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Shame containment theory—a new approach to shame

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Abstract: Shame is often overlooked in therapy in favour of anxiety and guilt (Lansky & Morrison, 1998; Solomon, 2021). Indeed, there is little emphasis on shame within psychotherapy training and a noticeable lack of recognition to its relationship with attachment (Solomon, 2021). And yet, shame is described as an attachment emotion by some shame theorists (Lewis, 1971; Schore, 1991). Shame is a complex emotion that is often hidden, making it difficult to work with and can leave clients feeling frustrated that they are stuck in the same relational patterns. Ultimately, unacknowledged shame in the therapy room and the understanding of how shame influences self-perception can be detrimental to therapeutic outcome. This article introduces a new theory of shame: shame containment theory (SCT). The premise being that shame is vital to self-protection and attachment. By exploring the history of shame in psychoanalytic psychotherapy and presenting current models of shame, this article will demonstrate how SCT is a needed addition to contemporary shame theory, with particular relevance to attachment theory. Using a brief case study, this article will demonstrate how SCT relates to presentations in the therapy room. This lens on shame as an attachment emotion offers therapists a new model with which to understand and work with shame.

Keywords: shame, attachment, psychotherapy, theory.

Lay summary

Shame is a complex emotion that is often hidden in psychotherapy. This is because it is not recognised by either the therapist or the client. However, it has a significant and detrimental impact on adults' relationships with self and others if not addressed. This article is introducing the shame containment theory (SCT), a new theory on shame which offers a model for understanding and working with shame for psychotherapists.

Introduction

Shame is a complex emotion. It is also one of the most difficult emotions to experience (Epstein, 2021; Lewis, 1995). Whilst there has historically been a lack of interest

in shame, this has been changing in recent years. This shift is welcome as shame is often underneath various pathologies (Kaufman, 2004; Morrison, 2014; Nathanson, 1994). When considering difficulties that present in the therapy room, shame is often at the core. However, there is a surprisingly lack of literature written on shame from an attachment perspective (Solomon, 2021). Most shame researchers will state that shame is relational, given shame's purpose, which is to help us to maintain social bonds (Lansky & Morrison, 1998; Lewis, 1971; Schore, 1998). Therefore, the focus of this article will be on attachment and developmental shame, created by relationships in childhood.

Shame and its therapeutic history

It is a widely held view that Freud paid little attention to shame, but this is not entirely accurate (Lewis, 1995; Stearns, 2017). In his early writing, shame was considered as part of conscious awareness and a painful affect that must be defended against. However, shame did fall from prominence in Freud's work, with guilt and anxiety being pushed to the fore (Lansky & Morrison, 1998; Lewis, 1995; Stearns, 2017). Freud was to eventually consider shame to be an infantile and inferior emotion, often attributed as feminine and, therefore, not worthy of consideration (Stearns, 2017). Additionally, Bowlby did imply shames significance in some of his writing, but it was never addressed explicitly. It could be said it was this lack of focus that led shame to be ignored in psychoanalytic theory and clinical practice, which remains problematic even today. Although others have theorised and written about shame, like Bowlby, the emotion has been discussed covertly. For example, in Horney's work on neuroticism, she talks of the false self, pride, and humiliation, which are all components of shame (Scheff, 1998). Equally, Silvan Tomkins dedicated much of his efforts studying shame as an affect in the 1960s, only for this work to fail to transfer into the psychotherapeutic space (Nathanson, 1994, 1998). However, in 1971, a major works on shame was published by Helen Block Lewis. As a result of shame's banishment from psychoanalysis in favour of guilt and anxiety, Lewis claims she experienced an influx of patients who were returning to therapy, feeling worse than they did when first starting their therapeutic journey. They could identify their anxiety and "interpret their own denial, projections and repression" (Lewis, 1971, p. 17), but could not understand why they were feeling distress. She realised that something had been overlooked by herself and her patients, which prompted her to go back over their case notes. By hermeneutically examining the notes from historic therapy sessions, she discovered her patients were in an "unacknowledged" state of shame. This "unacknowledged" state inevitably meant that the shame was either hidden or disguised and therefore missed by both the therapist and the patient (Lewis, 1971). Lewis' seminal work on shame prompted a significant interest from other psychoanalysts, such as Kaufman (2004), H. B. Lewis (1971), M. Lewis (1995), Morrison (2014), and Nathanson (1994), all of whom made major contributions to the field. However, all of this newfound enthusiasm for shame has not created a place for

shame in psychotherapeutic training or practice. As Kaufman (2004) states, there is shame about shame and to be able to be with client's shame, any therapist must have come face to face with their own.

Current shame theory

According to Mills (2005), developmental theories of shame fall into three categories: functionalist, cognitive-attributional (also known as social-adaptive), and attachment. However, Gilbert and Andrews (1998) add additional epistemological perspectives including psychoanalytical, Kohutian self-psychology, affect theory, developmental psychology, and anthropology. These differing theories are important to explore as each determines how we relate to and conceptualise shame.

The functionalist view of shame

The functionalist view of shame is that it has a protective role. If shame is experienced, it signals a threat to our self-view, meaning action must be taken to modify behaviour. From the functionalist perspective, shame ensures survival (Caplovitz Barrett, 2005; De Hooge et al., 2011; Dempsey, 2017). In contrast to the social-adaptive model, in which guilt is seen as adaptive and shame is considered maladaptive, functionalists consider that guilt and shame can be either adaptive or maladaptive, depending on the social goal. Emotion is experienced when we are presented with a barrier or facilitator to some desired goal (Mills, 2005).

Cognitive-attribution theory

Cognitive-attribution theory derives from the work of Helen Block Lewis in 1971 and is more aligned to psychoanalytical theory. Within this theory, guilt is deemed adaptive and shame is considered maladaptive, which is a stark contrast to the functionalist perspective. Those who subscribe to the theory of cognitive attribution of shame maintain that shame is created by immediate stimulus events (Mills, 2005; Tangney & Dearing, 2003). Lewis (1971) applies attribution theory to shame indicating that guilt and shame can never be considered separately or distinctly. For example, if a negative state was attributed to the whole self, this would induce the experience of shame. If the negative state was about a behaviour or action, this would induce guilt. Attribution theory therefore implies that humans *decide* (although without much awareness) whether they are going to experience shame or guilt due to the cognitive narrative they assign to the indiscretion. Tangney and Dearing's (2003) epistemological position is that of morality and standards. They assume that shame and guilt are experienced from a moral transgression that has either been seen by self or others. The difference being whether that transgression is perceived as the result of the person being bad (shame) or engaged in bad behaviour (guilt).

Attachment theory of shame

Attachment theory of shame considers early attachment relationships that influence the development of the self (Gouveia & Matos, 2014; Schimmenti, 2012; Schore, 1998). The quality of these relationships determines whether shame will hinder self-development as we progress from childhood to adulthood (Schore, 1994, 1998). If we take the perspective of shame first being experienced as devastating through attachment injury, for example, shame is experienced due to the unrepaired rupture that has been created by the parent or caregiver (Epstein, 2021). The child will feel terror at being abandoned and powerless to create reconnection, despite every effort to "right" the self in order to connect (Benau, 2022; Epstein, 2021; Lewis, 1995; Morrison, 2014; Schimmenti, 2021; Schore, 1994). The child who is repeatedly exposed to these ruptures will invariably feel it as a rupture to self, due to the narcissistic nature of the child needing to survive (Benau, 2022). Shame now feels like self-rupture (Kaufman, 2004). If, on the other hand, the parent or caregiver creates a rupture in the interpersonal bridge (ibid.) but repairs the rupture as soon as it is recognised, the child will feel guilt for the indiscretion. This is because the parent has taken the responsibility for the rupture away from the child and placed accountability for it solely on themselves.

Gilbert (2009) considers what he describes as high levels of shame and self-criticism to manifest from early attachment injuries, such as neglect and lack of attention. Poor early attachment can lead to the assumption of hostility and untrustworthiness in others and internalised shame, considering self to be unworthy and unlovable (Gilbert & Irons, 2005).

Gilbert developed compassion focused therapy (CFT) to work with shame and particularly those with difficult attachment histories (Gilbert, 2009; Irons & Lad, 2017). The premise of CFT which is influenced by evolutionary psychology, is to help people end self-blame and self-criticism by engaging in an internal compassionate relationship with self.

Why should we pay attention to shame?

Over recent years, there has been an increased interest in shame (Kaufman, 2004). Currently continuous professional development offerings are awash with shame training. However, little has been added to shame theory that helps us understand shame as a complete phenomenon. Brown's shame resilience theory (2006) is likely to have created some of the ongoing interest in shame. However, Brown did not present with a new model of understanding shame as an affect, but rather how to be resilient to shame once it had been felt.

Most shame scholars would agree that shame is relational (Benau, 2022; Epstein, 2021; Kaufman, 2004; Schimmenti, 2012, 2021; Schore, 1994; Solomon, 2021). It is born out of our relationships with caregivers and other significant relationships in childhood. Kaufman (2004), for example, states that we will experience considerable shame as a child if we suffer a rupture in the interpersonal bridge between

self and the significant other. Meaning, in our first experiences of shame, another person must be present. This rupture in the interpersonal bridge will create a sense of unlovability, unworthiness, and lack of value, provoking anxiety about being rejected and abandoned. It is for this reason that shame can feel so abhorrent as it is directly related to our survival. In other words, shame needs to feel painful enough to ensure we take notice of it and adjust our behaviour or self-view. In doing so we are attempting to guarantee our connection to caregivers. It is imperative to address shame in any therapeutic setting, due to shame's pervasive nature. It is possible that presenting difficulties are not resolved permanently if shame is not allowed into the therapeutic process, increasing a sense of failure in the client. There may also be shame about experiencing shame. Or the real issue that is disturbing a client may never be addressed as it feels too bad to bring to the therapist.

Shame is a universal human emotion; however, those from diverse populations such as LGBTQ+ experience shame more acutely due to ongoing heteronormativity within our culture (Lyne, 2023). Lyne (2023) concludes that for many LGBTQ+ individuals, a lack of celebration of the child's authentic self from attachment figures results in relational ruptures that are not repaired. It is easy to see how shame can then be ongoing for people from diverse groups as society reiterates early messages of wrongness and unacceptability, with the experience of everyday discrimination and microaggressions. For people of colour, shame is further complicated by intergenerational and transgenerational trauma (Alleyne, 2022). Alleyne states that shame and trauma are intrinsically linked, with past generational trauma being experienced in the here and now "through repeated experiences of rejection and betrayal by a society that relegates minorities to the margins of humanity" (ibid., p. 2).

Shame and relational trauma

As previously stated, shame is relational. Therefore, relational injuries must be a significant factor in the development of shame (Benau, 2022; Epstein, 2021; Gouveia & Matos, 2014; Kaufman, 2004; Schimmenti, 2012, 2021). Much of the current literature on shame development focuses attention on the childhood relationships and experiences. Other scholars such as Brown (2006), De Hooge et al. (2011), and Tangney and Dearing (2003) consider shame from the perspective of the adult who is experiencing shame, with little attention paid to the early origins of shame. However, without the exploration of early relational traumatic experiences, the client has the potential to remain stuck in the cycle of self-blame which re-enforces the perception of being shameful. Schimmenti (2012), describes relational trauma as "a condition of psychological vulnerability resulting from the lack of affection and care during childhood" (p. 196). What is significant about this definition is that it does not involve dramatic or overt behaviour, but rather, a parent being cold or unavailable for the child. This description of parental attitude is not uncommon in

the therapy room but is seldom seen as detrimental by the client. Despite the client describing shame (albeit implicitly) and reporting anxiety, the connection between this seemingly unimportant aspect of their childhood experience is rarely made by them. Benau (2022) and Schimmenti (2012) reiterate my own observations in that this type of emotional neglect correlates with the inability to regulate emotion or deal with stress in adult life. If the child is exposed to emotional neglect frequently, the subsequent adult will likely develop an insecure attachment style as the child has not experienced a secure base. To reiterate that shame and insecure attachment is relatively easy to produce in a child, Schore (1998) emphasises the importance of visual cues between mother and baby. He states that long mutual gaze is vital for the child's development, primary attachment, and safety needs. However, the mother would need to be present enough for the child to access this life affirming experience. Whilst experiences at this age (under the age of fourteen months), would not produce shame, as the child would not have developed a sense of self, the child is developing an attachment. If this attachment is not developed to an optimal level due to the caregivers lack of attunement, the baby will later develop shame when they are misattuned by the caregiver (Schimmenti, 2012; Schore, 1998). It is my clinical observation that clients who present with shame have had the experience of at least one unavailable parent. People will describe parents as being unaffectionate, often physically present but with no emotional capacity. A recurring theme is that of perceived disinterest towards the child. The experience of the unavailable parent is enough for the child to develop a shamed self (Benau, 2022; Epstein, 2021; Lewis, 1995; Schimmenti, 2012; Schore; 1994). Clearly, there will be those children who have experienced much greater adversity than this, such as sexual, physical, and emotional abuse and will experience shame. However, it is important to consider that shame can develop merely from the perception of not being worthy, good, or simply enough, and not from what might be considered more difficult experiences such as physical or sexual abuse.

To present a more practical example, Schore (1998) describes the practising toddler moving away from her caregiver, exploring the world around her. When she returns to the mother, the child expects to be met with celebration and joy at her reunion. Instead, she may be met with disinterest or a preoccupied response. This, according to Schore (1998), may be our first experience of a shame-inducing event. The child at this stage is developing a sense of self and will assume that the lack of joy is because of them, not because of the circumstances presently experienced by the mother. If this scenario is encountered regularly by the child, the child will develop trait shame, meaning shame will feel integrated into the very being of the child as part of their character (Epstein, 2021). Another example of shame development is the lack of repair in the ruptures of connection created by parent to child. Ongoing experiences of unrepaired ruptures will also create trait shame (Epstein, 2021; Kaufman, 2004). State shame, by contrast, is the shame we feel in the moment. It is the acute experience of being "in shame" (Tangney & Dearing, 2003). It is these repeated experiences of state shame that develop trait shame.

Shame containment theory (SCT)

Shame containment theory (SCT) has been developed as part of a larger PhD project. This new theoretical approach offers a model of working with shame as it enables clients to understand their own behaviour, allowing a more compassionate response to their shame. In SCT, shame is considered to have a protective mechanism. This can feel paradoxical, considering how distressing shame is when we experience it, and how much of our lives are taken up trying to avoid the feeling. However, shame needs to be painful so we will take notice of it and modify ourselves to remain pro-social. Therefore, shame offers us safety and the ability to remain connected and attached. I suggest that we suffer the consequences of shame because we do not understand its function and how to relate to this complex emotion.

Empathy and compassion are often considered as the antidote to shame (Brown, 2006), however in SCT, I have included permission. One of the many ways the state of shame is experienced is through lack of permission to feel and have authentic responses. For example, we may feel "ashamed" if we feel anger or fear, especially if we lacked permission to have what can be considered "negative" emotions as children. The child has not been given permission (usually by the caregiver) to have appropriate emotional responses (Epstein, 2021). Children can also be shamed for having needs, such as attention and connection, which can lead to feeling shame when we seek these as adults (Schimmenti, 2012). SCT enables people to recognise ways in which we avoid shame (state) by discovering what strategies we have developed that ensures the acute but devastating state of shame is not experienced.

Shame is part of the attachment system with an initial function of ensuring the child stays attached to caregivers (Solomon, 2021). It is a fail-safe system designed to compensate for caregivers' lack of attunement (ibid.). The shame function will be activated when the child experiences a rupture, created by the caregiver, that is not repaired. When the child experiences primary ruptures and misattunement it will feel threatening, as lack of connection from caregivers could result in abandonment and death (Epstein, 2021; Kaufman, 2004; Lewis, 1995; Schimmenti, 2012; Solomon, 2021). Shame forces the child to modify behaviour as a strategy designed to maintain connection, or what Lewis (1971) calls "righting behaviour". When the child repeatedly experiences ruptures in connection without repair, the child will feel ongoing threat and severe shame as a result. The child will not be given any information on why they feel threat, so the only attribution that they can make is that they are bad and responsible for the ruptures. This leads to trait shame, meaning the child perceives themselves to be either flawed, bad, or not good enough to be protected from perpetual threat, that this is who they are. Trait shame can be experienced consciously or unconsciously, but either way, it must remain unseen and unfelt, we must *contain* it. Contained shame is an inaccurate sense of self that has been created by lack of care or attunement. To protect themselves from the shame they feel when potentially doing something "bad" they create shame containment strategies. These strategies are designed to prevent the contained shame from

becoming uncontained, that is, felt by self and seen by others. As the child develops into adulthood, shame containment strategies become more sophisticated, enabling attachments to social environments, groups, and more intimate relationships. However, shame containment strategies can also become life limiting.

Contained shame

Contained shame is the residual feeling we are left with after having experienced relational or attachment injuries in childhood. I have termed this "contained shame" as we need this residual aspect of shame to remain unexposed, hidden, and unseen by others and even by self to ensure we stay attached and therefore survive. It is this contained shame that can make us feel unworthy, unlovable, and unvaluable, especially if we are scrutinised. It is the voice that says, "if only they knew who I really am". It is also the inner critic. If our contained shame is to remain unseen, keeping us from being rejected and abandoned, we need to create strategies to ensure that it remains in its contained state.

When shame is suddenly felt and seen, it is often with considerable force. On the contrary, contained shame is typically a quiet sense of unease about who we are. It is this contained shame that sits simmering until it is suddenly released, and we find ourselves in a state of uncontained shame.

Uncontained shame

One of the many problems with current shame theory is that it does not consider the multifaceted nature of this emotion. Indeed, numerous definitions only describe the acute experience of shame which I now term uncontained shame. An example would be this definition offered by DeYoung (2015) in which she states shame is "an experience of one's felt sense of self disintegrating in relation to a dysregulating other" (p. 18). Another definition describing the acute experience of shame is by Tangney (1996) in which she describes:

> The feeling of shame is an acutely painful experience because it's the entire self that is painfully scrutinized and negatively evaluated. Such self-scrutiny leads to a shift in self-perception, which is often accompanied by a sense of shrinking, of being small, by a sense of worthlessness and powerlessness, and by a sense of being exposed. As such, shame is an overwhelming and debilitating emotion that often serves to paralyze the self, at least temporarily. And so it is not surprising that people in the midst of the shame experience are often motivated to hide, to sink into the floor and disappear. (p. 743)

The difficulty with the above definitions is that we are not in this state permanently, giving the inaccurate picture of shame in its totality. We will only feel we are in a state of disintegration when our shame is uncontained, manifest by some event we are usually unprepared for. Uncontained shame is the re-experiencing of the original

ruptures of childhood and our relational trauma, in the here and now as adults. Matos and Pinto-Gouveia (2010) describes this type of shame as traumatic memory. It is the acutely painful feeling of being so wrong that we are to be rejected and abandoned by our caregiver, and ultimately not survive. Uncontained shame is often experienced as a shock, usually as resulting from being exposed in some way, often by being caught, found out, or making a mistake. For our shame to become uncontained, it needs to be seen or exposed by others. For example, someone who is using porn, knowing their partner is unhappy about this may feel guilt after viewing and masturbating. However, when their partner discovers their browser history or chat messages, this can create uncontained shame when the aggrieved partner confronts the person. Uncontained shame can feel like panic, shock, paralysis and, more distressingly, like we are going to be destroyed or annihilated. Often it can feel like the only option is to disappear and not exist, prompting a feeling of suicidiation in extreme cases (Epstein, 2021). Once our shame is uncontained, it can feel impossible to get it back in its box and re-contain it in the immediate. Often, we have to sit out the feeling until it passes (which will seem intolerable), or there is a desperate attempt to re-contain it. However, this can lead to a shame spiral continuum in which there is a sense of further powerlessness and loss of control when these attempts do not work.

Not all uncontained shame is unexpected and unprepared for. Public speaking is a good example of how we can be prepared for uncontained shame. The person who is preparing to speak at an important conference will talk of feeling anxious about the event. They can picture in their mind what it will feel like if they freeze or say something wrong. However, what they are experiencing is what Wurmser (2015) calls "shame anxiety". They are anxious about the shame they will encounter when they seem to be inadequate in some way in front of an audience. It is not the anxiety of public speaking that people are wanting to avoid, but the shame they will feel when they don't live up to expectations.

As mentioned, people who have experienced relational trauma are not in a permanent state of uncontained shame. However, mechanisms must be found to avoid the potential of shame becoming uncontained, therefore, shame containing strategies are devised.

Shame containment strategies

Shame containment strategies (SCS) are behaviours, thoughts, and actions that attempt to protect our contained core sense of shame from becoming uncontained and exposed. Rarely are these SCS conscious or deliberately attributed to shame (clearly, there will be some instances where our avoidance of shame is obvious to us). Our SCS are always protective although they may not be conducive to a full and productive life. Where SCS were adaptive as children, they can become limiting in adulthood.

Examples of SCS

It is important to explore what SCS a client may have developed. Whilst there may be some common SCS that people adopt, they can also be personal and individual to the client. A common SCS is perfectionism, in which the person's need for doing everything right offers perceived protection from being exposed as "no good". Whilst perfectionism is active and to some degree can be seen as positive, SCS can also be avoidant. An example could be not applying for a coveted job, or more subtly, procrastinating. Other examples of SCS include ruminating, anger, or violence (towards self or others) grandiosity, narcissism, being overly nice or generous, risk aversion, humour or sarcasm, and avoiding relationships. This is not a complete list.

The following is a practical example, again using the experience of viewing porn. An adult may use porn as a way of numbing out or dissociating, therefore containing his sense of shame and inherent feeling of discontent. Porn viewing becomes preferable to having sex with their partner as there is no potential for vulnerable exposure whilst being alone, sat in front of a screen. It is a solitary activity with no risk in the immediate of any rupturing of self. When their partner discovers and confronts them about their browsing history, they rapidly move into a state of uncontained shame. They are exposed, dysregulated, and cannot manage to get their shame back into its contained state. At this point they may describe excruciating feelings such as being destroyed and the desperate need to disappear or not exist. A sense of death or suicidiation may also be experienced at this point. If we apply this concept of SCS strategies to sex, it is apparent where there is an attempt to avoid and contain shame but equally preventing a satisfying sex life. This containment strategy fails, however, when the person is "caught" or "found out" and they are plummeted into a state of uncontained shame. It is the attempt to re-contain their shame that brings them into therapy.

Re-containment strategies

The final component of SCTs are re-containment strategies. When our shame becomes uncontained, we need to do something to re-contain the shame. We are motivated to do this as an attempt to reconnect with ourselves or others. Depending on the circumstances and how devastating the uncontained shame feels will determine the type of re-containment strategies we deploy. For example, if we have made a mistake at work, we might move into what is often described as obsessive thinking or rumination. However, these terms in themselves can be shaming and do not describe the purpose of them. Instead, I call this continuous thinking "rescuing thinking". It is a desperate attempt to manage the uncontained shame that is threatening us. We will either imagine the conversation we are going to have with people or see where we can apportion blame or excuses elsewhere. If we feel under threat, even by our own feelings, it makes sense to try and get away or diminish that threat.

Other re-containment strategies can be similar or the same as containment strategies, such as attacking our self, attacking others or numbing activities. We can also use denial as re-containment. The motivation for a client to first present to therapy can be a re-containment strategy as they are desperate for therapy to eradicate the uncontained shame they are feeling.

Case study

Emma attended therapy stating she was feeling anxious most of the time but that the anxiety was a relatively new experience. She described how a couple of weeks previously it had been discovered that she had made a significant error at work that had lost the company several thousand pounds in sales revenue. She had been convinced that she was going to be sacked. Although she thought this was unlikely as it would have happened by now, she still thought her professional reputation had been severely affected.

When asked how it felt when she had been reprimanded for the error, Emma described a feeling of shock and a "punch to the gut". She described a feeling of being destroyed and that she was never going to recover from this. Emma also described having suicidal thoughts for a short period, which she found terrifying. At the time of the session, she stated she wanted to hide and that she would have to find a new career where she was not known to anyone. The scrutiny from her boss and other members of the work force was described by Emma as intolerable. She felt she was wrong, ineffective, and worthless.

Emma was describing uncontained shame resulting from having made a significant mistake at work. The mistake had come as a shock as she was usually very conscientious and rarely "got things wrong". However, when asked if the feelings she had experienced were familiar to her, although perhaps not to this magnitude, Emma was able to identify that she had experienced times like this before, going back into childhood. Emma was able to recognise that she would do certain things, ensuring she avoided situations like the mistake she had made at work. And that being conscientious, and a "good worker" was one of them.

Being able to look over her life and see where there had been moments of uncontained shame allowed Emma to see what strategies she had developed to avoid these abhorrent events. Emma could identify these SCS that presented as behaviours and thoughts. In the initial exploration of these strategies, Emma was given permission to have all of them. This permission is important due to the protective nature of SCS. If there is an attempt to have any SCS removed too quickly, this can produce an overwhelming feeling of being unsafe. However, Emma recognised that some strategies were limiting areas of her life, whilst others remained helpful.

For example, being a conscientious worker is generally a positive attribute. It keeps us aligned with teammates and enables us to have satisfaction in our work. It also helps us to avoid making mistakes. However, if we are consumed with getting things right and being perfect, this can be more limiting and certainly does not allow for humanness.

Over several months Emma explored various SCS and considered what kind of relationship she would like with them, which ones were serving her, and which strategies were holding her back, not just in work, but in all areas of her life.

As well as looking at how Emma managed the potential for uncontained shame, we explored where her shame had developed from by exploring her life story and attachment history. Emma stated that her father was loving and affectionate to her but being in the Merchant Navy, he worked away for considerable periods of time. Her mother had been a nurse until she had children, opting to stay at home until both children reached secondary school. Although Emma's mother was physically present, Emma described her as cold and emotionless most of the time, longing for her father to return from sea. She described how her mother would be animated when her father was around, but then "cut off" when he was absent.

Emma disclosed how making a mistake felt intolerable for her as a child as being suddenly seen by a mother, who was otherwise disinterested, felt overwhelming. The scolding she would experience would feel personal, with statements such as "you are so bad" or "how can you be so stupid?"

Emma thought that it was her job to make her mother happy but she had failed. Her mother only ever being happy when her father was home allowed Emma to attribute her father as being "good" and Emma as "bad" due to her mother's behaviour towards her when her father was not around. If she was "good enough" and never did anything wrong, her mother might like her.

As an adult, Emma generally felt inadequate, like she was about to be found out. She never felt as good as her friends and considered herself to be the less successful of the group. She had a constant sense of "if only you knew who I really am, you would not want to be around me". When applying SCT, this would be considered contained shame, or what others have termed chronic shame (Dolezal & Gibson, 2022). This is the shame that is a constant companion, the critical voice that tells us how bad or useless we are and how we need to do better.

Through therapy, Emma came to understand that shame is designed to help her remain attached to her caregivers, enabling her to compensate for her mother's lack of attunement (Dolezal & Gibson, 2022; Solomon, 2021). The shame function was activated when Emma was reprimanded by her mother, in which shame told her if she was better behaved, or a good girl, maybe she could connect with her mother and not feel so scared. Even the uncontained shame was an attempt to protect her as it was a warning to never do whatever she did to create that level of shame again. She could identify that as she became an adult, her shame containment strategies had become more sophisticated.

Being able to understand the protective function of shame, giving herself permission to have it, even when it felt most abhorrent, and approach herself and her shame with compassion, Emma was able to change her relationship with shame. She could see its role in trying to ensure she remained attached to her caregivers, but also that she no longer needed some of the strategies she had developed.

Conclusion

Shame containment theory offers a holistic and therefore greater understanding of shame, rather than viewing shame from one perspective. Current shame theory comes from siloed epistemic biases which limits the capacity for working with shame. SCT acknowledges the aetiology of shame, the mechanisms created to manage shame and a greater understanding of subsequent behaviour, meaning we can develop a more productive relationship with shame. SCT can be used to understand the function of shame in attachment, giving permission for shame to be present and approaching ourselves with compassion. SCS allows for the profound exploration of shame that is both gentle and validating.

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