[36] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 7, 8.
[37] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 52; DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 93.
[38] Morrison, "The Psychodynamics of Shame," 26.
[39] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 52.

performing certain actions, but shame is not so easily redeemed.[40] Although less acutely painful than shame, guilt may be accompanied by feelings of regret and remorse.[41] This fuels the incentive to resolve the predicament by for example confessing, apologizing, or redemption. However healthy, shame can be unbearable and generally make someone lash out, blame others, deny, or escape. Guilt and shame are both inclined to facilitate relational strength, but when shame develops for the worse, it tends to be destructive for interpersonal relations.[42]

In some sense it could be said the ultimate goal in healing guilt is receiving forgiveness and that shame requires acceptance.[43] Shame offers a greater challenge, however, dealing with a specific behavior that one disagrees with is simpler than dealing with the desire to change one's core self.[44] The former is arguably easier achieved because [besides being more tolerable] guilt isn't accompanied by external signs that self-consciously reinforce it, and the action tendencies of guilt make it more likely it is brought up during interaction.[45] Also, revealing shame to others is harder because the potential condemnation of others feeds into the feeling.[46]

People are not evenly susceptible to experiencing shame or guilt when responding to wrongdoing or failure. The likelihood to feel shame, guilt, or a combination of the two *shame-fused guilt,* varies from person to person.[47] Nobody is either solely prone to experience guilt or to experience shame. Instead, everyone falls somewhere on a continuum for every dimension respectively, which can be understood as dispositional tendencies to experience shame, guilt, or shame-fused guilt. These tendencies are called *guilt-proneness* or *shame-proneness.*[48] Chapter 3 it will be further explained why practitioners will benefit from recognizing the distinctions between shame and guilt.[49]

3.2 Chronic shame

Chronic shame is primarily researched within neuropsychology, clinical psychology, social psychology, and psychotherapy, with studies based on clinical observations, and anecdotal evidence.[50] Whereas shame can indeed influence our behavior in a socially and morally adaptive manner, it can, quite easily, be distorted and turn into something that is far more toxic. Luna Dolezal and Matthew Gibson, 'Beyond a trauma-informed approach and towards shame-sensitive practice', published in *Humanities & Social Sciences Communications* (Volume 9, Number 214, 2022), draw from many different studies and explain that, given certain circumstances, shame can develop into something harmful that is persistent and maladaptive. The shame response starts to serve as a basis for developing chronic shame, which can lead to problems in establishing and maintaining interpersonal relationships and is regarded as something with an entirely different phenomenological profile. Although it is called chronic, this doesn't mean it is a continuous experience of shame. And, while it does resemble the shame described above, it isn´t directly experienced as a reaction that causes feelings of torment and self-consciousness. Instead, chronic shame exists of the constant proneness

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[40] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 93.
[41] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 7.
[42] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 34.
[43] Morrison, "The Psychodynamics of Shame," 25.
[44] Epstein and Falconier, "Shame in Couple Therapy: Helping to Heal the Intimacy Bond," 168.
[45] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 8.
[46] Epstein and Falconier, "Shame in Couple Therapy: Helping to Heal the Intimacy Bond," 168.
[47] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 10.
[48] Dearing and Tangney, 10.
[49] Dearing and Tangney, 4:9.
[50] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*; Dearing and Tangney, *Shame Ther. Hour*; Sanderson, *Counseling Skills for Working With Shame*; Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*.

towards or anticipation of the possibility of experiencing shame, and the (often more hidden) sense of being inadequate and worthless. So, the experience of healthy shame doesn´t enter awareness, but instead, the experience is dominated by *shame anxiety*, which is a corrosive and undermining fear to be judged and looked down upon by others.[51]

So, due to shame being experienced as unbearable,[52] the constant proneness or possibility of it is followed by either a conscious or unconscious tendency to escape or hide from the trigger that causes it, and those with chronic shame often have a personality that is structured around shame and the avoidance of it. it may be done by either blaming others, lashing out, denying accountability, or other reactions that may cause adverse moral behavior,[53] which will be further discussed in 4.1.2. Research suggests shame may acutely stifle the capacity for considering others, it can cause one to become angry and may lead to problems with empathy.[54]

Chronic shame is, in addition, to describing the dispositional tendency to feel shame and suffer the consequences, a term that addresses a rich and challenging topic. Bradshaw's description from 1988 still counts now, for chronic shame is "[…] a unifying concept for what is often a maze of psychological definitions and distinctions".[55] This paragraph is explained what shame-proneness seems to entail for most of the writers used in this thesis. Shame-proneness, or chronic shame, can be used interchangeably with the terms unconscious shame,[56] maladaptive shame,[57] core shame,[58] pathological shame,[59] debilitating shame,[60] or even toxic/life-destroying shame.[61] What these terms have in common, is that they are used to set a phenomenon apart from shame as discussed in the previous paragraph, as something more harmful, disguised/hidden, permanent, and debilitating. Whereas the shame in the previous chapter evolved to maintain a connection to others, the shame discussed in this paragraph can, as described in the chapter from *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011)*,* 'Treating shame: A functional analytical approach', of Kelly Koerner, Bavis Tsai, and Elizabeth Simpson, be understood as a source of separation and pain.[62] In the remainder of this thesis, the central topic of shame-proneness will be referred to as chronic shame.

The reason that some writers choose the word 'chronic'*,* is for the example given by DeYoung, who out that certain circumstances can produce a lifetime of chronic shame.[63] Shame experts address this, and the consequent responses, by calling it pervasive.[64] Once enough ordinary shame responses have occurred without proper repair or resolution (which will be elaborated on in the next paragraph), it will eventually form lifelong lasting patterns of self-awareness and determining the response to others.[65] Drawn from serious cases in the clinical practice, by Frans Schalkwijk in his article ´Schaamte in psychotherapie´ published in

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[51] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 4.
[52] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 107.
[53] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 5.
[54] Dearing and Tangney, 5, 6.
[55] Bradshaw, *Healing the Shame That Binds You*, 14.
[56] Sanderson, *Counseling Skills for Working With Shame*, 25.
[57] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 52.
[58] Greenberg and Iwakabe, "Emotion-Focused Therapy and Shame," 81.
[59] Schalkwijk, "Schaamte in Psychotherapie," 372.
[60] Groth, "Pastoral Care in the Face of Shame : A Theologian of the Cross Perspective," viii.
[61] Bradshaw and John, *John Bradshaw Houston, Texas*.
[62] Koerner, Tsai, and Simpson, "Treating Shame: A Functional Analytic Approach," 91.
[63] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 18.
[64] DeYoung, 16; Austin, "Existential Shame, Temporality and Cracks in the 'ordinary "Filled in" Process of Things,'" 125; Brown, Hernandez, and Villarreal, "Connections: A 12-Session Psychoeducational Shame Resilience Curriculum," 357.
[65] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 26.

Tijdschrift voor psychotherapy (Volume 38, Number 5, 2012), shame can become a dominant aspect of emotion regulation and penetrates someone's emotions entirely.[66] DeYoung says the only realistic goal for ashamed clients is *shame reduction* because shame has become part of their being.[67] Clients may spend a lifetime banishing the parts of themselves that are ashamed, only to sustain its effect by not getting at it. One description given by DeYoung is that those with chronic shame do not live with the shame itself, but with what it costs them not to fall into it.[68]

Shame theorists also propose that chronic shame is not adaptive socially or morally; it ceased to serve a social purpose as a course-correcting emotion. Chronic shame means the individual is either consciously or unconsciously anticipating or fighting a disproportional sense of shame in situations where those without it don't have to.[69] Shame is usually felt as a reaction to an acute problem, but in those with chronic shame, memories of situations where shame was evoked get tangled up with the here and now.[70] The shame that once fulfilled a function concerning interpersonal danger now creates a sense of worthlessness and unlovability in response to even the most minor interpersonal trouble.[71] As DeYoung puts it plainly: 'Something went badly and consistently wrong in their early connection with others'.[72], and thus it's generally agreed upon its origin is interpersonal.[73] Shame can be experienced in many relationships, but from an *attachment theory* perspective, chronic shame is believed to develop in relation to the attachment figure,[74] or during formative relationships which can be with other persons as well. Specifically, chronic shame develops eventually from the moments when the caregivers and close ones, or rather those that should be available, had difficulty meeting interpersonal needs.[75]

Robert Karen, in his paper 'Shame', published in *The Atlantic* (1992), states: "A comprehensive picture of how shame operates in psychopathology is not yet drawn." and adds, "it may never be".[76] Yet, experts on shame draw these links abundantly. Research steadily confirms that shame is deeply connected to major mental health issues including depression, social anxiety, narcissism, borderline personality, post-traumatic stress, obsessions and compulsions, substance abuse, self-injury, and eating disorders,[77] which will be further discussed in 4.1.3.

3.3 Development of chronic shame

Here, it is first explained what conditions are often present and what factors may cause or increase the chances of developing chronic shame. In their chapter 'The Role of Shame in the Development and Treatment of Borderline Personality Disorder', from the book *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), Shireen Rizvi, Milton Brown, and Marsha Linehan, explain through a biosocial theory of the emotion regulation system, that there is a biological sensitivity or predisposition to feel shame, which is influenced

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[66] Schalkwijk, "Schaamte in Psychotherapie," 372.
[67] DeYoung, 119.
[68] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 18, 19.
[69] Epstein and Falconier, "Shame in Couple Therapy: Helping to Heal the Intimacy Bond," 169.
[70] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 52.
[71] DeYoung, 52
[72] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 119.
[73] Epstein and Falconier, "Shame in Couple Therapy: Helping to Heal the Intimacy Bond," 169.
[74] Teyber, McClure, and Weathers, "Shame in Families: Transmission Across Generations," 137.
[75] Koerner, Tsai, and Simpson, "Treating Shame: A Functional Analytic Approach," 100.
[76] Karen, Shame, 13.
[77] Park, "Chronic Shame: A Perspective Integrating Religion and Spirituality," 356.

by factors within the environment.[78] These factors are often continuous or repeated within the direct environment of the child, including physical and/or sexual abuse, humiliation, and emotional neglect.[79] This can then lead to a shame-based or shame-prone self.[80]

One way to understand how the self is influenced is way, is by both Thompson and DeYoung, who explain shame as *disintegration*.[81] DeYoung points out that from a self-psychology point of view, human beings must have a coherent sense of self. Shame is precisely the annihilation of this cohesion. People who are confronted with psychological annihilation feel shattered or as if they are falling apart.[82] The disintegrating process of shame starts with an interpersonal separation event. Then, our bodies set shame in motion which is accompanied by the previously mentioned internal and external effects. The flowing of our behavior and experiences of sensations, thoughts, feelings, and images deteriorates and we feel blank, incoherent, speechless, and unable to think.[83] Ironically, behaviors like turning away our gaze and bodies which are meant to alleviate us of the feeling reinforce the notion that we are shameful.[84]

Not before people have learned to regulate shame themselves, the self-referential shame state awaits interpersonal alleviation and will persist until we are removed from the situation, if a trigger changes or another person intervenes.[85] The disintegration that is felt as a result of the rupture, is genuinely and constructively resolved if an attuned caretaker that has actively sustained an emotional connection reacts.[86] In the ideal situation, the momentary shame is resolved by returning to relational connection, restoring the sense of self.[87] This idea of shame as a disintegration of self, caused by problems within the emotional connection with others, is seen as such in virtually every developmental theory used in this thesis.

What leads to chronic shame, is when the disconnection caused by shame is repeatedly left unrepaired.[88] It is when the shame response continues and the child is left to struggle alone in recovering a sense of who he is to the other.[89] DeYoung describes that in resolving shame, we should feel connected to someone calm and strong, recover the sense of coherence, and return to feeling focused. Instead, we are left to feel alone, out of control, and overwhelmed.[90]

An unrepaired shame rupture creates a feeling that the child cannot make happen what it needs from the parent, and the repetition of it increases the propensity to feel shame. From then on, shame is felt around the components that constitute the shame experience: overwhelming feelings, the need for emotional connection, and problems in interpersonal interaction.[91] The repeated experience of shame, long past its opportunity to be resolved by a parent, will increasingly hardwire one's mind to experience it.

It should be noted, however, that not everybody agrees with DeYoung's, relational and attachment-theory approach. In his review of her book, Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach', published in the *Transactional Analysis Journal* (volume 48, number 1, 2018), Cornell writes that due to DeYoung's central

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[78] Rizvi et al., "The Role of Shame in the Development and Treatment of Borderline Personality Disorder," 239.
[79] Rizvi et al., 81.
[80] Teyber, McClure, and Weathers, "Shame in Families: Transmission Across Generations," 144.
[81] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 26; Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 9.
[82] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 27.
[83] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 67.
[84] Thompson, 68.
[85] Thompson, 66.
[86] Thompson, 66.
[87] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 27.
[88] DeYoung, 27.
[89] DeYoung, 27.
[90] DeYoung, 28.
[91] DeYoung, 28.

focus on the earliest caretaking relationships, she supposedly doesn't engage properly with the actual complexity of shame and the other factors involved and therefore overlooks "[…] a myriad of factors that may occur throughout a lifetime to create shame".[92] An example of this can be found in the chapter 'Emotion-focused therapy and shame' by Leslie Greenberg and Shigeru Iwakabe, in *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011). They add that chronic shame can also sometimes develop through repeated experiences of being rejected or judged inferior based on race, gender, class, ethnicity, sexuality, or because of just being different from others.[93] This will be further discussed in 4.2.2. Since this is still an open dispute, and both claims require some extra research, we´ll assume that chronic shame can be developed in early childhood, but also across the lifespan for various reasons.

However, still, these experiences are felt as interpersonal rejection and failure. The ongoing experience of the self that is disconnected from others, turns into a fundamental sense of isolation, leading chronically shamed individuals to see themselves as fundamentally flawed, defective, and unworthy of love[94]. Austin, in her chapter 'Existential shame', poses that this hardwiring means that shame becomes firmly ingrained in our systems, even before we construct thoughts about anything. She says it is as if already in the act of "[…] drawing perceptual data together into 'a something' (and this includes the experience of oneself as 'a something') is shot through with a deeply distressing sense of badness or wrongness".[95] Van Schalkwijk describes it as an "[…] undercurrent of experience without emerging into awareness".[96] In other words, before a verbal thought is thought, the individual starts thinking with an innate sense of self (and others) as wrong, bad, or dangerous.

Although the shame supposedly lies deeper than active verbal thoughts, it does find its way into the narratives people have about themselves and others. According to Van Schalkwijk, chronic shame becomes interwoven with a long string of unconscious fantasies of negative self-esteem, deficiency, and being unworthy of love. These unconscious fantasies are a collection of interconnected thoughts that the client has about himself, that form a description of the self.[97] Thompson remarks it is often barely noticeable, but shame schemas are woven into the fabric of the stories that people share about their lives.[98]

Well-hidden shame can be disguised in general, neutral, or even positive remarks, but it can also emerge in more obvious, explicitly negative ways. For example, it may be recognized in the tendency to objectify self and others, feelings of (self)disgust, and an aspiration to be 'good' all the while thinking about oneself as actually bad,[99], but more often than not these narrative schemas are seen as part of someone's character, not directly considered to be shameful.

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[92] Cornell, "Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach," 73.
[93] Greenberg and Iwakabe, "Emotion-Focused Therapy and Shame," 82.
[94] Brown, Hernandez, and Villarreal, "Connections: A 12-Session Psychoeducational Shame Resilience Curriculum," 358; DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 26.
[95] Austin, "Existential Shame, Temporality and Cracks in the 'ordinary "Filled in" Process of Things,'" 125.
[96] Greenberg and Iwakabe, "Emotion-Focused Therapy and Shame," 81.
[97] Schalkwijk, "Schaamte in Psychotherapie," 373.
[98] Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*, 70.
[99] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 43, 44.

4 Chronic shame within the clinical practice

The previous chapter describes what the current writings say about chronic shame and its development. To answer what the current understanding of chronic shame is among spiritual counselors in the Netherlands, and to determine the implications of it for specific aspects of spiritual care, the following needs to be answered first: (II) What are the prevalent perspectives within the literature on the role of chronic shame in clinical practices? In the following chapter, these answers will be used to see how it relates to spiritual care. In this chapter, I want to describe what role shame has in clinical practice through how it is recognized by practitioners (4.1), what stance and attitude practitioners take towards it (4.2.1), and in what different ways it is handled (4.2.2). In the last paragraph (4.3), it will be discussed why it is important for a practitioner that looks at his shame if he wants to recognize and treat chronic shame.

4.1 Encountering chronic shame

To understand shame it is important how to recognize it when one encounters it. For various reasons more malignant variants of shame are often called the ´hidden emotion´[100], and it is important to understand how it hides and why (4.1.1). Afterward, it explained what possible indicators of shame are possible (4.1.2), followed by an overview of different pathologies related to shame (4.1.3), and its relation to trauma (4.1.4).

4.1.1 The hidden emotion

As was illustrated in the previous chapter, an important difference between healthy shame and chronic shame is that the latter hides unconsciously in stories in which it does not seem to be prevalent.[101] In his book, *The Soul of Shame* Thompson writes: "How common it is for shame to be silently lodged and active in every nook and cranny of our lives when we have little to no idea of its presence".[102] Whether it's about clients or practitioners, chronic shame most of the time manages to be a reality kept out of sight in all kinds of settings and situations.

The emotional pain belonging to repeated shame and humiliation is pushed out of conscious awareness, where it may be dissociated from the experience that caused it in the first place,[103] explaining its inherent relationship with hiding and concealing.[104] The disintegration discussed in 3.3 is only being reinforced by others who witness it, thus hiding and concealing helps to keep others that pose an extra threat out. It should be said upfront that this easily appears to be the most challenging aspect of shame. This is a challenge because shame needs uncovering to be healed, and needs to be grasped to be understood. Yet, shame is notoriously elusive, disguising itself in many forms and often kept out of the awareness of those who either treat it or suffer from it. According to Michael Stadter, in his chapter 'The Inner World of Shaming and Ashamed: An Object Relations Perspective and Therapeutic Approach', in *Shame in the Therapy Hour* (2011), both therapist and clients tend to hide the shame from themselves and others, because it is too much to bear and overwhelming, or because they feel ashamed of

[100] Shapiro and Powers, "No Shame and the Paradox of Group Therapy," 133.
[101] Thompson, 60.
[102] Thompson, 60.
[103] Sanderson, *Counseling Skills for Working With Shame*, 19.
[104] Dearing and Tangney, "Introduction: Putting Shame in Context," 2011, 6.

their shame.[105]

Sanderson's explanation of the mechanic which places shame outside of conscious awareness and into hiding is that it happens through active *dissociation*. He described that while there may be some initial bodily reactions to shame, the "[…] feeling is immediately split off through dissociation".[106] DeYoung also addresses this aspect, specifying it may be suited to imagine that two different things are happening at the same time: the unrepaired shame rupture is followed by a combination of dissociating from the shame experience and yet a continuation of the shame affect.[107] According to Sanderson, this dissociation is on the one hand a response that helps numb the physiological disintegration of shame, but it also enables one to deny to self and others that the shame even exists. This in turn may lead the individual to feel no shame at all, leading to excessive self-centredness.[108] Another way it can manifest is when it turns inward and shows itself through apparent shame feelings similar to the shame underneath, but which are not identified as such.[109]

Some people that have survived experiences like abuse, neglect, and trauma have, as was observed by Koerner, Tsai, and Simpson explained in their chapter 'Treating shame', from *Shame in the Therapy Hour* (Washington, American Psychology Association, 2011), learned to completely hide their shame expressions while they may, in fact, experience severely uncomfortable feelings underneath. The difference between what is shown on the outside and what is felt on the inside can become huge. They illustrate this by an anecdotal example from the clinical practice, where a "[…] well-loved, successful, articulate man, seemingly fully engaged in therapy", then suddenly "[…] says in a matter-of-fact voice that simply sitting in your office evokes the feeling that he does not deserve to "take up space". He can barely stand to exist".[110]

4.1.2 Indicators of shame

In his chapter 'Therapy With Shame-Prone Alcoholic and Drug-Dependant Clients', in *Shame in the Therapy Hour* (Washington: American Psychology Association, 2011), Ronald Potter-Efron presents his clinical findings around drug-dependent and alcohol clients and chronic shame. He shares that clients often do not directly communicate their shame experiences,[111] and DeYoung says that in her entire career, not one of her patients ever said: "I need help with my chronic shame".[112] The shame underneath has to be indicated in different ways on different levels. Shame can be indicated by various gestures, behaviors, traits, psychological illness, emotions, and feelings. The related content for the subject of this paragraph is so vast, that for example addiction as an indicator of shame alone already can easily fill several books. Therefore, I choose to highlight all the indicators of shame briefly with only short examples or descriptions of how they may show the shame underneath.

On the surface level, practitioners may look for rather subtle non-verbal cues like: "[…] covering all or parts of the face, gaze aversion, eyes downcast or averted, hanging head, hunched shoulders, squirming, fidgeting, blushing, biting or licking the lips, biting the tongue, or false smiling".[113] More confusing perhaps, is the peculiar way in which shamed individuals

[105] Stadter, "The Inner World of Shaming and Ashamed: An Object Relations Perspective and Therapeutic Approach," 61.
[106] Sanderson, *Counseling Skills for Working With Shame*, 25.
[107] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 101–14.
[108] Sanderson, *Counseling Skills for Working With Shame*, 26.
[109] Morrison, "The Psychodynamics of Shame," 26.
[110] Koerner, Tsai, and Simpson, "Treating Shame: A Functional Analytic Approach," 98.
[111] Potter-Efron, "Therapy With Shame-Prone Alcoholic and Drug-Dependent Clients," 230.
[112] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 16.
[113] Herman, "Posttraumatic Stress Disorder as a Shame Disorder," 268.

behave during a conversation, in which they may suddenly stop talking, avoiding seemingly neutral or innocent topics, or avoiding the here-and-now in a conversation.[114] Shamed individuals may also shrug off laughter that seems to cover a form of embarrassment,[115] or jokingly downgrade therapy.[116] Additionally, they can become angry or anxious, and in a clinical setting, they may refuse to share clinically relevant material.[117]

There are also more subtle paralinguistic clues like talking rapidly, taking long pauses, stammering, mumbling, soft-toned speech, and being hesitant.[118] During a conversation, a shamed state is also indicated by the words someone uses, one of which could be: "[…] ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed".[119]

Lastly, the very behaviors to avoid shame also tells that may function as indicators of the shame underneath. Donald Nathanson wrote in his book *Shame and Pride* (1992) about the *compass of shame*, which has been widely used, reproduced, and popularized ever since.[120] The compass of shame is used to describe that shame-avoidance behavior follows four particular patterns: attack self, attack others, avoid, and withdraw (figure 1).[121] The complex ways in which this occurs will be further discussed in 4.1.3.

Figure 1

[114] Shapiro and Powers, "No Shame and the Paradox of Group Therapy," 119.
[115] Greenberg and Iwakabe, "Emotion-Focused Therapy and Shame," 74.
[116] Greenberg and Iwakabe, 74.
[117] Herman, "Posttraumatic Stress Disorder as a Shame Disorder," 261.
[118] Herman, 268.
[119] Herman, 268.
[120] Dearing and Tangney, *Shame Ther. Hour*; DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*; Pattison, *Shame: Theory, Therapy, Theology*; Thompson, *The Soul of Shame Retelling the Stories We Believe About Ourselves*; Sanderson, *Counseling Skills for Working With Shame*; Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice."
[121] Nathanson, *Shame and Pride*, 305–77.

4.1.3 Where shame resides

It has been explained that the experience of shame itself can be unbearable, which therefore is either consciously or unconsciously avoided at all costs by the chronically shamed. In the course of their lives, people with chronic shame often develop a range of powerful compensatory behaviors that bypass the intense emotional suffering of shame itself and the chronic anticipation to avoid it. These mannerisms, which are supposedly oriented on the compass of shame in one or multiple ways (4.1.2), are called *defensive scripts* by Stephen Pattison in his book *Shame: Theory, Therapy, Theology* (2003),[122] or *strategies* by Sanderson,[123] and thus these shame-avoidant behaviors are organized in such a way they prevent possible exposure of the shame underneath.

These defenses come in many forms and are far better known than the shame underneath. All shame-avoidant strategies are harmful to oneself and one's relationships.[124] Many different factors play a role in what manner the shame is avoided, and thus in determining what shame-avoidant strategies will occur. Individuals may develop depression, hopelessness, excessive self-hatred, and suicidal thoughts or tendencies. Shame-avoidant behaviors can also lead to addiction, eating disorders, narcissism, and perfectionism.[125] To provide some extra insight into the mechanisms involved, and with the estimated directions of the interviews in mind, the relationships both narcissism and perfectionism have with shame will be further explained here.

As was said at the end of 4.1.1, shame as it is pushed out of awareness, can cause either turn inward, or instead outwards causing excessive self-centredness. Chronic shame as excessive self-centredness is rigid in denying the shame, which may result in grandiosity, arrogance, excessive pride, and narcissism.[126] Narcissism is not understood as a pathological personality disorder but as the psychodynamic phenomenon that describes "[…] the yearning to be unique- special to the significant other".[127] Most sources used in this thesis propose a strong relationship between shame and narcissism.[128] DeYoung for example calls chronic shame the "[…] underside of narcissism", which is a classical self-psychological perspective on the shame that is felt when a person is experiencing the self isn't living up to the ideal self-image.[129]

As a result of chronic shame the sense of self is diminished, which leads to low self-esteem, and when both are acquired early on, this results in a self-definition that is fundamentally linked to shame. Self-definitions cast barriers between self and others, and when this is accompanied by the absence of trust, and the fear of being dependent, abandoned, or rejected, the chances of receiving interpersonal reality checks are severely diminished since interacting with others is probably experienced as pure agony. Due to this distance, the person may over-identify with others, searching to attain traits and qualities that are not his. This may grow into the drive to prove to self and others that one is completely able and competent in everything he does. Sadly, now being put under extreme pressure, any failure exposes their shame and inadequacy. As Sanderson explains: "Perfectionists dehumanize themselves by never allowing themselves to make mistakes or fail to hide their shame and a diminished sense

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[122] Pattison, *Shame: Theory, Therapy, Theology*, 111.
[123] Sanderson, *Counseling Skills for Working With Shame*, 24.
[124] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice."
[125] Dolezal and Gibson.
[126] Sanderson, *Counseling Skills for Working With Shame*, 26.
[127] Morrison, "The Psychodynamics of Shame," 24.
[128] Stadter, "The Inner World of Shaming and Ashamed: An Object Relations Perspective and Therapeutic Approach," 46; Morrison, "The Psychodynamics of Shame," 24; Sanderson, *Counseling Skills for Working With Shame*, 12; DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 47.
[129] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 47.

of self'.[130]

4.1.4 Shame and trauma

Chronic shame and *trauma* appear to have a close and important relationship, yet it is not clear in exactly how many ways and how all of them work. In this paragraph, it is explained that through different concepts and theories, shame and trauma are directly and indirectly linked to each other.

Although it is not exactly clear what the dynamics between shame and trauma are, Dolezal and Gibson in 'Beyond a trauma-informed approach' show with an extensive amount of references that scientists are increasingly convinced that they are inextricably linked.[131] Dolezal and Gibson introduce the trauma by saying that although "[…] there is no unified approach or understanding of trauma", it is generally agreed that trauma involves the following description n, mentioned by Judith Lewis Herman, in her book *Trauma and Recovery* (1992): "[…] threats to life or bodily integrity, or a close personal encounter with violence and death",[132] of which the event is experienced as overwhelming, "[…] resulting in long-lasting effects which can encompass significant alterations to one's experience of self, others and the world".[133] They propose that post-traumatic shame plays a central role in shaping post-traumatic states,[134] and it is also argued that trauma is not only an anxiety disorder but also a shame disorder, for which Herman cites studies that find significant correlations between *post-traumatic stress disorder* PTSD, chronic shame, and dissociation (4.1.1).[135] She has also observed that in traumatized patients not the PTSD symptoms are the reason for seeking treatment but rather a relational rupture that reveals a seriously affected sense of self, which often is the result of underlying shame[136]. Further research is needed to create a fuller understanding of '[…] the role of shame in posttraumatic symptom formation'.[137]

Trauma is associated with many maladaptive behaviors that are not always easy to explain by trauma alone. For example, the lacking of empathy and trust after experiencing trauma is by some considered to be a central characteristic of trauma survivors. These characteristics are adequately understood by putting shame central to post-traumatic states.[138] Melvin Lansky proposes in his paper 'Shame dynamics in the psychotherapy of the patient with PTSD: a viewpoint', published in the *American Behavioral Scientist* (Volume 38, number 8, 1995), that those who live with trauma experience a posttraumatic state that creates shame, which causes for the corresponding defensive strategies, with the effect of keeping 'shame arousing awareness from consciousness' (see figure 2, 4.1.2).[139] Interestingly, Terry Taylor, in his article 'The influence of shame on posttrauma disorders: have we failed to see the obvious?', published in the *European Journal of Psychotraumatology* (Volume 6, number 1, 2015) says that defensive behaviors like aggressiveness, anger, addiction, isolation, avoidance and depression are consistent when comparing PTSD and chronic shame.[140] Yet, Gail Theisen-

[130] Sanderson, *Counseling Skills for Working With Shame*, 60.
[131] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 4, 5.
[132] Herman, *Trauma and Recovery*, 33.
[133] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 2.
[134] Dolezal and Gibson, 5.
[135] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 58.
[136] Herman, "Posttraumatic Stress Disorder as a Shame Disorder," 262.
[137] Herman, 272.
[138] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 5.
[139] Lansky, "Shame Dynamics in the Psychotherapy of the Patient with PTSD: A Viewpoint," 133.
[140] Taylor, "The Influence of Shame on Posttrauma Disorders: Have We Failed to See the Obvious?"

Womersly in his book *Trauma and Resilience Among Displaced Populations: A Sociocultural Exploration* (2021) states that in attempts to provide support, care, and treatment, defensive behaviors are easily misunderstood, leaving the underlying shame hidden and unacknowledged (4.1.1).[141]

Why is this relationship considered to be important? If the shame-trauma relationship is almost inseparable, shame thus follows everywhere where trauma goes. But, as was previously made clear, shame easily hides out of sight from where it silently brings about obstacles that prevent any direct therapeutic engagement with the trauma. The defenses to prevent exposing the defective self may lead to negative effects like refusing to receive healthcare, avoiding reporting traumatic events like sexual and physical abuse, or being prevented from reporting shame they feel because they are afraid of exposure and rejection.[142] Also, Herman writes that in receiving treatment, the goal is to be exposed to what has happened and to acquire mastery over themselves in the face of trauma. Obstructive, unacknowledged shame for the traumatic experience prevents clients from gaining mastery over themselves.[143]

Dolezal and Gibson are convinced that extending a shame perspective alongside the existing trauma perspective is extremely important. They stress that shame-sensitivity should not only be limited to their treatment of trauma, but that shame is widespread and therefore is ideally brought to attention in all places where shame is currently overlooked. They propose a shame lens has the potential to transform all types of professional relationships by providing a greater awareness of emotional dynamics, countering the possible intensification of shame in unequal power relations, and enhancing sensitivity and support to eventually diminish the chances of re-traumatization and harm that is easily inflicted when working with shame.[144]

4.2 Dealing with chronic shame

Shame is not only renowned for its hiddenness but, taking into account how it is related to many problems, also for the consequent problem of being hard to treat or obstructing kinds of treatment. It is therefore important for a practitioner to take the right stance, which will be discussed in 4.3.1, and to be careful and properly educated on how to treat shame, which will be discussed in 4.3.2.

4.2.1 Taking a stance

Before anything else, the practitioner should adopt the right stance, because doing so reduces the chance of problems that may occur within the relationship with the client. Chronically shamed individuals are afraid to be weak, vulnerable, and needy, and ironically, this is exactly what is asked of them to be in therapy. As was said before, shame is felt around the components that constitute the shame experience like overwhelming feelings, the need for emotional connection, and problems in interpersonal interaction, and yet all these things ought to be addressed and explored. Naturally, the defenses that were in place for many years, won't just suddenly disappear, especially not when therapy is experienced as shameful itself.

Also, to be compassionate it is important to be sensitive and attentive towards experiencing distress, yet the chronically shamed are (partially) detached from their feelings

[141] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 5.
[142] Dolezal and Gibson, 6.
[143] Herman, "Posttraumatic Stress Disorder as a Shame Disorder," 267.
[144] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 8.

(2.3). And, if someone engages in becoming more attentive to one's feelings and needs, this may stir up all sorts of unwanted thoughts and feelings that can be overwhelming, confusing, or deemed too much to bear. Consequently, this may threaten the therapeutic relationship.[145]

The shame defenses are named in 4.1.2. may also provide to be powerful obstacles in treating shame. Specifically, emotions like anger, contempt, envy and even rage may be evoked and conceal the shame underneath. Anger itself may become the subject of treatment, with the result of overlooking the shame underneath. With contempt the shame is directed onto the other through projective identification, shifting the focus of one's failure to someone else.[146] In the case of envy, someone experiences the self as inferior to another and shifts the attention from the self to the other through hostility and anger.[147]

For therapists to effectively work with shame, several writers on shame have developed a *stance* that can be adopted by them and their colleagues. A stance is meant a particular attitude that is composed of several behaviors that the practitioner can work from. In the last chapter of Dearing and Tangney's 'Working with shame in the therapy hour: summary and integration' from *Shame in the Therapy Hour* (Washington, American Psychology Association, 2011) they summarize that all the contributors favor a certain stance when working with shamed clients. Here, they call this *relational validation*, which means the basic attitude is one that 'de-shames' the client. Relational validity is a word that is meant to capture what this de-shaming attitude entails. What all the writers that contributed to Shame in the Therapy Hour stress in that regard, is the need of forming a relationship that supports and validates the client, and where the therapist is attuned and emphatic. By doing so, the practitioner aims to create a space of safety in which the client is more likely to allow himself to face and acknowledge their shame.[148]

In his book *Attachment-Focused Family Therapy* (2007), Daniel Hughes proposes to acquire four abilities: playfulness, acceptance, curiosity, and empathy. Hughes summarizes these four in the acronym PACE, which he proposes to implement as the fundamental therapeutic stance when performing attachment-focused family therapy.[149] DeYoung has praised and adopted this stance for its therapeutic value in working with shame, yet also underscores the difficulties around it.

With playfulness DeYoung aims to describe an attitude of a relaxed openness towards everything that might occur in the conversation. By doing so, the practitioner invites the other to a patch of discovering and exploring whatever may come up and occur during therapy. With playfulness, DeYoung wants to capture the attitude that everything is okay within therapy and communicate to the client he doesn't need to do anything right to successfully undergo it. A powerful and important ally is humor.[150] Although most of the shame defenses are named in paragraph 4.1.2. may challenge this attitude, the therapist should aim to return to this stance over and over again.

DeYoung goes on to say that acceptance should be radically imposed when adopting a playful attitude. Everything that occurs in the conversation that is unfolding itself in the here-and-now, should be accepted just as it is here and now. There is a need to judge anything that occurs, because for shamed clients it may be counterproductive to say certain feelings are better or worse than others. DeYoung says the most important thing is that the others feel validation for everything that occurs in the here and now.[151]

Curiosity and empathy go together according to DeYoung. Empathy isn't easy, but it

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[145] Gilbert, "Shame in Psychotherapy and the Role of Compassion Focussed Therapy," 342.
[146] Morrison, "The Psychodynamics of Shame," 29.
[147] Morrison, 30.
[148] Tangney and Dearing, "Working With Shame in the Therapy Hour: Summary and Integration," 382.
[149] Hughes, *Attachment : Focused Family Therapy*.
[150] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 67.
[151] DeYoung, 67–68.

is a vital part of the relational validity that practitioners need to work with shame. Empathy is described by DeYoung as the '[…] tireless effort to feel into our clients' reality'.[152] This can, of course, be painful, hard, and challenging. Painful because of the depth of their feelings, hard and challenging because it isn't always clear what the other feels and needs to be inferred from the spaces between what the other says, from what isn't being said.[153]

DeYoung says curiosity functions to motivate playfulness and ask questions accordingly. The therapist needs curiosity to dive into the room that is created by acceptance. Curiosity helps to stay clear of any hasty conclusions, and remain motivated to find demanding certainty too early. According to DeYoung, curiosity needs empathy because, without it, curiosity may feel aggressive or intrusive. And, the other way around, curiosity is needed to work with what the other is telling the therapist because without it only being empathic may quit the conversation.[154]

Lastly, DeYoung also introduces *authenticity*.[155] For people who are chronically ashamed, it is not only necessary that they do not have any people in their lives, but because these relationships have been inauthentic.[156] This means that they hold up a pretense of connection, but leave out most of themselves. One of the first steps, even before talking about shame, is to share emotions according to DeYoung. When people start talking about emotions, empathy for themselves and others increases, then shame can decrease.[157]

4.2.2 Handling shame

The treatment of chronic shame is important because it can help in working with other pathologies as discussed in 4.1.3 and possibly remove barriers when treating trauma (4.1.4). Throughout the literature, different authors propose different therapies meant for psychologists and psychotherapists that effectively reduce shame. Since the thesis addresses spiritual counselors, however, I will limit this section to that which with certainty overlaps with the work of the spiritual counselor, and what ways of handling shame are either recommended or discouraged. This paragraph includes the act of naming shame, either talking about it or avoiding it.

In 4.1.1. it is explained why shame is called the hidden emotion, which can potentially cause all kinds of problems and prolong the suffering of the client. Multiple authors, therefore, say it is one of the most basic yet delicate steps in dealing with shame, but there is also disagreement about whether using the word shame is necessary.[158] The word itself can elicit shame and is therefore avoided by people themself, which is another possible reason for the different terms people use for shame as was discussed in 4.1.2. Additionally, people may choose to project their feelings of shame outward, so they might call the situation or the behavior of others embarrassing or awkward. Sanderson explains that these either conscious or unconscious ways of avoiding shame need to be managed with caution.[159] More specifically, as was explained in 2.3, chronically shamed individuals have deeply internalized the expectation that others will not understand them, and they will feel overwhelmed and disconnected. Since this is what they expect and are afraid of, speaking of shame too early will expose the shame they try to hide, and cause a repetition of exactly the experience they are so afraid of.

To name the shame, the therapist also needs to be ready to do so. The practitioner needs to overcome any forms of resistance towards it. Morrison says a therapist too might

[152] DeYoung, 66.
[153] DeYoung, 66.
[154] DeYoung, 68.
[155] DeYoung, 164.
[156] DeYoung, 164–70.
[157] DeYoung, 170–76.
[158] DeYoung, 88.
[159] Sanderson, *Counseling Skills for Working With Shame*, 25.

experience hesitation or embarrassment to name it.[160] Teyber, McClure, and Weathers write in their chapter 'Shame in Families', from *Shame in the Therapy Hour* (2011) that if the therapist complies with any prescriptions of the family or culture used to avoid the shame, he is in a sense colluding with the shame that is present and is therefore giving it legitimacy. It thus seems of vital importance that the therapist is familiar with their shame and has worked through any shame-based issues it may have.[161]

If the shame is somehow to be healed, Sanderson says that at all costs the therapists can't refuse to talk about it, move the focus away from it, or ignore it. This can give the client the sense that he is being judged and silenced. Also, he may think that the shame is beyond repair. Additionally, any soothing or reassuring remarks that the shame isn't that bad or that it will disappear with enough time are also wrong. If the therapist can tolerate the shame, then the client is helped in also tolerating it.[162] Sanderson strictly remarks, that this can [again] only be achieved if the therapist worked through his shame, which will be further discussed in 4.3.[163]

Emi Furukawa and Dennis Hunt explain in their chapter 'Therapy with refugees and other immigrants experiencing shame: A multicultural perspective' in *Shame in Therapy Hour* (2011) that it is possible for a therapist to feel that the client's shame is a defense or something that is momentarily altering thought negatively.[164] However, wanting to make it stop, explaining it away, or denying it, will feel to the client as condemning something that might've helped them survive. Because shame is active in the client´s belief system, rejecting it may feel like a rejection of their worldview.[165] For the shame to decrease, Teyber, McClure, and Weathers write that the therapist needs to be able to listen with acceptance and compassion to the client's shame.[166]

4.3 Practitioner Shame

Another important way chronic shame plays a role within the clinical practice is through the practitioners themselves. In her book, DeYoung mentions that for practitioners 'knowing our shame' is one of the prerequisites for working with shame.[167] In chapters 10 and 11 of *Counseling skills for working with shame* (2015) Sanderson too devotes a large part to the counselor's shame and the importance of knowing it[168]. In the chapter 'Therapist Shame: Implications for Therapy and Supervision' in *Shame in Therapy Hour* (2011) Nicholas Ladany, Rebecca Klinger, and Lauren Kulp too write about therapist shame and how it potentially influences the process and outcome of therapy.[169] Although some problems are only relevant to the practitioner, some appear to be more universal, and therefore maybe also relevant to the spiritual counselor. First, it is explained how shame can influence the practitioner and what kind of problems are related to this. Secondly, three different skills are discussed that are suggested as important to work with shame. In conclusion, some consideration is given to the scope and feasibility of actually working through it.

Practitioners may suffer from chronic shame just as their clients do, and for them, this may go unnoticed. DeYoung states that shame-prone individuals are drawn towards these

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[160] Morrison, "The Psychodynamics of Shame," 28.
[161] Teyber, McClure, and Weathers, "Shame in Families: Transmission Across Generations," 154.
[162] Sanderson, *Counseling Skills for Working With Shame*, 160.
[163] Sanderson, 160.
[164] Furukawa and Hunt, "Therapy With Refugees and Other Immigrants Experiencing Shame: A Multicultural Perspective," 208.
[165] Furukawa and Hunt, 208.
[166] Teyber, McClure, and Weathers, "Shame in Families: Transmission Across Generations," 154, 155.
[167] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 64.
[168] Sanderson, *Counseling Skills for Working With Shame*.
[169] Ladany, Klinker, and Kulp, "Therapist Shame: Implications for Therapy."

professions, because here they can hide '[…] behind masks such as *expert* or *helper*, making use of their emotional sensitivity, and their '[…] deep desire to see emotional hurts eased and relational brokenness repaired'.[170] Throughout the different texts arguments are given for the importance of practitioners addressing shame within themselves. First of all, practitioners unfamiliar with their shame contributes to overlooking it in others. Furthermore, considering that shame needs uncovering to heal (4.3.2) and that it can help to make better sense of some other psychological problems (4.1.3), and because it's considered a treatment-barrier in working with trauma (4.1.4), it's safe to assume the capacity to spot shame is beneficial to a practitioner.

In addition to the benefits of seeing it in others, getting to know one's shame can help to prevent impasses, ruptures, and other negative client-therapist outcomes that - without an understanding of shame - could've been difficult to explain or are falsely attributed to the wrong causes.[171] Two internal responses through which shame can negatively influence the relationship, called *transference* and *counter-transference*, are generally familiar among most healthcare workers.[172] The former describes the unconscious patterns and forces that drive the relationship the client has with the practitioner, whereas the latter are the modes and feelings the practitioner has in reaction to the client. A practitioner working with a chronically shamed client can, especially without being insufficiently aware of their inner workings, become vulnerable to the ashamed states of their client. They may start to feel shame, or experience contempt and shaming thoughts toward others.[173] Again, these reactions can potentially rupture the therapeutic relationship, which can be damaging to the practitioner and especially to a chronically shamed individual. It may re-shame the client and, given the nature of chronic shame (3.3), feel like a repetition of interpersonal failure, emphasizing the deeply felt notion of being flawed, precisely where the client hoped to experience something different.

To stay present DeYoung proposes that the practitioner needs to face his or her shame in a sustained way, learn to feel it, name it and understand where it lives within[174]. In their chapter 'Shame in families: Transmission across generations*,* in the book *Shame in the Therapy Hour* (Washington, American Psychology Association, 2011) Teyber, McClure, and Weathers include a section on therapist shame, which they stress that when working with shamed individuals, it is extremely important to learn not to be flooded with one's shame. They argue that the therapeutic relationship means being truly present without any defenses, which is distorted when experiencing shame[175]. Whereas Sanderson provides some exercises to individually identify, address and work through one's shame,[176] DeYoung seems more concerned. She reminds us that shame is a devious trickster that sometimes may only be truly uncovered when having sustained it for a prolonged period. And, remembering the relational nature of shame (3.3), DeYoung proposes to do so with a therapist. On top of that, the therapist ought preferably to be shame-wise, making sure he or she doesn't "[…] collude [with the client's shame] to look the other way", and to forge the emotional connection shame needs.[177] Although DeYoung's perspective can be considered to be somewhat extreme, other authors advocate for different attitudes towards shame and ways of handling shame, on many different levels. S*hame sensitivity* means the application of understanding the inevitability of shame, that shame-avoidance is purely negative, and it is incumbent to deal with it to reduce

[170] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 64.
[171] Sanderson, *Counseling Skills for Working With Shame*, 182.
[172] Stadter, "The Inner World of Shaming and Ashamed: An Object Relations Perspective and Therapeutic Approach," 48, 49.
[173] Stadter, 63.
[174] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 64.
[175] Teyber, McClure, and Weathers, "Shame in Families: Transmission Across Generations," 147, 148.
[176] Sanderson, *Counseling Skills for Working With Shame*.
[177] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 64, 65.

its effects.[178] Another they introduce is *shame competence,* which means having a theoretical and practical understanding of shame including seeing, knowing, and dealing with it.[179] The last one, *shame resilience,* is used throughout Sanderson's book. Once shame is ideally released, this can be followed by '[…] enhanced awareness, breaking the silence, becoming more visible and the consolidation of skills'.[180]

Keeping in mind that shame often operates as a pre-verbal undercurrent (3.3), and of the powerful ways it tends to hide (3.2, 4.1.1, 4.1.3), identifying, handling, and working through shame may just as well be a challenge for practitioners as it is for clients. Therefore, demanding this happens perfectly with a shame-wise therapist might be too far-fetched for many and in some cases maybe even impossible. Of course, the arguments on the benefits of working through shame are supported by many of the authors, but since it is probably the case that many shame-prone practitioners are currently active and perform effectively without knowing their shame, nuance is hard to find in the texts. There must be a way of determining that a certain amount of reflecting on or working through shame is sufficient. Drawing from Donald Winnicott's concept of *Good Enough Parenting,*[181] mentioned in his book *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development* (1965), he proposes that to provide security and safety for the child to grow and develop, a parent doesn't have to be perfect but rather 'good enough', meaning they provide a proper balance in nurturing and structuring, so the child can develop a strong enough sense of self. So too may the therapist require a standard that constitutes what level of understanding is good enough concerning working with shame, for example, aimed at maintaining a healthy connection. Although therapist shame appears to be a 'prodigious and salient phenomenon' and deserves continued attention, Ladany et al. write that significant mistakes are bound to happen for the therapist too is only human.[182] With the spiritual counselor being central to this thesis, this point will be developed further in 5.5.

[178] Dolezal and Gibson, "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice," 6.
[179] Dolezal and Gibson, 6.
[180] Sanderson, *Counseling Skills for Working With Shame*, 187.
[181] Winnicott, *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*.
[182] Ladany, Klinker, and Kulp, "Therapist Shame: Implications for Therapy," 320.

5 Spiritual care and shame

By answering what chronic shame is (I) within chapter 3, and its role within the clinical practice (II) in chapter 4, the question of how chronic shame relates to spiritual care specifically (III) can now be answered. It is important to understand what a spiritual counselor is (5.1), that they busy themselves with certain aspects of human life (5.2), and that they work with trauma (5.3). To explore one way in which chronic shame may relate to spiritual care is through the stance that is taken by the spiritual counselor (5.4). Lastly, the biography of the spiritual counselor and thereby certain aspects of their education are presented, providing another potential aspect affected by chronic shame (5.5).

5.1 The spiritual counselor

An important source to understand what spiritual counselor does, the quality standards that apply to them, and what can be expected of them, is the 'Beroepsstandaard geestelijk verzorger 2015', published by the VGVZ (Vereniging van Geestelijk Verzorger) (2015). Here, it is explained Spiritual counselors work alongside these professionals in institutions such as hospitals, psychiatric facilities, disabled care, Child Welfare, elderly care, and primary/first-line care. In addition to a multidisciplinary team of healthcare workers, Dutch spiritual counselors provide professional guidance, counseling, and advice concerning meaning-making and philosophy of life. They are academically trained in theology, religious studies, or humanistic studies, and educated on religion, group counseling, interviewing, advising on meaning and philosophy at the organizational level, and supporting ethical decision-making.[183]

Spiritual counselors also fulfill a function in Justice, the armed forces, TBS-clinics, and prisons. They are available to provide sanctuary and act as a confidant for anyone, regardless of their specific religion, spirituality, or belief. They offer support in situations involving loss, separation, connection, life or death, ethical questions, or other themes and topics around life philosophy and meaning. The spiritual, or meaning-making, aspect, is closely related to religious practices, which is why it is expected of the spiritual counselor to reflect on philosophies of life, and spiritual and ethical themes, in whatever cultural or work-related context they may present themselves. This often takes the form of individual or group counseling, and the spiritual counselor helps the client find personal or traditional sources of inspiration and strength. Additionally, the spiritual counselor may also make use of rituals and sacraments that suit the client's particular religion or spirituality.[184]

Given the range of aspects spiritual care has, it is important to narrow down which aspects are relevant to the research question. In the previous chapters, it is discussed what chronic shame is and how it is embedded in clinical practice. In doing so, several aspects were highlighted. In this chapter, some of that is used to draw a relationship between chronic shame and spiritual care. The first aspect of spiritual care relevant to the research question is to provide professional counseling, care, and advice with regard to meaning-making and life philosophy. In 5.2 is explained how this relates to chronic shame with the help of the information provided in paragraphs 3.1, 3.2, and 3.3. The second important aspect is the role of the spiritual counselor in working with trauma (5.3), which is an example of an aspect that is affected by shame (4.1.4). The third aspect of importance to this study is the stance and attitude of the spiritual counselor (5.4), which is explained to play an important role for those

[183] Smid and Jacobs, "Geestelijke Verzorging in de Psycho-Traumazorg: Een Plaatsverkenning," 60–61.
[184] VGVZ, "Beroepsstandaard Geestelijk Verzorger," 7.

working with shame (4.2.1). Last is the biography of the spiritual counselor and thus the awareness and insight of self, which could be affected by an understanding of chronic shame (4.3).

5.2 An existential category

To understand the significance of spiritual counselors to chronic shame, it is first important to further explain its role in meaning-making and philosophy of life. In Dutch, a spiritual counselor is called *geestelijk verzorger*. In the 'Beroepsstandaard geestelijk verzorger 2015', it is said that *geestelijk,* which translates to 'spiritual' in spiritual counselor, refers to the human desire to derive and assign meaning to life, to find purpose. This is reflected in how individuals approach and experience life, and in their search for connection and direction. In the 'Beroepsstandaard geestelijk verzorger 2015' is stated that 'In-depth as well as width, the spiritual counselor is knowledgeable and has an affinity with meaning-making processes'.[185] In other words, the spiritual counselor is supposed to have a personal connection and a professional understanding of the mechanisms and processes that are at play in assigning meaning to life. Among many things, existential themes are closely related to those processes.

So what is an existential theme? To understand this concerning shame is further explained through the idea of existential feelings or emotions. Matthew Ratcliffe, in his book *Feelings of Being: Phenomenology, Psychiatry, and the Sense of Reality* (2008) developed a definition, says described as: "[…]a sense of reality of self and world",[186] which is about how we relate to the world, which can "[…] range from a feeling of belonging to the world to a feeling of detachment or alienation".[187] David Weberman, who draws from Ratcliffe's work in his article 'What is an Existential Emotion', published in *The Hungarian Philosophical Review* (volume 64, number 1, 2020), says that something is existential: "[…] if it brings to light in a profound manner something central to the human condition".[188] So, when trying to understand shame as existential in light of these explanations, it is important to examine the emotional and personal aspects of shame with regard to self and world, including how it deeper feelings of unity or detachment, whether it causes us to feel connected or disconnected, and if it relates to fundamental aspects of being human. A function of the spiritual counselor is to guide clients within their existential problems, which is explained in the 'Beroepsstandaard geestelijk verzorger 2015' through the following four guidelines:

- The existential dimension refers to the experience of existence as such, in its everydayness and with its (contingent) experiences of horror and wonder and everything in between.
- The spiritual dimension refers to transcendent meaning and experience.
- The ethical dimension refers to the field of values, norms, and responsible action.
- The aesthetic dimension refers to the formative meaning of experiences with beauty in both culture and nature.[189]

From an existential perspective, shame can be understood as a struggle with the reality of being a finite and mortal being that has flaws and limitations. In 3.2 it is explained that shame is a complicated, elusive, and deep-rooted emotion that is fundamentally tied to how we experience the self and world. In his chapter 'Foreword: from shame to wholeness: an

[185] VGVZ, 11.
[186] Ratcliffe, *Feelings of Being: Phenomenology, Psychiatry, and the Sense of Reality*, 2.
[187] Ratcliffe, 3.
[188] Weberman, "What Is an Existential Emotion?," 94.
[189] VGVZ, "Beroepsstandaard Geestelijk Verzorger," 10.

existential positive psychology perspective', from the book *The Bright Side of Shame: Transforming and Growing Through Practical Applications in Cultural Contexts* (Cham: Springer, 2019) Paul Wong explores shame and describes it together with guilt and anxiety as part of the tragic triangle that has plagued humanity for a long time. He says that "[…] shame stems from the human condition of being conscious of our nothingness, aloneness, and insignificance in this vast cosmos as helpless orphans".[190] Combined with the idea from 3.2 that shame is evoked when we're left alone in this feeling and when the rupture is not repaired, a certain reality of our fundamental nature is experienced when feeling shame. By questioning the quality of relationships, social value, worth, and sometimes even the very right to exist, chronic shame has a deep impact on mechanisms and processes used to assign meaning to life.

5.3 Spiritual care and trauma

Another way in which the relationship between spiritual care and chronic shame can be helpful is through trauma. In 4.1.4 it is explained how trauma and shame share a complex but important relationship that only recently has been brought to attention. In roughly the same timeframe as Dolezal and Gibson published 'Beyond a Trauma-Informed Approach', Geert Smid and Gidia Jacobs published 'Geestelijke verzorging in de psycho-traumazorg; een plaatsverkenning', in *Tijdschrift voor Psyciatrie* (volume 64, number 3, 2022), in which they explore the role and place of spiritual care in working with trauma, moral injury, bereavement, palliative care, and multicultural care. Given the relationship between shame and trauma, it seems important to establish the relationship between spiritual care and trauma to highlight the importance of chronic shame sensitivity to spiritual care.

Smid and Jacobs explain that existential questions around meaning and purpose are evoked by situations that disrupt the everyday way of being and acting, and where common sense is no longer sufficient.[191] Jacobs identifies four types of experiences that are central to spiritual care: (1) fracture experiences such as illness or loss, (2) experiences of ontological uncertainty when faced with difficult choices, (3) societal boundary experiences involving the violation of human rights or freedoms, and (4) moral tensions resulting from conflicts between personal values and those of others or organizations.[192] Just like shame, these types of experiences can be called boundary phenomena (3.2), because they too are often characterized by a rupture or disconnection of the usual connection with self and others, but also with values, ideals, and the world. Restoring these ruptures is central to spiritual care, generally by using methods of presence and narrative methods. By being truly present and by co-creating stories, connections are made and restored, which help create values and meaning. Additionally, spiritual counselors can make use of rituals to mark important moments of transition and make connections between people and their experiences of loss and trauma.[193]

Spiritual care can be an important aspect of trauma care throughout the care process, including offering support, prevention, and early detection; providing guidance on existential issues and helping with meaning-making; supporting those in the process of resocialization or receiving palliative care. Spiritual care distinguishes itself from other disciplines that offer help in trauma care, by the way, they ask questions and listen, because they look for the question of meaning behind the primary request for help. The goal of that approach is to strengthen someone's orientation in their life, expand their spiritual well-being, and increase personal recovery.[194]

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[190] Wong, "Foreword: From Shame to Wholeness: An Existential Positive Psychology Perspective," v.
[191] Smid and Jacobs, "Geestelijke Verzorging in de Psycho-Traumazorg: Een Plaatsverkenning," 161.
[192] Smid and Jacobs, 161.
[193] Smid and Jacobs, 162.
[194] Smid and Jacobs, 163.

There are some limitations to spiritual care, however. This includes the lack of a diagnostic lens, which means that in encountering complex psychiatric conditions and personality disorders the spiritual counselor may need guidance from a professional that has diagnostic expertise. Additionally, if it is a given that it is important to use a shame lens when working with a trauma lens (4.1.4), it may be helpful to discover in what way the relationship between chronic shame and spiritual care influences the discipline's relationship to trauma.

5.4 The attitude of the spiritual counselor

In 4.3. it is explained why shame is hard to treat, how important it is to take a stance when working with shame (4.3.2) and how to reduce and heal shame in 4.3.3, and what difficulties and benefits naming shame has (4.3). Although there is no mention of 'creating a shame-free space', creating 'shame-sensitivity', or of 'chronic shame' in Dutch papers on spiritual care, they do seem to account for shame and are – at least to a certain extent – attuned to it in a general sense. In this paragraph, some attitude aspects are discussed that are considered to be central to spiritual care in the Netherlands and seem to correspond with the attitude aspects of PACE as formulated by DeYoung.

In 5.2 it was discussed that chronic shame can have a significant impact on meaning-making, with which the spiritual counselor is involved. To do so, spiritual counselors learn among many other things to adopt a basic stance that is to them the base and precondition for the professional relationships they engage in. Myriam Braakhuis, Sjaak Körver, and Martin Walton write in their paper 'Professionele nabijheid', published in *Tijdschrift Geestelijke Verzorging* (Volume 22, Number 95, 2019) it is 'A basic attitude of attentive engagement on the other from openness, empathy, selfless disinterestedness and without judgment, creating a relationship of trust'[195]. One might say that perhaps more than anything else, the spiritual counselor needs to be present and have room for the other, making the other feel truly heard. Doing so breeds trust and causes the other to feel taken seriously when sharing stories.[196]

Although the attitude of the spiritual counselors is composed of many aspects, here the focus will mainly be on *presence* and *congruence*, which the latter will be discussed in a moment. The term presence comes from Andries Baart's *theory of presence*,[197] presented in his book *Theorie van de presentie* (2001), which is a vast and often misunderstood theory on stance widely used by spiritual counselors. Despite these discussions, which are too expansive to discuss in this thesis, it is generally considered to be very important to spiritual care. According Job Smit, in his book *Antwoord geven op het leven zelf: Een onderzoek naar de basismethodiek van de geestelijke verzorging* (2015), it's considered to be a milestone in considering the work of the spiritual counselor. For many, it is considered to be the methodical ground for their work. Here, presence is meant to point towards the attitude aspects that are derived from it.[198] As Smit explains, presence can be understood as an existential category of the meaning of 'being' with and for others that translates to a way of doing.[199] Presence means 'being there'. So, concerning stance, presence means truly being there with the other, which translates to some practical aspects for the spiritual counselor. Some points are important: embracing that the weirdness, uniqueness, or deviation of the other is not to be seen as a phenomenon that needs to be fixed, but is rather acknowledged and honored in his logic and meaning.[200] Another aspect is what Smit describes as freeing oneself of attitudes, preferences, and convention to make room for

[195] Braakhuis, Körver, and Walton, "Professionele Nabijheid," 15.
[196] Braakhuis, Körver, and Walton, 15.
[197] Baart, *Een Theorie van de Presentie*.
[198] Smit, *Antwoord Geven Op Het Leven Zelf*, 21.
[199] Smit, 167.
[200] Smit, 168.

radical receptiveness of the other in his otherness, and for responsibility and commitment towards the other.[201]

Congruence, which is sometimes also called *genuineness*, is introduced by Carl Rogers in the article 'The necessary and sufficient conditions of therapeutic personality change', published in the *Journal of Consulting Psychology* (Volume 21, number 2, 1957).[202] The reason congruence is discussed here, is because it is regarded as a prerequisite for transmitting empathy and positive regard for the client.[203] Congruence consists of practitioners to be truly and freely being themselves, which means being mindfully and genuinely present with the client.[204] According to Gregory Kolden et al., in their article 'Congruence/genuineness: A meta-analysis' published in *Psychotherapy* (Volume 55, number 4, 2018), elaborate on the work of rogers, the practitioner communicates authenticity and personal awareness, and does so in both word and action.[205] In his book, Smit calls congruence not only fundamental to the conversational techniques of the spiritual counselor, but rather an active and effective component of spiritual care.[206] The reason that congruence is addressed here, is because of the elements it consists of that seem to be susceptible to the effects of chronic shame, hypothetically undermining empathy, authenticity, and positive regard. To explore this hypothesis is further investigated during the interviews.

In 4.2.1 DeYoung's relational validity and the attitude aspects of playfulness, acceptance, curiosity, and empathy (PACE) are discussed. Taking both this paragraph and 4.2.1 together, the attitude aspects and stance explained in both 4.2.1 and here, can be used to determine if the aspects provided in the interviews may be helpful when engaging with chronically shamed individuals.

5.5 Biography of the spiritual counselor

In paragraph 4.3 the relationship between chronic shame and practitioners was explained, and in the first two chapters, it is explained that chronic shame can potentially harm the client, the practitioner, and their relationship. In this paragraph, an additional problem is presented from the literature primarily used by spiritual counselors and is then related to some of DeYoung's thoughts on shame and the practitioner, in order to show if an understanding of chronic shame can provide extra insight into the work of the spiritual counselor. Afterward, an example is given on an aspect of the education to become a spiritual counselor, exploring how this relates to the problem above and how it relates to 4.3.

Paragraphs 3.2, 3.3, and 4.1 explain in what way shame can affect someone, including its effect on narcissism and self-esteem. In their book, *Zorg voor het verhaal* (2014) Ruard Gansevoort and Jan Visser reflect on spiritual care and suggest the possibility that those with low self-esteem and narcissistic hurt may choose a profession that provides them with a certain prestige.[207] They propose the cause for taking one's feelings and needs too lightly, which might also be the reason for becoming a spiritual counselor in the first place. They suggest that these needs will never be truly fulfilled by the job and their unfulfilledness may hurt the relationship. Looking at the literature on shame may provide some explanation for low self-esteem and narcissistic hurt.[208]

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[201] Smit, 168.
[202] Rogers, "The Necessary and Sufficient Conditions of Therapeutic Personality Change."
[203] Rogers, 96.
[204] Rogers, 97.
[205] Kolden et al., "Congruence/Genuineness," 323, 324.
[206] Smit, *Antwoord Geven Op Het Leven Zelf*, 118.
[207] Ganzevoort and Visser, "Werken Met Verhalen."
[208] Ganzevoort and Visser, *Zorg Voor Het Verhaal*, 405, 406.

DeYoung proposes that chronic shame, in addition, to causing internal reactions like countertransference (4.4), may be the motivation for becoming a practitioner. She proposes that an in-depth therapy process may reveal the shame underneath, followed by the discovery that he or she wants to do something else with their life. May they realize there are easier ways of making a living, and of making a difference in the lives of people who are hurt.[209] Although Gansevoort and Visser do not name it explicitly, DeYoung's proposition on chronic shame as a hidden drive for becoming a therapist may provide them with an additional explanation. Harry Stroeken says in his article 'Furor therapeuticus/sanandi', on the website Psychoanalytisch Woordenboek (last modified on September 23, 2003) that when the need for helping others, or the desire to heal them, is so big that the practitioner needs the client at least as much as the other way around, some might speak of the *furor therapeuticus* or *furor sanandi* (also called the *hulperverlenerssyndroom,* which translates to 'helpers' 'syndrome').[210] So, here too an understanding of chronic shame may contribute to spiritual care, for this seems to be tied to the proposed shame-based need for becoming a practitioner.

To ensure the quality of care, spiritual counselors are also held to a standard concerning self-care, tending to one's biography, self-reflection, and so on.[211] An important example of this is given by Jannet Delver and Wim Smeets, in their article 'Een leven schrijft zich niet vanzelf. De training Spirituele Autobiografie in een beroepsvoorbereidend programma tot geestelijk verzorger', published in *Psyche en Geloof* (Volume 26, number 4, 2015).[212] The paper is a documentation of the experiences students have with training in which they have to methodically write a spiritual autobiography. Through different rounds, and by addressing different themes, personal experiences, situations, and memories are collected, written down, and shared in groups under supervision. By doing so their experiences are placed within larger philosophical, theological, spiritual, and pastoral-psychological perspectives. Their motivations, sources of inspiration, and other factors are brought concerning the life story of the participant. At several moments in the course of the training, the biographical texts are shared with others and the other participants are allowed to ask questions to which the participants choose whether they want to answer or not. The way of questioning is directed towards a non-interpretive engagement and has as its goal to set in motion internal processes of reflection and to deepen, re-examine, and reinterpret one's story. The exercise proves to set in motion a range of active processes with multiple effects on the professional development of the participant. The participant learns by which ways one's vision of life has developed itself, how to methodically reflect through question-asking, gains insight into how the acquired expertise influences the processes of their role as a spiritual counselor, and [once actively working as a spiritual counselor later on] the training may provide help in identifying and understanding occasions of countertransference.[213] Within the different Dutch educations to become a spiritual counselor reflecting on one´s spiritual biography has become a fixed part, similar to the obligation to follow supervision and learning therapy for therapists and counselors in other disciplines.[214] By doing so, the spiritual counselor develops their spiritual as well as personal competence.

So, how does the method just mention relates to chronic shame? Writing a spiritual autobiography can be beneficial for spiritual counselors, as it allows for self-reflection and a deeper understanding of their own experiences, motivations, and perspectives. However, it may not be enough to address shame on its own, and for some individuals sustained work with

[209] DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*, 68, 69.
[210] Stroeken, "Furor Therapeuticus/Sanandi."
[211] VGVZ, "Beroepsstandaard Geestelijk Verzorger."
[212] Delver and Smeets, "Een Leven Schrijft Zich Niet Vanzelf. De Training Spirituele Autobiografie in Een Beroepsvoorbereidend Programma Tot Geestelijk Verzorger."
[213] Delver and Smeets, 230.
[214] Delver and Smeets, 228.

a therapist may be necessary. Whether the process just explained is "good enough" (4.3), depends on the situation and circumstances the spiritual counselor is in.

6 Results

In this chapter, the results are presented that primarily aim to answer sub-question IV "What are the experiences and perceptions of Dutch spiritual counselors regarding shame in their practice?". In doing so, it helps answering all the different aspects of the research question: "What is the current understanding of chronic shame among spiritual counselors in the Netherlands…", and "…to what extend is there a foundation for furthering the understanding of chronic shame", and "and its implications for specific aspects of spiritual care?".

6.1 Encountering shame

In this paragraph, the relevance of chronic shame to Dutch spiritual care is preliminarily explored by looking at it, and if so to what degree, spiritual counselors are involved with shame in any way that already extends beyond situational shame. First, it established whether or not the participants learned about shame during their education. Secondly, it is further explored if and how they learned about the subject through personal experience. Third, an overview is given of where participants say to encounter shame.

Name	Education	Description
Kees	No	Kees told about Buddhist teachings and the position shame has within them, but his description of shame did not extend beyond situational shame.
Bas	No	Bas didn´t explicitly say if he received education on shame. He did say that the word chronic shame made him think of a given in his education where it was said that if one is triggered by something the other tells, this often signifies that there is something to work through in oneself. Here, Bas discovered through his reaction when encountering shame in other places that this was something he was suffering from.
Julia	Unclear	Julia says there was a module about shame and guilt by Ton Jorna during her education. However, she remarks that she didn't follow it and she doesn't provide further information on whether or not she learned about shame during other subjects. She did state that she noticed guilt received far more attention than shame when she was studying.
Linda	Yes	Linda started the interview by presenting the book "Echte Woorden" (2009) by Ton Jorna. During her education as a spiritual counselor, she learned about shame during the classes of Ton Jorna on shame and guilt, in which he lectured from his book. At the end of the interview, Linda remarked that she never systemically reflected on shame.
Nicole	No	Nicole said that she hasn't thoroughly investigated shame and that she also didn't receive any education on the topic. Nicole guessed this always was the case for all the participants of this study. For her, it became an important topic in her work and during her therapy.
Monique	Yes	Monique said to have never heard of the word chronic shame and that during the interview she was thinking about it in news for the first time. She did say that shame was discussed in her studies during 'psychopathology and religion' and 'care ethics'.
Sandra	Yes	Sandra said to have been educated on shame during her education as a spiritual counselor, with shame as a very basic sense: a "shame-lens", alongside "guilt-lens". Additionally, Sandra has researched shame herself a lot.

Table 6.1

As was explained in chapter 3, everyone gets to know what healthy shame is at a very early age, but this isn't so straightforward for chronic shame. As was explained in 4.1.1 and 4.1.2, chronic shame isn´t easily recognized in oneself or another, and it seems to be one of the less familiar psychological topics. Of course, one can always stumble upon the subject of chronic shame, but in general, it seems that getting to know chronic shame may take some effort in the form of investigation, education, reflection, or other sources or forms of inquiry. As the interviews progressed it has become clear that chronic shame isn't a widely used term among the participants. Although all the participants heard about shame in one way or another, the word chronic shame was seldom repeated by them. In this paragraph, the question of where

the participants learned about chronic shame is therefore taken loosely and extended to where and how they acquired any knowledge on more malignant types of shame that extends beyond situational shame. One of the first things that became clear from the interviews is that there is a variety in how the spiritual counselors acquired such knowledge and it isn't given to receive education on it. For some, it was the case that they learned about it during their education, but others didn't and got familiarized with it through various ways as well as outside as inside their work as a spiritual counselor, depending on the participant. In the table below you can see whether or not the participant said to have learned about more severe types[215] of shame.

Besides receiving theoretical knowledge on shame as shown in the table above, some participants also seemed to have learned about shame through their subjective experiences. Several participants however shared stories that revealed a more personal relationship with shame, rather than a theoretical understanding of the topic. For them, a significant part of their knowledge of shame seems to come from their subjective experience and, importantly, their reflection on it. The importance of their reflection on it is stressed because some of the stories show that the participants already suffered from shame for a very long time, but only realized this much later. Also, the participants may suffer from chronic shame without knowing it themselves. In the table below the stories are shown with 'yes' meaning the participant acknowledges to have and to draw from personally felt experiences of more toxic forms of shame and with 'no' meaning he or she either reflects on ordinary shame or at least doesn't shares knowledge on toxic shame drawn from personal experience.

Name	Personal	Description
Kees	No	Kees said that he remembers being ashamed when he was a kid, but saw this as normal and healthy. It was *for* something he did, and it disappeared as soon as he adapted his behavior.
Bas	Yes	When I asked Bas about the reason he was interested in my thesis, he answered it made him think of what was told to him during his education: "When you are triggered during a conversation and by something someone is telling, then this is always because it relates to something within you". Bas experienced several moments where he was triggered in one way or another, and although skeptical at first, Bas came to understand that in his particular case, this had to do with ongoing shame. Only recently, Bas discovered shame severely influenced his family and therefore how he grew up. Shame for example appeared to be the reason he was limited to engage with others and wasn't involved in any groups already from when he was very little.
Julia	Yes	Julia explains shame has been a large part of her life, and names several factors that she thinks caused that to be the case. Some examples are problems around sexuality, identity, and also ADHD. Julia explains that it took a very long time before she understood she suffered from shame a lot. It was only somewhere in the last decade, after a psychological crash she experienced in the aftermath of physical injury, that she noticed she frequently could feel deeply ashamed throughout her entire being, and only then realized she has experienced a lot of these periods throughout her life.
Linda	No	When Linda was asked about her personal experience of shame in her life, she says that she has had to do a lot with shame in her life, but that it wasn't the most important theme in her life. Although 'allot' seems to indicate Linda suffered from more than just situational shame, she also says she doesn't feel like she had to free herself from it. She summarizes her experience with it as: 'I grew up and let things go'. Additionally, when Linda was asked about a story that involves shame, she seems to be ashamed *of something* but not necessarily of herself.
Nicole	Yes	Nicole tells that she was abused and that she has a lot of experience with shame because of it. During her therapy, she learned that shame was a very important theme for her and her fellow victims of abuse. She explains that this shame is felt for what happened to them because they let it happen to them.
Monique	No	Monique says that she never experiences shame within herself when working with clients and their close ones. She says that she does remember feeling ashamed throughout her life, for the behavior her mother expressed in public for example. When Monique was 15 she experienced a lot of shame, but she was able to quickly move past or beyond it since she started working as a spiritual counselor.

[215] It isn't wholly correct to say it is a different type of shame, see 3.1 to 3.3

Sandra	No	When Sandra was asked if she ever suffers from shame, she said that of course, she suffers from shame, but that she thought it was hard to think of examples. Sandra eventually only said that she suffers more from shame in her private life than during work because work is for others which makes it to place yourself outside of your shame.

The last two tables show if and how the participants acquired shame-knowledge beyond ordinary shame, whether or not they do so from their education as a spiritual counselor and/or from personal experience, provided with descriptions to explain alternatives or important details. At least Kees, Bas, and Nicole appear not to have heard about shame during their education. Linda, Monique, and Sandra did so for sure, but with the added note that Monique never heard of chronic shame before she received the invitation for the interview. With Linda and Julia both pointing towards Ton Jorna for education on shame, it can be concluded that participants acquire knowledge on shame from personal experience and many different sources, yet which ones outside of their education aren't clear.

Besides being educated on or learning about shame from personal experience, the participants also encountered shame in clients, colleagues, or students, depending on who you ask. The following table it is shown what places spiritual counselors say to have encountered shame and in whom they've done so, followed by a brief explanation. Importantly, the instances of shame are not yet rated on their resemblance to either adaptive or maladaptive shame. Rather, they are the answers provided by the participants when they were asked about chronic shame. When wondering about the relevance of specialized knowledge on chronic shame for the spiritual counselor, spiritual counselors need to say in what way, to what degree, and where they encounter shame in the general sense.

The interviews showed that shame can be felt by individuals in many different settings, including universities, hospitals, nursing homes, and prisons. At universities, students may feel shame because of their appearance, their choice of study, perhaps the way they communicate, getting poor grades, or because of the chances of not submitting a perfect assignment. During internships, students in spiritual care may experience shame towards clients and teachers for not being able to fully present themselves without showing signs that they may be having a rough time. In hospitals, patients may experience shame due to their illness, physical changes caused by treatment, and difficulty performing daily tasks. In nursing homes, female residents may feel shame for past experiences of abuse, incest, and sexual assault. Additionally, residents, in general, may feel shame for 'failing bodily functions, not being able to eat or go to the toilet by themselves, feeling like they can no longer contribute to society, not being able to cycle, or being in a wheelchair. Family members of nursing home residents may also experience shame for the dementia of their loved one and the accompanying expressions. Inmates in prison may also feel shame for the crimes they have committed. Outside of these institutions, the interviews showed that shame may be felt by many other groups and for many different reasons. Shame may for example be felt by lonely people, by a male who shows his feelings, by those who take refuge, or by those who have financial problems. On a more personal level, shame may occur with problems around intimacy or sexuality. Nicole concluded that [at work] shame is almost always in the background, silently penetrating many conversations, and Linda too remarked that shame is a theme she sees all around her.

Table 6.2

When investigating if chronic shame is relevant to the spiritual counselor, two preliminary main points can be made within this paragraph. First of all, the previous paragraph shows that shame is first of all prevalent in the work field of the spiritual counselor. It occurs in many places, on many occasions, and for many different reasons among people with which the spiritual counselor engages. So, given the statements presented in paragraphs […] and […], and that shame occurs often in many different ways, spiritual counselors may too benefit from knowledge on chronic shame. Secondly, the results seem to indicate in several ways that neither in the past nor present there was or is a general approach to educating students about spiritual care for chronic shame.

6.2 Defining and describing shame

In the previous paragraph it was concluded that although shame is prevalent in the work field of the spiritual counselor, there yet seems to be no clear-cut way in which spiritual counselors are educated on it. In this paragraph, it is presented how the participants define shame, what descriptions they provide about it, and what can be said accordingly about the participants' understanding of shame. To answer the main question on the understanding of chronic shame, it is insightful to explore their current understanding of the topic (table 6.3).

Table 6.3

Participants	Definition/description
Kees	Shame is a disruptive and unpleasant emotion, but it is neutral and regarded as beneficial when it prevents someone from engaging in harmful activities. Shame is some sort of alarm that goes off and stops you from doing what you are doing. Shame may also be refraining from telling something wrong that you did. Shame can also be not wanting to be seen because of something wrong you did. 'Shame makes someone small and pushes one into a corner'. It can make someone wonder: 'Am I a bad person?'
Bas	Shame means there is something that you cannot talk about, which potentially influences all sorts of relationships. Shame is also a feeling or state which can suddenly be triggered by someone else´s story, which is indicated by a thought like "I can't handle this anymore". The feeling of shame is a 'cutting-yourself-off-from'. Also, shame is about having parts within yourself that you are not happy about. For Bas, shame was something that was hidden throughout his life.
Julia	Shame is related to self-worth, and being severely ashamed means feeling worthless. One is afraid someone might see this, and the gaze of the other can make you feel like you are shriveling away, which feels unbearable. This shame can be felt everywhere and for long periods. Shame is an existential theme, yet it is different from other themes because it is harder to share with others. With different emotions like crying it is possible to feel connected, whereas with shame this isn't that easy. Shame can be accompanied by the anxiety to experience it, to keep it at bay. Julia related shame to loneliness as well.
Linda	Shame can be felt for things of yourself, for someone else, for what you may have done to someone else, or for what someone else does. It is felt for something someone has like: the body, education, clothes, way of speaking, interrupting someone, etcetera. Shame is relational and a moral concept and can be seen as beneficial. Shame is a moral category or it is about what is good or bad, yet it is one among many existential themes, just as important as others.
Nicole	Shame is a mechanism that is evoked to protect someone hurt and shame can occur around secrets [like a history of abuse], and the misery that is felt in the deeper layers underneath someone's biography. Shame often lies in the background yet it penetrates numerous conversations. Nicole's stories indicate that shame is related to abuse and trauma.
Monique	Shame is not living up to the standard that you have set for yourself. It is a sort of inability to deal with a fundamental vulnerability or it is used to hide the fundamental disappointment that life isn't malleable. Monique didn't look at the shameful triggers within her work from a shame lens, but rather a vulnerability, reciprocity, and equality. In assessing her experiences with shame, Monique expressed the likelihood of shame being overlooked by her. Monique also related shame to narcissism and an extremely low self-image.
Sandra	Shame is about the question of whether you or certain parts of you are allowed to be or not. Shame is something that occurs more nowadays in combination with individualism, and contrary to shame, guilt is relatively easily resolved, because you can apologize for it. Yet it almost seems impossible to solve shame because what does someone have to say, as Sandra wonders, "Sorry for my existence"? Severe cases of shame may not even be detected by the person himself. For Sandra, shame is strongly related to abuse, perfectionism, and narcissism.

In addition to these definitions and descriptions, the participants told different stories about themselves, their clients, and their students, which help to show their particular understanding of shame. In table 6.4, the stories are shown that the participants describe of a situation that involves shame.

Participant	Subject	description
Kees	Other	Before the interview, Kees provided a short story he received from his Buddhist teacher. In the story, one is asked to imagine walking through a department store with a lot of attractive items. In such a situation one may consider stealing something: there are a lot of the same items and because nobody sees it one knows for sure that he or she will not be caught. According to Kees, shame is when someone decides not to steal because he or she doesn't want to be that way, for the reason of not wanting to steal.
Bas	Self	Bas was triggered by a book that he read. It was a book written by a holocaust survivor about living in a concentration camp and life after that. Bas didn't realize it at the time, but later discovered the story resonated with him because of her family history. He explained that his grandparents were nazi sympathizers and only recently discovered to what extent. Throughout his life, Bas was never truly informed about this, but his family always was really reserved towards others and they had always avoided groups. Only in the last couple of years, Bas realized what the cause for this was. Bas explains that there is a large part of his life that was never talked about and he still can't.
Julia	Client	Julia had a client that she describes as mentally off track, psychologically completely out of balance, and unmanageable. In the course of their relationship, they talked about rage, hopelessness, and sorrow, but never about shame. Only after a long while Julia asked about it and when she did the client remarked: "All the time!". From that moment on, the enormous amount of shame the woman felt often became a topic of their conversation. The shame formed an explanation for that she sometimes didn't dare to go outside, that there were a lot of people she didn't want to face, and that she experienced a lot of anguish and anxiety.
Linda	Self	Linda told about an experience she had during her internship in prison as a spiritual counselor. Here, she had a single conversation with a detainee who for years stole money from his boss. Because he was in debt counseling, he couldn't legally give presents to his kids and therefore secretly used this money for that purpose. Linda remembered that she felt deeply ashamed of the Dutch society and how it contributed to the situation man was in. She also felt ashamed of herself, because she didn't know what she could do for him. Linda said that this was at the beginning of her education and that she wasn't able to express what she felt to the man. She noticed that to suppress the shame she started to act moralizing and very rational toward the man.
Nicole	Client	Nicole once helped a client who couldn't talk and therefore communicated via paper. Somewhere in their relationship Nicole was called because the man appeared very sad. By that time he had been there for a long time and he was in a very bad condition. Through writing the man slowly but surely revealed that the man was abused by his wife at home. The man was terrified to go home. Nicole says the man was ashamed 'through and through'.
Monique	Client	Monique tells about the shame clients can feel because the care they receive is given in improper ways. She gives an example of needing care around the most basic needs, and how clients can feel guilty towards the nurses for needing so much. When a nurse responds with: "That's okay, I gladly do this for you", this can cause shame because such an expression can make someone feel smaller than he is. One of her clients once said: "There are nurses that wash me, and nurses give me dinner, but I am merely a shadow of myself when I am being cleaned or fed".
Sandra	Student	In providing an example of shame, Sandra tells about a student who once managed to acquire an internship in a very nice location. The student was very skilled and made beautiful artwork and was busy with graphic design and meaning-making. After a certain, while things went more and

more wrong with the student however, up until the point it appeared that he wanted to commit suicide. It became clear that he had a troubled and traumatic history.

Table 6.4

Taken together, the results show that all participants see shame as something that is isolating and restricting at its core. Some of the participants, Kees, Linda, and - to a certain degree - Nicole, describe shame as having a moral, social, or personal benefit. Both Kees and Linda regard it as a morally guiding emotion and Nicole sees its value as protecting the one that is hurt. But where do their descriptions stand concerning the division that was made between situational and chronic shame? In chapters 3 and 4 situational and chronic shame are discussed extensively, of which the following points are selected because they help us define the understanding of chronic shame of the participants.

- One of the most important and devious properties of shame is its tendency to conceal and hide (4.1.1).
- Although shame can be morally or socially beneficial, chronic shame is characterized by the damage it can do to an individual. Calling shame 'good' or moral in some way strongly indicates that one is talking about situational (not chronic) shame (3.1, 3.2).
- The way chronic shame seems to set itself apart from situational shame, is through the anxiety to keep away from it (3.2).
- Understanding that shame is in many ways related to trauma is important when working with clients (4.2.2).
- Talking about narcissism and perfectionism shows an understanding of shame as something that can show itself in ways that er not always obvious (4.1.3).

In an attempt to provide additional insight into the participants' understanding of shame, the data presented in this and the previous paragraph was checked for several characteristics from the first chapters, regardless of whether they were talking about themselves or others (table 6.5).

Name	Chronic shame is not 'good' (3.1 & 3.2)	Hiddenness of shame (4.1.1)	Shame Anxiety (3.2)	Related to trauma (4.2.2)	Related other problems (4.1.3)
Kees	-	-	-	-	-
Bas	+	+	-	-	-
Julia	+	+	+	+	+
Linda	-	+	-	-	-
Nicole	+	+	-	+	-
Monique	+	+	-	-	+
Sandra	+	+	-	+	+

Table 6.5

The interviews in which shame was called good several times, Kees and Linda, were almost entirely about situational shame which is supported by most of the points not being checked. Since the participants were in fact given a detailed description of chronic shame beforehand their contribution indicates some sort of trouble with either reading or understanding the information, which unfortunately wasn't reported. With overall certainty, it can be said that Kees and Linda shared their specific knowledge on their ideas of shame in general.

With some of the participants, it was challenging to determine whether they were talking about chronic shame or not, or if they potentially talked about something that wasn't discussed in the theoretical framework. In Bas' case for example it is evident that shame has played an important role in his life, yet it is less clear in what way Bas has experienced this shame. Although Bas explains his shame as isolating and tells about feelings that he sometimes 'cannot handle any longer', Bas didn't mention any characteristics from 3.2, for example feeling

worthless or unlovable. The shame named by Bas may be of a different form that wasn't discussed in this thesis.

The same goes for Monique but for wholly different reasons. The first is that she often talked about *vicarious shame* [plaatsvervangende schaamte], which wasn't addressed in the theoretical framework. As of now, it is unclear how vicarious shame relates to the forms of shame in this thesis. Given that Monique used the term multiple times, and that she describes in different ways her engagement with it within herself and others, further investigation of this topic seems appropriate. A second reason is that it is hard to determine Monique's stories on shame in the framework of this thesis, is because, on the one hand, she seems to explain occasions of shame among the elderly of which almost anyone would be ashamed, while on the other hand, the frequency with which they occur is aberrant. It isn't clear if and how an increase in shame in seniors [failing bodily functions, deterioration of the ability to care for oneself] due to changing circumstances [aging/moving to a nursing home] relates to chronic shame and its potential development.

Nicole gives detailed descriptions of shame within her clients and herself. She explains that she can sense it around certain subjects within her clients and that she remembers it from her history of abuse. When asked if she still feels it when she works with abused clients she answered she doesn't feel it in contact with the other, but she does recognize it and it resonates with her on all levels. Nicole says that she probably has reflected on it sufficiently and learned from it to the degree that there is no countertransference. Nicole seems to possess a thorough and developed understanding of shame for which she also draws from personal experience, yet here it is completely clear if she has an understanding of chronic shame specifically.

Julia appears to have an understanding of shame that resembles the information on shame and chronic shame from the theoretical framework of the past. Julia is for example the only participant that accurately described shame anxiety as was mentioned in 3.2. Also, she was the only participant that told stories about her shame defenses, her negative self-image, and how pervasive shame has been throughout her life. Julia is followed by Sandra concerning understanding shame, who primarily acquired her knowledge through her education and her interest in the topic.

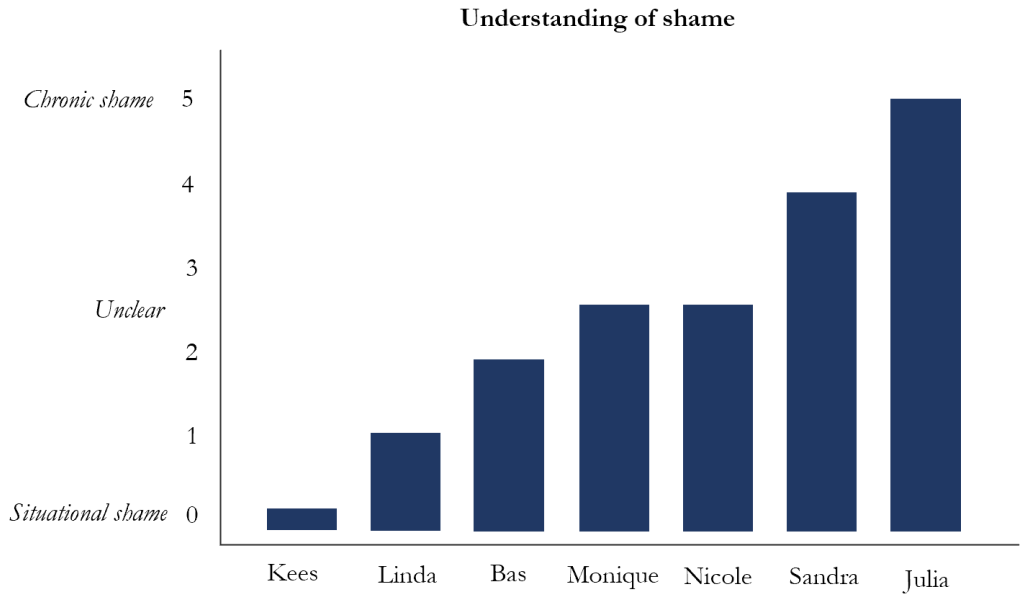

Figure 2

6.3 An existential category

As was mentioned in 5.1, most of the participants too talked about shame as also being an existential category. Nicole, Monique, Sandra, Linda, and Sandra all explained their views on shame being an existential category.

Linda introduced the book *Echte woorden* by Ton Jorna, and Jorna considers shame, together with guilt, to be central to spiritual care. Linda herself thought this proposition was too strong, concluding shame is indeed important but an existential theme among many others like death, freedom, and so on. Another way in which Linda expressed shame as an existential category was through it being a moral category, which was also done by Kees. Kees proposed that from a Buddhist perspective, shame can even be considered to be something good because it is something that challenges the ego.

Both Sandra and Julia describe shame as being about the fundamental question ´am I allowed to be?', which profoundly brings to light something central to the human condition (5.1). To Julia, shame is different from other existential themes because it is uniquely hard to share it with others. With different emotions like crying it is possible to feel connected, whereas with shame this isn't easy. Ultimately, people themselves can only answer whether they are allowed to be and take in space in the world. Julia continued that shame is about being visible or invisible, and the struggle around accepting what one is in its entirety, including everything good or bad one has done.

6.4 Dealing with shame

To explore the foundation for furthering the understanding of chronic shame and its implications for specific aspects of spiritual care, this paragraph focuses on results that relate to the attitude and stance (5.4, 4.2.1) that is taken towards chronic shame and how they potentially deal with it (4.2).

6.4.1 Attitude and stance

Three of the participants with a sufficient understanding of chronic shame shared what attitude or stance they adopt in working with shame (table 6.6).

Participant	Attitude
Julia	She illustrated her attitude and stance towards shame with stories from working with a particular client and from her role as a teacher. Julia tells about the way she behaves around her severely ashamed client (table 1.1). When the client started to talk about shame, Julia was supportive, encouraging, and open to sharing about it. Julia said she showed that her 'heart went out' to her, and she felt for her deeply. Julia remarks on the importance of humor in the conversations she had. By playfully approaching some issues with absurdity, Julia could make the shame a little bit lighter. Importantly, Julia said that one should never explain away the shame of denying it. Instead, one should be accepted, try to level with the client, and approach it with curiosity.
Nicole	Nicole has worked with the elderly in hospitals, rehabilitation, and homes. She says that when she asks questions, she wonders if it is 'her own' curiosity, and if so she keeps quiet because she doesn't like asking questions just for herself. She explains that it should be a genuine encouragement for the other to share, and if not she should just stay off the subject entirely. If she appears as the one to which they want to tell their story, then she provides an open space but she doesn't steer towards it. And, in places like the hospital, where people are presented in disgraceful situations, you place human dignity up front. Nicole says guarding this human dignity isn't necessarily healing or a cure for shame, but what it doesn't do is add more suffering to the suffering that is already there.
Monique	Monique, when working with narcissism, neutralizes herself as a threat, places herself below them, and gives a lot of compliments, this can give help give them the feeling they can beat her, and in that way, she can come truly close. And, eventually, see what someone's desire is and make contact over that. Monique seems with her stance to be focused on reducing the severity of narcissistic reactions in clients.

Table 6.6

Some of the attitude aspects presented in the table above correspond with the theoretical framework. Julia for example names playfulness, empathy, curiosity, and acceptance (4.2.1), and Nicole pays attention to the proper use of curiosity. Although Nicole's and Monique's contributions are not in the theoretical framework, they seem to provide valuable information in working with shame or shame-related problems.

6.4.2 Handling shame

In 4.2.2 some ways are explained in which shame can be handled, and some ways in which it shouldn't. One of which is addressing and naming shame. Sandra, Nicole, and Julia address this topic too. Sandra explains that shame can provide many challenges when working with it. Sandra experiences asking chronically shamed people basic questions about their background as quite the challenge, for this often proves to be a long process, for example, because of their problems around vulnerability. Sandra expresses it is very important to know about shame when engaging with a client, but it could be the other doesn't even know he has it.

Nicole said it is important to notice shame, provide the space to share it, and then, if needed she could name it but not necessarily: 'If I notice shame is right below the surface, because of how cautiously people speak, then I suspect that there is a particular theme that has shame around it'. I am not going to be the person who breaches it, I then first build on the relationship. And, if I then appear as the person to whom they want to tell their story, that they trust me, then fine but I will not steer towards it.

The interview with Nicole shows several things about naming shame. The story about her and her client shows the effect naming shame can have. During a large part of their relationship, Julia had never talked about shame. Once she asked about it, the client replied 'All the time'. After that, it was an important topic and the client spoke about it with openness and vulnerability, which Julia felt was right.

Paragraph 4.2.2 also mentions some things that shouldn't be done when working with shame. One example is also expressed by Julia, who says that you should never deny the shame, or explain it away.

6.4.3 Treating shame

This paragraph is presented what the participants do, or think one can do, to alleviate, cure, heal, or reduce the shame. The participants responded in different ways to different situations where shame played a role, which it did in varying degrees, in a variety of ways, and not all participants had such an action or move.

Julia shared a view on shame and a way of dealing with it. She explained that every person leaves a trail of bad and good deeds, like ripples in a pond. And, whether these ripples are good or bad, doesn't matter. There are always people who do not agree with what you did or who praise you for it. It is inescapable that your presence is seen with all its deeds. At some point, it may come down to the radical question of whether you are allowed to be. And, according to Julia, it can be liberating to accept this and to face the situation and see: 'This is it and I have to do it with this'. She suggests that as a spiritual counselor, you may be able to facilitate this, by presenting this question to the client, to invite them to accept or start accepting their lives. Julia says that for people to truly heal, they can only really help themselves. To heal their shame, they need to be able to receive.

Sandra also expressed how one can deal with intense chronic shame. The only way to heal for one is to accept their shame, to feel compassion with your shame: 'It is not bad, it is not wrong, it is not instantly narcissistic. It is there. When she was asked if she meant 'radical self-acceptance?', she replied: 'Yes, and remaining friendly towards it […]'. According to Sandra, shame needs to be truly embraced with compassion to bring about that development.

Bas said that handling all intense emotions, including shame or shame-based emotion, helps to realize those feelings are 'not yours'. Bas came to this realization through his education as a spiritual counselor and by working through trauma and shame. One of the expressions he often uses is: 'This is not me, this is not mine and this is not my self'. He explained that in practice, this means you do not shield yourself from the emotions of the other because you are not able to handle it, instead you open yourself up completely and know: 'This suffering is not mine. At the moment this resonates – so when it touches upon something I did not yet process – I experience it as mine.'

6.4.4 Spiritual counselor shame

In 4.3 it is explained how chronic shame may affect the practitioner, and in 5.5 some additional information is provided about this with regard to the spiritual counselor. They also address different problems practitioners might experience that may be caused by chronic shame and the dangers of not knowing about it or addressing it. This paragraph attempts to show if the participants were directly or indirectly told about these kinds of problems. In order to do so this also includes information on students who study spiritual care. Additionally, this paragraph shows what the participants said about working with one's shame.

6.4.3.1 The spiritual counselors themselves

As was shown in 6.2, three participants learned about shame through personal experience, and may therefore also experience problems in their work related to shame. Participant Nicole said not to experience any problems related to her shame like countertransference or suddenly feeling her shame because she says to have adequately worked through it. Bas only recently discovered he has suffered from shame throughout his life. He describes situations in which he can feel overwhelmed and needs to quit the conversation, and that certain stories can trigger him into a state in which he cannot listen objectively anymore. Especially Julia, who most likely has experienced chronic shame throughout her life, appeared to experience problems related to her shame.

Julia explained her feelings and thoughts during different moments, which seem to be related to shame. One example is when Julia talks about presence within particular workplaces, working alongside other professions. She explains that this is sometimes horrible to her, and feels she is being seen as '[…] some sort of loser that gets way too much money and only drinks coffee', even though nobody ever said that. Another example is how she recently lashed out during a meeting and shortly after that harshly shamed herself. Another example is how she reacted to a student of hers, which was often afraid and extremely visibly ashamed. To Julia, the student didn't properly deal with her shame and wasn't honest about it. Julia could react in extreme ways to the student which would then threaten the student causing Julia to be kept at a distance. Julia's actions appear to be examples of shame-avoidant behaviors (4.1.2), and of shame reactions in response to shame, leading to more shame (4.3).

To understand how spiritual counselors may be affected by shame they were asked about the effect of shame on congruence and presence (explained in 5.4). To Sandra presence means being truly there, making space and time for the other, really connecting with the other, not judging the other, being mercilessly moved by the other, and so on. Importantly, to Sandra shame can never stand in the way of these things. Linda says that being uncomfortable with any feeling affects presence, regardless if it this shame or something else. Bas and Julia, who were talking about situational shame regarding this subject, state that it isn't possible to be truly present during such an experience. Bas proposes to open a window, get a drink, or something else to stop the shame and restore presence.

According to Bas, a spiritual counselor should make sure to be congruent, which

means that one is being honest towards self and others, despite having negative thoughts or feelings. Bas noticed that especially people with negative feelings themselves can appreciate this for it shows they talk with a human and not a therapist. Nicole too said it is truly important to be congruent because especially ashamed people are highly sensitive to what the other brings with them. If people have a lot of shame in and around their stories they cannot act be someone else because they will feel this (also mentioned in 4.1.2). But, as Kees explains, an experience of shame can cause one to escape from the shame, and therefore can lead to incongruence. Concerning dealing with the shame that causes it, Linda proposes you have to be able to recognize it within yourself and relate to it in a way that you can share it, which to Linda is what it means to be congruent. To Linda, the spiritual counselor is always able to become congruent despite feeling shame, because experiencing shame can always be shared with someone else. Congruence has to allot to do with the fundamental components of the profession because congruence is related to 'inner-space' and one's shameful 'I position.' If the shameful part of a counselor is too dominant, this probably disrupts the ability to be congruent. Sandra explains this potentially causes too many problems in being a counselor, requiring attention to one's inner dialogue.

6.4.3.2 Students

Besides Julia and her student, Linda, Monique, and Sandra mention occasions of shame among their students. Linda talks about the shame around all kinds of things that frequently surfaces during group conversations. Sandra talks about shame-prone students that sometimes cannot continue their internship because of it. Monique talks about the instances of vicarious shame within her students and the shame around meeting deadlines. Each of them highlights different aspects, differently judges the severity of it, and deals with it in another way.

Julia says that when occasions of shame are brought to the table, the informs her students about it. She then tells them that a lot of feelings of shame and anxiety eventually go back to the question: can I take up space, am I allowed to be, can I have room to breathe? And, that only they can fix that within themselves. When students feel resistance to going to their clients, Julia notices this is because they hold themselves to very high standards in being present. She advises students to go despite these feelings and shows the client that they also have feelings and are allowed to be vulnerable. And, allowing themselves with mildness and understanding to adjust their routine to make it less demanding if they need that.

Sandra tells she encounters students with chronic shame, who often struggle to pass their internship. And although they sometimes can and should be coached in dealing with it, the shame underneath cannot just be fixed and therefore may fail to pass their internship. Sandra says the teacher should be able to signal these problems as quickly as possible and direct the student to professional help. Linda on the other hand reacted differently, possibly with a different understanding of shame. When she was asked if students should reflect on shame she answered that students should be able to reflect on existential themes within themselves and that if something influences the ability to be present it should be reflected upon, but that shame - just as much as guilt - does not deserve extra attention.

Monique attempts through examples in which she either gently ridicules herself, when she needed to be vulnerable, or when she struggled with something, to make them think, or carefully probe where her students may feel ashamed, but also to actively show that accidents and mistakes happen. Although Monique actively tries to alleviate or take away instances of vicarious shame in her clients, she treats her students differently. She leaves her students to find their way in their shame, and through experiencing struggle she hopes to kickstart a process, adding this is eventually not her responsibility. When students fail to meet their deadlines, Monique consciously doesn't get angry at them and argues that because some of the stressed-out students are already flooded by nasty thoughts, she actively refuses to add any

more shame to it. Sometimes Monique notices that they project anger onto her when she doesn't alert them, which to her shows they still need to work through their feelings.

6.5 Further investigation

All the participants mention that they encounter shame within their practices and outside of them. Nicole, Monique, and Sandra explicitly stated their support of further research on it.

For Nicole, shame is a very important theme within her work field, yet isn't addressed during multidisciplinary meetings: 'We do talk about death, bereavement, depression, loss, about rituals and religion, yet never about shame." The explanation she gives for it is that "[…] the spiritual counselors probably think that it belongs to the psychologist", "However," she continues, "we ought to do something with it, to find our voice within that". She concluded that "It is a theme that deserves attention because it shouldn't stay hidden any longer because this adds suffering to the suffering as if it is not already bad enough".

Monique, who heard about chronic shame through the thesis for the first time, and who generally didn't use a shame lens in approaching her clients, explains that shame is a large source to draw from. According to Monique adding shame to the vocabulary of the spiritual counselor would be helpful, because it would add layers to add. Words like vulnerability and reciprocity risk becoming shallow and empty, and shame may add depth to those words and reinforce them.

In the conversation with Sandra, it became clear that she values being present and making a connection with clients. When I asked her about shame and the ability to know it, to work through it, and to research it, she stressed the importance of knowing about it and at the same time the probability of the other not knowing about its shame. Sandra said that chronic shame touches upon the basic, elementary aspects of the profession of the spiritual counselor. Then she explained that it is important to understand there is most likely a large grey area between shame and guilt, and that every situation is always different of course, but that it is in the end "truly important" to have an understanding of shame. However, it can never cause one to put someone in the corner or write them off.

Sandra gave some substance to the question whether you should deal with it, or what way of dealing it 'good enough', as was expressed in 4.3 and 5.5. She says that it is important to wonder to what degree it disrupts one's inner space, if it is unhealthy, or causes harm.

7. Discussion & conclusion

The following question was answered in this thesis: "What is the current understanding of chronic shame of spiritual counselors in the Netherlands and to what extend is there a foundation for furthering the understanding of chronic shame and its implications for specific aspects of spiritual care?"

The results show that the level of understanding differs greatly among the participants, ranging between an understanding limited to situational shame (6.2) to a thorough understanding of chronic shame, and some also expressed their existential understanding of shame (6.3). Several participants had a thorough understanding of the role of shame within the clinical practice. They explained how they dealt with shame by way of attitude and stance (6.4.1), how to handle it with clients (6.4.2), how to deal with shame within both themselves and in students (6.4.4), and how chronic shame may relate to different theories in and aspects of their field (6.5). However, some participants haven't completely differentiated chronic shame from situational shame, thereby reflecting on the wrong phenomena.

The foundation for furthering understanding is established by exploring what constitutes the relation between spiritual care and chronic shame, followed by interviewing the spiritual counselors on the current relationship between spiritual care and shame. Since the overall importance of shame-knowledge was established in the theoretical framework, results about the prevalence of shame and stories of spiritual counselors who deal with it[216]support the value of understanding shame. The foundation is strengthened if the value of understanding chronic shame to spiritual care is endorsed yet is followed by results that show a current lack of understanding. Given the weighted value of understanding chronic shame among spiritual counselors on the one hand and the general absence of familiar ways to acquire a leveled understanding of chronic shame on the other, there currently seems sufficient ground for furthering the understanding of chronic shame within spiritual care in several directions.

Furthering the understanding of chronic shame has implications for several aspects of spiritual care in the Netherlands on different levels. On a substantive level, by contributing to subject-related knowledge on meaning-making (6.3), trauma (6.2), and its methods and techniques (6.4.2, 6.4.3). Also on a personal level, through the biography (6.4.4), and on both through its relation to attitude and stance (6.4.1). Several participants added their interest in further research of chronic shame, like determining the position of the spiritual counselor to shame in multidisciplinary teams, its relationship and perhaps value to other concepts within spiritual care, and because chronic shame supposedly touches upon the fundamental and elementary aspects of the profession (6.5).

An important remark is a call for more intra- as well as interdisciplinary exchange on shame. The results show some occasions of a strongly developed awareness of chronic shame, and at the same time, through the mentioning of only a handful of sources, there currently seems little exchange of this wisdom or experience (6.1, 6.2). However, the gain among spiritual counselors from exchanging their wisdom and experiences is indicated by different paragraphs.

Several characteristics are provided to limit the results to a certain extent. During the orientational phase it was decided that before in-depth interviews, a focus group of academics involved with spiritual care was needed for several reasons. This might've helped to bypass a lack of prior research, quickly develop a sense of direction, determine the pitfalls of interviewing about this subject, and decide on the relevant aspects of both chronic shame and Dutch spiritual care. Unfortunately, the group was repeatedly canceled due to logistic and time constraints, directly moving on to in-depth interviews. Unable to tackle the different constraints, some hasty decisions were made concerning direction and core concepts. The

[216] Given the similarities between psychologists and spiritual counselors within the clinical practice

decisions about what aspects of spiritual care are relevant to the subject were probably most affected by this, followed by an insufficient insight into what language helps explore chronic shame within Dutch spiritual care.

Another limitation affected by time constraints is the sample size, which in turn impacted several aspects of participant selection. To further develop the understanding of chronic shame within Dutch spiritual care, the selection should've included all denominations and spiritual counselors from additional workplaces like the armed forces. Now adjustments had to be made leading to the exclusion of denominations and therefore missing out on input from entire sectors and information on the related populations.

There were also some limitations regarding the interviews. To yield proper results, in-depth interviews are preferably held by an experienced researcher. This wasn't the case, however, and inquiring about chronic shame proved to be challenging on top of that. The lack of experience with explaining chronic shame limited proper communication about it, when there was a need for clarification, or when a participant was hesitant and needed some guidance. This resulted in quite some stories that seem mostly unrelated to the research. Additionally, it might've helped to ask for clarification and argumentation too, eventually strengthening the information in the results. The answers on presence and congruence are of limited value because they lack validity as research instruments. Especially presence was in some sense underestimated in its vastness as a concept, thereby causing limitations in data collection because the participants intuitively reacted to one aspect of something multi-faceted. The findings on stance and attitude (6.4.3.1) are therefore best considered to be somewhat substantively deficient, due to the compromised validity of the research instrument.

The results provided no clear answer on the benefits of the training mentioned in 5.5 to understanding one's chronic shame, and it should therefore be investigated how education spiritual care accounts for their student well-being, and if there is or isn't a need for implementing an understanding of chronic shame.

Spiritual care should also research chronic shame concerning its commonly used theories and perspectives, rituals, interventions, and diagnostical tools. Future research should include exploration of other fields and disciplines that were positively affected by either awareness, sensitivity, or an understanding of chronic shame because it is currently unclear to what degree disciplines and their populations are affected by it and benefit from awareness around it. Another interesting direction is finding out if and how supposedly hidden chronic shame is addressed in the different language fields of particular regions, ethnicities, religions, workplaces, and so on. Or exploring the relationship between the narrative aspects of chronic shame and the narrative approaches within spiritual care.

Lastly, given the suffering chronic shame causes, how well it is hidden, and yet the supposed prevalence of it in so many places, future research might inquire into the following: How is the well-being of Dutch spiritual counselors, their students, or their clients influenced by the contemporary relationship the field has with chronic shame and the understanding of it?

8. Bibliography

Austin, Sue. "Existential Shame, Temporality and Cracks in the 'ordinary "Filled in" Process of Things.'" In *Temporality and Shame*, edited by Ladson Hinton and Hessel Willemsen, 1st:119–38. Oxfordshire: Routledge, 2017.

Baart, Andries. *Een Theorie van de Presentie*. Utrecht: LEMMA BV, 2001.

Braakhuis, Myriam, Sjaak Körver, and Martin Walton. "Professionele Nabijheid." *Nursing* 24, no. 1 (2018): 1–12. https://doi.org/10.1007/s41193-018-0004-x.

Bradshaw, John. *Healing the Shame That Binds You*, 1988.

Braun, Virginia, and Victoria Clarke. *Thematic Analysis: A Practical Guide*. Thousand Oaks, CA: SAGE Publications, 2021.

Brown, Brené, Virginia Rondero Hernandez, and Yolanda Villarreal. "Connections: A 12-Session Psychoeducational Shame Resilience Curriculum." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 355–72. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Buber, Martin. *The Knowledge of Man*. New York: Harper and Row, 1965.

Cornell, William F. "Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach." *Transactional Analysis Journal* 48, no. 1 (2018): 73–76. https://doi.org/10.1080/03621537.2018.1397974.

Creswell, W John, and J David Creswell. *Research Design: Qualitative, Quantitative Adn Mixed Methods Approaches*. *Journal of Chemical Information and Modeling*. Vol. 53, 2018. file:///C:/Users/Harrison/Downloads/John W. Creswell & J. David Creswell - Research Design_ Qualitative, Quantitative, and Mixed Methods Approaches (2018).pdf%0Afile:///C:/Users/Harrison/AppData/Local/Mendeley Ltd./Mendeley Desktop/Downloaded/Creswell, Cr.

Dearing, Ronda L., and June Price Tangney. "Introduction: Putting Shame in Context." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 3–20. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

———. "Introduction: Putting Shame in Context." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 3–20. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

———. *Shame in the Therapy Hour*. Vol. 4. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Delver, Jannet, and Wim Smeets. "Een Leven Schrijft Zich Niet Vanzelf. De Training Spirituele Autobiografie in Een Beroepsvoorbereidend Programma Tot Geestelijk Verzorger." *Psyche & Geloof* 26, no. 4 (2015): 227–38. https://www.lvsc.eu/sites/lvsc/files/content/Psyche en Geloof njaar 2015 PG_26_nr_4_Delver.pdf.

DeYoung, Patricia A. *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*. New York: Routledge, 2015.

Dolezal, Luna, and Matthew Gibson. "Beyond a Trauma-Informed Approach and towards Shame-Sensitive Practice." *Humanities and Social Sciences Communications* 9, no. 1 (2022): 1–10. https://doi.org/10.1057/s41599-022-01227-z.

Epstein, Norman B., and Mariana K. Falconier. "Shame in Couple Therapy: Helping to Heal

the Intimacy Bond." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 167–94. Washington: American Psychological Association, 2011. https://doi.org/0.1037/12326-000.

Fern, Jessica. *Polysecure: Attachment, Trauma and Consensual Nonmonogamy*. Portland: Thorntree Press, 2020.

Furukawa, Emi, and Dennis Hunt. "Therapy With Refugees and Other Immigrants Experiencing Shame: A Multicultural Perspective." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 195–216. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Ganzevoort, Ruard, and Jan Visser. "Werken Met Verhalen." In *Zorg Voor Het Verhaal*, 4th ed. Zoetemeer: Uitgeverij Meinema, 2014.

———. *Zorg Voor Het Verhaal*. Zoetemeer: Uitgeverij Meinema, 2014.

Gilbert, Paul. "Shame in Psychotherapy and the Role of Compassion Focussed Therapy." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 325–54. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Greenberg, Lesie S., and Shigeru Iwakabe. "Emotion-Focused Therapy and Shame." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 69–90. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Herman, Judith Lewis. "Posttraumatic Stress Disorder as a Shame Disorder." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 261–76. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

———. *Trauma and Recovery*. New York: Hachette Book Group, 1992.

Hughes, Daniel A. *Attachment : Focused Family Therapy*. New York: Norton Professional Books, 2007.

Koerner, Kelly, Mavis Tsai, and Elizabeth Simpson. "Treating Shame: A Functional Analytic Approach." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 91–115. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Kolden, Gregory, Chia-Chiang Wang, Sara Austin, Yunling Chang, and Marjorie H. Klein. "Congruence/Genuineness." In *Psychotherapy Relationships That Work*, 323–50. Madison, 2019. https://doi.org/10.1093/med-psych/9780190843953.003.0009.

Ladany, Nicholas, Rebecca Klinker, and Lauren Kulp. "Therapist Shame: Implications for Therapy." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 307–22. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Lansky, Melvin. "Shame Dynamics in the Psychotherapy of the Patient with PTSD: A Viewpoint." *American Behavioral Scientist* 38, no. 8 (2000): 133–46. https://doi.org/10.1521/jaap.1.2000.28.1.133.

Morrison, Andrew P. "The Psychodynamics of Shame." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 23–44. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Nathanson, Donald. *Shame and Pride*. New York: W. W. Norton, 1992.

Pattison, Stephen. *Shame: Theory, Therapy, Theology*. New York: Cambridge University Press,

2003.

Potter-Efron, Ronald T. "Therapy With Shame-Prone Alcoholic and Drug-Dependent Clients." In *Shame in the Therapy Hour*, edited by June Price Tangney and Ronda L. Dearing, 219–36. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Ratcliffe, Mattew. *Feelings of Being: Phenomenology, Psychiatry, and the Sense of Reality*. Oxford: Oxford University Press, 2008.

Rizvi, Shireen L., Milton Z. Brown, Martin Bohus, and Marsha M. Lineham. "The Role of Shame in the Development and Treatment of Borderline Personality Disorder." In *Shame in the Therapy Hour*, edited by June Price Tangney and Ronda L. Dearing, 237–60. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Rogers, Carl R. "The Necessary and Sufficient Conditions of Therapeutic Personality Change." *Journal of Consulting Psychology* 21, no. 2 (1957): 95–103. https://doi.org/https://doi.org/10.1037/h0045357.

Sanderson, Christiane. *Counselling Skills for Working With Shame*, 2015.

Shapiro, Elizabeth L., and Theodore A. Powers. "No Shame and the Paradox of Group Therapy." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 115–37. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Smid, G. E., and G. Jacobs. "Geestelijke Verzorging in de Psycho-Traumazorg: Een Plaatsverkenning." *Tijdschrift Voor Psychiatrie* 64, no. 3 (2022): 160–65.

Smit, Job. *Antwoord Geven Op Het Leven Zelf*. Delft: Eburon, 2015.

Stadter, Michael. "The Inner World of Shaming and Ashamed: An Object Relations Perspective and Therapeutic Approach." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Prince Tangney, 45–68. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Stroeken, Harry. "Furor Therapeuticus/Sanandi." Psychoanalytisch Woordenboek, 2013. https://www.psychoanalytischwoordenboek.nl/lemmas/furor-therapeuticus-sanandi/.

Tangney, June Price, and Ronda L. Dearing. "Working With Shame in the Therapy Hour: Summary and Integration." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 375–404. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Taylor, Terry F. "The Influence of Shame on Posttrauma Disorders: Have We Failed to See the Obvious?" *European Journal of Psychotraumatology* 6, no. 1 (2015): 1–7.

Teyber, Edward, Faith H. McClure, and Robert Weathers. "Shame in Families: Transmission Across Generations." In *Shame in the Therapy Hour*, edited by Ronda L. Dearing and June Price Tangney, 137–66. Washington: American Psychological Association, 2011. https://doi.org/10.1037/12326-000.

Thompson, Curt. *The Soul of Shame Retelling the Stories We Believe About Ourselves*. Illinois: InterVarsity Press, 2015.

VGVZ. "Beroepsstandaard Geestelijk Verzorger," 2015, 1–46. https://vgvz.nl/wp-content/uploads/2018/07/Beroepsstandaard-2015.pdf.

Weberman, David. "What Is an Existential Emotion?" *Magyar Filozofiai Szemle* 64, no. 1 (2020): 88–100.

Winnicott, Donald Woods. *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. Madison: International Universities Press, 1965.

Wong, Paul. "Foreword: From Shame to Wholeness: An Existential Positive Psychology Perspective." In *He Bright Side of Shame: Transforming and Growing Through Practical Applications in Cultural Contexts*, edited by Claude-Hélène Mayer and Elisabeth Vanderheiden, v–ix. Cham, Switserland: Springer Cham, 2019. https://download.e-bookshelf.de/download/0012/1144/05/L-G-0012114405-0035615581.pdf.

Appendix I: interviews

1. Bas

Bas is currently working for <5 years in a prison as a Buddhist spiritual counselor. During his education, bas was told that every time he would be triggered or activated by something in the conversation this is because this touches something within himself. First he challenged this, but then noticed this was actually true. Bas explains that this is something that causes a spiritual counselor to always grow and develop, to make sure there is always enough space for the other. In other words, retracing what happens to you, is a big catalysator for growth.

Bas only recently discovered that he was in particular triggered by the second world war and stories of people who survived a deathcamp. This happened due to a friend who was asked why he hung out with Bas, because his: '[…] grandparents of dad´s side of the family were on the wrong side in the war,' and he added ´[…] how wrong only recently became clear to me´. This background, together with previously not understood feelings around stories of deathcamps, caused Bas to finally understand in the last couple of years that his family, including himself, felt deeply ashamed for their family history.

The concept of shame illuminated the causes of a lifetime of feelings, behaviors and attitudes his family had towards other people: 'This is what shaped my entire childhood, that I didn't know about this and that this was the cause, the cause of not to step out of the family, to avoid contact with groups, it has totally shaped me. But that this was the foremost cause of it all, that has only recently became clear to me', and to emphasise he adds: ´If that is not chronic shame…´.

To Bas, this is shameful because there is a part of his history that he cannot talk about. Although she is two generations separated from the actions of her grandparents, other people still say he is to be ashamed for what happened. Bas explained he rather doesn't share his story and that he feels he cannot do anything about it, which both are shame reactions.

Then we discussed the question whether someone can be present if you are ashamed, to which she answered that she '[…] thinks this is actually impossible'. In feeing ashamed there's a moment of 'cutting-yourself-off-from', and here you cannot be present.

Bas says he thinks shame is a Christian concept, that is directed towards rejecting or disapproving of certain parts of your personality. But Bas wouldn't really call it shame, although she links it to self-hatred and a negative self-image.

To Bas, it is very important that a spiritual counselor is congruent, because when you are not, you are dishonest to yourself and other. And, she adds, this is truly a good thing, because when you are truly congruent they will see that they are talking to a human and not just 'a practitioner'.

On the question of what this brought him as a spiritual counselor, Bas answered that it provided him with understanding that there are always places where people don't want to go, and that this is okay.

He explains that he can listen to the most horrible stories, until he is struck by them and his own feelings and experiences start to resonate. Then, when something is too much for him, he signals this to his clients because she cannot be truly present anymore.

In experiencing shame during a conversation with a client, Bas chooses to perform an action that disrupts the moment. He might open a window or get a drink to provide some 'air' to the conversation.

Bas says its very helpful to learn about shame, because it is about the aspects of

yourself that you do not yet approve of. In his education, this wasn't called shame, but it was considered important to know what parts of yourself you do not approve of and you were advised to go in therapy so that when you are a spiritual counselor you do not take your own problems to your clients.

Having endured much, in terms of having a turbulent past, may really help you a spiritual counselor says Bas, bevause you are better capable of understanding what the other is talking about. Importantly however, only knowing how something feels does not make you a spiritual counselor, it is important to know what to do with that pain, where it comes from and how to relate to it. To Bas, in that way working through your own pain truly improves you as a spiritual counselor.

Bas proposes a helpful exercise, which is realizing that feelings and thoughts aren't yours, he cites: 'this is not me, this is not mine, this is not my true self'. To him, the art of listening is not in creating a wall to keep the other out, but to totally open up and realising that 'this suffering is not mine'. And when the suffering resonates, this simply means there is something that he still has to work through. And when he works through the experience, it ceases to be something that he feels that belongs to him and he can then see it as simply something that has happened and distance himself from it. Bas also tries to teach his clients to do this.

Bas also approaches suffering as something that humans attach themselves to, and therefore get caught up in it. As opposed to for example just hurts his head when walking into a while, humans get attached to it, and they get attached to everything. To escape this, they can accept the pain they feel and try to understand it is only human to feel the way they do. That way, they decouple it from themselves. In some occasions this may to diminish the sadness, but it does upset one less than before.

2. Julia

Julia had been working for **20>** years at GV-thuis. Besides that, she has been working with the elderly, in immigration detention, the earthquake area in the Netherlands, she has her own practice and she is a supervisor.

She is personally very familiar with the subject of shame, she gets in touch with it in the earthquake environment, the northern area in general, it is an important theme in the contact she currently has with a particular client of hers, and she knows allot of people who live with shame and visit her with their story. To her, it is therefore very important to know it as a spiritual counselor.

The first time she heard about shame was as a child, when it was used as a threat when her mother shouted to her ´Shame on you!´. But somewhere between 5 to 10 years ago, she got ill in several ways and although she was in a good place psychologically and physically, she deteriorated quickly because of the sudden illness and noticed after a certain period she had become deeply ashamed because of it, because she wasn´t able to ´remain standing´ in the face of such challenges. She said it took her a long while before she was able to understand it and name it as shame.

Julia has also felt fear and shame as a spiritual counselor in the gaze of other health-care professionals, which she counters by rejecting them in her mind before she even speaks to them. She explains that, in the eyes of other healthcare workers, she feels as if she is some sort of scam that receives a giant salary for only drinking coffee. And she also felt it some time ago after she bursted during an important meeting, where she was extremely angry and mean, and emotionally out of control.

When Julia was asked about literature, she said that there once was a module of Ton Jorna about guilt and shame, but that she didn't follow it, but that there were allot of people

who followed that one. But, according to Julia, guilt eventually got allot more attention than shame.

Julia also sees allot of shame in our society, because it is directed towards individual achievements and achieving in general.

And, Julia also thought of a song by Treintje Oosterhuis: 'Ken je mij wie ben ik dan', [do you know me who am I?]

Julia has also noticed that people are ashamed of their illness, and that people go to extreme lengths to cover up for others how sick and miserable they truly are are. People with cancer who are ashamed because of it because others can now see it.

Julia also noticed shame in villages of interdepence and intersocial support and control. Because people lean on eachother when something goes wrong, they go to great lengths to hide themselves when something go wrong.

Julia has had allot experiences with shame and to her shame is suffocating, and that shame is able to pull everything she had achieved up until then away from under her. She herself felt ashamed because she wasn´t able to keep herself together when she became ill, and that *everything* she could do and her worth was diminished and reduced to nothing. Shame is, according to Julia, strongly related to self-worth. She experienced shame as broader than just relational, and she felt it everywhere and as something that not the other, but she herself does. Shame feels to her as if she herself is not worth enough and that others might be able to see it, which is unbearable to her.

Julia says she associates shame with anxiety, because it co-appears often. Shame is feeling yourself shrivelling away under the gaze of the other, and when people try to avoid it this turns into anxiety. After a while, Julia explain, people become afraid for these kind of situations which only adds to the drama because when something happens they are additionally scared as well.

Shame is an existential theme, but differs from the others because it is exceptionally hard to connect with. She elaborates by telling a story about the particular client:

"She was mentally completely out of control, and unmanageable, and psychologically completely out of balance. And when I met her all she could do was cry and scream. And then she would swear at me with a strong tone and everyone she spoke to that happened to it. A lot of people thought she was a creepy crazy lunatic and neighbors had set up a campaign to make it clear to everyone that she was dangerous, needed pills, compulsive meds and hospitalized, and I'd go in there and sit down and let her go for an hour and a half raging and in between I said encouraging things that she was always a colorful figure and that all that was still in her, things like that. And then after a while she was slightly better.

We had never talked about shame, anger, impotence, sadness, and then I asked her, "Gosh, are you ever ashamed" and she said, "Wow, all the time!" And then I asked about what and then I asked what for and then she said: 'for everything'." […] and at one point she had taken some form of medication again and then it turned very bad and she became sad and very anxious. She almost didn't come out the door anymore. And then the theme was that incredibly life-sized shame. She also had rows of people she was afraid to see and face and everyone knew what she had done. That really everyone who saw her thought of actions a, b, and c that she had taken during the period when she was unstable and that she thought of nothing else."

The shame Julia felt after the meeting mentioned above, can also be considered a shame-defence, in which she attacked herself by calling herself a 'hysterical fish-lady' and punishing herself by questioning how she could give such a horrible speech. It was beyond guilt she said, because she apparently should know better but she doesn't.

When Julia was asked what she thought about shame existentially, she said it is about being seen and not seen. She said she had to think about Hannah Arendt, because you open

yourself up and show yourself to society. From that point of view, you leave a trail of actions and you are unable to not do this.

To Julia, the question about shame is always interpersonal, relational and existentially relational as well. You never know for sure if you are allowed to be, and it is therefore an open question.

Julia also noticed that shame is related to loneliness, as if people can smell that people are lonely and therefore hide, which is a self-exciting/enforcing process.

Julia herself handled her shame by expressing herself, by self-disclosure, by open herself up to others and by being vulnerable.

In the period where she was severely ashamed, she also was annoyed by how perfect others were and she also expected this from herself but it made her feel robot-like, which lead her to realise she didn't like this robot-like behavior and others probably not as well, which caused an image to shift an she asked herself: 'what do you need to be to be worth it?', to which she answered 'not perfect'.

Julia explains that in the ´exposure´[which is a term from the presence theory] you show yourself to the other(s), given you are in a situation that you are truly are in control, you are able to observe the other with interpreting, acting, judging, or reacting, which is extremely hard according to Julia. And, she continues, acknowledging that that is hard, and being okay with yourself through mildness and kindness, and being honest to yourself that you are not capable today, that is truly important for students and more experienced professionals. And, she concludes, that is in fact is also easier and more bearable for yourself and for your clients as well.

For Julia, shame is an existential theme and although difficult in that regard, one in which one should attempt to open up remain open because someone is never outside of existential theme's and there is a workable sharedness in existential theme's, and they touch you and the other because these themes are the bedrock of existence.

In working with the particular client above, Julia noticed that naming shame was particularly helpful. So, she decided to keep addressing it. She noticed that her client talked about it with a certain vulnerability and openness of which she thought, 'this is good'. So, she walked with he, counted her achievements during the day, steered towards not hiding all the time, showed compassion, and that she was bummed for her. She used allot of humor, playfulness, absurdity, she explicitly didn't deny it, and she chose to stand besides her and ask curious questions.

When Julia was asked about congruence, Julia said that you cannot remain congruent when you are ashamed, at least not towards the one that is opposed to you. But when I asked Julia what happens if you name it in the moment, she says you break through it. One example she gives is remarking: 'That makes me uncomfortable/warm!', which you have to be able to do, without burdering the conversation too much with it, with its goal to return to the conversation and restore the congruence.

When asked about her time as a supervisor, Julia explains allot of students are severely ashamed during their internship. One example is that according to Julia students may sometimes need, just like herself, less intense conversations with clients so they can recharge. But often students do not allow themselves to need these moments, and therefore reject their own fatigue and therefore rejects themselves in some sense. Granting yourself something, or acknowledging yourself, is felt as weakness.

But according to Julia it is important to be there with whomever you are, and people do not want to talk to an empty shell. But, Julia explains, after students tell something about themselves or show something of themselves, they often feel lighter and better afterwards.

An important example that Julia provides is from a student who was severely ashamed during her internship, for herself, and especially in presence of the group, and her internship-

location. She would on occasion stand in the corner with her hands in front of her face, of which Julia thought, that doesn't help at all. Julia reacted to this student with the suggestion to shift the focus away from herself to the curiosity for her client, to do that and ask 'who is the other really?' When Julia was asked if it worked she said: 'I don't remember if it worked, I mostly remember my own frustration. I found it really difficult to work with her and that didn't help her at all, and she kept me at a large distance'.

The same student also triggered Julia, in the sense that she erected defences like acting as if she could do everything and that she wasn't insecure at all. This in turn erected shame-defences of Julia, because she felt as if the students was acting as if she was better than she was, which made her a threat to the student and Julia felt as if she was a 'bull reacting to red cloth'.

To other students that struggle, [so freeze up or think that you are not allowed to be when something unwanted happens during a conversation] Julia explains to them that such a shame-feeling truly goes back to the question: 'can I take up space?', 'Am I allowed to be?', 'Can I take up space to breath', and that nobody else can give them that (only they themselves can).

About naming shame, Julia says the most important thing is that the shame does not need to be named (yet), but at least the feeling underneath needs to be acknowledged. And, the other needs to be provided with handles in dealing with it, one of which is [as was previously named] that the other can give you something when you open up to it and grab it yourself.

When I asked Julia if you always need others (the client needing the spiritual counselor for example) to deal with a thing like shame, she answered: 'Is there ever anything you can do without others being part of it? Or, to put in in another way, if you do not do it yourself, the other cannot help you'.

The earlier named reference about Hannah Arendt is sometimes laid in front of her clients by Julia, saying she sometimes presents it to people who are dying. Sometimes, these people can think 'what have I done and meant to others', and 'was my life meaningless', and 'everyone will forget me'. To them, Julia sometimes replies with several questions like: 'who was your most important mentor?', 'With what girl were you in love for the first time?', 'Who left an impression on you?'. And, Julia adds to this:

'There must have been someone, maybe even on the street, who made an impression on you once, and in exactly the same way you have been in the world and made an impression on the life-world of others. You leave behind traces and you don't know in what way, by whom and where, but you've been here and walked around for so many years and left a trail'.

The suggestion of Julia is two-sided, in the sense that it has a horrible and beautiful side to it. You have not control over your trail and people can endlessly trace the good and bad back to you. It is inevitable that you are visible with all your deeds, and that happens and it is part of life. And, in part this can be because of something wrong or evil you did [which can be about guilt], or it is about that life isn't the way you wanted it to be, and you wished it of even you had looked differently.

Julia says that life-adherence/acceptance, is utterly radical in this regard. If people say they do not want to exist, or say no to their lives, they in some sense never say 'yes' to life. Julia present people with the following statement: Life is a package deal, and you get your traits, and the situations, and parents, and time and place in which you are born, and your character, and this is irreducible in some sense. And this is then followed by the question: 'Can you accept this for what it is?', and this acceptance she calls an existential decision. And, for some people this truly happened once in a certain moment, but you can also give this to them; present them with this decision.

Julia also noticed shame in people who suffered a quake, and she notices in the way

that they first downplay their own sorrows and start every conversation with the statement that they themselves do not bother. But then, after a short while, she notices that they are in fact afraid about moving and losing their houses.

Julia wondered about the relationship between shame and ´sterf-stijlen´.

3. Linda

Linda is a spiritual counselor and teacher on university, worked in a prison, and works <5 in the hospital. Linda began the interview with presenting a book that she has read from Ton Jorna from the previous generation of spiritual counselors on the university of humanistics called Echte Woorden, from which she drew allot in the beginning of the interview, in which she said to have been educated. In her education, she was invited to look into herself and see how shame and huilt played a role within herself, in society, and how they relate to questions of meaning.

Currently, Linda explains, this has changed and the current generation has decreased in focussing on shame and guilt, although they are still important, they are now considered not the fundamental pillars of spiritual counselors but two important existential theme's among many like power, death, bereavement, and so on. What is left of it, according to Linda, is the invitation, or even obligation, to reflect heavily on one's personal history and there is clear line in: how can you recognize these theme's within yourself. To Linda it is not important to reflect on shame specifically, but it can arise or occur as an important theme. Importantly, to Linda it can be about shame but it doesn't have to be and she doesn't think every spiritual counselor should work through their own shame. The capacity to reflect properly on any existential theme is more important than reflecting on shame specifically.

Linda adds she hasn't think hard and systematically about shame, and therefore doesn't know for sure if she agrees with Ton Jorna whether they are the only theme´s to which everything can be reduced.

In working with her students, Linda constantly notices that they are ashamed of lots of different things. She for example facilitates group conversations in which the students talk about existential theme´s like freedom for example. Here, they then have an existential conversation and it becomes clear that most of them are ashamed about several things, and that this is in fact something that is shared.

Here their masks fall off as Linda describes it and they discover they may feel ashamed about loneliness, the way they speak, because they interrupt each other, their body, and so forth.

Linda also remembers that especially guilt was an important theme when she worked in a prison, where guilt was always an important theme.

She also notices now, that shame is important theme in the hospital. Here, shame is often felt for what people might wear, because someone wasn't able to reach someone else on the phone, how someone who is ill lies in bed, how people look, and so on.

Linda said she appreciated the subject for this thesis and couldn't remember any books or other thesises, but she did assume that internationally there would be literature.

Linda draws from Ton Jorna and explains his ideas first. She explains that he thought spiritual care as a whole is about two things in particular: guilt and shame. He said that you are your own instrument in spiritual care because the spiritual counselors makes contact and therefore you should be comfortable with the shame within yourself and be able to face it, because what you couldn't face in yourself, you also couldn't face within the other.

To a certain extent, Linda disagrees with Tom Jorn,a because she doesn't think that all life-crisis and questions can be brought back to shame and guilt. She thinks that shame is

very often a theme but that students shouldn't be obligated to look at it.

When Linda was asked about presence and shame she says that the degree to which someone is able to make contact with himself influences transference and countertransference.

I said I noticed that I heard Linda often say guilt and shame together, and asked why she did this and what the importance may be of pulling them apart. She said it is important because they slightly differ from eachother, because it does feel a bit different, but they are often intertwined with eachother. She says that shame has so many forms, like being ashamed for things of yourself, or for the other, or what you think you have done to someone else, or what another does, feelings of vicarious shame also.

Linda herself describes shame as a truly human emotion and a spiritual counselor is not beyond shame in any sense.

Linda also sees shame as being about the good life, and therefore as a moral and existential category, it poses the question 'how do I orient myself to what is good and bad'. And shame is that sense something relation, because you are ashamed for something or because of yourself, and being hamefree would therefore be inhumane and you would move out of relationships that way. The fact that shame is isolating shows it is relational, because it is in fact so estranging. It is relational because it is about you in relation to the other.

Linda says it is very important to be comfortable with your existential questions and be not ashamed for them, and be comfortable with the theme's that live within them, and be comfortable with the shame for the profession or something like that. To her, it is important people are comfortable with shame but just as much with their feelings of guilt, indicating she sees the one not more important than the other.

When Linda was asked about shame and congruence, she said up front that she doesn't think a spiritual counselor shouldn't be allowed to be ashamed. Linda says she isn't the one who would say that a spiritual counselor should develop in such a way he is comfortable with everything that goes on within. You should be able to recognize it and be able to relate to it, and share it by naming it and say: 'I am ashamed as well' or, 'this is what I feel now', which would to her be congruent.

As said before, as a spiritual counselor you don't have to be and shouldn't beyond the common emotion of shame, but you shouldn't be imprisoned by it and be able to handle it as a spiritual counselor.

Linda gave on emotion of a situation in which she felt shame, when she was working in the prison and talked to a man who was in jail for stealing money in different ways to provide for his family. At that point, Linda felt extremely ashamed for he position in which she didn't have to do those things.

Her reaction within herself to this situation was that she thought extremely moralising and spend allot of time in her head, and she regarded her own behavior as incongruent. She didn't know what to do for him, felt ashamed because of it and pushed it away by thinking. She said she should've said: 'Wow, I feel so ashamed for how our society brings you to the point that you are where you are and I do not know what to do for you' and 'I sense that you just want to be a good dad'. But instead she was moralising and asked questions like 'was that the only option for you to provide for your children?', with which she seemed to steer away from her feelings. That instance of shame extremely influenced the situation, she explained, and would've rather self-disclosed. But, eventually she did deal with these feelings by sharing it with her supervisor and talking it through.

Another moment at which Linda felt shame and uneasiness, was when she had conversations that felt fun even though it was, for example, with someone who had sexually assaulted someone. This was a large part of her internship reflections. Here she learned to be

congruent about these things and make these things part of the conversation.

When a spiritual coumselor is ashamed it is welcome, as long as you share it with the other within the conversation. Sometimes you might draw a line in the conversation, but hopefully you can use it in the conversation and make a connection over it. Asking whether the other is also feeling it maybe, or, when it is truly too much, say you need some space and it is too much.

Linda is curious what others said about shame and what they answer when they do in fact have systematically thought about shame.

4. Nicole

Nicole doesn't work from a denomination, and is instead part of the Ring GV. She has been working as a spiritual counselor for 15> years, within elderly care, and a general hospital.

Nicole experiences shame as primarily a female theme, which she in part also contributes to the demographics of a care home. Shame here circles around feelings and desires that weren't allowed to be there. And these restrictions are all related to the time they grew up in, to being a woman, but also because there were often forms of abuse, incest, and domestic violence present in these families. Nicole estimates that shameful experiences and events like abuse, incest and violence are in fact in three to four conversations are the to what people do and do not tell to her.

Nicole said that there a joke she shares among colleagues in which spiritual care is called 'The Department of Hopeless cases'. Although this is meant as a joke, she said that it is in fact true that they end up with the cases that are not finished and sometimes never will be. Additionally, she says it truly belongs to the spiritual counselor to dive into the deeper, hidden layers, in the existential or spiritual dimension, beneath the stories and biographies of people, and either start this inward journey, keep it going, and guide the client in ending it properly as well. And, Nicole adds, it is precisely within those layers where the darker side with its misery is, of which one may indeed be ashamed.

Nicole once helped a elderly woman whose son was addicted. This woman and her family were so ashamed for their addicted son and how he neglected himself, that these people weren't able to continue their lives properly. They were afraid to move in the care facility or even play bingo, because they suffered from a sense of shame that excluded themselves, because nobody can know what's going on. They felt shame in the sense that they asked: what are the neighbours going to think? And, eventually they accepted Nicole, but that took allot of effort.

Nicole says that shame is different in the elderly home and a recovery centre. In an elderly home there are much less secrets because they are also harder to keep, but in a recovery centre people where people stay temporarily, it is way easier to show just one side of themselves. With dementia in particular, Nicole thinks that people are sometimes beyond their shame in the further stages of the disease. And, some of the shame that was present before, may also disappear when moving to a facility where people are older and increasingly less dependent.

Shame was not a theme in the education of Nicole, of which she says that it was about anything, but not about shame. Nicole did talk about shame during her therapy however, in which she worked through her experiences of abuse. Here shame was an important theme,

often in the form of: 'I might be a victim but I let it happen and so I keep it with me'.

Nicole's clients were often still children when events and experiences like abuse and violence happened, and Nicole thinks they were still very attached and dependent to their parents when this happened. Therefore, the feelings they have are often, 'what could or should I have done?'.

Nicole understand the feeling of shame as often being a reaction or consequence to a certain pain underneath the surface, which is often indicated by the caution with which people speak. She possess to see shame as a mechanism that has a function of protecting the one that is hurt.

When asked about presence and shame, Nicole said that presence is in the way of shame. She briefly said that, if she would experience the shame just discussed, she herself wouldn't call it shame.

When Nicole was asked how she thinks spiritual counselors in general see and react to shame she compared it to psychologists. She said that whereas psychologists are inclined to mark, name, identify, and demarcate certain things like shame, spiritual counselors are a bit more receptive and allow whatever presents itself in the conversation. She dearly hoped that people know how to react to shame in that regard, but she wasn't sure about it.

In a home where allot of people live with late stage dementia, people also notice from each other that they are not the only ones that have trouble eating without spilling, need continence material, and suffer from 'failing bodily functions'. Although a person from outside the facility may feel ashamed and think 'I'll never show the state my husband is in, in this place', Nicole says that personal inside the facility handle these occasions naturally/matter-of-factly. She says that there is a sort of implicit code inside these facilities that prescribe how people talk about it, how they should and shouldn't handle it, which helps to alleviate the shame of the personal, family and clients. They talk about it in a normalizing way, at the same time acknowledge the pain, and place human dignity to the opposite of shame. Although Nicole wouldn't say this behavior is healing the shame, she answered it is at least not contributing to the suffering; there is not any more suffering added to the suffering that is already there.

Nicole herself suffered abuse in her own life and when someone talks about it she recognizes it and it resonates on all levels, with which she means she is activated to wonder how the shame for example feels. But, since Nicole had therapy for the abuse she suffered, she doesn't feel the shame anymore she once felt for her own situation, but she does recognizes it. Nicole said that she is probably skilled enough these days to dodge her tendencies towards transference, because she dwelled upon, reflected upon, and learned from her own experiences. Therefore, Nicole is able to endure such stories even though she might not have any words for it, and still she is able to stay close, of which she says that can be considered presence. To her, presence is not only something that occurs in the moment, but also consists having actively decided to become a counselor and knowing deeply that it is demanding. Nicole said she was at her best at the intensive care, because she was able to remain present during severely traumatizing situations, showing that she was able to be present and mean something.

When however, something is too big and the spiritual counselor is unable to be present, either because it comes too close, or the counselor notices he cannot help from his expertise, it may be necessary to redirect clients to other professionals like a psychologist.

When I asked how she was able to remain present during these traumatic situations, she explained the following. She said that when people tell her "I would never be able to do that, endure all that misery of others", she always replies: "Exactly, it is the suffering of others and not mine". She added that she hopes that others are, just like her, able to listen to her problems without taking it home too much.

When Nicole was asked what it took to see herself so separate from others, she

explained that she thinks spiritual counselor need a tremendous amount of psychological knowledge about the human psyche, for example from trauma, war-trauma, suffering, anxiety, and so on, in addition to the costumery skills of listening to life-stories and narrative methods. As a spiritual counselor you may also benefit from knowing sociology and philosophy. All of which are needed according to Nicole to be truly present, which also includes knowing how they work and what they talk about. She says that if you do not have any experiences yourself, it is important you studied a subject like shame, knows what reactions people may to it, maybe learn what its relation is to certain theme's, because eventually also shame is 'not green here and blue there'.

When asked about congruence and shame, Nicole said that because shame is such a powerful defence mechanism, it is very important to be congruent, because the people you work with are often hypersensitive to what others bring with them. Therefore Nicole says that if she isn't congruent, people feel this which in turn amplifies the distance between her and her client. If the counselor pretends to be someone else, even though something is discussed or needs to be discussed that affects the self-image of the other, the counselor shouldn't act bigger or smaller than he is, because then people will not accept your help. According to Nicole, it is about the fine-lined border between knowing what you and the other feel, without directly telling the other what you think he feels. Additionally, one should also avoid talking in the language of health-care workers, come with solutions or models, and avoid telling ones own life-story. The most important thing is being reliable and providing a listening ear, and being truly there for the other.

Nicole notices that on the one hand the shame shows itself in peculair ways. People often tell about their childhood and the formative periods in which they suffered abuse and so on, yet on the other hand they are not easily questioned. Nicole notices that although here clients talk allot and there is an appearance of openness and hospitality among them, they do not necessarily like being asked many questions. When Nicole feels the urge to ask a question, she always wonders if its her curiosity speaking or if it is an encouragement to let the other speak. If it is her own curiosity, she may often decide to keep quiet.

Nicole says she isn't going to be the one to break through the feelings of shame people feel, but keeps working on the relationship instead. And, if it appears that people do want to share their stories and feelings with her, she allows and encourages this but she doesn't steer the conversation towards it in advance.

"This story is about a man who could no longer speak, he could only write. he could write I am hungry, thirsty or in pain, but no more. I was called to him because the gentleman seemed very sad and then I started a conversation and that developed through paper in which I read what he had written to give him a voice after all and then I could let it work on him for a while and then I commented. And I had a few weeks, he was hospitalized for a long time and it went really bad, and it turned out, well, you can't make it up, but he was in a home situation with a woman who abused him and, little by little, came that story upwards, through paper. And, he was terrified to enter his house. And that woman would then casually come to visit and a cousin and an uncle and the whole room was always nice and full and he couldn't talk anyway so he would sit in the bed like that and then I would sometimes come by to see how things were going. But then the day of discharge came very close and he would therefore have to go home and justice had been called in, the police had sometimes been at the door, but he was still being abused by her so he was terrified to go home. He didn't dare go home. Then I wrote that GP a letter on his behalf, asked if it was allowed and explained the whole story, and it is then called so nicely an 'intervention' I had to commit and then a response came back, we can do nothing do, we can't put anyone out of the house... and then I went through a really strange way and asked like, what's the life expectancy of this man? Well he was less than three months so I thought great then he can go to hospice. So called the hospice and asked 'do you still have room?' Then he went there, she was not informed of where he went and then he died there. And in the meantime nobody knew about this, was not allowed to know about it."

Nicole surmises this client has someone who is the embodiment of severy and utter shame. Her stance in this particular case was 'we're going to solve this' and 'this is not allowed to exist'. For her, this is the case because she has suffered shame herself and thinks that this particular shame is one that only adds more suffering, and therefore a layer of shame she wants to break through. Because Nicole has worked through her own shame, she knows that if people who suffer in these ways keep quiet, help never comes, and even if people come out some people may not even respond, but she does want to be the one that responds.

Nicole remarks that spiritual counselors often suffer a burn-out, yet learn nowhere to prevent this, even though this is very important, because you want to protect the people you help from pain or trauma.

Nicole also talked about the interdisciplinary aspect, and said that spiritual counselors work multi-disciplinary, meaning they talk with other health care workers. Nicole thinks that the theme of this thesis never is the subject of conversation within these MDO's, and she thinks this is truly a shame. They talk about anything, but Nicole reasons that the spiritual counselors think that shame belongs to the psychologists, even though it is present in so many conversations and so often in the background. According to Nicole this means that spiritual counselors need to do something with that and find their own voice in dealing with shame as well. Because if you do not add any attention to it or act as if it is nothing, this does in fact adds suffering to the suffering.

5. Monique

Monique is a spiritual counselor for over 10> in a (chiatric) nursing home. She also teaches students. Although Monique had never heard of chronic shame, she did remember ted-talks, readings, and books she read about regret, guilt and shame. She knows shame in relation to vulnerability, annoyance, and guilt. The subject evoked certain images and subjects in Monique's head, like the loyalty children feel towards their parents, partners, children, caregivers, vicarious shame because of the way people express themselves when suffering from dementia. Monique says she never feels shame herself during work, but that she does experience guilt when she could've done better, for example in being present or free up time. But, besides the guilt, she is able to pray, sing and dance loudly in the middle of the room with her clients, and doesn't feel ashamed about it.

Monique noticed shame primarily lies in the psycho-analytical and philosophical corner. When she studied, it was part of psychopathology and religion, and within care-ethics. So, spirituals counselors might have some involvement with shame conceptually, but not in a professional manner. Monique defined shame sharply: "Shame is often an expression of the inability to embrace a fundamental vulnerability or to hide the disappointment that life is not malleable. Sometimes shame is an expression of, 'why didn't I take better care of my body' and 'what will people think of me when they see me in my wheelchair. " Monique effortlessly adapted the possibility that chronic shame may be the basis for narcissism. Monique also described it as not living up to a standard you set for yourself, as opposed to guilt in which you do not do something even though you know you can. It is when you try to manage a self-image that you want to show to the outside, but that doesn't fit your abilities (anymore), and being confronted with it may feel like being caught as an imposter.

Monique lost her shame as soon as she walked in the nursing home during her internship, because she had to. If she wanted truly to connect with the people, she had to throw her own feelings of shame overboard. To her, the professional need for making contact and being able to do interventions for her clients, weighted as far more important then what people might've

thought of her. So, she was quickly able to sing and dance and pray with her clients, in an open room with other colleagues present if needed.

With herself, she says she is able to take herself and her behavior with a grain of salt. She can laugh about herself and joke about herself. So, if someone might be offended or feel shame by her behavior in the common room for example, she can approach her colleagues that might looked at her with somewhat critical, and explain that although it might've sounded horrible, it was meant for the residents and if they enjoyed it then all the discomfort around it doesn't really matter. Here she attempts to neutralise the vicarious shame the other might be feeling. She reflects on a situation with her mother, where she would dance in the middle of the street in front of a barrel organ, and feel deeply ashamed. However, she could also feel a form of pride because in one way her mother is also defiant of implicit norms, and her behavior also shows that people are actually kind of okay with that behavior and that you are allowed to walk out of line sometimes, which gives some kind of pride and comfort to Monique. When she was 15, the shame was indeed very strong, but now she tries to communicate to her colleagues that they don't have to feel bad about her behavior, because she doesn't either, and it was meant for the residents. She also uses compliments and acknowledgement to tell her colleagues that this is her way of connecting with the clients and that they have theirs. By doing so, she also hopes evoke a sort of healthy professional pride instead of shame and vicarious shame.

When I primed Monique that chronic shame may be related to narcissism, contempt, denigration and intense self-loathing, Monique started to focus on narcissism specifically. She goes on that she takes a certain stance, in which she especially wants to communicate she is no threat she is not of more worth or value, and tries to get closer this way. She does this with compliments, try to get just a little below the other.

Another way Monique deals with possible occasions of shame, is by finding a way in through listening attentively. She listens for theme's like sexuality or intimacy, or financial issues, and tries with sharing personal examples and anecdotes to alleviate some of the shame around it and invite them implicitly to share their own stories.

When I asked she ever encountered a form of intense shame she couldn't handle, she said she instinctively wanted to say 'no', but generally feels obligated to second guess a quick thought like that. How she misses these possible to-much-to-handle occasions of shame seemed mysterious to her, but she guessed she sometimes rushes over or might skip to accidently downplaying the shame, or that her stance felt too bountiful to some. She thinks maybe sometimes, the relationship was ended, which in hindsight may be caused by a failure in her stance when unknowingly was facing a particular case of shame. With this, she expresses curiosity for those cases if shame might be the cause for ending contact. Also, she wonders if it may be a hidden cause for problems.

In her work with the elderly, she sees shame occurring on many occasions, for example as something that occurs when people cannot function in society anymore. A society that '[…] is centred around self-reliant, young, vital, autonomous, rational white men', may facilitate situations where shame occur when people lose these abilities. Monique thought of a man who always had advice, but now no-one to give it to. She also mentions the posters on the wall of the nursing home that show healthy, active and happy elderly that are together with their partners and friends. Or when a caretaker belittles someone by making them smaller, relative to the person that cares for them. A man put it beautifully when he said: "there are nurses that wash me and nurses that clean me, and there are the ones that feed me and the ones that provide me food or the ones that feed me, and I am merely a shadow of myself if I am washed or fed". In the society as described above, vulnerable people start to feeling ashamed for who and what they are.

Monique always focussed on vulnerability, equality and reciprocity when working with clients, but she things shame as a lens a great source to draw from in the future. According to Monique, shame needs to be brought in relation to the above-mentioned topics, for it may be able to preserve their strength.

In working with students she is less explicit in supporting them through their shame, and she does with clients and colleagues. Monique tries to stimulate the students, or help in dealing with feelings of vicarious shame, by showing her vulnerability with personal examples that are comfortable for her to tell and to not put to much weight on her listeners. She primarily wants to use the examples to make them wonder about 'what is the worst that can actually happen'. With some challenging biographical aspects, and failed contacts, she tries to show that these feelings are okay. She notices that shame is often the source of contempt towards her as a teacher. It may cause students to become angry at her for not doing her job properly, not setting strict deadlines. Here she chooses to remain friendly, because she doesn't want to add any more suffering and rejection to the rejection they already put upon themselves. She has a understanding attitude, and thinks that them getting angry at er is often a running away from their fundamental vulnerability, of which she thinks they still have allot of self-exploring to do. She is curious about her methods and wishes get some feedback about it.

6. Sandra

Sandra educates spiritual counselors and trains them in various roles and competencies, as they are presented in the ´beroepsstandaard´. This includes the meaning of being a counselor, educator, representative, and she also teaches them things like conversation skills related to meaning and life-philosophy. She has <5 years of experience as a spiritual counselor and worked as such within psychiatry. When she was educated shame was mentioned a lot and there was literature about it as well. Today, she says shat guilt is less popular then shame, and that shame is something that plays an important role especially in relation to individualism and, more extreme, narcissism. When she was a spiritual counselor herself, she always was probing whether there was shame or guilt at play. It was already present in the 'anamneses' in some sense, wondering what the other is dealing with.

To Sandra, it's better so suffer from guilt then shame, because guilt can be settled. Shame however permeates the whole being and is much more difficult to deal with. In case of guilt someone can say 'I'm sorry', but in the case of shame someone can say nothing except maybe: 'Sorry for existing'?. Sandra also shares her experience working as a spiritual caregiver found it challenging to deal with shame.

When Sandra was asked if there is attention for shame in the university she teaches, she said she didn't know for sure. She said that she doesn't see it in any of the papers that are currently around, and that she doesn't teach about it explicitly. When she was asked if she thought it was necessary to know about it, she said that it very important to be able to distinguish between shame and guilt, know about the ways in which they overlap and relate to each other, and that they are different in every situation, but that in the end, it is truly important to know about it. But, they can never cause you to put someone in a corner or write them of as narcissist for example. Knowing about it, and using it as a diagnostic lens is okay, but the client should never suffer from it. But, it is important to distinguish between shame and guilt, because looking through a wrong lens in the wrong situation may be harmful.

Sandra expresses the different ways in which shame can show itself, like insecurity, narcissism and perfectionism. She tells about a talented student who started his internship. But as the time passed he had a hard time showing himself. The problems of the student evolved to the

point he became suicidal. Sandra then explained how it became clear that all different kinds of feelings underneath arose and showed themselves, including abuse. Here, she explained her role as a teacher as spotting these types of problems and referring them for professional help.

Sandra states that presence and shame should never get in the way of each other. True presence is being there, making time for the other, level with the other, wanting to go along with the other, that is to her the presence of a spiritual counselor. If the patient suffers from shame, it can be scary for them to let someone come close, but Sandra believes that it is important for the spiritual caregiver to know something about shame in order to be able to be present and help the patient. When asked about her own shame, Sandra says she does feel way more shame in her personal life than during her work. She is better able to be present during her work and not feel shame, because she can place herself outside or besides herself.

She remarks that everyone suffers from shame, yet that it is the question how much and if suffer from it too much, or if it is unhealthy. If it disrupts your normal life, or distorts your inner space too much, you should consider working on it. If it indeed influences the inner-space too much, someone also can't help the other in doing so. Therefore, reflection and self-exploration should be necessary.

Sandra sees chronic shame potentially affecting the spiritual counselor, because it affect fundamental aspects of spiritual care. When she was asked about congruence, she drew relations between congruence, the balance between different I-positions, and how chronic shame may disrupt the inner dialogue. Sandra sees chronic shame affecting these different things, because they all affect how people talk to themselves, others, what they show of themselves, and can cause problems within these processes, ultimately also affecting the work of the spiritual counselor.

Sandra also expresses her interest in how chronic shame relates to students and young people 'these days'. She believes that shame plays a big role among millennials and that it is often about performing and showing what you can do. She is concerned about the constant pressure to perform and the impact of social media on this topic and finds it frightening and despondent. Sandra sees that shame can be a source of meaning, because of the relation someone can have towards dealing with it, and is interested in exploring the other forms of meaning that come with it. She also mentions that shame is related to the worship of heroes and can be hard to distinguish between toxic and chronic shame and shame that is manageable. She believes that the media constantly contributes to chronic shame and that this is a negative aspect of society. She expresses her concern about the impact of reality shows and social media on people's lives and how it may cause them to perform and constantly compare themselves to others, which can lead to toxic shame. Sandra despairs about the negative impact of media on society and how it makes people more susceptible to chronic shame.

7. Kees

Kees has 15> years of experience as a buddhist spiritual counselor. He works for the department of justice, within a prison. Kees is a tibettan buddhist specifically, and follows the Gulugpa tradition, the tradition of the Dalai Lama. He explains that within Buddhism, there are many different traditions someone can follow. Kees talks about disruptive emotions, which he calls "nyon mong". They do not have a word for emotions as a category in its entirety. Besides disruptive emotions, buddhist say people have positive qualities called Jun Ten. People can be 'attached', to your teacher, to your girlfriend, and to Kees we use many different words for it, but whatever form of attachment one may have, every form of it is considered to be a disruptive mental factor. In Buddhism, everyone wants to achieve full wakefulness, or

enlightenment. Wakefulness is developing everything beneficial, and get rid of everything that causes suffering. One of the beneficial factors is shame, says Kees. And Kees acknowledging's that this doesn´t have to feel good at all. But shame is a beneficial factor, because it keeps one from doing harmful activities.

Kees was asked to consider a child that was bullied and how he views shame in that regard. He remembers using a word (example of 'comical' when he was a kid) to much, and that the children around him didn´t like that and so he felt ashamed and stopped. Kees things about doing something kind, like putting a rainworm in the grass, and considers that everyone can think something of that, and that can give you the feeling of shame, but according to Kees, that isn´t shame in Buddhism. That is something else then. So, even though physiologically shame might be the same, in Kees´ tradition it is something else. And, there is allot of the feeling that shame that is not beneficial present. If you are ashamed for trivial, non harmfull actions, than that is not shame in Tibetan Buddhism. In Buddhism, an activity can be threewold, so it can be neutral, harmful, or beneficial. So, when Kees is, for example ashamed for using the word 'comical' too much, than that the shame is unwarranted and there is no need for it, and thus it isn't considered the shame that the Buddhists talk about.

Then Kees was asked about the 'aanvullende informatie' again. Kees said that he thinks shame is also about a lack of trust in the other, and that it is relationally. But, he remarked it is a positive thing, that, although it feels horrible, but feeling ashamed for what you did is in the end nothing wrong about that. For Kees, shame seems for like an warningsign to stop you from doing the things you do. Kees things about where he sees shame. He things about detective shows where someone tries to coverup a murder, about wrong decisions in politics, and thinks that that behivour originates in something that you could call shame. So, for Kees it is beneficial that humans possess the shame response. And it becomes beneficial when it motivates to stop doing something harmful.

Kees says that, if there is something that is contested in Buddhism, it is the existence of the 'I', self or ego. So when the self is challenged or attacked, that is not considered to be something wrong. But, the problem is to Kees that people don't want to feel the alarm signal of shame, and that causes them to develop differently. So, they become angry because of it.

When Kees was asked about congruence, he needed some explanation as to what it was. He said that given the definition of congruence, this is indeed is influenced by shame, because someone starts to act differently from how he really feels, and thus shame causes one to become incongruent. Then he was asked about presence, and he said he never fully studies the theory of presence, yet expresses the value of truly being present. Being present, regardless of shame, is not always easy or possible. When Kees was asked what could disrupt this, he proposed that everything that removes you from the here-and-now to thoughts either in the future or past.

When Kees sees someone is ashamed about something, he tries to make it lighter. Kees names it, or confirms someones feelings that might be shameful, and then tries to comfort the other that it is okay what he feels. Kees remarks that people judge so much. He thinks that he only judged twice during his work in the last <20 years. When Kees was asked if he ever judges himself he said: *No, I do judge aspects of my behaviour, but not myself as a person.* When he was asked if his collegues would maybe do so, he said that is a very good question.

Kees ended with a story about a detainee that was always busy with criminal activities, from his puberty on. He once asked, 'am I really bad?' And to Kees this person also has really wonderful aspects, but he just wore the 'bad' parts on the outside and made the wrong friends. To Kees, nobody really wants to be bad, but instead wants to be good. Kees told about another detainee, which he uses to describe 'shame that is as high as a mountain'. The person got a

heavy sentence for what he did, and expresses that he want to be in another place where nobody can see him, where nobody can see what he did. And this again is for Kees the beneficial shame, because it is about feeling the responsibility for what he did. But Kees remarks he also things this is very Calvinistic, Christian and culturally determined, saying: 'you are wrong'. The Dalai Lama once had a conference in which he expressed how strange he thought it was that the people in the west don't love themselves. And then he asked who on earth and why wouldn't he love himself.

To Kees, shame makes you small and pushes you in a corner, whereas regret or guilt makes you face up to your actions and say 'this is what I have done', which provides to opportunity to say: 'I am sorry'. Standing in a corner isn't going to solve anything, says Kees.

Appendix II: Interviewguide

Interviewguide chronische schaamte en geestelijke verzorging

1. Introductie (5 minuten)

Doel: "Dit interview wordt gehouden om een licht te schijnen op chronische schaamte in relatie tot geestelijke verzorging". U zei dat u het mooi vond hoe ik het aanvloog, maar momenteel ben ik nog aan het onderzoeken hoe ik het moet aanvliegen. Wat kan ik er theoretisch over zeggen? En hoe beinvloed het zorg?

Inhoud: Ik wil graag de definitie van psychotherapeut Patricia DeYoung met jullie delen: *schaamte is de beleving van de desintegratie van het ervaren gevoel van 'zelf' in relatie tot een niet-regulerende ander.*

Chronische schaamte ontwikkelt zich als deze ervaring van schaamte zich keer op keer blijft herhalen en uiteindelijk lijdt tot de vorming van bepaalde patronen in het zelfbewustzijn en in de interactie met anderen. Chronisch geschaamde mensen hebben mogelijk problemen met zelfwaardering, liefde richting zichzelf en anderen.

Deze problemen vinden hun uitdrukking in psychopathologische beelden en gedragingen als angst, depressie, dissociatie, verslaving, isolatie, perfectionisme en narcisme. Hieronder volgt een vrij vertaalde omschrijving van schaamte, zoals beschreven door Patricia DeYoung met bijna dertig jaar ervaring als psychotherapeut:

"Komt schaamte aan het licht, dan is de pijn ondragelijk. Om onszelf te redden duwen we de schaamte weg zo snel als we kunnen en bedekken we hem met meer verdraaglijke toestanden."

Ik denk dat belangrijk is te benadrukken dat het dus gaat om chronische schaamte en niet om schaamte, als een soort verweer tegen fundamentele kwetsbaarheid, of begrepen kan worden als een ernstige verlegenheid.

Vertrouwelijkheid: Zoals ook in het toestemmingsformulier stond aangegeven worden alle gegevens en het verzamelde beeld en geluidsmateriaal hier in de lijn met de privacyrichtlijnen van RuG verwerkt. Alle data zal dus geanonimiseerd worden en zodoende alleen vertrouwelijk en anoniem met derden worden gedeeld.

Akkoord opname

2. Algemene informatie (5 minuten)

Zou iedereen om de beurt de volgende punten kunnen toelichten:

- Werkveld
- Naam organisatie
- Aantal jaar ervaring als geestelijk verzorger
- Andere mogelijke relevante ervaring
- Denominatie

3. Vragen (30 minuten)

Introducerend

- Wat roept het begrip 'chronische schaamte' bij u op?

(Optioneel)

Verkennend

- Is de geestelijk verzorging gemoeid met chronische schaamte of schaamtegevoeligheid?
- Bent u chronische schaamte tegen gekomen in uw opleiding/studie/zelfstudie?
- Bent u persoonlijk bekend met schaamte?
- Heeft u ooit van schaamte gehoord in een college, lezing of buiten uw gebruikelijke opleiding?
- Heeft u zelf ooit schaamte onderzocht?
- Wat voor houding moet een geestelijk verzorger aannemen als hij werkt met schaamte?
- En hoe moet een geestelijk verzorger omgaan met haar eigen schaamte?
- Denk je dat aandacht voor een begrip als chronische schaamte helpt bij de kwaliteit van zorg binnen geestelijke verzorging?
- Wat is van belang in de grondhouding van geestelijk verzorger bij het tegen komen van schaamte?
- Heeft u schaamte in een bepaalde vorm systematisch onderzocht/bestudeerd?
- Kunt u over een casus vertellen waarbij u denkt het fenomeen te hebben meegemaakt? En hoe ging u ermee om?

Theorie-specifiek

- **Op wat voor manier denkt u dat -theoretisch gezien- chronische schaamte het werk van de geestelijk verzorger kan beïnvloeden?**
- Wat is de verhouding tussen (chronische) schaamte en congruentie?
- En met presentie?
- Of innerlijke ruimte?
- Kent u kunst, muziek, boeken, verhalen of ander materiaal dat te maken heeft met chronische schaamte?
- Welke theorieën binnen geestelijke verzorging zijn mogelijke gerelateerd aan het werken met de schaamte van anderen of uw eigen?
- "Als ik onderzoek naar chronische schaamte zou doen zou ik willen weten…"
- Hoe ziet u schaamte als existentiele categorie?
- Wat is de waarde van het hebben over deze diepere, fundamentele schaamte?
- Heeft u een casus?
- Hoe herkent u schaamte in de praktijk, bij uzelf of de ander?

- Heeft u al eens systemisch nagedacht over of zich verdiept in (chronische)schaamte?

Afsluitend

- Wat is de waarde voor de geestelijke verzorging om te leren over chronische schaamte?
- Denkt u dat er kennis of ervaring met chronische schaamte u professioneel vooruit kan helpen?
- Denkt u dat chronische schaamte in het domein van de geestelijk verzorger licht?
- Denkt u dat verder onderzoek over chronische schaamte belangrijk is?

4. Pauze (10 minuten)

5. Voortzetting vragenronde (30 minuten)

6. Afsluiting (10 minuten)

- Hebben jullie alles kunnen delen?
- Wat vonden jullie van de focusgroep?
- Mochten er nog vragen of mededelingen ontstaan na afloop dan kunnen jullie contact met mij of de scriptiebegeleider opnemen via de gegevens in de mail.
- Ik wil jullie allemaal hartelijk bedanken voor de deelname aan mijn onderzoek.

Appendix III: Additional information

Interview over geestelijke verzorging en chronische schaamte

Exploratief onderzoek naar de verhouding tussen geestelijke verzorging en chronische schaamte

Inhoud onderzoek

Ter afronding van de master 'Geestelijke Verzorging' aan de Rijksuniversiteit Groningen ben ik voor mijn scriptie opzoek naar geestelijk verzorgers die geïnterviewd willen worden over de relatie tussen geestelijke verzorging en 'chronische schaamte'. Het onderwerp chronische schaamte is uitgebreid onderzocht in de psychologie, maar in een mindere mate binnen geestelijke verzorging. In de bestaande psychologische literatuur over chronische schaamte wordt vaak benoemd dat het belangrijk is voor een behandelaar om zijn eigen schaamte te verkennen, maar hoe zit dit bij de geestelijk verzorger? Mijn onderzoeksvraag is hoe kennis over chronische schaamte de kwaliteit van Nederlandse geestelijk verzorgers beïnvloed heeft of kan beïnvloeden, of anders gezegd: hoe zit het met geestelijke verzorging en chronische schaamte?

Chronische schaamte

De definitie die ik hanteer van schaamte is afkomstig van psychotherapeut Patricia DeYoung en luidt als volgt: *schaamte is de beleving van de desintegratie van het ervaren gevoel van 'zelf' in relatie tot een niet-regulerende ander*. Vervolgens ontwikkelt chronische schaamte zich als deze ervaring van schaamte zich keer op keer blijft herhalen, met uiteindelijk de vorming van bepaalde patronen in het zelfbewustzijn en veranderingen in de interactie met anderen tot gevolg. Chronisch geschaamde mensen hebben mogelijk problemen met zelfwaardering en liefde richting zichzelf en naar anderen. Deze problemen vinden hun uitdrukking in psychopathologische beelden en gedragingen als angst, depressie, dissociatie, verslaving, isolatie, perfectionisme en narcisme.

Relevantie voor geestelijke verzorging

De auteurs die zich hebben verdiept in chronische schaamte benadrukken dat de kwaliteit van therapie en de professionaliteit van de behandelaar toenemen met de herkenning van chronische schaamte. Hoewel er internationaal over chronische schaamte is geschreven vanuit een theologisch of pastoraal perspectief, is het tot nu toe nog niet gelukt om materiaal te vinden over geestelijke verzorging en chronische schaamte in de Nederlandse context'. Desalniettemin hebben Nederlandse geestelijk verzorgers – gegeven de raakvlakken tussen geestelijke verzorging en andere vormen van geestelijke gezondheidszorg – in relatie tot zelf en ander, bewust of onbewust en in meer of mindere mate óók te maken met chronische schaamte. De vraag is wat voor effect het heeft als er binnen de geestelijk verzorging aandacht is voor dit onderwerp. Juist omdat er niet veel over is geschreven, is uw inbreng van belang om binnen ons vakgebied een verdere verhouding ten opzichte van dit onderwerp te bepalen.

Relevantie voor u

In de huidige literatuur over chronische schaamte wordt beschreven dat een behandelaar zijn eigen chronische schaamte moet verkennen, begrijpen en doorwerken om de client effectief te kunnen helpen. Door de eigen schaamte te begrijpen, kan de behandelaar zachtaardiger en een stevige en angst-vrije connectie vormen met de client. Door deelname aan het interview krijgt u de kans uw eigen perspectief op dit onderwerp in relatie tot de geestelijke verzorging te delen, wellicht nieuwe kennis over het onderwerp te vergaren en de discussie over dit onderwerp verder vorm te geven.

Invulling en deelname interview

Het interview zal maximaal één uur duren en telefonisch op digitaal plaatsvinden op het door u gewenste platform. Het interview zal via worden opgenomen en de gegevens worden anoniem verwerkt. Wilt u meedoen aan het onderzoek? Mail dan naar w.g.a.bosman@student.rug.nl welke van de volgende data u zou kunnen deelnemen of bel me op +316 53 68 24 32. Mocht u een plekje vinden, dan is het de bedoeling dat het interview afgelopen is op de gegeven eindtijden.

31 mei *Dinsdag* 19:00 – 21:00	**1 juni** *Woensdag* 9:00 – 10:30	**3 juni** *Vrijdag* 9:00 – 14:00	**4 juni** *Zaterdag* 12:00 – 17:00
6 juni *Maandag* 9:00 – 13:15	**7 juni** *Dinsdag* 9:00 – 11:00 18:00 – 21:00	**8 mei** *Woensdag* 12:00 – 14:30	**10 mei** *Vrijdag* 9:00 – 14:00

*Mocht het pas na een van deze data kunnen, dan kunnen we even bellen!

Samengevat

- Het onderzoek gaat over de verhouding tussen chronische schaamte en geestelijke verzorging.
- Het interview duurt maximaal een uur en kan digitaal of telefonisch worden afgenomen.
- De data wordt anoniem verwerkt.
- Als u wilt meedoen aan het interview stuur dan een mail naar w.g.a.bosman@student.rug.nl met uw naam en **alle data waarop u kan deelnemen** of bel me op +316 53 68 24 32.
- Zodra we een afspraak hebben gemaakt zal u een toestemmingsformulier en een bevestiging van de datum ontvangen.
- Voordat u deelneemt aan het interview stuurt u een **ondertekend toestemmingsformulier** naar het bovengenoemde emailadres.

Heel erg bedankt voor uw interesse & inzet!

Appendix IV: Consent-form

Toestemmingsformulier

Werktitel onderzoek: Geestelijke verzorging en chronische schaamte

Chronische schaamte is een onderwerp dat in de psychotherapie wordt onderzocht en besproken. Binnen die discipline wordt het door experts gezien als een onderwerp dat relevant is voor de kwaliteit van de zorg. Door chronische schaamte zowel bij zichzelf als de ander te kunnen herkennen, is de behandelaar beter in staat aan te sluiten en therapie te leveren. Heeft dit onderwerp ook invloed op het werkveld van de geestelijk verzorger? Hoe wordt het onderwerp momenteel beschouwd door geestelijk verzorgers? Wat roept het bij hen op om hierover te praten? Wat vinden zij van een gesprek over dit onderwerp? Wat in chronische schaamte raakt het werk van de geestelijk verzorger? Naast een literatuuronderzoek zal met individuele interviews geprobeerd worden zo goed mogelijk antwoord te geven op deze vragen.

Contactpersoon: Wilco Bosman, w.g.a.bosman@student.rug.nl

Scriptiebegeleider: Anja Visser, a.visser-nieraeth@rug.nl

Tijdens het interview kan het voorkomen dat u persoonlijke informatie delen van uzelf, collega's of cliënten deelt. Om deze reden is het belangrijk dat er rekening gehouden wordt met privacy. Het verzamelde materiaal wordt volgens de wetenschappelijke RUG GGW richtlijnen opgeslagen en vertrouwelijk behandeld. Dat wil zeggen dat derden geen toegang krijgen tot het primaire bronnenmateriaal en informatie geanonimiseerd verwerkt wordt in rapportages van bevindingen: analyses en wetenschappelijke presentaties. Er worden verder geen extra inspanningen van u gevraagd.

Een gesprek over chronische schaamte kan gevoelens of emoties oproepen die als ongewenst worden ervaren. Om deze reden is het belangrijk dat u weet dat u op ieder moment het interview mag verlaten. U heeft daarnaast het recht om ervoor te kiezen informatie niet te delen die ongewenste emoties of gevoelens bij u kan oproepen.

Door dit document te ondertekenen…

- bevestig ik te weten dat ik op vrijwillige basis meedoe aan een onderzoek en dat ik het document **'[Interview] aanvullende informatie'** heb gelezen.
- verklaar ik op een voor mij duidelijke wijze te zijn ingelicht over de aard, methode, doel en [indien aanwezig] de risico's en belasting van het onderzoek. Ik weet dat de gegevens en resultaten van het onderzoek alleen anoniem en vertrouwelijk aan derden bekend gemaakt zullen worden. Mijn vragen zijn naar tevredenheid beantwoord.
- geef ik aan dat ik begrijp dat film-of audiomateriaal of bewerking daarvan uitsluitend voor analyse en/of wetenschappelijke presentaties zal worden gebruikt.
- stem ik geheel vrijwillig in met auditieve [en eventueel visuele] opname van dit interview en deelname aan dit onderzoek. Ik behoud me daarbij het recht voor om op elk moment zonder opgaaf van redenen mijn deelname aan dit onderzoek te beëindigen.

Naam deelnemer:……

Datum: ……..

Handtekening deelnemer:……