Internalized Shame: Origins, Impact, and Pathways to Healing

by

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Abstract

Internalized shame is a deeply embedded, self-conscious emotion that negatively impacts mental health, relationships, and overall well-being. Unlike state-based shame, which arises in response to specific events, internalized shame becomes an enduring aspect of self-identity, contributing to mental health difficulties such as depression, anxiety, PTSD, eating disorders, and personality disorders. Despite its widespread impact, research on targeted therapeutic interventions remains limited. This capstone reviews the current literature on internalized shame, examines its developmental origins and psychological effects, and presents IFS as a framework for addressing it. Clinical applications for working with clients with internalized shame are discussed, with a focus on building a strong therapeutic relationship, working with protective parts, resolving internal conflicts, and fostering Self-leadership. While preliminary research suggests that IFS may be effective in reducing shame and increasing self-compassion, further empirical studies are needed. This capstone highlights the need for continued exploration of IFS as a therapeutic intervention for internalized shame and encourages clinicians to consider its application in practice.

Keywords: shame, internalized shame, Internal Family Systems, self-compassion

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Chapter 1: Introduction

Clients who come to counselling are often struggling with complex emotional experiences that have become deeply intertwined with their sense of self, impacting their well-being. Among these, shame stands out as a uniquely powerful experience with a profound impact. Everyone experiences shame, but for many, shame becomes a chronic and insidious part of daily life. This has been referred to in the existing literature as internalized, maladaptive, chronic, dispositional, trait-based, or toxic shame (henceforth referred to as internalized shame). Internalization of shame refers to a process where an individual absorbs and integrates feelings of shame into their sense of self, perceiving themselves as inherently flawed, bad, or unworthy, rather than experiencing shame as a response to a specific behaviour or situation (Norder et al., 2023). Existing research has shown that internalized shame is associated with a wide range of mental health challenges, including depression, anxiety, personality disorders, substance use, post-traumatic stress disorders, eating disorders, suicidality, and non-suicidal self-injury (Goffnet et al., 2020). Thus, understanding how shame operates is essential for effective therapeutic work, yet it remains a difficult emotion for counsellors to understand and address.

Shame is a self-conscious emotion that emerges primarily in relational contexts. Internalized shame is thought to be rooted in early attachment experiences, developing in response to attachment injury (such as repeated relational ruptures without repair, neglect, abuse, or frequent criticism and shaming). It is important to note that shame often emerges in the context of societal power structures, such as racism, sexism, colonialism, ableism, and homophobia, and can become internalized when individuals are repeatedly devalued or marginalized. Counsellors must be able to recognize how internalized shame is shaped not only

by personal history but also by broader systemic forces. Failing to acknowledge these macro-level contributors may lead counsellors to pathologize the individual without understanding the societal context that gave rise to their shame.

Because internalized shame is fundamentally an interpersonal wound, healing must also occur in relationship. This means that the quality of the therapeutic relationship is paramount to healing internalized shame in a therapeutic context. Research on common factors across therapeutic approaches has consistently demonstrated that the quality of the therapeutic relationship is among the most significant predictors of successful therapy outcomes (Wampold, 2015). This may be particularly true for individuals experiencing internalized shame (DeYoung, 2015; Tangney & Dearing, 2011). For these clients, the counsellor serves as a stable, attuned, and accepting presence, offering a relational experience that contrasts with the client's previous experiences of being shamed. This corrective emotional experience can begin to shift deeply embedded shame-based beliefs. As the client experiences repeated moments of attunement, empathy, and unconditional positive regard within the therapeutic relationship, they can replace their internalized sense of being defective or unworthy with a new relational reality where they are seen, valued, and safe (Goldfried, 2012).

Additionally, the therapeutic alliance provides a safe container for exploring shame without the usual withdrawal, self-attack, or dissociation that often accompanies it (Tangney & Dearing, 2011). As the client brings shame-laden experiences into therapy, the counsellor's response, marked by curiosity rather than criticism and warmth rather than rejection, begins to disconfirm the client's entrenched expectations of relational harm. These moments of compassionate witnessing and co-regulation help the client build new neural pathways for self-

compassion and trust in relationships, and as a result, decrease shame (DeYoung, 2015). Thus, working with internalized shame is not simply about cognitive insight or behavioural change, but about offering a new relational template in which the client can feel safe enough to soften their self-protective strategies and begin to relate to themselves with greater kindness and acceptance. The therapeutic relationship itself is the most important intervention.

This capstone reviews the existing literature on internalized shame and therapeutic interventions to address it, highlighting gaps in both our understanding and treatment of the issue. It examines the shortcomings in how internalized shame is conceptualized and treated, and presents Internal Family Systems (IFS) as a promising modality for helping clients who experience internalized shame. Chapter 1 provides an overview of the general research area on internalized shame and treatment approaches. In addition, Chapter 1 will present a theoretical framework and statement of positionality, as well as key definitions that are used throughout the capstone. In Chapter 2, a comprehensive review of the literature is presented, exploring the research to date on internalized shame, its impact on mental health, approaches to treatment, and an overview of Internal Family Systems. In Chapter 3, suggestions for clinical applications will be discussed, with a focus on specific IFS techniques.

Overview of the Research Area

Internalized shame is characterized by a pattern of frequently experiencing shame in situations where it is unwarranted. Rather than originating from others or from mistakes made, internalized shame "originates within the self and involves self-generated criticism and negative self-evaluation" (Norder et al., 2023, p. 132). Shame has been described as an adaptive emotion that helps us strive towards pro-social behaviour and forge bonds with others (Gilbert, 2007).

When we have done something wrong, shame can help redirect our behaviour and make repairs in our relationships. When shame becomes internalized, however, it has the opposite effect, causing us to withdraw from others (Norder et al., 2023). As noted above, internalized shame has been linked to a myriad of mental health issues (Goffnet et al., 2020). Shame has also been linked to higher levels of cortisol and inflammatory cytokines, which can cause physical health issues (Dickerson et al., 2004; Lupis et al., 2016). In addition, shame can interfere with help-seeking behaviour and the therapeutic process itself. Shame has been linked to poorer treatment outcomes as well as premature treatment termination (Norder et al., 2023). Despite an understanding in the field of counselling that shame is an important transdiagnostic therapeutic target, there has been limited research on therapeutic interventions that specifically target shame.

In this capstone, I will explore Internal Family Systems (IFS) as a potential therapeutic modality for reducing internalized shame. Developed by Dr. Richard Schwartz in the 1980's, IFS theorizes that we are all made up of different parts which interact much like members of a family. These parts have disagreements, make alliances, and engage in protective behaviour. The central premise of IFS is that there are no bad parts. Therefore, IFS is an inherently accepting and non-pathologizing perspective. Due to its focus on self-acceptance, it is a promising treatment for healing internalized shame.

Tangney and Dearing (2011) point out that the topic of shame is often avoided by therapists. Shame is a naturally uncomfortable emotion, and subconscious efforts by the therapist to avoid provoking this feeling in themselves or their clients may result in the avoidance of shame-eliciting topics and, consequently, limit the potential for healing. Yet avoiding shame in the therapy room reinforces the very dynamics that generate and sustain it: shame thrives in the

dark.

IFS offers a way to actively engage with shame in the therapy room. A key component of the IFS model is that therapists are encouraged to develop awareness of their own internal system, including parts that may feel discomfort, judgment, or protectiveness in response to clients' shame. This self-reflective stance reduces the likelihood of therapist-driven avoidance and fosters a more open, curious, and connected therapeutic environment. Further, IFS does not view shameful parts of the client as problems to be fixed, but as protective strategies that emerged in response to pain, rejection, or systemic harm. By honouring each part's role and origin, including the cultural and social context in which it developed, IFS provides a respectful and trauma-informed approach to working with internalized shame.

In sum, internalized shame is a pervasive, entrenched, and maladaptive sense of shame that originates from within. Research has shown that internalized shame is a factor in a myriad of mental health and somatic issues. Therefore, it is an important transdiagnostic symptom that counsellors should be aware of and equipped to treat. Despite this, there has been limited research on interventions that help to treat internalized shame and a failure to come up with a clear conceptual definition of internalized shame. In the remainder of Chapter 1, I will outline the research problems that I seek to address through this capstone, explain the significance of this topic to clinical counsellors, review the key theoretical underpinnings of this capstone, present my social location and positionality, and provide definitions for key terms.

Research Problem, Rationale, and Clinical Applications for Counsellors

As previously discussed, there has been limited research to date focused on internalized shame as a therapeutic target, despite its recognition as both a critical focus of treatment and a

potential barrier to therapeutic engagement (Di Sarno et al., 2024). More research is needed to elucidate a clear conceptual definition of internalized shame, explore its etiology, examine the role of shame in the therapeutic process, and develop tailored interventions that target internalized shame. This capstone will address the following research questions: (1) How does internalized shame develop? (2) What are the impacts of internalized shame? (3) How can counsellors help to alleviate internalized shame? Answering these questions will help to provide a roadmap for counsellors working with clients who are experiencing internalized shame.

Theoretical Framework

The primary theoretical underpinnings of this capstone project are attachment theory (Bowlby, 1969) and interpersonal neurobiology (Siegel, 2001). Attachment theory, created by John Bowlby and Mary Ainsworth, profoundly changed our understanding of human psychology. Bowlby and Ainsworth drew attention to the importance of early attachment experiences between child and caregiver. Later research has illustrated that early attachment experiences significantly impact individuals throughout the lifespan (see Fraley, 2019 for a review). Interpersonal neurobiology posits that when there is attachment disruption or interpersonal trauma while the brain is still developing, the nervous system is impacted, resulting in difficulties with interpersonal relationships, emotion regulation, and core negative beliefs of self (Siegel, 2001). Interpersonal neurobiology and attachment theory are extremely prominent in the literature and are well-accepted as explanations for why internalized shame develops in some individuals. Internal Family Systems aligns with interpersonal neurobiology and attachment theory, positing that parts develop extreme roles in response to early attachment injuries (Schwartz & Sweezy, 2019).

This capstone is also informed by critical theory, which emphasizes the importance of understanding psychological experiences such as shame within their broader socio-political and historical contexts (Loewenthal, 2015). Critical theory invites a questioning of dominant discourses and power structures, drawing attention to how systems of oppression such as colonialism, capitalism, racism, and patriarchy shape individual experiences. This lens encourages us to view shame not simply as an internal problem to be treated, but as a response that often emerges in relation to systemic devaluation and social control. As such, it informs my belief that therapeutic work must be both personally attuned and socially aware, creating space for healing that acknowledges and challenges the larger forces at play.

Researcher's Position Statement

As someone with a background in experimental and clinical psychology, I have been deeply influenced by the post-positivist worldview that has dominated the field of psychology for over 100 years and favours quantitative, experimental research (DeCarlo et al., 2022). My undergraduate training stressed the importance of quantitative research methods and the "scientific process" with no acknowledgement of other research methods. As I have advanced in my career, I have become more critical of the dominance of this worldview and its myopic lens. This approach favours a certain type of research that can only be done in a certain type of way by a certain type of person working in a certain type of institution, and is inextricably intertwined with colonial, patriarchal, and capitalistic structures. Additionally, the experimental or post-positivist approach has a rigid hierarchy or power structure with researchers at the top and participants or "subjects" at the bottom. It reduces the complexity of human beings to numbers and statistics and does not help us understand the rich tapestry of human experience, which I feel

is essential to the field of psychology and especially counselling. Thus, although I see the value in post-positivism and experimental quantitative studies, I aim to maintain a critical lens when examining what kinds of research are prioritized within this field of study and take a pragmatic approach to examine all types of research (including qualitative, case-study, and community-based studies).

The inspiration to research this topic comes from my personal experience, and thus it will be especially important to be vigilant in my attempts to minimize bias. It is important for researchers to situate themselves and their social location and worldview, as these factors invariably impact the research process (DeCarlo et al., 2022). I am a Canadian settler of European and Middle Eastern descent. I benefit from white, able-bodied, heteronormative and cisgender privilege. Western research has traditionally centred people who hold the same identities I do (DeCarlo et al., 2022). It is essential for me to acknowledge the ways in which I benefit from the marginalization of other identities in our society, to keep in my awareness the bias that comes from my unique social location and lived experiences, and to critically reflect on ways in which that bias may impact my research and counselling practice. For example, in the past, a blind spot for me was failing to critically examine the generalizability of research that centers identities close to my own (predominantly white, middle-class university students at Western institutions).

My passion for this project arises from my personal experience using an IFS framework to heal internalized shame. Therefore, it is important for me to be cognizant of the bias my personal experiences will impart throughout this research project. While I may be more drawn to intervention approaches that have worked for me, and biased against ones that have not, I strive

to be objective in my evaluation of the research, as well as hold a critical lens of what is and is not prioritized and centred within our field.

Definition of Key Terms

Exiles

In Internal Family Systems, exiles are typically younger parts that emerge in early childhood and hold burdens or hurts that typically originated in childhood (Schwartz & Sweezy, 2019). Through IFS therapy, these parts can let go of their burdens and experience release.

Firefighters

Firefighters are type of protective part in Internal Family Systems. Firefighters seek to soothe the exile through distraction or dissociation, and often manifest as addictive or compulsive behaviours (Schwartz & Sweezy, 2019).

Internal Family Systems (IFS)

Internal Family Systems is a therapeutic modality created by Dr. Richard Schwartz in the 1980's and is heavily influenced by his background in family systems therapy. The central premise of IFS is that we all contain different internal "parts" that interact with each other much like members of an actual family. These parts often take on extreme roles, such as a harsh inner critic or a part that uses alcohol to cope. Schwartz posits that all of these parts play a protective role, and once they are understood, they can let go of their extreme roles take on more adaptive roles (Schwartz & Sweezy, 2019).

Internalized shame

Existing literature has failed to come up with a cohesive definition for internalized shame. Throughout this capstone, internalized shame will be used as an overarching term for

what has been described in the literature as internalized, maladaptive, chronic, trait-based, dispositional, or toxic shame. Broadly speaking, this is shame that becomes internalized (originating from self) and chronic, becoming disruptive to a person's relationships and well-being (Norder et al., 2023).

Managers

Managers are a type of protective part in Internal Family Systems. Managers seek to protect exiles (vulnerable parts of the system) through controlling the environment and avoiding potential triggers, and often manifest as a strong inner critic or self-shaming part (Schwartz & Sweezy, 2019).

Self

The Self in IFS refers to a person's core, the part that is not a part, which is embodied by the following characteristics: calm, curiosity, clarity, compassion, confidence, courage, creativity and connectedness (termed the 8 C's; Schwartz & Sweezy, 2019). The goal in IFS is for exiles and protectors to take on more adaptive, healthy roles and work together harmoniously while led by Self-energy. The IFS therapist helps to promote a part-to-Self relationship or attachment to Self. As the parts begin to know and trust the client's Self, the parts can begin to let go of extreme roles, allowing the client to become more Self-led.

Overview of Capstone

This chapter provided a brief overview of internalized shame and Internal Family Systems, explained the rationale for this capstone, outlined its theoretical foundations, addressed personal positionality, and defined key terms. Chapter 2 will present an overview of the current research on internalized shame, including theoretical explanations of shame and internalized

shame, the effects of internalized shame, approaches to its treatment, and the influence of shame on the therapeutic process. Additionally, Chapter 2 will overview the theory of Internal Family Systems and review research on its efficacy. In Chapter 3, practical applications of Internal Family Systems as a therapeutic modality to help reduce internalized shame will be discussed.

Chapter 2: Review of the Literature

The purpose of the following chapter is to review the current literature to describe what internalized shame is, how it develops, and how it can be treated. First, a review of current theories and research on internalized shame will be presented, including how internalized shame differs from state-based shame, the etiology of internalized shame, and its mental health correlates. Next, existing research on therapeutic interventions to address internalized shame will be reviewed. Finally, Internal Family Systems will be introduced as a promising modality to help treat internalized shame. Gaps in the current literature and recommendations for future research will be discussed.

Understanding Internalized Shame

Shame is a self-conscious emotion arising from the perception of having failed to meet personal or social standards, often leading to feelings of inadequacy, worthlessness, or a desire to hide (Di Sarno et al., 2024). Helen Block Lewis (1971) was one of the first shame researchers. In her pioneering work, she made the important distinction between guilt and shame. Guilt, she posited, is experienced when one makes a negative attribution about a particular act. Shame, on the other hand, is when one makes a negative attribution of their whole self. As Sinha (2017) writes, "if the voice of guilt uttered, 'I did wrong', the voice of shame shouted, 'I am wrong'" (p. 252). Abramson et al. (1978) made an important contribution to the field of shame research when they developed the cognitive attribution model, which posits that shame arises from a tendency to make internal (e.g. 'This is my fault'), global (e.g. 'I ruin everything'), and stable (e.g. 'I will always ruin everything') attributions to negative events (what they called a helpless attributional style). A helpless attributional style, like shame, is linked to depression (Rubenstein et al., 2016).

Many scholars have pointed out that shame can also be a powerful positive force and may have had evolutionary benefits. Gilbert's social mentality theory (2003, 2007, 2017) hypothesizes that shame is an evolutionary emotion designed to help us maintain social desirability in a system where belonging to a tribe is crucial to survival. While experiencing some shame may allow one to modulate their behaviour to increase social desirability and therefore connect better with others, experiencing too much shame causes one to withdraw from others, limiting well-being (Gilbert, 2007).

Researchers and theorists distinguish between acute (state-based) shame and chronic (trait-based) shame, also referred to as shame proneness, internalized shame, or dispositional shame. Acute shame arises in response to a specific event or behaviour and serves an important evolutionary function: encouraging prosocial behaviour and maintaining social cohesion (Dolezal, 2022). In contrast, internalized shame extends beyond individual incidents and becomes ingrained in one's self-concept. This maladaptive form of shame leads to withdrawal behaviours and psychological distress. As prominent shame researcher Michael Lewis (2019) notes, "the pathology of shame is in the extremes, too little or too much" (p. 327).

For example, if Sally makes a rude comment to a friend, she may feel an immediate wave of shame, prompting her to apologize and repair the relationship. However, if she continues to ruminate, thinking, "I can't believe I said that. I'm a terrible friend and a terrible person", her shame has become maladaptive. When this pattern of self-blame occurs frequently, it develops into internalized shame, which is inherently self-destructive and negatively impacts mental, physical, and social well-being (Norder et al., 2022).

Internalized shame is thought to develop at an early age and may be rooted in early attachment experiences. Allan Schore (1998, 2021) has made important contributions to the field by synthesizing brain imaging studies to illustrate how shame develops in the second year of life through interactions with attachment figures and can develop into maladaptive patterns. When infants receive positive feedback from their caregivers, they feel positive emotions. When they are ignored or receive a negative response, they experience shame. Schore (1998) suggests that persistent experiences of shame without repair from an attachment figure reorganize brain structures to reduce one's ability to regulate emotions and self-soothe. Gilbert (2007) posits that early attachment experiences that result in a reduced ability to self-soothe and an increased tendency for self-criticism lead to the manifestation and perpetuation of internalized shame. Evidence has supported the relationship between early attachment disruptions and internalized shame, with numerous studies highlighting how adverse childhood experiences (such as abuse, neglect, and parental substance use) contribute to its development (Constantian & Zaborek, 2021; Rollins & Crandall, 2021; Sedighimornani et al., 2020; Weaver & Sullins, 2021; Wojcik et al., 2019). Additionally, some emerging evidence links anxious attachment and disorganized attachment to shame-proneness (Parks & Shields, 2023).

Impact of Internalized Shame on Mental Health

Researchers have linked shame to a myriad of mental health concerns, including depression, anxiety, post-traumatic stress disorders, personality disorders, and eating disorders. While a great deal of research has illustrated a link between shame and these symptoms, it is important to note that the relationship is not necessarily causal or unidirectional. For instance, the stigma often associated with a mental illness diagnosis may itself elicit shame.

Depression. In a 2011 meta-analysis of 108 studies with a total of 22,411 participants, Kim et al. (2011) found a moderate correlation between shame and depression symptoms. Emphasizing the conceptual differences between shame and guilt, shame had a significantly stronger association with depression than guilt. Further research has consistently identified shame as a significant mediator in the relationship between various interpersonal experiences and depression. In a study of 210 students, Bilevicius et al. (2018) found that shame significantly mediated the positive relationship between depression and addictive behaviours. In a study of 117 inpatient adolescents, Gambin & Sharp (2018) found that shame, more than guilt, mediated the relationship between the teens' affective empathy and depressive symptoms. The authors hypothesized that greater affective empathy may exaggerate a person's feeling of responsibility for the suffering of others, thereby increasing shame, which in turn may increase symptoms of depression. Another study of inpatient adolescents (n = 112) found that physical abuse had an indirect effect on suicidal ideation via guilt, shame, and depression (Sekowski et al., 2020). Interestingly, this was not the case for sexual abuse or emotional neglect. Carvalho et al. (2013) found that experiential avoidance mediated the relationship between shame and depression in a study of 161 caregivers. They suggested that exploration of shame-inducing events may be necessary to reduce depression symptoms. In a study that compared individuals with body dysmorphic disorder (BDD), obsessive-compulsive disorder (OCD), and healthy controls, Weingarden et al. (2016) found that shame was a significant risk factor for depression, suicidality, and functional impairment in both BDD and OCD, concluding that shame was an important contributing factor to both conditions. In a study of 244 adults, Ross et al. (2019) found that shame significantly mediated the relationship between emotional abuse and

depression. Taken together, these studies suggest that shame may be an important contributor to the development and maintenance of depression.

Anxiety. Several studies have investigated the connection between various anxiety disorders and shame. In a 2018 meta-analysis, Candea and Szentagotai-Tatar analyzed data from 143 studies including 29,001 participants and found that shame was significantly associated with symptoms of general anxiety, trait anxiety, state anxiety, phobic anxiety, social anxiety, and obsessive-compulsive disorder with a medium effect size. A notable exception was that shame was not significantly associated with panic symptoms (though only two studies were available).

PTSD and Complex PTSD. Research has also linked shame to both post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD). In 2019, Lopez-Castro et al. conducted a meta-analysis of studies on PTSD and shame. They examined 25 studies including a total of 3,663 participants and found a significant positive correlation between shame and symptoms of PTSD in a diverse array of populations (e.g. childhood abuse, combat veterans, sexual assault, sexual minority women). In line with Abramson's cognitive attribution theory, the development of PTSD is more likely the more global and stable the shame-based attributions (Lopez-Castro et al., 2019). In a subsequent study, Bannister et al. (2019) surveyed 144 veterans and found that those with higher ratings of internalized shame experienced more severe PTSD symptoms. A 2023 meta-analysis (DeCou et al.) of 25 studies found robust evidence for a link between trauma-related shame and symptoms of psychopathology in general and specifically depression and trauma-related symptoms.

Some evidence has shown that avoidance coping may mediate the relationship between trauma-related shame and PTSD. Avoidance coping is characterized by behaviours that distract

from the distress or memories, whereas approach coping is characterized by activities that directly address the trauma. In a study of 326 undergraduates, Leonard et al. (2020) found that experiential avoidance mediated the relationship between shame and post-traumatic stress. Tipsword et al. (2022) replicated these results in a subsequent study of 60 women.

Eating Disorders. A large body of research has documented the link between internalized shame and eating disorders. In a 2021 meta-analysis, Nechita et al. synthesized 195 studies with a total of 64,267 participants and found that shame was significantly associated with eating disorder symptoms. Studies included individuals with anorexia, bulimia, and binge eating disorder. Body shame and shame around eating were the most significantly associated with eating disorder symptoms. The authors emphasized the limitations of these studies and assessed most of the studies to be poor to fair quality. Despite this, these studies suggest that shame is an important therapeutic target when treating eating disorders.

Personality Disorders. There is some evidence for a link between shame and personality disorders such as borderline personality disorder (BPD) and narcissistic personality disorder (NPD). Buchman-Wildbaum et al. (2021) conducted a meta-analysis of 10 studies and found significantly higher levels of self-reported shame in individuals with BPD compared to a nonclinical sample. In this sample, greater shame was associated with younger age, lower educational attainment, and PTSD symptomatology. It remains unclear whether shame-proneness serves as a vulnerability factor for the development of BPD or whether the experience of living with BPD, a highly stigmatized diagnosis, exacerbates shame. It is likely that both processes contribute. Supporting this, Jorgensen and Boye (2024) conducted a qualitative study in which 21 women with BPD described profound shame, arising both from their internal struggles and

from the experience of being diagnosed with BPD. Higher levels of nonverbal shame behaviours and self-reported shame-proneness have also been found to predict non-suicidal self-injury, suicidal ideation, and suicidal behaviour in those with BPD, even when controlling for the severity of BPD symptoms (Brown et al., 2009; Cameron et al., 2019). These studies indicate that shame could be an important target for intervention in individuals with BPD. Some evidence has also shown elevated shame scores in those with NPD. In a study that compared 28 individuals with NPD, 31 individuals with BPD, and 34 non-clinical controls, Ritter et al. (2014) found that participants with NPD reported higher levels of shame than non-clinical controls, but less than those with BPD. A subsequent study also found significantly higher levels of shame in individuals diagnosed with NPD (n=61) compared to those without a personality disorder (n=56; Fjermestad-Noll et al., 2020).

Shame in the Therapy Room

Most shame researchers and theorists agree that shame emerges in social contexts and is shaped by perceived expectations of others. Moreover, many symptoms that lead individuals to seek counselling are linked to high levels of shame. Thus, shame is likely to show up in the therapy room. Tangney and Dearing (2011) note that the therapeutic relationship in and of itself is shame-inducing: “Clients who have unsuccessfully attempted to resolve problems or symptoms are expected to lay bare their failures and shortcomings before a therapist who is often imagined to be a paragon of psychological health” (p. 376).

Tangney and Dearing (2011) also suggest that shame is an emotion that clients and therapists alike naturally tend to avoid. Therapists, therefore, must be vigilant for signs of it by actively probing, and looking for both nonverbal and verbal cues. Nonverbal cues may include

withdrawal, avoiding eye contact, laughing to cover embarrassment, or a slumped posture. Verbal cues may include words like “ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed” (p. 378).

Research indicates that shame can contribute to nondisclosure, premature termination, and resistance to treatment (Di Sarno et al., 2024). Additionally, research has shown that higher levels of shame are associated with poorer treatment outcomes, including less improvement in PTSD symptoms and higher risks of suicide and self-harm among clients with borderline personality disorder (Di Sarno et al., 2024). These findings highlight the importance of recognizing and addressing shame in the therapeutic process.

Culture, Shame and Marginalized Identities

It is important to note the ways that discrimination, marginalization, and stigmatization of various identities may impact the prevalence or experience of shame, as well as explore different ways in which shame is experienced culturally. Due to oppression and discrimination, marginalized identities may face increased levels of shame. Research indicates that stigma related to ethnicity, physical and mental illness, weight, religion, poverty, and intimate partner violence often leads to shame (Collardeau, 2023). Women consistently report higher levels of shame (Ferreira et al., 2022), pointing to the likely involvement of socio-cultural factors such as prejudice and discrimination, as well as differences in socialization. For example, in many cultures, women are shamed for their sexuality, while men are not.

The prevalence of shame, and the factors that trigger it, are shaped by cultural contexts (Ferreira et al., 2022). For instance, Thomas et al. (2019) illustrated differences in shame triggers

between Australians and Japanese participants, with status inferiority, “loss of face”, and the behaviours of close others being more likely to trigger shame in Japanese respondents than Australian respondents. Studies have pointed out that shame tends to be higher in individuals from collectivist societies, and that in these cultures, shame is often not seen as a negative emotion (Collardeau, 2023).

Given these diverse and often complex cultural dimensions of shame, it becomes clear that therapeutic approaches must be adaptable, nuanced, and responsive to the systemic and contextual layers that contribute to internalized shame. A one-size-fits-all approach may overlook the lived experiences of clients whose shame is shaped by cultural expectations, historical trauma, or ongoing discrimination. The next section explores current therapeutic interventions for internalized shame, reviewing the evidence for widely used approaches such as Cognitive Behavioural Therapy, mindfulness- and compassion-based therapies, and Acceptance and Commitment Therapy. It is important to note that these therapeutic modalities often fail to incorporate the wider systemic considerations that may be contributing to individual stress. Thus, it is essential for counsellors to practice cultural attunement regardless of the therapeutic modality they are using.

Culturally informed or attuned care is essential because it recognizes that people’s emotional experiences, including shame, are not formed in a vacuum, but are deeply shaped by their cultural, social, and historical contexts. Without this lens, therapy risks misinterpreting or minimizing the impact of systemic oppression, discrimination, and marginalization on a client’s inner world. For instance, what may appear as low self-esteem or social anxiety in a racialized client might actually be a survival strategy shaped by experiences of racism or cultural

invalidation. Culturally attuned care also helps avoid imposing dominant cultural norms about what health, healing, or emotional expression should look like. It invites counsellors to remain curious and humble, recognizing that clients bring their own cultural frameworks, values, and sources of resilience into the therapeutic space.

Interventions Addressing Internalized Shame

Some research has shown that therapy can be effective in reducing internalized shame. The most studied therapeutic approaches to working with shame are Cognitive Behavioural Therapy, self-compassion-based therapies, mindfulness-based therapies, and Acceptance and Commitment Therapy. The following section reviews the existing studies on each of these approaches to treating internalized shame.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a therapeutic approach that focuses on addressing dysfunctional thoughts and behaviours that contribute to emotional distress. According to CBT, much suffering stems from maladaptive cognitions. To alleviate this suffering, CBT employs various techniques to identify and modify these thoughts and the behaviours they influence. By fostering healthier thought patterns, CBT aims to reduce emotional distress and promote more adaptive behaviours.

Studies have indicated that CBT can be an effective intervention for treating internalized shame in various populations and contexts, including men in prison, children with a history of trauma, and individuals experiencing psychosis, PTSD, sex addiction, body shame, and social anxiety disorder. In a randomized control trial of 56 incarcerated men, 40 sessions of group CBT reduced self-report scores of shame, with a small effect size (Brazao et al., 2015). In a study

comparing Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) to treatment as usual (Child-Centred Therapy) in 229 children with a history of sexual abuse, TF-CBT resulted in a greater reduction in self-reported shame than Child-Centred Therapy (Cohen et al., 2004). Murray et al. (2013) also found a significant decrease in shame in a study of 58 children with a history of trauma after 11 weeks of TF-CBT, though this study had no control group and did not use a validated measure of shame. In a pilot study of 29 individuals experiencing psychosis, Morrison et al. (2016) found that CBT-focused psychotherapy (up to 12 sessions) was more effective at reducing self-report scores of shame and internalized stigma than treatment as usual. Although this study included a control group, the treatment-as-usual group exhibited high variability in the services accessed and provided. Additionally, participants in the control group also had access to treatment as usual, which resulted in inadequate control of confounding variables. In a sample of 45 university students experiencing symptoms of PTSD, Ojserkis et al. (2014) compared a single Acceptance and Commitment Therapy exercise (comprehensive distancing) to a CBT exercise (challenging cognitions). They found that both exercises equally reduced self-report scores of shame. In a study of 38 self-identified sex addicts with no control group, Klontz et al. (2005) found that an intensive inpatient 8-day treatment group involving both CBT and experiential techniques resulted in a significant reduction of shame from pre-test to a six month follow up. In a pre-posttest of 52 women participating in a CBT-based group designed to address poor body image, Cassone et al. (2016) found that six sessions of group CBT resulted in reduced self-reports of body shame. Similarly, Rouyan et al. (2023) found that ten sessions of CBT significantly reduced body shame in a group of 12 adolescents, when compared to a waitlist control group. Several studies have examined the impact of CBT on shame in social

anxiety disorder. In a pre-posttest of 67 adults with social anxiety disorder, Hedman et al. (2013) found that both individual (16 weekly sessions) and group (17 group sessions) CBT resulted in reduced shame. In a randomized control trial with 104 participants with social anxiety disorder, Wang et al. (2020) compared an online self-directed eight-week CBT program to an online 8-week guided CBT program as well as a waitlist condition and found that both CBT groups resulted in decreased self-reported shame. In another randomized control trial of 201 individuals with social anxiety disorder, Wen et al. (2024) also found that an online CBT program resulted in a significant decrease in self-reported shame. While most of these studies have a small sample size, and many have methodological issues such as no control group and the use of convenience samples, together they offer compelling evidence that CBT can be effective when treating internalized shame.

Self-Compassion-Based Approaches

Self-compassion-based therapeutic approaches focus on increasing one's ability to be kind to oneself in the face of suffering. Dr. Kristin Neff (2003) conceptualized three components of self-compassion, "(a) self-kindness—being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical, (b) common humanity—perceiving one's experiences as part of the larger human experience rather than seeing them as separating and isolating, and (c) mindfulness—holding painful thoughts and feelings in balanced awareness rather than over-identifying with them." (p. 85). A small body of research has indicated that self-compassion-based interventions may help to reduce shame. In a randomized control trial of 479 women, Albertson et al. (2015) found that individuals who listened to a daily 20-minute self-compassion meditation for three weeks had significantly lower scores of shame

when compared to the waitlist control group. In a study of 40 women with anorexia, Kelly and Waring (2018) found that those who engaged in a self-compassion letter writing activity for 14 days reported significantly reduced scores of shame when compared to a waitlist control, though with a small effect size. In a randomized control trial of 79 individuals seeking treatment for alcohol abuse, Scherer et al. (2011) found that three 90-minute group sessions focused on self-forgiveness resulted in reduced shame scores when compared to a control group (treatment as usual). However, this study had a significant rate of attrition in the control group, possibly confounding results. Au et al. (2017) investigated the effect of a 6-session self-compassion-based individual therapy protocol in ten participants with PTSD and found significant reductions in shame post-treatment.

Compassion-Focused Therapy (CFT) was designed by Paul Gilbert (2009) to address shame by cultivating self-compassion through various experiential exercises. Some studies have suggested that CFT may be effective at reducing shame. In a small pilot study of 6 participants (Gilbert & Proctor, 2006), a 12-week CFT group reduced shame scores, though this study was very small with no control group. In a non-randomized control trial (Cuppage et al., 2018), 58 individuals seeking support at a mental health non-profit who were placed in a 14-week CFT group had reduced shame scores when compared to 29 individuals receiving treatment as usual (a combination of psychiatry support, psychoeducational groups, counselling, and occupational therapy). Judge et al. (2012) and Lucre & Corten (2013) also investigated group CFT among community mental health populations and found reduced shame scores, though neither of these studies had control groups and were very small ($n = 27$ and $n = 8$, respectively). While most of these studies had small sample sizes and no control group, and more research is needed, they

indicate that self-compassion-based therapeutic interventions may be effective at reducing shame.

Mindfulness-Based Approaches

While mindfulness-based approaches have grown in popularity over the past several decades and have widely been demonstrated to be efficacious when working with a myriad of mental health symptoms (Goldberg et al., 2018), less research has been done on their efficacy in reducing shame. In a group of 92 women struggling with infertility, Galhardo et al. (2013) found that women who participated in a ten-week mindfulness group had significantly lower shame scores at post-test when compared to a waitlist control group. In a pre-posttest of nine adults with trauma exposure and symptoms of post-traumatic stress attending an eight-week Mindfulness-Based Stress Reduction group, Goldsmith et al. (2014) found that shame significantly decreased at post-test. In another pre-posttest, Proeve et al. (2018) found that 32 individuals with depression and/or anxiety who participated in an eight-week group of Mindfulness-Based Cognitive Therapy had reduced shame-proneness at post-test, but this study had no control group and a high attrition rate. A randomized control trial of 40 prison inmates found that an eight-session mindfulness group increased shame compared to a treatment-as-usual group (Malouf et al., 2017). The authors hypothesized that the mindfulness intervention caused individuals to reflect more on the nature of their crimes, thereby increasing shame. Overall, more research needs to be conducted to demonstrate the efficacy of mindfulness-based interventions on internalized shame.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is a third-wave therapy that is growing in popularity. ACT encourages noticing and distancing from one's thoughts, as well as a focus on identifying and living from a place of one's personal values (Harris, 2006). Some research suggests that ACT may be effective in treating internalized shame in individuals with substance use issues, social anxiety disorder, schizophrenia, obesity, and parents of children with autism, as well as in reducing internalized stigma among people of colour. In a randomized control trial with 133 individuals in residential treatment for substance use, Luoma et al. (2012) found that those who participated in three group sessions of ACT had more significantly reduced shame scores at post-test, with a small effect size, when compared to treatment as usual (process and life skills groups as well as individual therapy focusing on 12-step adherence). However, the researchers note that the effects may have been due to these participants receiving attention from more skilled clinicians off-unit rather than effects due to the therapeutic modality itself. In another study involving 38 individuals struggling with substance use, those who participated in eight sessions of ACT had reduced scores of internalized shame compared to a waitlist control (Ghaleh & Atashpour, 2020). Interestingly, no significant reduction in self-criticism occurred, suggesting a distinction between these two constructs. In a study of 22 students with social anxiety disorder, Khoramnia et al. (2020) found those who participated in 12 sessions of ACT reported significantly reduced shame when compared to a waitlist control group. In a randomized control trial of 24 individuals with schizophrenia, Chowdhary and Jahan (2014) found significantly decreased scores of internalized stigma after 10-12 sessions of ACT when compared to treatment as usual, which included psychoeducation and supportive therapy. Lillis et al. (2009) conducted a study of 84 individuals participating in a weight-loss program and found that those

who participated in a single-day ACT workshop had significantly greater reductions in shame than waitlist controls. In a randomized control trial with 18 parents of children diagnosed with Autism Spectrum Disorder, Hahs et al. (2019) found that parents who attended two sessions of an ACT group workshop had a significant reduction in internalized shame compared to waitlist controls. In a study on internalized racial oppression, 20 black women participated in a six-week ACT group and had lower scores of internalized shame from pre- to post-test (Banks, 2021). In a randomized control trial of 535 Asian men by Fung et al. (2021), participants who received three group sessions of ACT had significantly reduced levels of internalized stigma compared to groups that received psychoeducation-based interventions. Taken together, these results suggest that ACT may be an effective intervention for treating shame.

Limitations and Future Directions

While some evidence points to the ability of certain therapeutic interventions to reduce internalized shame, further research is needed. Many of the studies reviewed above relied on a pre-posttest design with no control group and did not adequately control for confounding variables. Because most studies that did use a control group used a waitlist control rather than comparing two different therapies, it is unclear whether therapy in general is effective at reducing shame, or whether specific approaches are more effective than others. Further studies should have large, representative samples, have a randomized control group design, and compare different therapies rather than using a waitlist control group. Even in studies that used an effective study design, small sample sizes in limited populations limit the generalizability of results. Additional research is needed on therapeutic interventions that can effectively treat

internalized shame. One promising avenue for addressing internalized shame is Internal Family Systems (IFS), which was developed in the 1980's but is beginning to grow in popularity.

Internal Family Systems as a Model for Treating Internalized Shame

Internal Family Systems (IFS) was chosen as the central focus of this capstone because it offers a distinct and promising approach to working with internalized shame that differs from commonly used modalities such as CBT, ACT, and mindfulness and self-compassion-based approaches. While these modalities offer valuable tools for increasing awareness, managing symptoms, and promoting psychological flexibility, they often fall short in addressing the deeply relational and identity-based nature of internalized shame. IFS, by contrast, views the psyche as inherently multiple and relational, creating a framework in which even the most shamed and exiled parts of the self are welcomed and invited into healing dialogue. Rather than attempting to challenge or neutralize shame-based cognitions, IFS works from the inside out, facilitating a direct relationship between the client's core Self and the parts of them that carry shame. This internal relational process provides a depth of healing that many other modalities may not reach, particularly when shame is rooted in complex trauma or long-standing relational wounding. By making space for each part's experience without judgment, IFS offers a model of therapy that mirrors the very antidote to shame: compassionate, attuned connection.

The premise of Internal Family Systems is that a person's intrapsychic world is inhabited by a myriad of different "parts", which take on various roles (Schwartz & Sweezy, 2019). There are three different types of parts in the IFS framework: exiles, managers, and firefighters. Each hold different roles and purposes within the system. Exiles are parts who hold on to historical traumas or burdens, often from childhood. Most of the time, they are "exiled" and kept out of

view by protectors. Protectors take one of two forms: managers and firefighters. Managers manifest as the internal critic, perfectionist, or taskmaster. Their job is often to create success to avoid further shaming or rejection. Firefighters are internal self-soothers, who often turn to food, drugs, alcohol, or compulsive activities like gambling, shopping, and social media to numb and minimize distress.

Another important principle in IFS is the concept of the Self. The Self is characterized by what Schwartz termed the eight C's: Compassion, Curiosity, Courage, Clarity, Creativity, Connectedness, Confidence, and Calmness. The goal of IFS therapy is to help a client "unblend" from their parts and embody their Self energy, to relieve exiles of their burdens, and to help managers and firefighters let go of their rigid protective roles (Schwartz & Sweezy, 2019).

Efficacy of IFS Therapy

Internal Family Systems is becoming an increasingly popular therapeutic model, with over 6000 therapists trained in the modality (IFS Institute, 2024). Despite this, there have been few empirical studies published demonstrating its efficacy. In a pilot study of 37 undergraduate women, IFS was found to be equally as effective as Cognitive-Behavioural Therapy and Interpersonal Psychotherapy to treat depression (Haddock et al., 2017). In a study of 68 adults with rheumatoid arthritis, Shadick et al. (2013) found that a nine-month IFS group performed better than treatment as usual (psychoeducation) in reducing pain and improving physical function. Case studies have illustrated the impact of using IFS with combat veterans (Lucero et al., 2018), but no quantitative studies have been conducted with this population. A pilot study on survivors of childhood trauma diagnosed with PTSD found that 16 sessions of IFS resulted in a significant decrease in symptoms of PTSD, dissociation, somatization, affect dysregulation,

negative self-perception (shame), and depression, as well as an increase in self-compassion (Hodgdon et al., 2022). However, this study had no control group and a limited sample size (17 participants). The efficacy of IFS for complex PTSD has also been outlined in many case studies (Anderson, 2021; O'Shea Brown, 2020, 2021). While these preliminary studies indicate that IFS may be a promising treatment for various mental health and physical issues, more evidence is needed to demonstrate the efficacy of IFS and compare it to other treatment options.

Mechanisms of Internalized Shame According to IFS

According to IFS theory, when shame becomes internalized, some parts are shamed, while other parts do the shaming (Anderson, 2021, Sweezy, 2023, Schwartz & Sweezy, 2019). Sweezy (2023) explains that when a child is shamed — whether inadvertently or not — parts of them split off to avoid associating the shameful part with the entire self, and the shameful part is exiled. This protects the system because the person can now replace the thought "I am shameful" with "part of me is shameful, but I will push that part deep down and not show it to anyone".

Schwartz and Sweezy (2019) make an important note that even a person who grows up in a supportive, loving environment will experience shame and wounding at some point in their childhood. Therefore, splitting is inevitable, and parts exist in all people. When someone grows up in an abusive or neglectful environment, shaming is more pronounced, and parts often take on more extreme and polarized roles (Anderson, 2021).

IFS uses the term managers to refer to protective parts that use control strategies, such as shaming, to protect the system and keep exiles out of view. Managers internalize the shaming voices we have experienced and become the inner critic. The goal of this shaming is to protect the system by making the person more acceptable to others, and therefore more likely to be loved

and accepted. The shamed parts are exiled, and the system views it as unsafe for them to experience their big emotions. Protector parts (both managers and firefighters) work hard to keep exiled parts out of view and not activated.

The cycle of shame often results in a polarization between managers and other parts of the system. Managers do the shaming, and firefighters often respond to the shaming with anger, projecting the shame onto others, or numbing strategies such as drinking, shopping, or gambling. For example, a child who was shamed for showing emotions may develop an inner critic (manager part) that begins to shame them any time they get close to showing an emotion. This shame can become so unbearable that a firefighter may step in to numb the system by spending evenings drinking and mindlessly watching television. This results in a destructive cycle that, while meant to protect the system, ultimately ends up hurting the system. It is important to note that protectors, even those who shame, always have a client's best interests at heart. As Sweezy (2023) notes, "rather than perpetuating the bad thing that happened, they aim to prevent it from happening again" (p. 57.) In Chapter 3, specific clinical applications for utilizing IFS to reduce internalized shame will be discussed.

Summary

Extant literature has repeatedly shown a link between shame and transdiagnostic mental health issues. Despite this, research on effective interventions to mitigate shame, as well as process-oriented studies to determine what exactly is working has been limited. A limited body of research has explored interventions that can help to alleviate internalized shame, including Cognitive Behavioural Therapy, mindfulness-based interventions, self-compassion-based interventions, and Acceptance and Commitment Therapy. However, these studies have

methodological limitations, and more research is needed to explore effective interventions for internalized shame. Future research must consider the impact of culture on shame, both in terms of manifestations and perceptions of shame across cultures, as well as the potential impacts of marginalization and discrimination on the development of internalized shame. Internal Family Systems, a therapeutic modality that has existed for over 20 years but has recently been increasing in popularity, offers a promising antidote to internalized shame due to its emphasis on accepting all parts of oneself, even the shame-inducing ones. IFS endeavours to understand and extend compassion to all parts and behaviours, which could act as a powerful counterpoint toward factors which contribute to the development and maintenance of internalized shame. Further, IFS's focus on therapist self-work and therapist embodiment of Self-energy can help counteract the potential impact of countertransference and therapist avoidance of shame in the therapy room. More research is needed to examine the efficacy of IFS and its impact on internalized shame. Specifically, larger studies that incorporate a control group, account for allegiance bias, have a large sample size, and include different populations would be effective at illustrating the efficacy of IFS. In the following chapter, specific IFS interventions and opportunities for integrating various modalities to address internalized shame will be discussed.

Chapter 3: Clinical Applications

The following chapter explores clinical applications and treatment considerations for counsellors working with clients experiencing internalized shame. Building upon the literature reviewed in Chapter 2, this chapter outlines practical strategies that can help clients recognize, understand, and ultimately heal their shame-based patterns. Emphasis is placed on the application of Internal Family Systems therapy as a treatment approach, illustrating how its principles can be used to address internalized shame. Additionally, this chapter highlights the importance of the therapeutic relationship in treating internalized shame and explores transtheoretical factors that contribute to successful shame reduction.

A Transtheoretical Approach to Internalized Shame

Many agree that the antidote to internalized shame is cultivating self-compassion. Chapter 2 illustrated that the most-researched therapeutic modalities used to treat internalized shame are CBT, self-compassion-based approaches, mindfulness-based approaches, and ACT. Indeed, across modalities, techniques to enhance self-compassion may be at the core of what helps to alleviate internalized shame. In CBT, challenging automatic negative thoughts with rational counterstatements allows us to combat the inner critic or shamer and bring in more self-compassionate thoughts and beliefs. In ACT, a goal is to allow difficult thoughts to be there without judging, shaming, or trying to force them to go away, as well as to shrink the inner critic by creating some distance from it and recognizing that thoughts are not facts. A core component of mindfulness-based interventions is cultivating self-compassion. In IFS, the focus is on finding compassion for all parts of the system and expressing gratitude for how they have protected, while also helping them to soften back into less rigid roles. Therefore, regardless of the modality

a counsellor is rooted in, focusing on cultivating self-compassion will likely reduce the impact of internalized shame. IFS offers a practical and accessible way to allow clients to cultivate self-compassion.

IFS Techniques for Reducing Internalized Shame

The Six F's of IFS Therapy

In IFS, the main goal is to help a client get to know their parts, eventually building towards more inner harmony and Self-energy. The process of getting to know a client's parts is outlined in six key steps: Find, Focus, Flesh Out, Feel Towards, Befriend, and Assess Fears (Schwartz & Sweezy, 2019). These steps help clients build a deeper awareness of their internal system, fostering self-compassion. The following description of these steps is adapted from *Internal Family Systems Skills Training Manual* by Schwartz and Sweezy (2019).

Find: Identifying a Part. The first step is to find a part within the client's internal system. This often happens naturally during a session. The therapist listens carefully for any recurring thoughts, emotions, bodily sensations, or behaviours that indicate the presence of a part. Parts can show up in different ways: as an inner voice, a physical sensation (such as tension in the chest), an image, a strong emotion, or a habitual pattern of thinking or reacting. For example, in a client struggling with internalized shame, a therapist might notice a manager part that frequently criticizes or shames the client. The therapist can then invite the client to focus on this part and begin the process of understanding its role.

Focus: Turning Attention Toward the Part. Once a part has been identified, the next step is to focus on it. This means guiding the client to bring their attention to this part with curiosity and openness. The therapist may ask, "Can you turn your attention toward this part?

How does it show up for you?" At this stage, the client may begin noticing how the part manifests (perhaps as an image of a client's younger self, a voice, or a physical sensation). For example, the critical manager part might appear as an authoritative voice saying, "You'll never be good enough," or it may be experienced as a heavy feeling in the chest.

Flesh Out: Understanding the Part's Role. Next, the therapist helps the client get to know the part in greater detail. This involves asking questions such as:

- What role does this part play in your internal system?
- What does this part believe it is protecting you from?
- Does this part feel connected to a certain age, memory, or life experience?

For example, a critical part that enforces harsh self-judgment may be attempting to protect the client from the pain of rejection. It might be linked to childhood experiences where the client was criticized by a parent or caregiver. The more the client learns about the part, the easier it becomes to approach it with understanding rather than resistance.

Feel Towards: Exploring the Client's Relationship with the Part. A key moment in IFS therapy is assessing the client's feelings toward the part. This is done by asking, "How do you feel toward this part?" The answer reveals whether the client is accessing their Self-energy, the state of curiosity, compassion, and calm that allows for true healing. If the client responds with compassion ("I feel for it" or "I want to understand it"), this indicates that they are in a place where they can engage with the part productively. However, if they respond with judgment or frustration ("I hate it" or "It just makes me angry"), this suggests that another part is interfering and may need attention before proceeding.

Befriend: Building a Relationship with the Part. The next step is befriending the part. Rather than trying to push the part away or "fix" it, IFS focuses on building a trusting relationship between the client's Self and the part. This allows the part to relax and feel safe. Befriending can take many forms, including:

- Simply sitting with the part and noticing its presence without judgment.
- Engaging in an internal dialogue, either silently or out loud, where the client acknowledges the part and asks what it needs.
- Using self-soothing techniques, such as gently rocking, placing a hand on the heart, or offering a self-hug.

For instance, if a self-critical part is identified, the therapist might guide the client to say internally, "I see you. I know you are trying to help me. Can you tell me what you need?" This helps shift the client from feeling overwhelmed by the part to developing a compassionate understanding of it.

Assess Fears: Understanding the Part's Concerns. The final step is to explore the fears that keep the part in its protective role. Many parts act out of fear of what might happen if they were to step back or change. Asking the part, "What are you afraid would happen if you didn't do this job?" helps uncover these fears. For example, a harsh inner critic may reveal that it constantly shames the client because it fears that, without its criticism, the client would fail and be rejected. In other words, the part is not intentionally trying to harm the client. By understanding and addressing these fears, the therapist can help the client reassure the part that it no longer needs to hold this rigid role.

Understanding and Befriending Protectors

Managers typically manifest as an inner critic, planner, or striver (Schwartz & Sweezy, 2019). They often go unnoticed as problematic because they produce behaviours that are socially valued, such as high achievement, meticulous organization, and people-pleasing. A manager might push a client to excel in their career, maintain control over their emotions, or constantly monitor their interactions to avoid rejection. While these qualities can appear beneficial on the surface, the strategies managers use to enforce them often rely on internalized shaming. A client's inner critic may berate them for not working hard enough, for saying the wrong thing, or for failing to meet unrealistic expectations. One way to identify whether a client is experiencing internalized shame is to listen to their managers. Do they have a voice that relentlessly tells them they are not good enough, no matter how much they accomplish? Is there a part of them that is hypervigilant about the emotions of others, shaming them for every perceived misstep? These managerial voices, though intended to protect, often contribute significantly to a client's distress by reinforcing cycles of self-criticism and perfectionism.

Firefighters, on the other hand, typically manifest as impulsive or numbing behaviours designed to immediately escape distress. A common source of shame for clients is their firefighter behaviours, such as drinking, drug use, compulsive shopping, or binge-eating. However, these behaviours are not the root cause of internalized shame; rather, they are symptoms of it. Firefighters act as last-resort protectors, seeking immediate relief from unbearable emotional pain. When a client feels consumed by shame, firefighters step in to numb, distract, or escape. Unfortunately, these coping strategies are often met with further shame, strengthening the cycle rather than breaking it.

The key to working with any part is to understand its motives. In clients experiencing internalized shame, there is often a complex system of polarized parts in conflict with one another (Sweezy, 2023). Managers, in their attempt to enforce control and prevent failure, inadvertently deepen shame. Firefighters, seeking to extinguish distress, engage in behaviours that the managers then condemn. Cycles of polarization like this can be incredibly painful. Once a client recognizes these protectors and their good intentions, self-compassion naturally begins to arise for these parts and the roles they have had to tirelessly work at. This self-compassion has the power to break the cycle of shame.

Look for Polarizations

Polarizations often look like parts getting angry with each other for how they manage a client's distress. There is the inner critic, and then the part that shouts at the inner critic for being so hurtful. There is a binge-eating firefighter, and then a manager angry with the firefighter for eating too much. How can counsellors help to defuse these polarizations? The answer is simple: Parts simply want to be acknowledged. When we take the time to ask a part what it is hoping for, afraid of, or trying to accomplish with our behaviour, it feels acknowledged. When we show compassion for the part, it feels understood. In working with these parts and fostering internal dialogue, they begin to become more aware that the client has a Self-energy that is capable and begin to accept that they may not have to hold on to such rigid roles (Schwartz & Sweezy, 2019). Through this, the inner system begins to feel more unified and peaceful.

Unburdening Exiles

Beneath both sets of protectors lie the exiles, the parts of the client that hold the original wounds of shame (Schwartz & Sweezy, 2019). Exiles are younger, more vulnerable parts that

carry the emotional pain of past experiences, typically rooted in early attachment injuries, neglect, or traumatic events. These parts may hold intense feelings of worthlessness, fear, or abandonment and are frequently hidden away by the system's protectors to prevent the client from becoming overwhelmed by these painful emotions. However, because exiles remain burdened by their past experiences, their presence continues to shape the client's internal world, often fueling cycles of shame, self-criticism, and emotional distress.

One of the core goals of IFS is to relieve exiled parts of their burdens, a process referred to as unburdening. This is done by helping clients access Self-energy and gently guiding them toward their exiles with curiosity and compassion. A crucial step in this process involves witnessing, simply allowing the client to acknowledge and validate the exile's pain without avoidance or judgment. Following this, the therapist facilitates a reparative experience, often referred to as a "do-over," in which the client provides the care, protection, or reassurance that was missing during the exile's original wounding. This experiential process allows these parts to release the deeply held beliefs or emotions that have shaped the client's sense of self.

Schwartz and Sweezy (2019) emphasize that a counsellor should not attempt to work with or unburden a client's exiles without training in IFS. Given the deeply sensitive nature of this work, attempting to access exiles prematurely, without sufficient trust and Self-energy, can be destabilizing for the client. This is true of most trauma therapies, which typically include a stabilization phase consisting of building up resources for tolerating distress. IFS therapists are careful to ensure that protective parts feel reassured and supported before working directly with exiles (Schwartz and Sweezy, 2019).

One of the most compelling aspects of IFS in addressing internalized shame is how explicitly and consistently it attends to shame throughout every stage of the therapeutic process. From the outset, IFS emphasizes the importance of creating a safe and respectful relationship with parts that carry shame, rather than attempting to override, fix, or reframe them too quickly. This approach inherently resists pathologizing the client and instead fosters curiosity and compassion toward internal experiences that are often buried under layers of protectiveness. By slowing down and befriending protectors, gaining permission, and witnessing the pain of exiles, IFS makes space for shame to be seen, understood, and transformed in a relational and non-coercive way. Unlike some modalities that focus on cognitive restructuring or symptom management, IFS allows for a deeper, more integrated engagement with the internalized beliefs and emotional burdens that fuel chronic shame. This relational and non-hierarchical framework also offers a unique opportunity to challenge systemic and cultural layers of shame, as it validates the larger contexts in which these internal parts were shaped. In this way, IFS not only supports individual healing but also invites broader conversations about the social and systemic origins of shame, offering a hopeful path forward for both clients and clinicians.

Conclusion

This capstone aimed to explore the origins, impact, and treatment of internalized shame, addressing three key research questions: (1) What is internalized shame? (2) How does internalized shame develop? and (3) How can counsellors help to alleviate internalized shame? Through an extensive literature review, it became evident that internalized shame is a deeply embedded, self-conscious emotion that negatively impacts mental, physical, and relational well-being. Rooted in early attachment experiences and reinforced through interpersonal and societal

factors, internalized shame is linked to a broad range of mental health concerns, including depression, anxiety, PTSD, eating disorders, and personality disorders. Despite its significance as a transdiagnostic factor, research on targeted therapeutic interventions remains limited. Existing studies have shown that Cognitive Behavioural Therapy, mindfulness-based interventions, self-compassion-based approaches, and Acceptance and Commitment Therapy may help to reduce internalized shame, but more research is needed to identify effective treatment interventions for internalized shame.

This capstone explored Internal Family Systems (IFS) therapy as a promising but under-researched approach to treating internalized shame. Unlike many traditional therapies, IFS provides a non-pathologizing framework that embraces all internal parts, including those that shame and those that bear shame. By fostering a relationship between the client's Self and their protective and wounded parts, IFS offers a pathway to self-compassion, internal harmony, and the unburdening of shame-based identities. Preliminary evidence suggests that IFS may be effective in reducing shame and increasing self-compassion, though more rigorous empirical research is needed to validate its efficacy.

The findings of this capstone hold important implications for clinical practice. Counsellors must be attuned to the presence of internalized shame in their clients, recognizing its manifestations in protective parts such as inner critics, perfectionism, and avoidant behaviours. The therapeutic relationship itself plays a crucial role in healing shame, providing clients with a corrective relational experience that counters their internalized sense of unworthiness. Integrating IFS principles, such as identifying protectors, resolving internal polarizations, and unburdening exiled parts, may offer a transformative approach to working with internalized

shame. Ultimately, this capstone highlights the need for further research on effective interventions for internalized shame.

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