

# Shame and the Fear of Feeling

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**TOPIC.** *Toxic shame and the concomitant fear of feeling are core issues needing to be addressed during group therapy with adult survivors of childhood sexual abuse.*

**PURPOSE.** *To increase awareness of the toxic shame that survivors experience and to describe the impact of group therapy based on a family systems model.*

**SOURCE.** *The authors' clinical experiences.*

**CONCLUSIONS.** *Symptom management, repatterning of cognitive distortions, and the improvement of self-care strategies are identified as crucial aspects of healing shame-based feelings and behaviors. Group treatment offers members the opportunity to cease reenacting family rules and roles that create toxic shame.*

**Key words:** *Child abuse survivors, group therapy, sexual child abuse, shame*

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**P**sychediatric clinical nurse specialists (CNSs), practicing in the arena of managed care, often are challenged to support and empower their clients in short-term, problem-solving endeavors. When dealing with crisis situations, the brief therapy perspective is advantageous. This model, however, is not the treatment of choice with women who were sexually abused as children (Courtois, 1988; Kepner, 1995; Kaufman, 1992).

The core issue of shame and the concomitant fear of feeling usually escape resolution in brief therapy (Kaufman, 1992). Nurse-therapists working with women in individual and group therapy offer survivors the opportunity to manage symptoms, repattern cognitive distortions, and improve self-care strategies.

Group treatment, using a family systems model, offers female adult survivors of childhood sexual abuse an opportunity to cease reenacting shame-based family rules and roles (Kreidler & Fluharty, 1994). The group becomes like a new family, promoting integration of new learning and allowing for reparation of shameful abuse experiences.

## Shame

Shame as a concept is described frequently but seldom defined. Within early psychoanalytic theory, Freud's exploration of shame was limited by his focus on anxiety and guilt. He viewed shame as a social moderator opposing the pleasure principal. Shame was both reactive and inhibitive, relegated to the status of a defense mechanism (Broucek, 1991; Freud, 1905/1953). Other psychoanalysts have viewed the function of shame as promoting repression and blocking insight into one's own sexual dynamics (Kohut, 1971; Wurmser, 1981).

Erickson (1950) viewed shame as a negative ramification of the second stage of psychosocial development.

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He identified the critical task of early childhood as autonomy versus shame and doubt. Mahler (1968), Kohut (1971), and Thomas (1997) expanded on Erickson's theory and related the child's need for unconditional parental acceptance and its primary influence on a positive sense of self. Within this school of thought, it was believed that shame developed from a failure in mastery of childhood tasks with a resultant view of the self as defective (Lewis, 1971; Morrison, 1989; Silverstein, 1993). Lewis described guilt as about *what one does* and shame about *who one is*.

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Theorists who are proponents of affect theory view shame as an innate affect (Broucek, 1991; Kaufman, 1996; Nathanson, 1992; Tomkins, 1963). Affect is regarded as primal over cognition, drives, and language. Shame, as an affect, functions to amplify awareness, moderate intensity, and protect one's humanity. It is seen as a positive mechanism in controlling behavior and offering societal boundaries. Pathological or toxic shame is presented as debilitating and restrictive in the expression of appropriate feelings.

The development of shame and its residual effects can be viewed on a continuum. The positive end of the continuum illustrates the protection of one's humanity contrasted with the negative end of the spectrum, which manifests the destructive debilitating effects of toxic shame. Shame, then, is a complex human experience that can create unparalleled emotional misery. Each shaming episode has the potential to jeopardize a person's sense of self and self-worth. Toxic shame is precipitated by reactions to or interactions with others, and is perpetuated by the self (Pines, 1995).

Because shame is central to conscience, indignity, identity, and disturbances in self-functioning, this affect is the source of low self-esteem, poor self-concept or body image, self-doubt and insecurity, and diminished self-confidence. Shame is the affect that is the source of feelings of inferiority. The inner experience of shame is like a sickness within the self, a sickness of the soul. If we are to understand and eventually heal what ails the self, then we must begin with shame. (Kaufman, 1996, p. 5)

### Shame and Sexual Abuse

Toxic shame is a central issue for most women who were sexually abused as children. Shame keeps the victims silent. In many cases, the abuse experience remains secret and hidden throughout a woman's life. Often the sharing of the abuse comes about when the aftereffects of the trauma significantly interfere with life functioning.

Kaufman (1992) describes the emotional bond that develops with others through communication, caring, and trust as an interpersonal bridge. It is the severing or damage of this interpersonal bridge that creates shame and allows it to be internalized with an amplitude of self-blame. Once this shame is internalized, it magnifies into a bad sense of self (an inner sense of failure), and a child loses the ability to be connected to other feelings. This experience of shame is perpetually reinforced by outside experiences and the child's own perception of self. As the child grows and more secrets become hidden, shame continues to rule her life, inhibiting her emotional, spiritual and psychological development. Advanced practice nurses must help women deal with the core issue of shame, not just the more obvious developmental lags.

### Group Therapy and the Fear of Feeling

Since 1986, psychiatric CNSs at the University of Akron College of Nursing have cofacilitated closed therapy groups for women who were sexually abused as children. During the 2-hour, 50-week sessions, the six to

eight survivors are encouraged to deal with the impact of childhood abuse on current adult functioning, especially shame-based issues. Originally the groups were held for 18 months, but the authors found that limiting the time to a year motivated the women to deal with their abuse issues and target closure to an anniversary date that was a year after the group began (Kreidler & Fluharty, 1994).

Eligibility for group membership includes being (1) sexually abused as a child (under 18) by someone trusted by the child or her family, (2) in individual counseling and having the counselor's support for entering group therapy, (3) willing to deal with painful issues, and (4) tolerant of all people. The rules of the group are to (1) maintain group confidentiality, (2) attend all sessions unless ill, (3) afflict no intentional physical or emotional pain on group members, and (4) prohibit sexual activity with other group members.

Throughout the group process, members share their abuse histories, their childhood and adult feelings toward their abuser(s) and nonprotector(s), and the impact of the abuse on their adult lives. The risk of exposure, fear of betrayal, and vulnerability of each member must be embraced slowly and protected until an adequate level of trust is established. As members share their trauma, the group is able to be a safe place where feelings can be expressed and validated.

The suffocation of all feeling remains fixated until the undoing of shame and the working through of feelings begin. The women have little tolerance for experiencing emotions and sensations. They need to be guided and gently encouraged to reacquaint themselves with the trauma experience while staying present and grounded in the present. The experience is akin to a swimmer dipping her toes into the ocean. The toes touch the water, she shivers and backs away, then steps forward again. She gets a little wetter, still fearful of the chill, but goes forward knowing it is what she needs to do to enjoy swimming in the ocean.

The abuse survivor, like the swimmer, must learn to venture forward even though feelings are stirred. Frequently, when she begins to feel the affect, she wants

to run far away. It is essential at this time and throughout the group process that symptom management, cognitive repatterning, and self-care strategies be addressed. Only through repetition can new knowledge and understanding transcend underlying shame and allow affect to be expressed appropriately.

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The group experience allows each woman to focus specifically on her personal abuse and helps members heal by sharing the common ground with others who have suffered. The group members accept shameful feelings, secret pains, and denied tears. They encourage each other to be consciously in tune with themselves and their emotions. Feelings can be felt and embraced as signs of shame-free living.

#### **Example**

Delaney was only 3 years old when her father began fondling her. Initially, she felt he was playing with her, and she enjoyed the attention. She became uncomfortable and tried to push him away as she grew older and the playing progressed. He then began using his power and threats to continue to abuse her. Internalizing her father's force and blaming messages, she stifled her reactions and blamed herself. "I must have been bad for daddy to hurt me." Constant repetition by her father reinforced her feelings of badness, responsibility, and shame. His positive response to her submission and the hiding of her feelings and reactions suggested this

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behavior was good. These messages continued to reinforce her sense of badness and fill her with shame, which she carried through life. Although able to appear functional as an adult, she has had little enjoyment of life's pleasures or her own successes. Keeping herself nonreactive and shame filled cost her personal fulfillment and wholeness.

### Symptom Management

Group members are encouraged throughout the year to relate and talk about their own symptoms. The women identify with each other's shame and the different ways it is manifested. Some have difficulty touching or trusting and hold a deep sense of failure. Sleep disturbances, nightmares, poor body image, relationship problems, flashbacks, and impaired emotional or sexual functioning are acknowledged and accepted by those who share similar challenges. Issues surrounding the need for control and the sense of betrayal by one's own body often manifest as destructive behaviors such as perfectionism, suicidal thoughts and acts, sexual dysfunctions, self-mutilation, eating disorders, obsessive-compulsive disorders, and drug and alcohol abuse. Promoting the awareness that these behaviors are related to past abuse is paramount. Integration of the connection between the past and the present is an ongoing process.

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Early in the group experience, the women tend to be very intellectual and fear emotional expressions, such as a release of tears or angry words. As group cohesiveness builds, they share the emotional bond of being trauma

survivors. The women begin to realize that creative resources like denial, dissociation, and numbing that they used as children to survive now have become intrusive and maladaptive in their lives. Group members are encouraged to offer each other techniques or strategies that have helped them cope with certain symptoms. They begin to offer themselves and each other nondestructive ways to deal with the intensity of emotions. They share how difficult it is to be patient with their own progress. A real sign of healing is an increasing ability to laugh with each other.

### Repatterning of Cognitive Processes

There are many cognitive distortions present in survivors of childhood sexual abuse. These ingrained perceptions learned in childhood are carried into adulthood and influence the lives of the survivors. Separating old childhood beliefs and empowering the members to reexamine their thinking takes trust, time, and repetition. "That was then and this is now" is frequently used to remind the women to sort through distorted childhood thinking patterns.

A self-diminishing thought like "I am bad" is gently reframed as "What he did to you was wrong." Group members learn the reframing techniques from the nurse-therapists and are soon offering them to each other. When a member says, "I made you cry," she is helped to see that what she related was sad and may have triggered another member. "I don't belong in this group" rarely needs to be addressed by the therapists. Rather, group members respond to let the person know she may feel that way, but she very much belongs.

Group members frequently try to discount positive statements or events. An old recurring message like "What you do is who you are" is translated, "If you don't have a good job, you are not a good person. If you do, it doesn't count because anyone could do it."

There exists a duality of thought in the adult survivor. Teaching a survivor to recognize this duality and change her beliefs is arduous. A woman often looks back at the child she was and judges herself, believing she held

enough power to fight back and change what happened. At the same time, she judges her adult self as bad, weak, and shameful. Interminably, abuse survivors deny their feelings of helplessness, powerlessness, and anger. Keeping oneself nonreactive and shame filled costs survivors personal fulfillment and wholeness. Addressing toxic shame deflates its power and allows ownership of the past and present reality.

### Self-Care Strategies

Group members generally exhibit difficulties with self-care. Having disowned or depersonalized their bodies, they need to work on awareness, balance, and connection with self and others (Pearlman & Saakvitne, 1995). Godbey and Hutchinson (1996) wrote that "the work of recovery is to recognize that part of the self, the integral self, has been buried by the pain of the abuse and to resurrect the buried self" (p. 306). Restoring the ability to feel good about oneself requires an uncovering of the survivor's goodness and her right to exist.

Despite the fact that negative consequences occurred because of the abuse, it is important that each woman recognize the courage and creativity it took to survive. "Quite typically, survivors of abuse have great difficulty giving themselves support even in the simplest ways. The abusive environment often offered no models of caring or conveyed the clear message that the survivor's needs were unimportant compared with the needs of others" (Kepner, 1995, p. 83).

Survivors can begin to initiate simple daily affirmations and repeat them throughout the day. Statements such as "I am good, the little child was good," "there is no good reason that this happened to me," and "I am, I can be, I have value, I exist" can be used to begin a new way of thinking, believing, and nurturing the self.

Validating positive growth in small steps is another self-care strategy. Self-talk is used to affirm positive coping, new ways of thinking, and any decrease in symptomatology. There is ongoing group affirmation for supportive statements, such as "I am feeling what is going on," "I am recognizing my pain, fear, and vulnerability,"

"I am reaching out to others," "I am able to talk about my feelings," "I have a crisis plan," and "I am doing a good job."

Women come to recognize that children who were raised in a supportive environment learn they can say yes and no and the limits of both. Abused children, on the other hand, learn they have no control over bodily boundaries or body functions and no right to say yes or no to others (Kepner, 1995). Therefore, when a member shares the new ability to create personal boundaries, it is always cause for celebration.

Women in the group environment practice making their needs known and standing up for themselves. They determine personal space and use broken-record techniques to respond to invasive or intrusive statements. Use of breathing and grounding techniques facilitates their recognition of what they are feeling during interactions with others rather than being absorbed by another's feelings or needs.

### Conclusion

Shame has been described historically by theorists in a variety of ways. We suggest that shame and its residual effects be viewed on a continuum. The positive end point reflects the societal boundaries that protect one's own humanity. Whereas toxic shame is viewed as the extreme negative end point of the continuum.

Toxic shame is a central issue for most women sexually abused as children. Fear of feeling has been identified as the long-term repercussion of abuse and the response to toxic shame. This consequence of shame disables women and prevents the appropriate expression of feelings in adulthood.

Group therapy facilitated by advanced practice nurses is a specific means of dealing with toxic shame. Symptom management, repatterning of cognitive distortions, and the improvement of self-care strategies have been identified as crucial aspects of healing. Feelings can be acknowledged, constructive behaviors used, and self-esteem improved using a family systems model. The validation of feelings, fears, and coping strategies not only

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supports new cognitive perceptions but also reinforces the concept of a positive self. Group treatment offers members the opportunity to cease reenacting shame-based family rules and roles, and develop greater ego strength and improved coping skills.

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### References

- Broucek, F. (1991). *Shame and the self*. New York: Guilford Press.
- Courtois, C. (1988). *Healing the incest wound*. New York: Norton.
- Erickson, E. (1950). *Childhood and society*. New York: Norton.
- Freud, S. (1953). Three essays on theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 135–243). London: Hogarth Press. (Original work published in 1905)
- Godbey, J., & Hutchinson, S. (1996). Healing from incest: Resurrecting the buried self. *Archives of Psychiatric Nursing*, *X*, 304–310.
- Kaufman, G. (1992). *Shame: The power of caring* (rev. ed.). Rochester, VT: Schenkman Books.
- Kaufman, G. (1996). *The psychology of shame* (2nd ed.). New York: Springer.
- Kepner, J.I. (1995). *Healing tasks*. San Francisco: Jossey-Bass.
- Kreidler, M., & Fluharty, L. (1994). The "new family" model: The evolution of group treatment for adult survivors of childhood sexual abuse. *Journal for Specialists in Group Work*, *19*, 175–181.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Lewis, H.B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.
- Mahler, M.S. (1968). *On human symbiosis and the vicissitudes of individuation*. New York: International Universities Press.
- Morrison, A. (1989). *Shame: The underside of narcissism*. Hillsdale, NJ: Analytic Press.
- Nathanson, D. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York: Norton.
- Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.
- Pines, M. (1995). The universality of shame: A psychoanalytic approach. *British Journal of Psychotherapy*, *11*, 346–357.
- Silverstein, J. (1993). Secrets versus privacy in group psychotherapy. *Group*, *17*, 107–114.
- Thomas, H. (1997). *The shame response to rejection*. Sewickley, PA: Albnel.
- Tomkins, S. (1963). *Affect, imagery, consciousness, Vol. 2: The negative affects*. New York: Springer.
- Wurmser, L. (1981). *The mask of shame*. Baltimore: Johns Hopkins University Press.

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### News From the International Organization of Psychotherapists in Nursing (IOPN)

The membership of IOPN has voted unanimously to become a chapter of the American Psychiatric Nurses Association (APNA). There are a number of advantages to this move. First, membership will increase as APNA members who are primarily interested in psychotherapy will want to belong. Second, we will be able to hold conferences attached to the annual APNA conference, as will occur in Toronto on October 27, 1999. All the details have yet to be worked out, but the model will be based on the American Psychological Association, which has many special interest subgroups. As it appears now, members will join APNA instead of paying dues to IOPN and will enjoy all the benefits of APNA membership. In addition, we hope to continue to provide *Perspectives in Psychiatric Care* to members, though the details have not yet been worked out.

The Second Annual Nurse Psychotherapists Conference has been planned and you will receive brochures soon if you do not already have them. The conference features a plenary session, a debate, a master class, and breakout sessions of clinical papers.