As a bona fide expert on emotions, Greenberg's exposition of shame and anger is surely destined to be an enduring contribution to the field. This deeply integrative work incorporates sources ranging from Darwin, the Buddha, and Schopenhauer, to Spinoza, attachment researchers, and the most cutting-edge emotion-focused empirical work. The number of subtle distinctions that many readers will likely be unaware of will make this book a great source of learning—guiding the reader through emotion-focused therapy in an explicit, step-by-step fashion, with many clear, concrete, and rich transcripts. It is a true gift to the field to have such a seasoned clinician and scholar delve so deeply into two emotions that are so central to the work of depth-oriented psychotherapy.

—Andre Marquis, PhD, Associate Professor, Counseling & Human Development, Warner School of Education, University of Rochester, Rochester, NY

This is a treasure trove of a book written by one of the foremost experts on the role of emotion in psychotherapy. Readers will gain a richly detailed understanding of how both anger and shame function, as well as of clients' subjective experience of them. The book presents concrete and practical research-based suggestions for practice. These are illustrated by extensive and useful clinical examples. This is a book for practicing therapists, theorists of psychotherapy, researchers, and students.

—Arthur C. Bohart, PhD, Counseling Psychology Department, Santa Clara University, Santa Clara, CA; Professor Emeritus, California State University, Dominguez Hills

Ask therapists about their clients' sadness or anxiety and many of them will tell you, "I got that." The author skillfully describes when and how to help regulate such toxic and pervasive effects of shame and anger. And as in his previous books, Greenberg scores at the theoretical, practical, and empirical levels. This book is another majestic hat trick from a clinical researcher extraordinaire.

—Louis G. Castonguay, PhD, Pennsylvania State University, University Park; Former President of the Society for Psychotherapy Research

In this very well-written volume, Leslie Greenberg, who is a world expert on the study of emotion and a pioneer of emotion-focused psychotherapy, brings his sophisticated theoretical and clinical acumen to bear on two central affective states—shame and anger. He elucidates both the obvious and subtle interactions between these emotions—for example, how one can mask the other—thereby easing the clinician's recognition of and ability to work with these emotions. The fascinating and informative cases bring to life the various ways in which such feelings manifest themselves in therapy, and provide an unusually helpful guide for clinicians to enhance any brand of therapy they practice. Highly recommended!

—Stanley B. Messer, PhD, Distinguished Professor Emeritus and Former Dean of the Graduate School of Applied and Professional Psychology, Rutgers University, New Brunswick, NJ

Contents

1 INTRODUCTION

The Complementary Emotions of Shame and Anger

You should never soak anybody in shame. It's the prolonged existence of shame that then flips out into destructive rage.

–Hannah Gadsby

Whatever is begun in anger ends in shame.

–Benjamin Franklin

Shame and anger both appear to play crucial roles in therapeutic change. How to work with them in psychotherapy often presents challenges to therapists and clients alike. In this book, I discuss each emotion, their relationship with one another, and how to work with each of them to produce change.

The importance of shame in psychological disorder has often gone unrecognized by therapists or has been avoided because it produces such pain for the client. Often, therapists shy away from shame because they do not know how to deal with it. On the other hand, anger, which is possibly the most socially undesirable emotion and is often confounded with aggression, is viewed as

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needing to be controlled. In this book, I discuss how shame and anger need to be approached by both the client and the therapist, and I discuss how intimately they are intertwined. This approach will help therapists work with each emotion separately and together to facilitate therapeutic change.

Finally, it is well known that shame can lead to rage, and a shame–rage cycle has been well documented (Scheff & Retzinger, 1991). It is therefore important when dealing with anger to see it as often protecting against shame. However, shyness and shame often prevent people from being assertive and expressing empowering anger. In this book, I distinguish between different types of shame and anger and discuss how they interact. This understanding will help therapists make process diagnoses of what is occurring at different moments in sessions and thus guide them regarding how to intervene.

WHY DISCUSS SHAME AND ANGER TOGETHER?

Shame and anger are important emotions, each in its own right, and they share a complex relationship in society, in disease, and in therapeutic change. An underlying experience of shame often manifests in overt anger. It is easier for people to feel angry than to feel shame. Like the cry of an infant who is in distress, anger can be a reaction to and distraction from emotional pain—like shame. Anger can be the smoke that distracts attention from the pain. It also can hamper our capacity for connection and intimacy and may even be used to distance. Again, anger can be seen as protection against shame (Kaufman, 1996; Paivio, 1999). On the other hand, people often feel ashamed of or guilty about their anger (Kim et al., 2011; H. B. Lewis, 1971a, 1971b). Because anger is often socially unacceptable, people feel ashamed of being seen as losing control. Shame and anger often then are sequenced, and they interact. When people feel inadequate or defective, they get angry to protect themselves, and they may even later feel ashamed that they got angry. This sequence can develop into a type of shame–rage cycle that can erupt into violence, domestic or otherwise (Retzinger, 1995). But anger that is not expressed or is unacknowledged can lead to lack of assertion, withdrawal, hopelessness, and depression (Bridewell & Chang, 1997; Gross & John, 2003; Gross & Levenson, 1997). Therefore, therapists need to consider what type of shame and what type of anger they are dealing with and how the two emotions interact.

For instance, when people feel primarily ashamed, they often show secondary anger, but they may later feel ashamed of their anger. However, almost paradoxically, primary adaptive anger is generally a resolution to shame. Becoming empowered and expressing assertive anger, and feeling

deserving of respect, often help undo shame. People sit up, feel stronger and more worthy, and this transforms shame into confidence. As a result, anger can be a consequence of shame, a cause of shame, or even a cure for shame (Harper & Arias, 2004; Tangney, Miller, et al., 1996). Shame at times can also help people transform anger into harmony and conciliation, or into healing apology or submission. This last relationship is less frequent and a bit more tenuous, but it is a relationship of interest.

Both shame and anger play a crucial role in society in terms of what is viewed as morally correct and the norms that develop about the experience and expression of these emotions (Plaks et al., 2022). This affects how these emotions appear in dysfunction, in therapeutic work, and in different cultural contexts. Anger is the most eschewed emotion in many cultures, and shame is differentially favored (Matsumoto et al., 2010). Some cultures or countries with more individualistic views, such as countries in North America, have more anger–guilt moralities. Anger is more freely expressed, and children are socialized by anger, which leads to guilt. Other more collectivist cultures, such as in Japan, have shame–disdain norms in which anger is avoided and disdain is used to socialize, leading to shame (Flanagan, 2022). The societal norms around shame and anger therefore play a role in how these two emotions give rise to dysfunction.

AN OVERVIEW OF EMOTION AND EMOTION-FOCUSED THERAPY

An emotion-focused therapeutic approach privileges bodily sensing over language and emotion over cognition. To understand how to work therapeutically with shame and anger, it is important to start with a basic understanding of emotion in general. Emotion is a complex state that results in physical and psychological changes that influence thought and behavior. At its core, emotion carries our most essential needs, which have evolved to help us survive and grow. The nature and function of emotion, as well as emotion schemes, are discussed extensively in Chapter 2.

TYPES OF EMOTION

Emotion assessment, which consists of a moment-by-moment assessment of the client's emotional experience as it unfolds in the here and now, is crucial in working with emotion. In this process, therapists attempt to understand the client's subjective experience as it unfolds. This assessment is done by attending to both nonverbal cues, such as vocal quality, facial expression,

body gestures, and posture and verbal communication about emotional states. It is crucial for therapists to distinguish between primary, secondary, and instrumental emotion and between primary adaptive and primary maladaptive emotion. No single emotion, such as shame, belongs exclusively to one category, and all can move among being primary, secondary, or instrumental and being adaptive or maladaptive depending on the situation and the specific activation. Therapists, therefore, need to assess the type of emotion being expressed and to intervene appropriately based on which type of emotion is being expressed. These distinctions prove very useful in helping the client deal with shame and anger and their sequencing.

ADAPTIVE OR MALADAPTIVE PRIMARY EMOTIONS

Primary emotions are a person's very first gut feelings in response to internal or external situational cues. People come into the world with an evolutionarily derived adaptive emotion system, and they rely on it throughout life to survive and thrive. Primary emotions are irreducible to any prior emotions or cognitions. They are direct, unmediated reactions to events and communicate intentions to others (Izard, 1990).

Primary emotions can be either adaptive or maladaptive. Adaptive emotions promote adaptation and survival. They orient us to the environment and provide good information. Adaptive emotions fit the activating situation and help a person to cope with it (e.g., sadness at loss that reaches out for comfort; fear at threat that prepares the individual to escape). They organize the individual for adaptive action and help the person get their needs met (Frijda, 1986). These emotions need to be attended to and expressed in therapy to access the adaptive information inherent in them and to experience the action tendencies that guide problem solving. Because they are fundamental, irreducible responses, primary emotions are not explored to unpack their cognitive–affective components but rather are validated. For example, anger at violation is a rapid, irreducible, primary emotional response. It is helpful in therapy to facilitate access to its experience, to be disposed by the adaptive action tendency of anger to protect the self and establish appropriate boundaries.

Primary maladaptive emotions differ from primary adaptive emotions in that they are chronic dysfunctional feelings that originally were adaptive responses to bad situations but are currently no longer adaptive. Primary maladaptive emotions are immediate reactions to external events that are unmediated by cognition or emotion, but they do not guide adaptive behavior. A traumatic history can result in a core sense of self as unworthy or vulnerable or in maladaptive emotional reactions such as fear, shame, and rage to harmless situations. Maladaptive emotions are reactions to the past in the present,

often as a result of trauma, neglect, or attachment problems, and they do not help people cope adaptively to the situation or satisfy needs. These emotions are feelings such as shame in response to a boss's voice that is reminiscent of humiliation by one's critical father and disgust at the touch of one's partner due to past sexual abuse. These emotions lead to reactions that are extreme or inappropriate to the situation, and they need to be activated to make them accessible to new experience. It is important to note that accessing these bad feelings in therapy is not making people feel bad. They already feel bad. What they feel is already there inside them. Speaking these feelings doesn't create the feelings or make them feel worse. Furthermore, not speaking them doesn't make them not exist or go away. The difficult feelings are already there, and people can stand to feel what is there because they are already feeling it.

SECONDARY EMOTIONS

Secondary emotions can be reactions to primary emotions or to cognitive processes. Secondary emotions in reaction to primary emotions often protect against primary emotions that are experienced as intolerable. Some classic examples are feeling angry to protect against the vulnerability of shame and feeling scared of one's assertive anger or of one's sadness. Symptoms often involve secondary emotions, such as the hopelessness of depression, which may cover primary maladaptive shame of feeling inadequate, or anger that covers the hurt of rejection. These are secondary responses to primary emotional reactions, and they often obscure or interrupt the primary emotional reactions. They are also often self-protective, and they generally hide primary emotions. For example, a husband who feels shame at not being an adequate provider may blow up at his wife, children, or dog rather than feel his shame. Emotions about emotions, what we can call meta-emotions, such as feeling shame about one's sadness, are also secondary emotions. Emotions can also be secondary to more cognitive processes (e.g., anger in response to conscious thoughts of unfairness but what led to the thoughts could come from more enduring automatic primary processes of feeling inferior). Most symptomatic feelings, such as panic, helplessness, or hopelessness, are generally secondary emotions.

INSTRUMENTAL EMOTIONS

Instrumental emotions are expressed to obtain a desired reaction from others. They are either used consciously or expressed automatically to influence others or to make others behave or feel a certain way. Examples include expressing sadness to evoke caring without having to ask for it and expressing anger to

intimidate others. These emotions are used strategically and serve a manipulative function. They are essentially an indirect way of getting what one wants, without having to experience the vulnerability of making direct requests or showing primary feelings. They often backfire, in the long run, and do not result in good relationships.

A QUICK OVERVIEW OF SHAME

Shame is a powerful master emotion. It is one of the most painful and least understood human emotions and probably the most avoided (Dearing & Tangney, 2011). Shame is the feeling that one is not good enough and is about the self's inadequacy and lack of worth. It arises from the sense of being unacceptable or immodest in the eyes of others. When shame is chronic, it can involve the feeling that one is defective and fundamentally flawed. Shame essentially makes people want to hide, close down, and avoid thinking too much because thinking makes them feel bad about themselves. It is typically characterized by an action tendency of withdrawal but may motivate defensive anger.

The evolutionary adaptive function of shame was to promote belonging to one's group by not violating social norms or by showing submission if one did (Izard, 1971, 1977). Shame promoted appeasement rituals such as eye aversion and making one's body smaller, prevented social devaluation and ostracism, as did a sense of anticipated shame and what would produce it All these tendencies promoted survival. Shame could therefore be adaptive or maladaptive, either keeping one belonging to the group or leading to unhealthy withdrawal.

Shame in psychotherapy, however, presents itself as problematic and in need of change. Shame operates everywhere in therapy as clients are constantly concerned about what aspects of their experience to reveal and what aspects to hide. When therapists work with shame, it is like shining a light in the hidden corners of a person's most private experience, which, because it has remained in the dark for so long, has left them feeling very alone.

A QUICK OVERVIEW OF ANGER

Anger, which is often viewed as a socially undesirable emotion, is an innate response to frustration and can be an adaptive feeling when it provides information of danger and an action tendency to protect people from harm

(Izard, 1971, 1977). Anger is an adaptive response to violation, boundary intrusion, or the thwarting of one's goals and can play a positive role in psychotherapy. It is characterized by antagonism toward someone or something whom one feels has deliberately treated one unfairly. Acknowledging previously unacknowledged anger in therapy can be highly therapeutic because it informs the person of unfairness, promotes the expression of negative feelings so they can be dealt with interpersonally, and motivates the person to overcome obstacles or to find solutions to problems. It promotes behaviors designed to remove the object of the anger or to protect boundaries against intrusion (Berkowitz, 1990).

Excessive or misplaced anger, however, can cause problems. Anger can range in intensity from a slight annoyance to destructive rage. It is important to note that while anger is a feeling, not a behavior, it can lead to acting-out behavior through aggressive actions or to blowing up because it was suppressed. As opposed to aggression, however, anger can be dysfunctional and can lead to rejection and rage; it can be destructive when it is acted out (Retzinger, 1995). Anger is not aggressive behavior intended to harm, but it becomes a problem when it is excessive and/or affects everyday functioning and relationships. Anger can be beneficial when, for example, assertive or loving anger sets boundaries. It is destructive when it is payback anger for revenge or is pain-inducing anger when, for example, one kicks the cat.

Much has been written about anger control, but anger suppression also needs to be recognized and discussed as a major therapeutic problem (Gilbert & Gilbert, 2003). Clients can present with problems of either too much or too little anger. A lot of attention in behavior modification approaches has been directed at teaching skills to manage excessive anger. This book attempts to balance this excess by focusing on the underrepresented problems of interrupted anger. Anger that is not expressed is as much a problem as excessive anger, and it needs therapeutic attention (Pascual-Leone et al., 2013). Many disorders, such as depression and anxiety, involve suppressed anger. Although secondary anger can be a symptom of depression, many depressions have primary underlying unexpressed anger (Greenberg & Watson, 2006). Suppressed rage is often at the base of somatization. Anger inhibition, submissive behavior, and poor assertiveness are linked with depression (Akhavan, 2001; Harmon-Jones et al., 2002), and many depressed clients show signs of strong feelings of anger (Brody et al., 1999; Fava et al., 1990). When anger is inhibited and its expression is blocked, it increases stress and contributes to depression (Gilbert, 2006; Gilbert & Gilbert, 2003).

SHAME-ANGER RELATIONSHIPS

Shame and anger, although quite different emotions with anger being an approach emotion and shame a withdrawal emotion, can be highly related in therapy. As outlined earlier in this chapter, there is a definite two-way street between anger and shame that deserves therapeutic attention because each can be the cause or the cure of the other. Therefore, the causal direction can go in both directions. There are four main ways in which shame and anger can interact:

1. One can be assertively angry at having been invalidated or at not having a deserved need met. Primary maladaptive shame is transformed by empowered anger.
2. One can kick the cat or yell at one's partner when one feels inadequate or like a failure. Primary maladaptive shame leads to secondary reactive anger or destructive rage.
3. One can feel embarrassed about being angry. Secondary shame hinders or prevents primary, adaptive, assertive anger.
4. One can be maladaptively angry from a history of trauma and maltreatment initially as protection against harm but now overgeneralized. This hair-trigger anger is a response to a primary perceived threat, such as shame, loss, or danger, that no longer exists. When the threat is accessed, attended to, and symbolized, the focus shifts away from the anger to understanding its origins.

Thus, primary maladaptive shame can lead to secondary anger and rage while primary anger can transform primary maladaptive shame. Alternatively, primary anger can be blocked by secondary shame while understanding the origins of maladaptive anger, which is somewhat primary (see Chapter 8) and can access even more primary shame and threat.

CASE DESCRIPTIONS

The cases in this section exemplify the concepts discussed in this chapter.[1]

Dell is a 39-year-old African American man who expresses a lot of secondary anger to protect against his underlying core shame. This case indicates

[1]The clinical material used in this book has been adequately disguised to protect client confidentiality. Client identity has been maintained.

one of the key ways in which shame and anger intersect and how important accurate process diagnosis guides therapists on how to intervene (Goldman & Greenberg, 2015). Not seeing that anger is a protection against shame might lead to anger management interventions, which would provide Dell with only a palliative treatment and would leave unresolved his underlying shame, the determinant of the anger. Dell has been recently released from prison and is on parole. He is struggling to find employment and expresses a lot of anger at societal unfairness. As a result, he approaches potential employers with a chip on his shoulder, which protects him from his shame. His wife refuses to support him, as he has previously let her down so often. He blows up at the frustration of not being able to come home or to see his son. He grew up with an alcoholic abusive father who both modeled shame, as he was a failure and was in and out of prison, and humiliated his son by putting Dell down at every chance he got.

Therapy involved first validating Dell's secondary anger and slowly approaching the shame of feeling so looked down on as an ex-convict. Eventually, with the help of his therapist, he was able to access his core feelings of shame and his unmet needs for validation and security as a child. Feeling that he deserved to have had a childhood free of fear and shame led him to access assertive anger at his father for all the unfairness. This anger empowered him and undid his shame. After accessing his primary adaptive anger, as often happens, he grieved the loss of safety and nurturance as a child. This example illustrates accessing anger to transform shame.

In another example, Susan, a 32-year-old heterosexual White woman, experienced lots of social anxiety and felt ashamed of her lack of wit and conversational skills in groups. She came from a family who wittily put each other down and made jokes at her expense because she was the baby. As the youngest, she was not equipped to retort and instead withdrew even as she yearned for recognition and approval. In therapy, accessing her need for recognition and anger at the unfairness helped her develop a voice and stand up for herself. As she became more confident, she was more able to speak up in social settings. This example shows how accessing suppressed anger helps overcome shame-based anxiety.

An example of how shame can suppress anger features Jamael, a 22-year-old African American man who grew up learning that expressing anger as a Black man was both dangerous and socially disapproved of, making him "just another angry Black man." Consequently, he made sure never to assert or challenge others at work. He had been so forced to internalize systemic racist attitudes that he never expressed anger, and if his anger ever broke through, he felt shame and immediately closed down. This example shows

how shame can suppress anger and how anger expression is influenced by societal factors.

In a final example, Paul, a 45-year-old White man, defended himself angrily for having had an affair, which he said was because of his wife's lack of interest in sex. When he grew to express his underlying shame at having betrayed their sacred vows of fidelity, he changed from being angry to disclosing how he felt that, in his own eyes, he had failed to find a better way of dealing with his feelings. He said he felt that he had not lived up to his moral standards. This expression of healthy self-directed shame led his wife to feel more trusting that he wouldn't betray her again. Seeing him suffer his own shame helped her feel a sense of justice for the pain she had suffered (Greenberg & Woldarsky, 2019; Woldarsky Meneses & Greenberg, 2014). This case exemplifies the acceptance of adaptive shame as it gets beneath defensive anger and helps resolve conflict.

MAP OF THE CHAPTERS

The chapters that follow expand on the content introduced here. Chapter 2 discusses the role of emotion in general and illustrates the basic approach for working with emotion to change emotion. Emotion is contrasted with cognition to understand the primacy of emotion in human function. Furthermore, the role of emotion schemes in producing bodily felt experience is described and contrasted with cognitive schemas that produce beliefs.

Chapters 3 through 7 are dedicated to the topic of shame. They include discussions of different aspects of working with shame and numerous transcript examples. Chapter 3 focuses on the nature and function of shame, highlighting the differences between primary and secondary and adaptive and maladaptive shame. Interventions for working with these varying types of shame are discussed. This chapter also covers different types of in-session shame presentations, such as core shame, self critical shame, and societal shame, all of which require various forms of intervention.

Chapters 4 through 7 cover the three specific ways to treat shame. Chapter 4 includes discussion of relational validation and accessing shame. Three important subprocesses in working with shame are considered: the provision of a safe relationship, the provision of a corrective interpersonal emotional experience, and helping clients to acknowledge and experience shame in the session. Chapter 5 on regulation of shame follows from accessing and facing shame and illustrates how to manage shame when it is overwhelming in order to be better able to cope with it. Interventions that teach explicit

emotion regulation skills are presented along with processes that promote the development of automatic, implicit, right-hemispheric affect regulation.

In Chapters 6 and 7, the focus is on how to facilitate the transformation of shame. Chapter 6 describes the novel principle of transformation by synthesis. This chapter presents methods to facilitate access to disclaimed adaptive anger at invalidation and illustrates how to help synthesize this experience with shame. One cannot withdraw in shame while asserting in anger. This chapter demonstrates how these emotions synthesize into a confident standing of one's ground. Chapter 7, the final chapter on shame, presents all these processes in transcripts from examples of cases with both good and poor outcomes. The transcripts[2] provide a view of what actually happens, rather than a reflective account of the process. Therapist actions and intentions are described within the transcript. Analyzing the therapist interventions in this way provides an opportunity to see what the therapist does, moment by moment. This analysis demonstrates that the therapist is a moment-by-moment emotional processing facilitator and every therapist response has an influence on the client's manner of emotional processing in the next moment. Looking at transcripts in this fashion is a way of staying close to the action and is an excellent training tool, as it reveals what therapists actually do that is helpful, not what they, or their theory, says they do.

The focus in the latter half of the book shifts to working with anger and highlighting its relationship to shame. Chapter 8 focuses on the nature and function of anger and its different manifestations, as well as gender-based and cultural and racial aspects of how anger is viewed and managed. Chapters 9 through 11 look at how to work with anger in therapy. These chapters deal with three ways of treating anger, activating interrupted anger, steps in facilitating the resolution of anger, and, finally, working with overcoming nonadaptive anger. Throughout these chapters, the importance of accessing previously unexpressed adaptive anger as an important therapeutic process of change, rather than anger management to down-regulate anger, is highlighted. Noting that anger management is so prevalent, these chapters offer an expansion of this view by discussing the therapeutic importance of accessing interrupted anger to help clients become more empowered.

Specifically, Chapter 9 illustrates ways to help clients overcome blocks to anger, express their interrupted anger, and become more empowered. Clients need to be helped to be able to access and accept their underlying adaptive anger. They have to overcome their myriad ways of blocking their anger. So, the major work is helping clients overcome the fear of anger and

[2]All clinical material and transcripts used in this book have been adequately disguised to protect client confidentiality. Client identity has been maintained.

the guilt of expressing it by dealing with the many processes they engage in to deflect and not feel the anger. Chapter 10 presents the process of helping clients resolve interrupted anger, based on a task-analytic study of this process in clients. This chapter also proposes a set of treatment steps to help clients access and resolve their interrupted anger. Chapter 11 focuses on working with nonadaptive anger. This chapter discusses work with secondary protective anger and with primary maladaptive anger. Chapter 11 also looks at how to regulate and to explore these nonadaptive forms of anger. Chapter 12 provides a session-length case example. And finally, the book ends with a short conclusion integrating how to work with shame and anger.

CONCLUSION

In summary, this book discusses the role of shame and anger in psychotherapy and shows therapists how to work with each of these two important emotions separately and together, when appropriate. Understanding the different kinds of shame and anger may help therapists facilitate therapeutic change. The reader may see, for example, how often anger protects against shame and essentially hides it. Conversely, this book also shows how shame can prevent people from asserting their adaptive anger. Seeing these differences may help therapists make process diagnoses of what is occurring at different moments in sessions, and this process diagnosis may guide them on how and when to intervene. The earlier chapters in the book focus on the nature of shame and how to work with this emotion, while the latter chapters focus on anger and how to work with this quite different emotion. Helpful discussions of how and when to work with both together to promote change are dispersed throughout the chapters.