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"Disclosing the innermost part": Exploring therapists' constructions of shame using a story completion method

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Abstract: Previous research on shame has indicated that it is an important phenomenon that can benefit or hinder the therapeutic process, depending on how it is understood and managed by therapists. However, therapists' conceptualisations of shame have not been explored adequately. This study utilised a novel method of data collection called story-completion to examine how therapists talk about shame, and the impact this can have on how they manage it. Forty-five therapists were asked to complete a story-stem describing a therapist working with a client's shame via an online survey platform. Foucauldian discourse analysis (FDA) was used to critically analyse participants' stories. Shame was constructed as a rather problematic emotion that hinders the therapeutic progress by preventing the clients from revealing their "true" self. In these narratives, the therapist's task was to uncover what is hidden behind shame. Some participants constructed the therapist as an expert, holding the appropriate knowledge to manage it. A counter position was the therapist conceptualised as humane, where they were de-skilled and vulnerable in relation to shame. We invite practitioners to be mindful of the ways that their understanding of emotions, and their role in relation to them, can impact the direction of therapy.

Keywords: Shame; Story-completion method; Therapist discourse; Foucauldian discourse analysis

Historically, shame has been described as "one of the most intense experiences in the affective repertoire" (Ward, 1972, p. 232). In the psychological literature, it is often classified as a self-conscious emotion and has been described as a highly unpleasant sense, arising when someone fails to meet standards important to them. It has been associated with a negative evaluation of the self, social withdrawal and feelings of exposure, mistrust, and powerlessness (Tracy & Robins, 2007; VandenBos, 2007).

Compared to other emotions, shame had received relatively little attention both in research and clinical practice, with therapists [1], supervisors and researchers avoiding open discussions about it (Rosenrot et al., 2020, Shepherd et al., 2013). Over the last decades though, this seems to have changed, with more practitioners and researchers recognising the importance of understanding the role of shame in the therapeutic process (Goffnett et al., 2020). Despite the increased interest in shame, some aspects of it remain "under-theorised and under-researched" (Dolezal & Lyons, 2017, p.

[1] The terms therapist, therapeutic practitioner and practitioner are being used interchangeably throughout the study. Through these terms we are referring to practitioners with a background in psychotherapy, counselling, psychology, or psychiatry who identify themselves as working therapeutically, utilising different therapeutic modalities.

257). Understanding shame in the therapeutic context is important for several reasons. Feelings of shame are one of the most common concerns for people who seek therapy (Goffnett et al., 2020), yet it has been argued that the therapeutic process may trigger or prolong one's sense of self-consciousness and increase feelings of shame (Dearing & Tangney, 2011). Previous research suggests that in its extreme form, shame can be "incapacitating and destructive", but it is a universal phenomenon experienced by patients as well as therapists (Allan et al., 2016; Hahn, 2000, p. 10). As such, it has proven difficult for therapists to address in clinical practice, and supervision, which can further complicate the therapeutic process (Gans, 2018).

Given the limited investigation of shame in the context of therapy and its importance for the therapeutic process, this study aims to examine how therapeutic practitioners talk about shame in the therapeutic context.

Literature Review

Shame is a powerful, primitive emotion that plays an important role in identity formation. It contributes to the development of socially acceptable behaviour and moral conscience (Kaufman, 1974). In social settings, including therapeutic settings, its presence contributes to social integration, through conscious, or unconscious conformity with the norms of the environment, such as the therapeutic boundaries (DeYoung, 2015).

Although moderate levels of shame can assist social integration, in most cases shame within the therapeutic practice is seen as problematic by researchers and practitioners. Most studies within the psychological literature focus on the links between shame and the occurrence or maintenance of psychological disturbance. From a diagnostic perspective, shame has been linked with different mental health difficulties, including eating disorders (Blythin et al., 2020), depression, anxiety (Callow et al., 2020), self-harm and suicidal behaviours (Sheehy et al., 2019). Shame has also been related with the exacerbation of symptoms of borderline and avoidant personality disorders in individuals with these diagnoses (Currie et al., 2017).

Shame and the Therapeutic Process

Despite the focus on the links between shame and psychological difficulties, much less attention has been given to the ways that client's shame can impact the therapeutic process, and the therapist's role in relation to that. Previous research that examined the impact of shame on the therapeutic alliance, suggested that shame-related behaviours, such as withdrawal or non-disclosure, can have a negative effect on the therapeutic relationship, which is a strong predictor of positive therapeutic outcomes (Black et al., 2013; McDonald & Morley, 2001). Moreover, client's shame has been related to poorer engagement, lack of self-disclosure and increased risk within the therapeutic process (Hook & Andrews, 2005; Swan & Andrews, 2003). It has been suggested that experiencing shame as particularly painful and unbearable can lead to avoidant behaviours and aggression towards oneself and others (Schoenleber, Berenbaum, & Motl, 2014).

It could be hypothesised that a representation of the self as defective in shamed individuals might make it less likely for them to be open about their difficulties and to develop a positive therapeutic alliance. Yet, it has been suggested that it is not the experience of shame per se, that creates difficulties within the therapeutic practice, but the ways individuals manage it. Nathanson's model, which is one of the most cited theories within shame research (Nathanson, 1992), describes four ways (*scripts*) that shame might present; attack self, withdrawal, attack other, and avoidance. Each set of shame-focused scripts is associated with different motivations, affects, cognitions, behaviours. It might be argued that all of the above coping mechanisms can have a negative impact on the therapeutic process, as they are likely to prevent clients' engagement and their ability to discuss their difficulties in an open and transparent way.

In spite of these propositions, we still know very little on how therapists' way of dealing with shame can influence the therapeutic process. This might be related to the fact that shame is not always discussed openly by clients, therapists, or supervisors in clinical practice, possibly due to its "aversive nature" (Shepherd et al., 2013, p. 42). Nathanson (1992) suggests that this is because shame itself tends to make us especially uncomfortable. It has been argued that "it is shameful and humiliating to admit that one has been shamed and humiliated" (Lazare, 1987, p. 1658). As a result, the emotion often remains unacknowledged in the therapy room, which might have adverse effects on therapy. It has been noted that therapists' failure to recognise and reflect on the effects of shame might make clients feel misunderstood or invalidated (Dearing & Tangney, 2011).

Rationale and Aims of the Study

The above findings emphasise the relationship between shame, psychological disturbance, and the quality of the therapeutic relationship. Although, shame seems to be an important part of the therapeutic process, it has received relatively little attention in the empirical literature. Moreover, we know very little on how therapists' way of managing it can

interfere with the therapeutic work. It has been suggested that the ways that therapists understand and process shame can have a great impact on how it is managed during therapy (Miller & Draghi-Lorenz, 2005; Petter, 2010). In accordance with this view, Willig (2008) argued that practitioners' conceptualisations of certain phenomena could influence how they deal with them in clinical practice.

To address this gap, in this study, we aim to examine the ways that shame is discursively constructed by therapeutic practitioners. Discursive approaches assume that the way we talk about particular phenomena has an impact on social and psychological life by reproducing or challenging culturally dominant understandings of them (Georgaca & Avdi, 2009). Discourses are understood as strongly related to power and thus, discourse analysis pays attention to power relations and aims to interrogate taken-for-granted ways of understanding realities (Willig, 2008).

By exploring discursive processes, this study aims to help therapeutic practitioners understand how they might frame clients' emotions, as well as the ways they are constrained or liberated by their engagement in different discourses about them. Moreover, this research attempts to make both therapists and supervisors aware of their active role and contribution to the client's direction of change and promote "socially aware therapy" (Georgaca & Avdi, 2009, p. 159; Spong, 2010). Understanding these processes is key to the maintenance of a critical reflective stance towards clinical practice [British Psychological Society (BPS), 2017a].

Methodology

Story-Completion as a Method of Data Collection

Story-completion is a relatively novel technique for collecting qualitative data in the form of stories (Clarke et al., 2017). Instead of being asked to report directly on their understandings of a phenomenon, in story-completion research, participants are provided with the opening sentences of a story about a hypothetical scenario (the story stem or cue) and asked to complete it. Story-completion ideally suits topics that are thought to be sensitive and which participants may hesitate to talk about, as they are asked to respond to a hypothetical, rather than a real scenario. Thus, they do not have to own or justify their stories in the way they would if they were asked directly about the topic in an interview situation (Braun et al., 2019).

It is worth mentioning that before being introduced as a qualitative research method, story completion was primarily being used in psychoanalytic contexts, as a projective technique (Rabin, 1981), and in quantitative developmental research (e.g., Bretherton et al, 1990). By introducing an ambiguous stimulus to clients, it helped them overcome their potential resistances or get in touch with unconscious emotions. Story-completion has also been used in positivist research as a way to better understand participants "real" thoughts and deal with "barriers of awareness and social desirability bias" (Kitzinger & Powell, 1995, p. 149). More recently though, it was suggested that instead of interpreting the stories as revealing the internal reality of the participants, researchers could read them through discursive lens as "reflecting contemporary discourses upon which subjects draw in making sense of experience" (Kitzinger & Powell, 1995, pp. 349–350; Walsh & Malson, 2010).

Rationale for the Use of Story Completion in this Study

We thought this method would be relevant to shame research for a number of reasons. As discussed in the literature review section, shame is a topic that can be difficult to discuss, in clinical practice, supervision, as well as research. Researchers in previous studies on shame noticed that participants struggled to name their experiences of dealing with shame and talk openly about them. Miller and Draghi-Lorenz (2005, p. 17) mentioned that "due to the inevitably social nature of the interviews", participants' descriptions seemed to reflect the "less threatening end of the spectrum of possible shame experiences". In a similar vein, it has been suggested that "shame tends to evoke shame" in research and clinical practice (Livingston & Farber, 1996, p. 608; Macdonald & Morley, 2001). Due to these issues, Macdonald and Morley suggested that, in order to develop a theoretical understanding of phenomena such as emotions, researchers need to use methods which "can encompass unforeseen factors that might otherwise be obscured by the researchers' a priori constructs" (2001, p. 3).

Based on these observations, we thought that the concept of an imagined, instead of a real therapeutic situation could provide a way to examine the power dynamics, as participants do not have to own their perspectives, so they are freer to reflect on the subject positions that become available in the scenario they are given. Finally, in previous studies, it has been noted that the ambiguity of the story stem gives participants more flexibility and allows them to reflect on issues that might be of significant analytic interest (Beres et al., 2017; Clarke et al., 2015; Frith 2013).

Design and Theoretical Foundations of the Study

According to Clarke et al. (2017), data from story-completion tasks can be analysed in various ways and involving different epistemological perspectives. As the aim of the study was to explore how participants understand and talk about shame, we thought that discourse analysis would provide the best form of analysis for our data. Discursive approaches provide a way to critically examine how a phenomenon is understood and spoken about by a social group (Willig, 2008).

Within the discursive framework, there are different approaches to analyse language material. All of them assume that the ways we speak about certain phenomena has an impact on how we deal with them (Burr, 2003). Whilst all of them provide useful approaches to discourse and data, the focus of this research was on how discourse enables certain ways of seeing and ways of being; as opposed to for example, a discursive psychological focus on how people use discourse to manage their social identities (Edwards & Potter, 1992). We therefore thought that Foucauldian Discourse Analysis (FDA) would the most appropriate analytic method to understand shame. From a Foucauldian perspective, therapeutic practice is thought to be part of a wider system of meanings and thus, what is happening in the therapy room can only be understood within a specific institutional framework (McNamee, 1996). We provide more details on the theory and methods of our analysis in the sections below.

Foucauldian Discourse Analysis

FDA is a widely used method for examining the constructive role of language (Willig, 2008). It is based on poststructuralist ideas and mainly the work of Michel Foucault. It places a large focus on the ways that power is exercised in different contexts, in direct, and indirect ways. Foucault did not prescribe a set of rules for conducting it. However, in an effort to outline why FDA is of interest to psychologists, contemporary theorists have stipulated certain sets of procedures for conducting this type of research (e.g., Arribas-Ayllon & Walkerdine, 2008; Parker, 1992; Willig, 2008).

The term discourse in this framework refers to "a corpus of statements whose organisation is relatively regular and systematic" (Arribas-Ayllon & Walkerdine, 2008, p. 100). Discourses offer "subject positions" which, when taken up, have implications for subjectivity and experience. In the biomedical discourse for example, people who experience ill health occupy the subject position of "the patient", which "positions them" (p. 113) as passive recipients of expert care within a trajectory of recovery. The term positioning in FDA refers to the available ways of being and seeing the world and is strongly related to the exercise of power (Willig, 2008).

Therefore, our analysis focusses on the ways that participants understand the role, or the position of the therapist in relation to shame, as well as how shame is constructed in the context of therapy.

Analytic Procedures

As mentioned previously, there are different ways of conducting FDA in psychological research. This study was informed by Willig's six steps of analysis (Willig, 2008), as we thought that this method provides a more structured framework for conducting this type of research and is more focused on the "consequences" of the different discourses for clinical practice (p. 117), which was the focus of this study.

In accordance with Willig's (2008) suggestions, the initial stages of the analysis consisted of multiple readings and personal reflections on the data as a way to familiarise ourselves with the overarching constructions (Steps 1, 2). We tried to highlight all direct or indirect references to shame, and the discourses participants drew upon when constructing the object of shame within various discursive frameworks (e.g., humanistic and/or cognitive behavioural discourses). To identify the action orientation or the discursive function of the different discourses (Step 3) we reflected on questions such as: "What is gained from constructing the object in this particular way at this particular point in the text?" and "What is its function and how does it relate to other constructions produced in the surrounding text?" (2008, p. 116). These questions aimed to identify the ways in which a particular discourse justifies certain practices. They also brought our attention to a macro-level conceptualisation of psychotherapy as a wider institution that legitimises certain ways of being for therapists and clients in relation to shame (Willig, 2008). At the next stage (Step 4), we identified the subject positions that became available through participants' stories (e.g., "expert" or "humane practitioner"). We attended to the "ways-of-seeing and ways-of being" in the world that were constructed in the discourses (Willig, 2008, p. 117). For example, the pedagogy discourse made available the subject position of the "expert practitioner", who aims to educate clients on ways to alleviate shame. Then, we focused on the opportunities for practice that become plausible from these positions (Step 5). We paid attention to the actions (both productive and restrictive) that follow from particular discourses. For example, by positioning shame as part of a psychological condition, the practitioner is more likely to be constructed as responsible for treating it and the client as a passive recipient of the expert knowledge. The final step (Stage 6) aimed to explore the links between discourses and subjectivities (the previous three steps). We attended to the possible realities that are constructed, given the available discourses and their

arising subject positions. The aim at that stage was to integrate the previous analytic steps and provide an overview of what can be felt or done from the subject positions identified in step 4.

Throughout all stages of the analytic process, we aimed to maintain a constant awareness of the ways that participants' narratives might have been influenced by our positions as researchers and therapeutic practitioners. Reflexivity forms an overarching principle of discourse analysis and throughout the analysis, researchers need to pay attention to their role in the generation of research data (Georgaca & Avdi, 2012). In accordance with a Foucauldian perspective, which calls for consideration of the ways in which the power/knowledge nexus functions to achieve certain subject positions, we tried to be mindful of the ways that our power as researchers is likely to be played out at all stages of the research process. We elaborate further in these issues at the end of the analysis section.

Data collection - Story Stem

Participants were presented with the opening sentences of a story (Text Box 1) and were asked to complete the rest of it.

Text Box 1: Story Stem

"You are invited to read the following story opening carefully and complete the rest of the story. There is no right or wrong way to complete it, so feel free to write whatever comes to your mind! Please write a story that is at least 10 lines/200 words long.

Alex has recently started working therapeutically with a new client named Jo. In their second session, Alex is feeling rather puzzled. Jo seems to avoid eye contact and stops talking at various points during the session. Then Jo discloses feeling ashamed …

Please complete and expand on this story by describing Jo, Alex and their interaction, focussing on: How the session(s) unfold(s)?

What was Jo's shame about?

What might be going on between them?

What was Alex's reaction to Jo's shame?

What happens next?

Your story can unfold into the next sessions and beyond. Please write your answers in the form of a story!"

The story was left deliberately ambiguous in terms of the therapist's gender, experience and length of therapy, as recommended by Clarke et al. (2017).

It is worth mentioning that the first two stories were used as a pilot study to examine the feasibility of story completion as a method of data collection and to make sure that the way the story stem is phrased is accessible to the participants towards increasing the quality of our research (Malmqvist et al., 2019). The character of the therapist was initially constructed as female, as there is a larger number of female than male therapists. However, after doing the first pilots, it was thought that the gender-ambiguous names would give greater freedom to participants and this might provide meaningful material for the analysis, in terms of the power relations. Moreover, we thought that participants would be more likely to reflect on the role of the therapist and the impact of shame on the therapeutic process if they were given prompts. Therefore, we added additional questions (i.e., How does the session(s) unfold(s)? What was Jo's shame about? What might be going on between them? What was Alex's reaction to Jo's shame? What happens next?).

Stories and Participants

Forty-five stories were written in total. The average story length was approximately 400 words, although the sizes of the stories ranged from 74 to 726 words. The 45 practitioners (Table 1) who wrote these stories identified themselves as working therapeutically, utilising a variety of therapeutic modalities. Thirty-eight of the participants identified themselves as female and five as male. 2 participants did not disclose their gender. Ages ranged from 30 to 70 years old. The participants' professional backgrounds were psychiatry, psychology, and psychotherapy. Theoretical orientation was described as cognitive behaviour therapy (CBT), integrative/pluralistic, humanistic [i.e., person-centred (PC)/existential/transactional analysis (TA)], and psychodynamic.

Data were gathered electronically using online survey software. The authors used convenience sampling. To reach participants, the first author used her professional network. She contacted organisations that employ therapeutic practitioners, such as mental health teams within the National Health Service and charities offering low-cost therapy, as these are the main places where therapists are employed in the United Kingdom (UK), according to the authors' knowledge and personal experience. Participants were approached via email and invited to complete the study and distribute the link to their networks. The study link was also posted in several social media interest groups. Our aim was to recruit a large number of participants, representing different therapeutic

orientations, so that the findings reflect the different discourses participants might draw upon.

There have been great variations in participant numbers in studies that have used story-completion. According to Clarke et al. (2017, p. 57-58), a sample of 20-40 participants is likely to provide the researcher with data that are "detailed enough for a meaningful analysis". Based on these suggestions, and in line with previous studies that have used this method within a discursive framework (e.g., Gavin, 2005; Walsh & Malson, 2010), we thought that 25 participants would provide us enough data to start our analysis. However, at that stage we could not see any patterns emerging through the data, so we continued the process of data collection. We finally recruited 45 participants, at which point we thought our data had reached saturation (Morse, 2003). We could see some patterns that would allow us to conduct a meaningful analysis from this perspective. Furthermore, after the first 42 stories, we could not see any new ideas coming up, so we decided to stop collecting further data.

Participants were asked demographic questions relating to their age, theoretical orientation and professional capacity. These data were considered in order to offer a context to the participants' stories and situate the sample. We thought that the contextual influences (e.g., participants' background and/or theoretical orientation) might be of significant analytical interest, so it would be worth collecting them in advance. Nevertheless, it should be noted that in discourse analysis, the emphasis is on what is being told, rather than who does the telling (Potter & Wetherell, 1987), so detailed demographic information was not considered relevant to the study. Based on these suggestions, and in order to ensure participants' confidentiality, we did not collect information on participants' place of work.

Among the inclusion criteria, was self-identification as a qualified therapeutic practitioner, whilst the participants' professional capacities varied. It was thought that shame is an important topic that could be relevant to anyone working therapeutically, regardless of their professional background and theoretical orientation, as was shown in the literature review (e.g., Miller & Draghi-Lorenz, 2005). FDA has no prescribed guidelines regarding the homogeneity of the sample, compared to other qualitative research methods. On the contrary, sampling in discourse analysis seeks diversity rather than representativeness or homogeneity in order to capture the variations in the discourse (Mays & Pope, 2000). Therefore, we thought that a well-rounded selection of different specialities and theoretical orientations would provide a better understanding of the different discourses that participants draw upon when constructing shame.

Ethical Considerations

The study received ethical approval from the University of Surrey research committee (Ref No: 1380-PSY-18).
The confidentiality and anonymity of participants was maintained throughout all parts of the analysis by giving unique IDs to each participant who completed the story online. Participants were informed of their right to withdraw from the study without further consequences.

Professional Background	*Number of Participants*	*Theoretical Orientation*	*Number of Participants*
Psychotherapist/Counsellor	25	Integrative/Pluralistic	20
Counselling/Clinical Psychologist	17	CBT	13
Psychiatrist	3	Humanistic (PC/existential/TA)	7
		Psychodynamic	4
		Did not disclose	1
		Total Number of Participants	45

Table 1: Participants' Professional Background and Therapeutic Approach

Analysis

The analysis mapped out some of the ways that clients' shame was conceptualised in the 45 stories. We identified two dominant therapist constructions of shame in the narratives, the *hidden self*, and *self-agency/autonomy*, and two accompanying subject positions for therapists as: the *expert* and *humane* practitioner. It should be noted that the extracts selected from the stories were chosen on the basis of better demonstrating the arguments we wanted to make and ensuring the coherence and plausibility of the analysis (Parker, 1992). Stories were randomly coded into numbers for identification, so within the analysis, extracts are presented as S1., S2. etc., whereby S1 means Story 1.

The Hidden Self

In many stories, clients were depicted as displaying different behaviours (e.g., withdrawal, non-disclosure) to hide the shameful parts of themselves. The therapist's task was understood in terms of uncovering the client's shame and helping them move beyond that. We suggest that in these narratives, therapists constructed shame as an individual's possession, something which was located within the individual, and as something which could be hidden from, or displayed to the therapist. Within the discourse of the hidden

self, the concept of confession seemed to play an important role. Shame was constructed as problematic within most narratives – something to move on from - posing a barrier to the therapeutic ideal of self-revelation, which could be overcome through the client's confession. Indeed, most stories were structured around a happy ending, whereby the client managed to talk about their shame and the feelings behind it and thus, felt liberated.

> S 7. Jo was used to hiding her true feelings, that she was unlovable, from the world. Sitting with Alex, Jo felt she wanted to be real and honest about herself and her feelings.
>
> S 32. Perhaps Jo has taken the first step in coming to therapy but is unsure of how to disclose the innermost part of her. The therapeutic alliance has not yet been established and she hasn't built trust in the relationship.

In S7, the client's "true" emotions are kept private and are conflated with the client's sense of self as defectiveness. Using the concepts of "hidden/true feelings" and one's "innermost part", the participant constructs a reality hidden behind emotions. Participants in both the above extracts refer to a real and "innermost" part, which is hidden by behaviours related to shame, such as non-disclosure, but can be understood under the right circumstances (i.e., "established alliance/trust"). These constructs imply a true/internal and a false/outer self which is mediated by feelings of shame. The hidden part of oneself might be seen as more real, and to some extent, uperior, than the part of oneself that is presented to the therapist. Based on these understandings, many forms of therapy aim to help the client become more congruent, or find their true self (e.g., Rogers, 1961; Winnicott, 1965).

The construct of a "hidden self" can be seen to provide a framework for emotional interactions between client and therapist. In the extract below, for example, therapy helps the client "express herself more openly" and operates to demonstrate that Jo is making therapeutic progress.

> S. 42 After a few sessions, Jo was able to talk more openly about her difficulties in their relationship with him and they gradually managed to move beyond that. Their relationship helped Jo identify alternative ways of expressing her emotions, which eventually made her more able to talk to her mother about the way she was feeling.
>
> S. 40 Jo tells Alex she has never spoken about this before, and she's not even clear that it's anything that important, but Alex can sense it is troubling her and reflects that back to her. Alex senses a mixture of reluctance and eagerness to "spit out" what happened, and asks Jo if that indeed is what is going on for her. Jo nods, and agrees "exactly that, but I think I'd have to tell you other stuff about me..." "Which you don't yet want to tell me?" "No".

The last extract constructs a tension between a tendency to hide behind shame-related behaviours and an impulse to confess. The therapist could be seen as a powerful figure, able to have an accurate idea of what is going on for the client and with an active role in driving the therapeutic process and influencing the client's self-narrative. Shame seems to be constructed as "reluctance" and, in a way, as resistance to self-revelation to the therapist.

Thinking more widely about the hidden self and emotional disclosure, it has parallels to religious confession. For Foucault, confession is one of the most pervasive examples of a power-knowledge relationship, as it offers to the person who is in authority a resource by which the other person can be assessed and dealt with in accordance with their wishes (Foucault, 1980). However, the compulsion to reveal our true selves, as described in the previous section, has become so deeply entrenched in Western societies that it is no longer experienced as a constraining power (Foucault, 1998). Instead, it is constructed as the true voice that demands expression in order to feel liberated, whilst any reluctance to confess is conceptualised as the effect of a constraint (Besley, 2005).

The discourse of the hidden self brings attention to the power/knowledge relationship within the therapeutic framework, and the ways that therapists' understandings of shame can impact the direction of therapy. It might be said that the implicit process of confession (in the language of the stories styled as disclosure and expression) gives the therapist a sense of procedure in which to understand, categorise and eventually manage the clients' shame. Indeed, it has been argued that confession is not only a communicative and expressive act; rather, within the therapeutic framework, clients almost recreate themselves through their narrative and bring the spheres of private, public, past, and future together, in a dialogue with another (Besley, 2005).

Self-Agency and Autonomy

In many stories, participants drew upon the ideas of autonomy, and self-agency. These concepts are often recognised within a humanistic therapy approach (Rogers, 1961). The following quotation illustrates how the therapist frames the client's narrative in terms of "self-sufficiency" and their ability to "act independently" and praises such acts:

> S 1. Jo reflects that they are feeling ashamed about coming to therapy: they have always prided themselves on being "self-sufficient", and they feel that attending therapy is an "admission of failure". […] Alex works with Jo to construct

> an image of themselves that encompasses coming to therapy – e.g., it might be that Jo reframes the action by emphasising their self-sufficiency in acting independently to seek help, and in taking action towards their therapeutic goals as a result of therapy.

In the above extract, the therapist seems to be reinforcing the value of "acting independently." Alex is constructed as helping

Jo become more self-reliant, rather than, perhaps, challenging the notion of self-sufficiency. Also, therapy is constructed as appropriate only when individuals cannot manage problems by themselves.

Overall, the concepts of self-agency and autonomy were prevalent in most stories and seemed to be constructed as a preferred way of being for the client. Shamed individuals, though, tend to focus on how others perceive them and often withdraw passively (e.g., Black et al., 2013) rather than act in an independent, rational way. This could be seen as a maladaptive alternative to the values of independence and self-agency, that seem to reflect more attractive traits in western cultures (Gergen, 2007).

Autonomy, then, is constructed as a desired therapeutic outcome in many forms of psychological treatment, including humanistic therapies (e.g., Rogers, 1961, Spinelli, 1994); one that is supported by the wider institution of therapy. Postmodern theorists have suggested that in most forms of psychological work, self-containment is legitimised as a preferred way of being. In contrast, alternative versions of the self are discursively minimised by therapists (Guilfoyle, 2002). In humanistic forms of therapy, the therapist aims to help the client self-actualise. The aim in these therapies is to assist the client self-regulate, discover their own values and liberate themselves from the conditions that others impose on them for acceptance (e.g., Rogers, 1961; Spinelli, 1994).

Positionings of Therapists

Based on an understanding of shame related behaviours as problematic, since they seemed to be preventing clients' self-revelation or self-actualisation, the therapist's role was discursively conceptualised in various ways by participants. In some stories, therapists were constructed as experts, capable of working with shame through the application of the appropriate psychological knowledge. Alternatively, client's shame was constructed as a powerful object with both the therapist and the client struggling to work with it in the session. It is suggested that these two positions provide different ways of being in the room and understanding the client's difficulties.

"Therapist as Expert"

Within the discourse of expertise, many participants drew upon cognitive-behavioural theories, which tend to focus on the use of skills, as a way to help the client overcome their shame (Fenn & Byrne, 2013). Most participants who drew on the discourse of expertise identified themselves as working from this perspective in their practices.

In the extract below, the participant could be seen as drawing on a pedagogy discourse, constructing the therapist as an expert who first observes and then has the skills to teach the client exercises to relieve their distress. Distress related to shame seemed to be a problem to be solved, and the therapist could be the one who knows how this can be done. The client, on the other hand, could be seen as a passive recipient of the therapist's knowledge, without which she may be unable to self-regulate. The therapist monitors and comments upon the client's body language, then provides teaching.

> S3. Alex gently probes, making comments about Jo's body language. Jo discloses a history of trauma. Alex teaches Jo grounding exercises, ways to relieve distress. Alex spends a few sessions making sure Jo is able to minimise distress before they elect to explore the trauma. Once Jo is able to self-regulate, they begin to explore Jo's past and the impact it has on the present. Jo is able to self-regulate and prevent flashbacks and dissociation.

Foucault (1980) theorised how knowledge and power are entangled with each other. Within the discourse of "expertise," the therapist's teaching skills might be seen as putting them in a position of power concerning the client, who could be seen as reliant on them and their skill to regulate their emotions. Constructing the client as unable to self-regulate creates a particular power dynamic in the session that is played out uncritically. A pedagogical discourse was also featured in the below story, where the therapist provides an education about the emotion of shame:

> S 10. It was important to address and welcome discussion about shame (initially just to clarify that this is the emotion underlying their distress), so that we can educate about shame as an emotion – normalise their reaction / use of shame – and challenge the associated cognitive distortions.

Shame in this story could be seen as related to cognitive distortions, with the therapist's task understood in educating the client about them and challenging them. This narrative frames the client's shame into a problem (i.e., cognitive distortions) that can be solved using the appropriate therapeutic knowledge.

It could be said that expertise and pedagogical constructs in the stories work on an underlying assumption that pre-defined psychological issues exist. Poststructuralist theories have problematised the concept of a pre-defined psychological category. Within this framework, the diagnosis of psychological problems is socially constructed by transforming observable behaviours into symptoms (Harper, 1994). Based on this perspective, we could suggest that within the discourse of expertise, participants understood the therapist's role in terms of re-formulating the clients' behaviours into pre-existing categories (in the above story as a history of trauma, or a certain maladaptive way of thinking), which be treated with well-established therapeutic methods (in this respect, “psychoeducation”). Foucault (1963) has suggested that doctors modify a patient's story to fit it into the biomedical paradigm by filtering out non-biomedical material. Within the therapeutic paradigm, we might reflect on how therapists can select out certain parts of a patient’s emotional narrative and obscure the rest of the narrative to fit an established psychological theory or a diagnosis.

“Therapist as Humane”

Although in some stories, the emphasis was on the therapist's ability to resolve the client's shame (as described in therapist as expert), in other stories the therapist was constructed as having the potential to be vulnerable in relation to shame. In the expert practitioner discourse, shame was constructed as a manageable object. In contrast, within the construction of the humane practitioner, shame was seen as a powerful emotion, with the potential to impact both the client and the therapist equally. Most participants who constructed the therapist as humane were practising within a humanistic or integrative framework.

In this extract, the therapist is constructed as being “decentred” by the client’s shame and rather unsure of what to do with it:

> S 11. Alex begins to notice a feeling of discomfort and self-consciousness in herself. She has become more aware of how she is in front of Jo, her body, her words, facial expression and silences between them. Alex feels changed (she is different in front of Jo now) and slightly decentred. Alex wonders whether or not to share this with Jo, but decides not to because it may create more shame for her. Instead, Alex decides to explore with Jo why she thinks she might be feeling shame in response to her feelings towards Alex.

It could be argued that power and agency in the above story are shifted more towards the client, whose emotions have the potential to make the therapist feel "uncomfortable and self-conscious". Rather than being a passive recipient of her therapist's interventions, she is conceptualised as more accountable for dealing with her shame through mutual "exploration". Therefore, shame is understood as co-constructed in the session, and the therapist decides to "explore" it with the client, rather than resolve, or alleviate it.

It is suggested that the discourse of the humane practitioner sits in tension with the discourse of expertise. In the previous section, the therapist was positioned as relatively competent and equipped to treat shame, based on their knowledge of the appropriate interventions (e.g., psychoeducation). However, within the humane practitioner discourse, shame is not necessarily constructed as a pre-defined condition. We could suggest that the therapist is faced with many possibilities in terms of how to understand and manage it. Therapists can be seen as more exposed and vulnerable (e.g., “self-conscious”), as there is no right way to deal with it, which may provoke uncertainty.

In the extract below the therapist is constructed as deskilled and powerless in relation to shame:

> S 23. Alex, recently qualified, is a highly self-critical person, and, as his questions gradually met the same evasive minimal response, his own anxiety became difficult to contain, and he responded – as he always does (a matter taken regularly to supervision) by intensifying, or heating up, his attentive empathic manner. He is good with effusive expressive clients; Alex and Jo are a perfect match. They cook up together a powerful climate of joint shame: Jo is deeply ashamed of his failure to answer questions, and his failure not to experience Alex's attention as yet more parental scrutiny; Alex is ashamed of his failure to manage Jo's evasiveness. They are in a transferential impasse. Jo stops answering questions. In the agonising silence, Alex begins to feel as he did in his parents' home before life, in his mid-thirties, began to offer him a sense of hope and direction.

It could be contended that therapists’ vulnerability and/or “anxiety” in relation to shame is conceptualised in negative terms in this story, being seen almost as the opposite of a confident, reassured therapist, as constructed within the discourse of expertise.

Shame in this extract is constructed as a rather powerful object, with both the therapist and the client being powerless in relation to it. The therapist seems to be constructed as deskilled, having lost his ability to “respond in an empathic, attentive manner”. Although he is “good with expressive clients”, with shame-related behaviours he feels like a “failure”. The client is also conceptualised as helpless and unable to participate in the therapeutic process in the way he is expected to - by “answering the therapist’s questions” and experiencing his interventions as “caring”, rather than “scrutinising”.

It is worth noting that in the discourse of expertise (e.g., S3), only the therapist has responsibility for its management. In this extract, though, shame is understood in more intersubjective terms as "cooked up together" or co-constructed between the therapist and the client. It could be suggested that the client is seen as less passive and, therefore, more accountable for dealing with it.

Moreover, it might be argued that through the use of rather strong, dramatic metaphors (e.g., "agonising silence"/"powerful climate of joint shame") the challenging nature of shame in the therapy room is emphasised, to a great extent. Shame is constructed as a problematic (rather than perhaps “inevitable”) emotion for the therapeutic process, which is about the whole "sense of self" rather than an act or behaviour (Morrison, 2011). In discourse analysis, these descriptions have been described as "extreme case formulations" (Promerantz, 1986, p. 219), which are rhetorical devices used to strengthen someone's position, display investment or a particular stance towards some state of affairs. It could be contended that in the above extract, the participant works hard to demonstrate the intensity that shame can generate and its capacity to unsettle the therapist and the client.

Within the discursive framework, participants’ constructions can move between subject positions in a fluid way (Foucault, 1980). In some of the stories, participants’ conceptualisations seemed to be slipping between different subjectivities within the same narrative. In the extract below, the therapist was constructed as an expert who has the skills to deal with shame, as well as a human affected by it:

> S 16. Alex doesn't know how to respond to that. A part of him wants to approach Jo and directly ask her what is going on for her. He wants to tell her that he feels she has been avoiding something. However, he is not sure if that would further distance her and how this may impact their relationship. Jo senses his uncertainty and finally discloses her concerns. Alex tries to respond gently and reassures her that it is 'ok' to be feeling that way, trying to normalise her shame.

The therapist in this extract could be seen both as uncertain in terms of how to approach the client's shame and somewhat confident that they can deal with it by "responding gently" and "normalising" it. This position recalls the concept of safe uncertainty whereby the therapist is confident enough to bear the uncertainty of taking relational risks (Mason, 2005). Indeed, it has been contented that therapists' flexibility and ability to move between the positions of a knowing expert and a not-knowing, non-expert can positively impact the therapeutic relationship (Roy-Chowdhury, 2006). By being more flexible, they can be more receptive to the influence of other perspectives and the different meanings the clients might put on events whilst maintaining their professional stance (Mason, 2005).

Post-Analysis Reflexivity

As mentioned previously, throughout the process of analysis, we tried to be mindful of the ways that participants’ narratives

might have been influenced by our own assumptions about shame, and our positions as therapeutic practitioners and researchers.

The research was initiated by the first author, as part of her doctoral thesis. I (Eugenia Drini), come from a background of working in substance use, and complex mental health. As part of my therapeutic work, I have encountered a number of clients who struggled with feelings of shame, as well as the wider stigma around substance use, and chronic mental illness. Dealing with the client’s shame around these issues was one of the most difficult parts of my work, both as a novice, and as a qualified, more experienced psychologist. When I started my training, I was searching, and hoping, to identify the best way of dealing with that, so I don’t encounter these difficulties in the future. Through this research, I became aware of my need to rely on evidence, as a way to justify my practice, and the difficulty I have in sitting with the uncertainty that shame might trigger for me, as well as my clients. I still find myself moving between the position of an expert, and a vulnerable, humane practitioner. Nevertheless, I am more mindful that there might be no ideal way to manage shame.

In terms of how my own position might have impacted the findings of this research, it is worth considering that despite the anonymity of the task, responses were based on the idea that they would be read by a fellow practitioner. It might be suggested that this made it more likely for them to draw on the discourse of expertise, by using specific technical terms or referring to therapeutic techniques (i.e., CBT skills). Arguably, the awareness that their answers would be read by another therapist becomes more evident in some stories whereby participants alternated between “I” and “Alex” (e.g., S. 10) when describing the therapist in their stories, despite the instructions on completing the story.

Reflecting on the therapist’s characteristics in the story-stem, it is worth mentioning that my initial thoughts were to construct her as female, as I thought that there is a larger number of female therapists. Following discussions with the second author (Tom Kent) it was decided to avoid offering a definite gender to the therapist, as a way to allow some ambiguity within it (Clarke et al., 2017). Therefore, the therapist and the client were given names that could be gender ambiguous (Alex and Jo) so that participants have the

freedom to construct their characters the way they wanted to. Yet, in in most of the participants' responses the client was constructed as female (in 34 out of 45 stories). Although this could be attributed to the fact that Jo is more often a female name, from a constructionist perspective, it could be seen as related to the qualities associated with shame in the study, namely "passivity", "neediness" or "vulnerability", which are often constructed as female characteristics (Seu, 2006).

This thesis was part of a doctorate that is grounded on humanistic values, including intersubjectivity, and relational therapeutic practice (Milton, 2010). Given this, I probably started the research process having already constructed a therapist whose stance in relation to shame is based on these ideas. It is likely that this impacted how I described the characters of in story-stem. Indeed, Alex (the therapist) is constructed as "puzzled" and Jo is referred to as "client" rather than patient, which is more often the case when therapists are working within a humanistic framework (i.e., "Alex has recently started working therapeutically with a new client named Jo. In their second session, Alex is feeling rather puzzled. Jo seems to avoid eye contact and stops talking at various points during the session. Then Jo discloses feeling ashamed."). The terms that I used might have directed participants towards a more vulnerable and human conceptualisation of the therapist. This is not an issue from a methodological perspective as, compared to other methodologies, in discourse analysis, the discourses are seen as a co-construction between the researcher and the participant. Within this framework the researcher is seen as a "co-author", rather than a "discoverer" (Willig, 2008, p. 126). Nevertheless, it could still be argued that the terms used in the story-stem made it more likely for them to assume that, as a researcher, I am expecting them to construct a therapist who understands shame within a humanistic perspective.

Discussion

Our interpretation of the stories emphasised the centrality of the individual self within the therapeutic discourse, which was constructed as hidden as a result of shame (the hidden self). The discursive themes of autonomy and self-sufficiency as therapeutic ideals seemed to predominate in participants' narratives. Behaviours by clients that related to feelings of shame seemed to be seen as problematic, often hindering the therapeutic process, or the clients' progress through therapy by preventing self-revelation. Drawing on a pedagogy discourse, many participants constructed the therapist as an expert, holding the appropriate knowledge to understand the client's shame and teach them skills to manage it. A counter position was the therapist conceptualised as humane where they were de-skilled and rather vulnerable in relation to shame.

We noticed that participants who identified themselves as working within a cognitive behavioural perspective were more likely to draw on the discourse of expertise, constructing the therapist as responsible, and capable of managing the client's shame. They were more likely to use technical terms such as psychoeducation, grounding exercises, cognitive distortions (S 3, S 10). These findings indicate the ways that therapists' personal biases, and theoretical orientation can impact their understanding of phenomena, such as shame, and the direction of therapy. It is suggested that dominant psychological theories can enhance our knowledge on shame. Nevertheless, when they are perceived as taken-for-granted truths, they can limit our understanding of the phenomenon and what we can do or feel in relation to it (Avdi & Georgaca, 2007).

In accordance with a poststructuralist perspective, we argued that the mainstream understanding of self, (i.e., that can be actualised and become autonomous), as constructed in many therapeutic discourses (e.g., Rogers, 1961; Winnicott, 1965) may suit some individuals in Western society. However, as therapists and supervisors, we need to consider our definitions of functional behaviours or emotions. The appropriate interventions are not facts, but reflections of context-bound, social discourses. Therefore, they may prove inappropriate for many clients. The expression and understanding of positive or troubling behaviours vary widely across cultures and societies. For example, self-sufficiency and autonomy are not necessarily seen as positive characteristics in Eastern cultures, where collectivism is seen as a preferred value (Parker et al., 2009). It is doubtful that there could ever be a global conceptualisation of healthy, functional ways of being (Johnstone et al., 2018).

Study Contributions

Our study was, to our knowledge, the first to examine the constructions of shame in the therapy room. Using poststructuralist methodology, this research tried to elucidate the subject positions that become available in relation to it. The findings extended shame research by demonstrating some of the ways that practitioners' conceptualisations of emotional distress can affect the therapeutic dynamics, which often go unacknowledged. The analysis discussed how therapists' theoretical framework and the wider socio-cultural discourses can influence their interventions and their clients' subjectivities, even when this is not their intention. Our aim was to critically reflect on the role of power in shaping them and promote a new understanding of therapy, as "jointly managed in the interaction between client and therapist" (Georgaca, 2012, p. 162).

Our findings may provide a starting point for further discussion on how the therapeutic discourse might reinforce specific ways of understanding one's emotions. We invite practitioners to be more critical towards taken-for-granted values of psychotherapy. To practice reflectively, they need to be mindful of the social construction of phenomena, such as emotions or the self, particularly when they are understood as occurring naturally and taken for granted in psychological theories.

Throughout the analysis, we reflected on the ways that power might be played out in the therapy room. However, it is important to emphasise that, the therapists' attitude and intentions are benevolent and altruistic towards the client in most cases. In accordance with Foucault (1980, p. 157), we argue that the exercise of power in the therapy room is not practised consciously. "It's a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised". For this reason, therapists and supervisors are encouraged to develop the skills and the vigilance to understand the effects of power in the therapy room.

Reflecting on the Methodology

This study has contributed to a small body of literature utilising story-completion and indicated the usefulness of this method in exploring the therapeutic discourse. In accordance with previous authors who have used this method (e.g., Braun et al., 2019; Walsh & Malson, 2010), we suggest that it provides an effective way to examine the therapeutic process. Due to its theoretical flexibility, it can support the implementation of studies from various epistemological paradigms. Furthermore, most therapeutic practitioners are familiar with the use of scenarios or vignettes (Milton, 2010), and thus, it can be used as an alternative to interviews in qualitative study designs (Shah-Beckley, 2017).

Reflecting on its use, it could be argued that despite the initial purpose of the story-completion method to “slightly remove them” from the topic (Clarke et al., 2017, p. 49), in our study most participants seemed to become involved in, and identified with, the role of the therapist, presumably because of their personal experiences of dealing with similar topics, as they were practicing therapists. It could still be suggested, though, that this design gave them more choice and control in terms of using the story-stem as a way to write about their personal experiences of dealing with shame, or not. On the contrary, in an interview situation they would have to own their perspectives. Participants who completed the pilot stories as part of the study, reported that the process of writing up the story made them reflect on their practice in relation to shame, whilst one of them said that she wrote about a real scenario she had experienced in her practice. As discussed earlier, the identification with the therapist’s role became more evident in stories where participants started by expressing their views on the topic or used a first-person pronoun.

Overall, it could be argued that participants in this study played diverse roles, as they had to draw and reflect on both their personal practices and the broader theoretical discourses, whilst talking about imaginary characters. In contrast to previous studies that have used this method (e.g., Walsh & Malson, 2010), participants in this research were more likely to have found themselves in a scenario similar to the one described in the story stem. Moreover, they were aware that their stories would be read by a fellow expert in this area. These issues might have impacted their motivation to write the story stem, as well as its structure, content, and its length. They might have put extra effort to prove their expertise or their interest in the topic.

Limitations

One of the most common critiques on deconstructionist forms of discourse analysis is that they are instead removed from the therapeutic thinking and the struggles that practitioners deal with in their practice (Georgaca & Avdi, 2009). Indeed, FDA is the most macro-form of discourse analysis and aims to critically reflect on current practices rather than identify ways of dealing with difficulties. It has also been argued that its focus stays on a surface level, rather than going into more depth and explaining the reasons why certain practices are taking place (Willig, 2008). Under the chosen methodology, it was beyond the scope of this study to attend to people's motives concerning the discourses they draw upon.

From an ethical perspective, one could reflect on the problem of participants’ agency, as well as the inherent power given to researchers analysing the data. Indeed, participants’ lack of agency has been described as a limitation in most forms of discourse analysis, as they attempt a theory-driven reading of the data, which does not take what participants say at face value (Willig, 2012). Arguably, the analysis of participants’ language runs the risk of presenting participants as constructing a phenomenon in particular ways, when this has not been their intention. In order to deal with that, we tried to be as tentative as possible in our interpretation of participants’ discourses and constantly mindful of the effects that the analysis might have on them if they read it. Throughout the analysis, it was also acknowledged that the current reading presents only a possible way to understand the data. Finally, it is important to reiterate that any critique made to participants’ claims as constructed in their stories aimed at a reification of shame-related practices within the wider institutional framework, rather than the individual therapists or their ways of constructing shame.

Suggestions for Future Research

Future research could usefully focus on understanding how therapists understand and process their own sense of shame within the therapeutic process and the way shame might arise relationally for both therapist and client. Indeed, shame has been identified as an issue for both therapists, and clients in previous research (e.g., Allan et al., 2016). This could inform supervision and therapeutic practice in relation to shame, and encourage a more open dialogue about therapists' vulnerabilities, help seeking, and the power dynamics within the therapeutic process.

In terms of developing story-completion research, future studies could use this method to examine the therapeutic discourse on emotions from the client's perspective and compare them with the therapist's perspective. Further research could also usefully contrast how practitioners of different modalities discursively construct and engage shame. Story-completion has been found to be a suitable method for comparative study designs (Clarke et al., 2017).

Future studies on shame could draw on transcribed therapy sessions and trace shame through naturally occurring talk between the therapist and the client, to explore the various constructions and subject positions. The transcripts could then be analysed through conversation analysis to trace the linguistic strategies through which therapists deal with shame. Through the use of this method, one could focus on the content of the talk rather than the broader discourses and explore the moment-to-moment interactions within a therapeutic session.

Conclusions

Overall, this study aimed to make therapeutic practitioners rethink their assumptions about shame and the different ways of conceptualising it. Throughout the process of this research, we reconsidered the assumptions that several therapeutic approaches conceptualise as "truths." Indeed, the analysis demonstrated that the same situation can be managed in a variety of ways, whilst a particular reaction can be deemed as either appropriate or inappropriate, based on the theoretical angle we look at it from. For example, the therapist's vulnerability was constructed as a positive element in stories that drew on a humanistic discourse or a problem for participants who drew on a CBT discourse.

In line with the Foucauldian stance, this study tried to adopt a critical position towards the contemporary ways of understanding and dealing with shame. It attempted to demonstrate that "things are not as self-evident as one believed" (Foucault, 1989, quoted in Margolin, 2017, p. 154). We suggest that therapists need to be more sceptical towards taken-for-granted values of psychotherapy such as the therapist's 'expertise', as well as the ways that dominant psychological theories may conceal power struggles within the therapy room.

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