The Teenager's Confession: Regulating Shame in Internal Family Systems Therapy

MARTHA SWEEZY, Ph.D.

This case study explores the clinical relevance of the differences among shame, guilt that is linked with shame, and pure guilt. Empirical literature on emotion suggests that shame is instrumental in a host of psychiatric symptoms while pure guilt is prosocial and adaptive. Regulating shame and being able to feel pure guilt may be especially important for trauma patients like the one described here, who have transgressors as well as victims The protocol of internal family systems (IFS), a mode of therapy that utilizes psychic multiplicity and actively recruits internal compassion, is described as a treatment for regulating shame and facilitating adaptive guilt.

KEYWORDS: shame; guilt; trauma; internal family systems therapy; IFS; self-compassion; psychic multiplicity

INTRODUCTION

The case described here features a 28-year-old suicidal woman who had been in therapy for many years when she stopped feeling the urge to suicide. Her story involves posttraumatic shame and guilt along with a treatment focused on self-compassion and psychic multiplicity called internal family systems therapy (IFS) (Schwartz, 1995). In this mode of therapy, the patient and therapist converse with *parts* of the patient, where parts are considered individually motivated, nonpathological beings in need of help. The patient described here, Angie, had a host of vulnerable and dangerous parts in need of help.

AN OVERVIEW OF ANGIE'S TRAJECTORY IN IFS

Almost a year into the IFS protocol, a part of Angie said she had something to confess; after negotiation, other parts allowed her to confess; then, wanting to atone, the confessing part crafted a repair that reversed the spirit of her transgression. Then Angie's "suicide voice," which had

Cambridge Health Alliance, Harvard Medical School. ***Mailing address:*** 44 Washington Ave, Northampton, MA 01060. E-mail: swzy@comcast.net

been a chronic symptom and threat to her life since she was 13, fell silent. How to understand this turn of events?

PARTS

Internal Family Systems Therapy

Internal family systems is based on the observation made by a number of clinicians and researchers (Bloom, 2008; Kluft, 1993; Schwartz, 1995; Watkins & Watkins, 1997) that psychic multiplicity is easily evoked and nonpathologic. Schwartz describes an *internal system* that anyone can attend to mindfully, consisting of a *Self*, whose salient qualities are compassion and curiosity, and multiple *parts*, or subpersonalities, that are most evident in strong feelings, judgments or physical sensations. The therapeutic use of direct interaction with a patient's subjective multiplicity is not new. For example, Watkins and Watkins (1997), analytically trained hypnotherapists, wrote about their theory of, and clinical practice with, *ego states*, a close facsimile to *parts* in the lexicon of Schwartz. Like Schwartz, the Watkins were struck by the efficiency of acknowledging (without pathologizing) psychic multiplicity.

Richard Schwartz (1995), who developed IFS, dubbed vulnerable parts *exiles* to describe their internal fate. He called the extreme parts that respond to their vulnerability and do the exiling *protectors*. The behavior of protective parts, such as criticizing, urging addictive behavior or pressing for suicide, may be a preemptive effort to contain the inflammatory beliefs and feelings of an exiled part, or it may be intended to numb, repress and extinguish inflammatory feelings, especially shame, once activated. Viewed through the lens of IFS, Angie's suicide voice was a protective part motivated to suppress and exile the emotional pain both of the part that eventually confessed and also of a younger part that had been shamed earlier in Angie's life.

FEELINGS

The Nature of Shame and Guilt

Although Angie endorsed guilt and, as it turned out, had good reason to feel guilty, it was shame expressed in global feelings of weakness and badness that was most evident in therapy. Patients often feel confused about guilt and shame (I *did* wrong; therefore, I *am* bad) and experience the two as linked, which is a reason for therapists and researchers to follow suit (for example, see Kubany, Hill & Owens, 2003; Stapleton, Taylor & Asmundson, 2006; Street, Gibson & Holohan, 2005; Resick et al., 2008). Another reason for conflating shame and guilt may be a procedural

similarity between them: both involve self-evaluation and, specifically, self-blame (Pineles et al., 2006; Seidler, 2000; Tangney & Dearing, 2002; Tangney et al., 2007b). Even so, shame and guilt differ. While shame involves a global assessment of self-value—I *am* bad, guilt involves an assessment of behavior—I *did* wrong (Lewis, 1971; Nathanson, 1992). Research on emotion correlates shame with self-attack and rage, and guilt linked to shame with self-attack, but *pure* guilt, free of shame, with concern for others and reparative action (Baumeister et al., 1994; DeWall & Baumeister, 2006; Gilligan, 1997; Mills, 2005; Pineles et al., 2006; Leith & Baumeister, 1998; Tangney & Dearing, 2002; Tangney et al., 2007a; Wilson, 2006). Nevertheless, when shame and guilt are conflated experientially for patients and then hypothetically in the minds of clinicians and researchers, the adaptive function of guilt may be missed. The case of Angie illustrates how therapy can disentangle guilt from shame and why this may be useful.

HISTORY

Angie came to me for skills training after being in various modes of therapy since early adolescence. Two years later we agreed to move on to an explicit focus on trauma with the IFS protocol: Angie had been hated and neglected by her mother, beaten and neglected by her father, and molested by an "uncle" who lived with the family and was sexually involved with both parents; as well, her beloved grandmother died when she was seven and her younger brother died when she was thirteen. In the first few months of communicating directly with Angie's parts, we met a protective part that accused her of being a lazy slut, several exiled parts that responded to this abuse with shame and despair, another protector that wanted to kill Angie to spare her further shame, another protector that felt disgusted with the vulnerable part that had been jealous when Angie discovered her "uncle" was having sex with her parents, and yet another protective part that wanted to kill all the people who had hurt her, et cetera. But we had not yet met this guilty teenage girl.

THE SESSION

The first step in the IFS protocol is to locate a target part, usually identifiable by its extremity (i.e., a harsh critic); by its conflict with another part (i.e., a part that feels angry at this harsh criticism); or by its distress (i.e., guilt). Focusing internally opens the patient's attention to her subjective experience and, where there are psychiatric symptoms, to the vulnerability and conflicts of her parts. Polarized parts can cause an IFS

session to move from one part to another. Since the guilty teenage girl we wanted to get to know was polarized with a critical part, this session began with the critic, visualized by Angie as an iron hand gripping her head.

I said, "*How do you feel toward the iron hand?*"
Angie replied, "*I hate it.*"
I asked, "*Would the part of you that hates it be willing to settle back and let you help the iron hand?*"
Angie thought for a moment and then said, "*Okay.*"
"*Now how do you feel toward it?*" I asked.
Angie replied, "*Afraid.*"
"*See if the fearful part would move back, too, and let you handle this,*" I said.
"*Okay,*" Angie replied.
"*And how do you feel now?*"
"*Angry.*"

Schwartz calls this process *parts detecting*, and it can go on for a long while or be over quickly. The goal is for the patient to express some feeling that falls along the continuum from curiosity to compassion toward the target part. Because relationships are dampened by negative affect (fear, anxiety, guilt, shame, hatred, anger) and cultivated by positive affect (curiosity, interest, concern, compassion, love), the patient is first asked to notice any strong negative feelings toward the target part and then to request that these parts separate, or *unblend*. Initially Angie hated the iron hand, next she was afraid of it, and then she felt angry. When these parts unblended, Angie felt curious. If she had had a stronger relationship with the target part she might have felt compassion or love. But curiosity was sufficient to reassure this critical part. It softened and complained that it was lonely and tired of protecting Angie. I asked Angie to ask the iron hand who it protected.

It replied, "*You.*"
I said, "*Ask the hand how old it thinks you are.*"
The hand replied that Angie was four.
"*Now ask how old the hand is.*"
Angie looked startled and didn't speak until I prompted her. Then she shook her head, saying, "*I'm confused. Now it's an eight-year-old boy.*"

No matter how strange the information coming from inside the patient's system is, accepting it is the right choice. There are common themes to internal worlds and this interaction with the iron hand-turned-boy captured three: first, the gender of parts is not necessarily linked to the

gender of the patient; second, parts are shape-shifters; and, third, the parts involved in psychological trouble tend to be young, often morphing from a metaphoric image to a child, perhaps explaining the commonly child-like cognitions of extreme parts (for example, *black and white thinking*).

I coached Angie to explain to the boy that she was a grown up and not a four-year-old girl. He was skeptical. To discover why the part was responding this way, I said, "*Ask him to look you in the eye and let you know what he sees you feeling toward him.*" He replied, "*Anxiety.*" When Angie asked the anxious part to move back, the boy relaxed. She thanked him for protecting the four-year-old and wondered what could be threatening her.

He replied, "*That girl.*"

Cutting to the chase, *that girl* turned out to be the teenager who wanted to confess what she had done at the age of 13 when her younger brother, Joachim, was dying of cancer. Angie's mother had always doted on her son and had been angry with her daughter. As the boy grew sicker, the mother's behavior grew more extreme. One day, out of jealousy, Angie took Joachim by the hand and led him to a neighboring basement, that was reliably inhabited by Billy, a 17-year-old boy who paid Angie to undress. Billy had repeatedly asked her to bring Joachim along and she had always ignored him. Now she anticipated Billy's look of disgust when he saw Joachim, who was crippled from several inoperable tumors on his spine. She relished her revenge on them both. But instead of looking with revulsion at Joachim, Billy whisked him off to a back room and raped him. Angie stood by paralyzed and, when her brother staggered out, she compounded her mistake by telling him to keep his mouth shut. Joachim stopped speaking altogether and died three months later.

Angie watched the replay of these events, as shown to her by the teenage girl, and wept. When a person is in this *witnessing* stage of interaction with a part, she may close her eyes or look down or sideways; she often becomes settled and still in the way of an intent observer, or she may feel the grief of (and for) a part. If she says that this level of feeling is ok, the therapist will not intervene.

When the teenager finished her story, I said to Angie, "*Ask her what she needs from you.*"

"*She needs to make amends,*" Angie replied. "*She wants Joey to forgive her. But I don't know how that can happen.*"

I said, "*Ask the part that doesn't know how this can happen to move back and let you help her.*"

Angie took a deep breath.

I continued, "*Now ask the girl what she needs.*"

Angie was quiet for several seconds and then reported, "*She's going to write to Joey but she needs someone to deliver the letter.*"

"*Who can do that?*" I asked.

Angie hesitated, looking surprised. "*Well, there's this little . . . cricket standing up on his hind legs. He's waiting.*"

In the letter the girl apologized to her brother, explaining her feelings that day and afterward. She asked his forgiveness. She put the letter in an envelope and handed it to the cricket, who hurried off.

"*How is she?*" I asked.
"*She wants to stay with me now,*" Angie said.
"*Is that okay?*" I asked.
"*Yes.*"
"*Is she ready to leave that time?*"
"*Yes.*"

So the teenage girl moved out of the past. Her exit was followed in this session by a last, ceremonial step signifying change which Schwartz calls *unburdening*. I asked if the teenage girl was ready to let go of the beliefs and feelings she had been carrying from that experience. She was. I asked Angie to have the girl find them on or in her body.

"*They're like knots of wood all over her,*" Angie reported.

The girl took the knots out of her body and burned them. Angie signaled me when she was done.

"*How is she now?*" I asked.
"*She feels light,*" Angie said.

Before ending the session, we checked with the two protective parts, the boy and suicide voice. Angie reported that the boy was feeling better but would keep his job for now. *Since he protects the little girl,* I said, *maybe he'd like us to come back and help her?* He was eager for Angie to do this as soon as possible.

Next we checked with the suicide voice, which had fallen silent. That day it refused to talk, but the next week it appeared to Angie for the first time in human form, morphing among multiple ages. The part explained that she had shielded Angie throughout her life from the little girl's feelings of worthlessness. If Angie could take care of the little girl, then she would be glad to give up the job. Meanwhile, the part agreed to stop advocating suicide and see what Angie could do. As a postscript, Angie did

take care of the little girl by witnessing her experience so that she could unburden, and the suicidal thoughts did not return.

Session Overview

Following the feelings, motivations, and interactions among the parts can be complex. I will track the dynamics of this session first by feelings and then by motivation. Angie's baseline feeling was a continual, undifferentiated state of self-blame that, as she developed a measure of self-compassion, differentiated into the feelings held by particular parts: shame on the one hand, intense guilt over a specific transgression on the other. Once Angie had regulated the behavior of the shaming protector enough to hear from a part that felt guilt, and had then helped that part to resolve her guilt by offering a repair, Angie became attuned to her early experience of being chronically shamed by her mother, and she set an intention to help that youngest part with her burden of historical shame.

Now tracking the session by motivation, a protective part (the boy) tried to keep the shame and emotional pain of a vulnerable part (the little girl) from being activated by the confession of another vulnerable part (the teenage girl) because the little girl's shame and suffering would provoke death threats from another protector (the suicide voice). That is, the boy feared that the confession of the teenager would stir the shame of the little girl, which in turn would activate the suicide part. Since his job was to keep the little girl alive, the boy felt compelled to block and suppress the voice of the guilty teenager. His tool was shame.

DISCUSSION

Historical Shame, Instrumental Shame

Shame, then, was both the core emotional problem in Angie's system and the strategy for containing that core problem. In essence, Angie had a dual experience of being shamed running in tandem, one historical, one current and instrumental. The first was instigated by caretakers while the second was a self-generated reenactment of that original shaming, now performed internally to control the flow of information among parts, inhibiting thoughts or feelings that might reactivate early shame. This recycling of shame for the sake of stability was, of course, an engine of instability.

The Beginning of Change

Even though his shaming strategy was a dismal failure, the boy had a legitimate concern; he rightly feared that the teenager's confession would activate a life-threatening chain of internal events. To retire from protecting the little girl, he needed Angie to take over and be kind. He needed her

to understand the collective danger of the situation for all her parts and to appreciate their attempted solutions. Once Angie was able to be with her parts in this spirit, change began: the boy calmed down, allowing the teenage girl to confess and make amends which caused the little girl, and thus the suicide voice, to feel hopeful. Angie's ability to feel compassion and to listen to the sense beneath the apparent chaos of her internal system was key to this cascade of change.

CONCLUSION

Treatment: Challenging Shame, Validating Guilt

Angie's case demonstrates the way in which adaptive guilt can be held hostage to shame: the teenage girl felt guilty (*I did wrong*) but could not get attention for her transgression because of the pervasive and threatening shame (*I am bad*) of the little girl. As a result Angie's therapists never knew what she had done, they knew only what others had done to her. Until the teenager confessed, no therapist could know that Angie's linchpin emotion was not separation or survivor guilt (feelings to which she was subject as well), and it was not shame; it was, instead, appropriate, deserved, adaptive guilt. Had I simply encouraged Angie to challenge self-blame as a generic post-trauma ill without the opportunity to sort guilt from shame, I suspect this therapy like others before it would have stalled.

As it turned out, Angie needed to challenge her shame but validate her guilt. The generic protocol of IFS served for both. It was the protocol of the treatment not my (nonexistent) insight that cleared the way for Angie's system to sort itself out. A global dosing with self-compassion as prescribed by IFS challenged her self-attack—the flow of self-criticism which kept updating her shame—and cleared the way for Angie to take notice of a specific, guilt-provoking event in her past. The emotional resolution of that event expanded Angie's self-compassion, allowing her to move back with confidence to the early source of her feeling of worthlessness.

A Life Revolving Around Shame: Feeling Shame, Shaming, Containing Shame

Therapeutic work with parts can help to unpack an amalgamated experience of shame like Angie's into its component parts, differentiating its origin from the ways in which it is maintained. Being shamed involves feeling foolish, stupid, diminished, small, child-like, different, alone, defective, unwanted, worthless and unlovable – and is exquisitely unpleasant. This diminishment was the core self-experience of Angie's childhood and of her little girl part. The continual updating of shame in Angie's system, however, was perpetrated internally in an effort at self-control by the part

that showed up as a young boy. His misguided shaming had, in turn, motivated a host of costly shame containment strategies, the litany of Angie's psychiatric symptoms, including an eating disorder, drug and alcohol abuse, self-harm, and suicidality—all behaviors that recursively evoked shame. In general Angie's behavior had been motivated by the arousal and containment of shame. But the irony of using shame to inhibit shame was certainly lost on her parts.

Progress: Shame Regulation, Psychic Multiplicity and Self-Compassion

Angie's progress with guilt as well as shame in this therapy was made possible by her ability to regulate shame. I believe the IFS protocol involves two strategies that could make any therapy effective at helping patients to regulate shame. First, a generic and continual focus on self-compassion commandeers the mental pathway of self-evaluation that generates shame, with self-compassion and shame acting as mutually exclusive opposites. And, second, psychic multiplicity is inherently relational; it is an experience of differentiation in an internal world that is lively—if at times conflictual—and engaged. This contrasts with shame, an experience at once deadening and inclusive. Psychic singularity and subjective worthlessness, the story line of shame, is an oppressive self-narrative barren of choice that tends to generate panic and despair. Exiled parts often live in this state, drawing the patient into social exile. Rescue by rage is a short-term distraction with long-term costs, including transgression and relational failure that deliver the exile (and the patient) deeper into fear, shame and isolation.

Although shame digs a deep hole, the human brain is fitted with exit strategies: guilt is one and compassion another. While shame promotes group cohesion and expels the offender to protect against human fallibility, guilt is a vehicle for staying together and tolerating fallibility, and compassion is a state beyond both—beyond judgment—a container for humans in all their fallibility.

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