Shame: An Emotion Needing Exceptional Interventions

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Shame can inflict deep and lasting psychological harm. However, its pervasive negative effects often go unrecognized by both patients and their providers, and thus, it may remain wholly unaddressed. Shame may be mistaken for guilt, embarrassment, or humiliation, but shame darkens patients' quality of life much more profoundly than these other emotions. For this reason, there is a greater need for providers to remain alert to cues that patients may feel shame and if they suspect this and are right, they may seek to help patients reduce their shame. This article discusses what shame is, how to detect it, and, once detected, how providers might best intervene. The experience of shame commonly results from a wide range of negative social experiences, including discrimination, social exclusion, and patients being medically ill. Recognizing and addressing shame are critical skills that providers should strive to acquire. The interventions discussed here may significantly help undo the shame that these patients self-inflict. **KEYWORDS:** Shame, guilt, quality-of-life, cognition, social influences, genetics, vulnerability, treatment

Shame implies a negative view of oneself that arises from the disapproval of others. Guilt involves the feeling that one has done something wrong. It is a private experience generated internally by pangs of conscience. People may become exceptionally susceptible to feeling shame due to their having experienced being shamed in their early childhood. Their feeling safe as in a trusting therapeutic relationship later in life may enable those plagued by this feeling to finally overcome it.[1]

This article is intended to increase readers' and particularly providers' awareness of the frequency with which people feel shame, consciously or unconsciously, and the profound degree to which this feeling can invidiously rob them of joy and meaning in their lives. Contemporary thinking regarding shame and its treatment was obtained by literature searches in both PubMed and Google Scholar under the topics "shame," "shame treatment," "compassion-focused therapy for shame," and "resilience treatment for shame," from 2022 to 2026. In some cases, earlier articles providing foundational discussions were discerned by searching through references provided in these recent articles.

SHAME: AN INTRODUCTION

Shame can inflict deep and lasting psychological harm. Yet, its pervasive negative effects often go unrecognized by both patients and their providers, and thus, it may remain wholly unaddressed.[2] Shame also may be mistaken for guilt, embarrassment, or humiliation, but shame darkens patients' quality of life much more profoundly than these other emotions.[3] For this reason, there is a greater need for providers to remain alert to cues that patients may feel shame. If they suspect this and are right, they may lessen these patients' pain from shame in only a few sentences.

How so? A provider may say, "I have done something like what you told me in my life, too. It is sad that most or all of us do things during our lives that we deeply regret. We just cannot see them at these times." Patients might place greater weight on what providers say, rightly or wrongly. Such remarks can therefore lessen the burden of patients' shame, though these interventions may be extraordinarily brief.

An example of such a beneficial effect is cited by Viktor Frankl, a psychiatrist who is well known for having survived being in concentration camps after losing family members during World War II and then establishing logotherapy, a type of psychotherapy that gives priority to helping patients find meaning in their lives. Frankl reports that only 1 in 28 persons survived being in these camps and those who did, he believes, may have done so primarily because they retained a belief that they still had meaning in their lives. He contends that life can have meaning up until its very last moment and that this meaning can even include our finding meaning of our suffering.[4]

Logotherapy emphasizes how patients can find meaning in their lives. However, the path to this may be counterintuitive and paradoxical. Patients may learn, for example, to see what they cannot change with humor. This occurred, for example, among those persons who were with Frankl in a concentration camp.[4] This practice allows people to distance themselves and thus better contend with what they might otherwise find unbearable.

Frankl describes what I am describing here as potentially a "one-sentence cure." His example involves a young physician who perspired most excessively. He would sweat profusely even when he just imagined himself joining other people. Frankl suggested to him that instead of fearing this outcome, he should try to sweat more at these times. The result was close to miraculous. The patient had been suffering from this phobia that produced sweating for 4 years, but with just this one insight, he enjoyed full and permanent relief within a week.[4]

With this example as background regarding the exceptional harm shame can cause and the possibility that providers can help offset this, the discussion that follows throughout the remainder of this article will elaborate on these thoughts. In order, it will discuss what shame is, how

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to detect it, and, once detected, how providers might best intervene.

Providers' efforts to both detect shame and reduce it might also evoke shame. This is, of course, the opposite of what providers hope to achieve. This paradoxical outcome illustrates the exceptional difficulty of providers' intervening with the hope of reducing this somewhat uniquely pervasive emotion. Yet, despite this risk, providers expending effort to try to reduce this shame are warranted. Any relief that a patient may gain will result disproportionately in their enjoying a greatly increased quality of life.

WHAT SHAME IS

Shame principally involves a negative evaluation of oneself that is global. Its hallmark is the belief, "I am bad." Whereas this sense of being flawed is pervasive, guilt is a negative evaluation of a circumscribed, limited behavior. Patients who experience guilt think, "I did something bad." They do not indict their entire self. Guilt typically is also associated with feelings of remorse, regret, and a desire to repair the wrong done to make amends, if possible. Guilt allows individuals to remain proud of who they are. Shame offers no such refuge. It may be inescapable.

The self-condemnation effected by shame commonly presents with feelings of worthlessness. Patients want to hide and avoid others.[5] This desire to avoid others increases each time it occurs. Every time these patients choose to avoid another person, they feel emotional relief. They spare themselves the additional shame they would feel when they are with this other person. Their avoiding this other person is then rewarded or, in behavioral terms, is negatively reinforced. This ever-increasing harmful cycle can also occur in patients who have a post-traumatic stress disorder (PTSD).[6] These people may similarly, continually experience negative reinforcement to avoid others. Individuals who repeatedly avoid others for any reason may undergo cycles of an ever-increasing shame. Each time they anticipate meeting another and they decide not to, they reduce their painful apprehension and are negatively reinforced. Thus, each time they do this, their avoidance response becomes stronger.

Triggers might not be what others would consider to be substantial. Providers using bare logic might presume that the only sources that can produce intolerable shame are those that are substantial. This, however, might not be the case. People may be exceptionally vulnerable to feeling shame. They may have what we could conceptualize as emotional Achilles' heels vulnerable to shame-producing arrows. An example might be their having obsessional tendencies such that they try to be and believe that they should be perfect. This impossible belief might stem from their having parents who punished them unduly whenever they made a mistake. Later, when they experience even the slightest interpersonal disapproval, this could trigger a debilitating degree of shame.[7–10] Each person's reaction to shame is different. An incident that invokes a mild twinge of embarrassment in one person can induce mortification in another.

Here again we can imagine this best with another example from Frankl, namely, people prone to blushing.[4] People most prone to blushing might be merely sitting in a restaurant eating, when they suddenly feel fear that someone is looking at them. This fear alone might be enough to evoke this shame-based, physiological response.

PTSD again offers an instructive comparison. It provides a second example in which a small stress may produce a disproportionately large response. Providers may tend to believe that the psychological trauma necessary to cause PTSD is exclusively severe trauma, such as actual or threatened death, a serious injury, or a sexual assault. These more severe traumas may be necessary and even optimal for establishing criteria for this diagnosis on which providers can agree. Clinically, however, even the slightest trauma can bring on severe PTSD symptoms. This is because these people, too, can be exceptionally vulnerable. Greater vulnerability might be due to genetic factors, social influences, or both. It may also change. An example is gambling. If those who gamble lose, they may become more desperate to win, feeling shame at having lost.[11,12]

An example particularly illustrating this possibility of a small stress causing disproportionately great shame is offered in the literature. It involves a person named Julie. She felt ashamed of her teeth, which were naturally colored. She felt ashamed every time she smiled. This was not because anyone suggested that she should feel shame for this reason; she felt shame because her dentist and commercials both suggested to her that people could smile with confidence only if they had sparkling white teeth.[13]

Any intervention risks evoking shame. A much more common, well-acknowledged source of people feeling shame is their being overweight. Often, even providers evoke shame in these patients though they do not intend this.[1,14,15] Providers might seek to persuade patients to lose weight by changing their eating habits and exercising. Medically, this endeavor makes sense because if patients can lose weight, there are clear health benefits. However, these patients might see their providers urging them to lose weight as implicitly blaming them and telling them that because they are overweight, they are at fault. Accordingly, these patients might dread coming in for medical check-ups. As a result, they might not continue to come in at all.[16,17] As one such patient, herself a physician said, "Why go to the physician if they will just point at your weight? May as well stay home and just deal with it."[18] Providers should be aware that even though they might be trying to give these patients the best medical care possible, they may unwittingly be evoking shame in patients who are overweight, which can do them more harm than good in the long run. Their words and/or tone might also be infantilizing as they tell these patients what they should do. This risk occurs whenever anyone tells others what they should do.

Some providers seeking to avoid this risk have advised providers to ask these patients if they are willing to discuss their weight. Others, seeking this same end of doing better, advise providers to tell these patients that they have every right to not change. Both wordings continue to imply, however, that this patient is at fault, since both still connote what the provider thinks these patients should do.

The critical, wider clinical notion here, applying to all patients as well as all people, is that especially when people feel more vulnerable to criticism from others, they tend to both see more ambiguity in the words others use and see the more negative meanings in these ambiguities than the meanings the speaker intended.[19–21] Patients might then register this as criticism and resent this. This process might occur only unconsciously, but their resentment might emerge at a later time. When it does emerge, it might even sabotage the provider's and patient's earlier efforts

and the patient's prior success in having lost weight. This sabotaging may be unconsciously intended to defeat the provider, despite this effort also harming the patient. The force of impacted, unconscious resentment may be this strong.[22,23] Snowden-Carr reflected on the crucial role of psychological factors in considering the maintenance of weight gain. She stated that 'prescriptive interventions' can lead to the reiteration of lapse and relapse cycles, reduced self-efficacy and increased shame.[24,25]

A patient's exceptional vulnerability to shame, weight-related or not, may also be culturally embedded, and, "To talk about shameful feelings within a therapeutic relationship can in itself be experienced as shameful."[26] Thus, despite providers best efforts, they may find it difficult or impossible to anticipate what could evoke shame so as to be able then to avoid it. Providers, as us all, obviously cannot know what they do not know.

Providers may also find their confronting these patients about their weight, even if only implicitly, painful. They may for this reason not see these downsides or choose to ignore them or view them as less important than they are.[27] If they do see these downsides and understand some patients' dread, their pain may be more than just seeing the pain they are causing to the patients before them. Seeing their pain clearly, if having not seen it before, they may see for the first time the pain they have caused other patients over previous years throughout their careers.

The empathic pain providers experience often affects their decision-making, though they are not privy to the effects this can have. This mutuality of pain, notwithstanding its vast difference between patient and provider, is captured nowhere better than in a pregnant provider's report of her interaction with a patient her same age whose abdomen was similarly protruding, but due to cancer, as she states, "Although we were about the same age, she knew that which filled my abdomen was quite different than the malignant ascites currently filling hers. 'I'm Dr. Chammas,' I introduced myself. Repositioning herself on her hospital bed in the hopes of finding some comfort, she calmly shared, 'People often ask me if I am pregnant too.'"[28]

Providers might feel ethically compelled to discuss health risks of obesity. Yet, there might be no way to do this without this posing the risk of connoting blame. If this occurs, these patients' feelings of shame, like fear, may be extraordinarily powerful, overwhelming them and eliminating from them the capacity they otherwise would have to hear and comprehend the objective importance of the information their provider gives them. They then could respond in ways most beneficial to themselves. Beset by shame overwhelming them like fear, however, they might want to flee. Providers may, considering this and their long-term wellbeing, choose not to even mention weight to these patients. The same physician cited earlier, sharing her experience of being overweight, states, "My obstetrician is a friend from medical school. We have worked together for 7 years. I have never heard her mention someone's size."[18]

Patients know their weight already.[29] They may profoundly appreciate their providers not bringing this up, as the previous quote exemplifies. This appreciation may after a time result in these patients acquiring sufficient trust in their providers' sensitivity to their feelings that they will bring up the question of what they should do about their weight wholly on their own. Then, with their provider's support, they may be more likely to succeed.

Viewing shame more widely, there is no approach that can fully escape the risk of causing shame. In the example of patients with overweight or obesity, patients might interpret providers not discussing their weight as stigmatizing them by neglect. They may feel that their providers should address this.

Common effects of shame in any context are emotional dysregulation, disturbances in interpersonal relationships, and alterations in consciousness. This last symptom includes dissociation, which can also occur in PTSD.[30,31] People experiencing dissociation might experience sudden lapses in their capacity to concentrate. Others who depend on them in some way might not know that these people have intense underlying feelings that cause them to have dissociative episodes. These others might then misattribute these lapses in concentration to their being thoughtless or worse, perhaps, irresponsible. They might judge them unfairly as a result. The invisibility of the cause of these people's dissociations might then result in an additional layer of shame, such as the negative reinforcement of their avoiding others to reduce their pain from shame and from anticipating this pain may both add an additional layer to these patients' suffering.[32,33]

Compassion-focused therapy might particularly help individuals beset by shame to care more for themselves. When children, these patients may have told themselves that they were "bad" because their seeing themselves as bad was preferable to their lacking control over their caretakers' unpredictable behaviors that would place them permanently at risk. These people may then have enormous difficulty in being kind to themselves. In compassion-focused therapy, they engage in several approaches to enhance their feeling self-warmth. This may include, for example, exploring what their ideal compassionate other might look like, imagining especially their facial expressions and voice tones.[34]

Two examples of people experiencing specific sources of shame illustrate additional therapeutic approaches that may benefit people with highly different sources of shame. The first involves female partners whose shame is secondary and occurs when they suddenly discover that their male partners have engaged in sexual abuse with a child. Therapists who urge these patients to leave their partners might lose these patients' trust. This example illustrates the importance of therapists remaining nonjudgmental to establish a setting that these patients experience as safe. These partners generally also need extensive information as to what they might expect, such as knowledge about recidivism risk, pedophilic attraction, and internet-facilitated crimes. Therapists should therefore have special expertise and experience in this area. Primary providers might not be able to offer what these patients need.[35]

The second group is patients who experience psychogenic nonepileptic seizures (PNES). They might experience shame because others may see their seizures as feigned for alternative purposes, such as to gain drugs or even just attention. Compared to patients with PTSD (without PNES), the exploration of shameful traumatic events in patients with PNES may trigger seizures. This work on traumatic memories might have to be preceded by psychoeducational interventions and exercises that raise patient awareness and tolerance of arousal. These patients might benefit, for example, from practicing sensory grounding techniques, such as holding an icepack or an

object with distinct textures, allowing them to remain focused in their present circumstances when dissociation threatens.[36]

These patients can also benefit greatly from shame resilience therapy, an approach that recasts shame experiences as opportunities for growth.[37] This therapy increases patients' confidence in identifying and recovering from shame through their becoming willing to reach out to others when they experience shame. Shame resilience is then thought of as active engagement with shame, rather than a feeling they must respond to by withdrawing from others. Patients recognize that their symptoms have emerged as safety strategies or as a threat protection system, operating automatically, predisposing them to perceive themselves as inferior and thus to feel the need to engage in appeasing behaviors to avoid interpersonal conflict. The therapeutic relationship provides a safe environment to explore the development of shame.[37–41]

In general, providers detecting emotional responses in their patients and then asking them about these responses is optimal care since this recognizes and responds to patients as whole persons. Some patients so-asked might, however, find providers asking them about their feelings intrusive. Still, considering these opposite responses and balancing them against one another, there might be a place for providers witnessing a patient's shame to go "all out" by inquiring to try to reduce the pain that comes from shame. For example, a provider might use self-deprecating humor, saying something like, "I recall myself doing something like what you just shared. Surely, not my sharpest moment, either!" Even this, however, runs a risk. The patient might then see this provider as less, or even insufficiently, competent.

Notwithstanding the above risks in other contexts as well, providers should consider responding to all cases in ways that are most caring whenever they can, though this might be a broad aspiration. This and only this will benefit patients most over the long term. This priority may apply even when patients and providers are at odds with each other due to their roles. An example is when providers are conducting an administrative evaluation for the state, as to determine whether a patient continues to have a mental disorder warranting disability compensation. Providers' customary practice and recommended posture is to remain interpersonally neutral and emotionally neither too warm nor too distant. Yet, a higher road, less often trodden we might presume, is to be more caring than this and to go further.

The persons they interview likely are frightened. They may fear that as a result of this re-evaluation, they and their families will have less food on their table. Thus, these patients may scrutinize every nonverbal and verbal response the provider evaluating them shows. These providers may here, imagining this, go an extra mile. They may openly and explicitly acknowledge that their two roles unavoidably conflict and even though neither can change their role, they can imagine that to the degree both are at odds, this is interpersonally painful for each. Providers could then go further and acknowledge that they understand that these patients, given their vulnerable state, may want to say whatever they can that would most favor a beneficial outcome for them. Providers can finally indicate that they want the patient to know that regardless of what these patients choose to say, they get and respect where they are coming from.

This unusual, indeed, radical departure from common professional, ethical thinking and practice is worth considering, always, in its own right, but for purpose of this discussion, this could also lessen these patients' shame. This example captures, therefore, the degree to which providers must be vigilant in looking for hints of patients' shame so that they can then take measures to lessen it.

HOW TO DETECT SHAME

The experience of shame commonly results from a wide range of negative social experiences. These include discrimination, social exclusion, and even being medically ill. A concept critical for detecting how and when this may occur is ableism. Ableism refers to a tendency we likely all have to see persons who are impaired in some way as also impaired in other ways, when they are not. We may then, if doing this, compound this first mistake. We may invidiously, even if unconsciously, regard these individuals as, in some basic way, not like us, but other.[42]

Conveying that patients aren't "other." Perhaps the most important prerequisite for providers to be able to help patients overcome their shame is for providers to see all their patients as wholly like them in all critical respects as opposed to their being in any way "other." This tendency to "other" is frequent, even among providers themselves. Providers might, for instance, see patients who come to see them in wheelchairs and then view them as impaired in other ways in which they are not. Providers might assume, for example, that these patients are less interested in sex and less sexually active, when this is not at all the case.

A second example perhaps depicting these errors, wrongful imputing and othering, best takes place with patients who have myalgic encephalomyelitis, which is commonly known as chronic fatigue syndrome. The cause of this a condition is not known. It presents as fatigue, pain, and other signs and symptoms that get worse with exertion, but do not improve with rest. Providers might see these patients as merely lazy or "whiners."[43]

Providers may possess these disrespectful attitudes consciously or unconsciously. Therefore, when they see patients whom they recognize as those who might most evoke ableism within them, they should particularly attend to this risk. They should especially attend to the language they use, their demeanor, and other responses, possibly outside their awareness, that might evoke shame in these patients.

They might also go beyond just not causing harm in this way. Providers may see if they detect possible signs of shame in what these patients say and in how they express themselves, and if they do, consider attempting to beneficially intervene. These patients might drop their voice; cover their face; cast their eyes downward; stammer; have long pauses; use words such as embarrassed, worthless, and inept; and, as we shall discuss more, make excuses when they are reporting an instance about which they feel shame.

Providers detecting this behavior may then inquire about it. This inquiry must be as nonthreatening and face-saving as possible. For instance, providers might say, "Sorry to ask, but it seemed to me just now that as you said what you just did, that you might have felt less than 100% optimal about what you told me. This may not be at all so, but if this was the case and you would like to share this with me, please do."

Seeing how excuses might reinforce shame. Patients often reveal shame by adding an excuse to past acts they report. They might say, for example, "but I had not slept," or "but I was worried about X at the time." These excuses

may be clues to underlying shame. Their doing this, while beneficial in the short term, is not, however, benign; just the opposite. Every time they make such an excuse, it reinforces their shame so that it then becomes more entrenched. Their making an excuse reinforces their underlying presupposition that they should feel shame for whatever it is that they did. This is because their making an excuse only makes sense if they should feel shame, because their making an excuse could then reduce the extent of their shame. This premise that they should feel shame is, however, false. A provider's goal should be to alert them to the opposite view—that as persons, they will always be erring. Providers should not seek to convince patients because this may elicit an oppositional response.

Their oppositional response may be then more and most able therefore to resist and reject whatever it is that their provider is trying to convince them of.

A provider's goal should be to heal as well. They might leave a patient feeling bad about what has happened because the result was bad, but on a wider scale, their response should lead the patient to accept themselves as worthy but always likely to err because we all are imperfect. No matter what has occurred, we can look forward and aspire to do better. Providers may be best able to detect their patients' shame and to convey this self-acceptance if they have felt shame, accepted themselves afterward, and sought then to do better.

Here, a nonthreatening approach by which providers can better discern whether patients are feeling shame is more challenging to concoct. A provider might say, in response to patients making the excuse that they had not slept, for instance, "You said you had not slept. I imagine it could be that makes you feel less bad about what you just said you regret. Is this so? Yet, it could be that that even though you feel better knowing you did not sleep, that adding in this makes you feel worse in the long run. Telling ourselves this leaves us feeling all the more convinced that we should feel bad about doing what we did in the first place. But we always make mistakes. We may not see what we do at the time. We may even see this, but respond to our feelings, nonetheless. No?"

Giving patients a say is also almost always preferable to not asking them their view. Asking patients what they think is therefore preferable to making a statement, especially because the latter may connote that the provider presumes that they have greater knowledge. This might be wrong and, in any case, may again elicit an oppositional, all-overriding response. Thus, providers might end as above, asking, "No?"

Self-disclosing despite the risk. Providers can point out how they have erred in similar ways that they regret and would take back if they could, as previously noted. They can add to this in more detail and explain how it is only human to err, and thus this inevitably will occur throughout their lives. As previously noted, patients might attribute exceptional wisdom to providers, rightly or wrongly. Thus, a provider's urging them to look forward may "take," even though they have heard this from others before but never responded.

Shame may be forthcoming due to a medical impairment, as the wheelchair and chronic fatigue syndrome examples illustrate, or result from numerous other circumstances, ranging from people having low literacy levels, poverty, social deprivations, food insecurity, homelessness, and criminal behaviors. If people have experienced shame from any of these sources or others, they will fear feeling pain from similar sources in their future.

Providers should not, however, overinterpret these tentative, most preliminary findings. Shame has, after all, likely been adaptive in our evolution. It might have enhanced our capacity to get along peacefully together and might continue to further this same positive outcome still today.[44] These feelings may alert us to emotional nuances regarding others to which we should attend without this resulting in our also feeling bad about ourselves.

As in innumerable other contexts, traits such as shame may be disadvantageous in some cases but valuable strengths in others. People who remain willing to acknowledge their vulnerability even into adulthood, as opposed to espousing invulnerability when growing up, is such an example. This retained asset may leave them to continue to enjoy being spontaneous and not limited due to feeling self-conscious. Regarding oneself with humility is paradigmatically anything but harmful shame.

Shame might be best conceptualized as our judging ourselves as predominantly defective at our core. Our self-appraisal of how bad we are may determine the intensity of our pain from feeling shame. Therapeutic interventions should focus on each source of our negative self-appraisal and through this assessment come to sounder conclusions. We can identify verbal and nonverbal cues that trigger our shame and find truths that can both interrupt our flawed logic and replace them. The remainder of this discussion will present additional ways in which providers detecting shame in their patients can seek to reduce it.

HOW TO INTERVENE

Shame left alone may fester. Then, like unresolved grief, it may remain unabated and darken literally every living moment of persons so afflicted.[45] As grief-stricken people also particularly report, they may think of their recent grievous loss not just every day but every minute. It is this ongoing omnipresence of shame that creates such an extreme need for providers to give the possible presence of shame in their patients' lives special attention. If providers do not see and act to interrupt this shame, it may be that no one will.

Grief is, in this regard, again singularly instructive. When people feel grief, if they have other residual feelings toward the person they are grieving, such as guilt or anger, these feelings may prevent them from being able to naturally heal over time. Even with this healing, their missing this person greatly may, of course, always remain. Yet, if providers attend to these feelings of guilt or anger that are obstructing this process of grief, they hopefully may free up this grieving process so that this healing can then take place.

This may occur more or less naturally with shame over time, too, but if and only to the degree that patients become fully aware of ways in which they continue to fuel their shame, learning of sound thoughts that must replace them, shared by persons they know care for them and whom they much respect and trust. The replacement thoughts and feelings these providers present cannot be "canned" beforehand. Providers must concoct them intuitively on the spot as they hear the precise ways in which individual patients are condemning themselves. Providers must select examples of self-correcting thoughts and by this means teach each patient how to do this for themselves as self-correcting thoughts occur to them.

In this sense, providers are helpless. They must depend then on whatever wisdom they

have based on their life experience bursting forth in their minds at these times, because then what they say will hopefully have a heartfelt integrity that gets through to these patients when nothing less will. Engaging in this process with these patients may be painful for both parties, but it is necessary.[46–48]

Shame-evoking events may differ and present in ways worth recognizing and distinguishing to maximize shame-bearers' gains. Patients may see themselves in these events, rightly or wrongly, as wholly or partially to blame, or not being blameworthy at all. If patients see themselves as having erred wholly or partially, the key intervention providers must provide these patients is to help these patients see how they want to be after this and grow.

Beyond this, the more formidable challenge is to respond to patients who cannot bear understanding any way in which they are blameworthy. This is just too painful for them. They must then deny all responsibility.[49,50] These patients need exceptional understanding and care. The ends at least are straightforward—to become aware of the cognitions that are causing such distress that denial is necessary and "find a way to resolve them constructively, or when we cannot, learn to live with them."[51]

CONCLUSION AND FUTURE DIRECTIONS

This discussion sees shame as a profound but unfortunately all-too-often unrecognized and unaddressed feeling. By noting shame and differentiating it from other feelings and acknowledging that shame may result from logically trivial causes, providers may be able to both better detect shame and then reduce it more effectively.[52] The essence of shame is global self-doubt. It may be as identity-shattering as severe trauma.[53]

Recognizing and addressing shame are critical skills that providers should consider striving to acquire, especially since becoming free of shame is so essential to patients having quality in their lives. These skills involve providers seeking to identify even the most subtle suggestions that shame may be present, and then pursuing a means with patients through which they may heal and ideally grow.[54] Providers must avoid, to the degree that they can, feeling and enacting ableism.

Specific approaches helping these patients see what they do from a wider perspective may be crucial to helping them do better.[55] There is also no place for providers or anyone to ever regard people as "other." To every extent that providers can create a bond between their patients and themselves, this may most further undoing patients' conviction that they are bad.[47] All the interventions noted here may, however, significantly help undo the shame that these patients self-inflict.

DISCLAIMER

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