DOI: 10.1002/j.2161-007X.2013.00027.x

Shame in Sexual Minorities: Stigma, Internal Cognitions, and Counseling Considerations

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Theorists, clinicians, and researchers have suggested that shame is a central concern in the lives of sexual minority individuals. Cognitive theorists believe that shame occurs when a person fails to achieve his or her standards, which are often based on social, cultural, and spiritual values. Although it is asserted that stigma causes shame among members of a sexual minority, the empirical evidence suggests that negative internal cognitions are partly responsible. By targeting negative beliefs, counselors can help sexual minorities reduce their sense of shame, particularly around issues related to sexual identity. The authors offer counseling strategies for reducing shame in sexual minority clients.

Keywords: shame, sexual minority, stigma, counseling

Shame is an intensely painful affect resulting from an exposure of the self as flawed or inferior, and a concurrent deep belief that this deficiency will result in rejection, abandonment, or loss of esteem (Adams & Robinson, 2001; Brown, 2004; Kaufman, 1996; Tangney & Dearing, 2002). Put simply, shame is the emotion resulting from self-condemnation along with a fear of condemnation from others. The experience of shame can be so painful that people will respond in destructive ways in order to escape or avoid it. The most common of these responses are withdrawal/avoidance, anger, and blame (Kaufman, 1996; H. B. Lewis, 1971; Lutwak, Panish, & Ferrari, 2003; Tangney & Dearing, 2002; Tangney & Fisher, 1995; Tangney, Wagner, Fletcher, & Gramzow, 1992). These reactive behaviors are an attempt to escape or control shame through hiding, protecting, or deflecting attention away from the flawed self; however, they have the unfortunate effect of perpetuating shame.

Research has correlated shame with a host of difficulties. Because self-condemnation is a part of shame, it is not surprising that several researchers have found that shame is associated with decreased self-efficacy (Baldwin, Baldwin, & Ewald, 2006; Covert, Tangney, Maddux, & Heleno, 2003), depression (Andrews, 1995; Feiring, Taska, & Lewis, 2002; Hoblitzelle, 1989; Tangney & Dearing, 2002), and poor psychologi-

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cal health (Tangney & Dearing, 2002; Woien, Ernst, Patock-Peckham, & Nagoshi, 2003). Because the fear of condemnation from others is also a part of shame, relational difficulties have been reported. These difficulties include interpersonal anxiety (Lopez et al., 1997; Lutwak & Ferrari, 1997), fear of intimacy (Lutwak et al., 2003), social avoidance/distress and fear of negative social evaluation (Lutwak & Ferrari, 1997), insecure attachment styles (Gross & Hansen, 2000; Lopez et al., 1997), and interpersonal isolation (Hill, Thompson, Cogar, & Denman, 1993; Macdonald & Morley, 2001). Given its pervasive and negative impact, it seems important for clinicians to address shame effectively, especially in populations that are vulnerable to experience it.

Shame in Sexual Minorities

Theorists and clinicians alike have consistently asserted that shame is a critical concern among sexual minorities (Hallman, 2008; Kaufman & Raphael, 1996; Tigert, 2001). The term *sexual minority*, used interchangeably in this article with those who are *same-sex attracted*, refers to "all individuals with same-sex attractions or behavior, regardless of self-identification" (Diamond, 2007, p. 142). Because culture is largely heterosexual, same-sex attracted individuals often experience feelings of difference, marginality, and alienation as described by sexual identity development models (Cass, 1979; Coleman, 1982; McCarn & Fassinger, 1996; McDonald, 1982). For example, in Cass's (1979) seminal model of sexual identity development, individuals go through a stage called Identity Confusion wherein they experience "feelings of personal alienation" (p. 223). Cass explained that the alienation is due to incongruence between an individual's original self-concept, as it relates to his or her sexual orientation, and new understandings of his or her behavior. In McCarn and Fassinger's (1996) model, the Awareness phase consists of a "general feeling of being different" (p. 522). Perceiving oneself to be different in the realm of one's sexuality and in a way that affects one's identity increases vulnerabilities to shame and shame proneness. Fromer (2003) wrote, "If there is anything universal in the experience of gay men and women, it is the centrality of shame as an aspect of their lived experience" (p. 66). Writing specifically about lesbian women, Haendiges (2001) stated, "It is accepted that shame is pervasive and deeply ingrained in the identity of a lesbian" (p. 9). Additionally, empirical studies have begun to document high levels of shame in those who experience same-sex attractions, as compared with a male heterosexual sample (Martins, Tiggemann, & Kirkbride, 2007) and as compared with a clinically significant cutoff score (Wells, 2003; Wells & Hansen, 2003). Finally, same-sex attracted individuals who also hold a religious identity commonly admit to conflict between their religion and their attractions and, consequently, feel shame and guilt (Brzezinski, 2000; Schuck & Liddle, 2001). From a number of perspectives, it seems

that sexual minorities are vulnerable to experiencing shame. How might that shame be addressed proficiently?

A Cognitive Framework for Understanding Shame

Treating shame requires a framework for understanding shame. Cognitive psychology holds that "how one thinks largely determines how one feels and behaves" (Beck & Weishaar, 1995, p. 229). In this case, the shame affect and its defensive responses result from thoughts of self-condemnation and beliefs regarding condemnation from others. A cognitive understanding of shame seems advantageous for counseling settings, because it is concise, is supported by research (Belsky & Domitrovich, 1997; Kelley, Brownell, & Campbell, 2000; M. Lewis, 1992), and takes into consideration both personality and culture (e.g., ethnicity, spirituality, familial values). According to M. Lewis's (2004) cognitive model, some emotions are basic to human biology, such as sadness, but self-conscious emotions like shame, guilt, and pride require more complex cognitive processes. Self-conscious emotions are based on how a person measures up to the standards, rules, and goals (SRGs) that have been informed by his or her culture, including values and belief systems (M. Lewis, 2004). SRGs are defined as the actions, thoughts, and feelings that are considered acceptable. How people attribute their success or failure to live up to an SRG determines which self-conscious emotion is experienced.

Shame is experienced when an individual fails to achieve his or her SRG, and then explains the failure with a negative global self-attribution (see Figure 1). The self condemns the whole self for the failure. The strength and pervasiveness of this condemnation leads a person to believe that others would also condemn him or her if the failure was made known. For example, a young man may believe that to be respected as a man, he must be a certain height (SRG). If he fails to reach that height in his growth (perceived failure) and believes that he is deficient as a man (negative global attribution) because of that failure, he will experience shame.

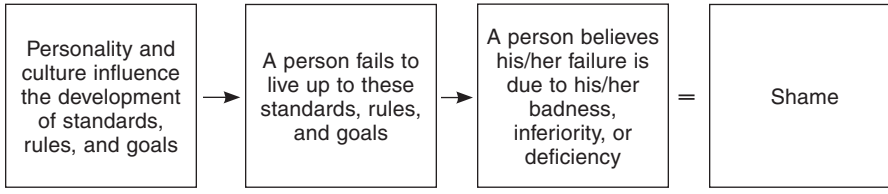

FIGURE 1

Formula for Shame

Note. Based on M. Lewis's (2004) cognitive theory.

In addition, his shame includes a certainty that others look at him with disdain because of his "flaw." A key aspect of M. Lewis's (2004) model is the understanding that shame is brought about by a person's perception, which may or may not accurately reflect reality. Instead, perception derives from an interaction of values, beliefs, and experiences. For example, an adolescent from a conservatively religious family may perceive same-sex attraction with a negative valence, whereas other adolescents may not. In addition, the self-condemnation can occur publicly or privately. The aforementioned adolescent could experience shame for merely experiencing a sexual or emotional attraction to a same-sex peer, even if his or her attraction was unknown to anyone else.

This cognitive understanding attempts to identify what elicits shame and does not preclude the existence of affective, behavioral, and relational sequelae in the experience of shame. In fact, according to M. Lewis (2004), shame is "a highly negative and painful state that also results in the disruption of behavior, confusion in thought, and an inability to speak" (p. 629). M. Lewis explained that the emotional and behavioral fallout of shame results from the focus being wholly on the self (i.e., a negative global attribution), as opposed to behavior. For example, when a person is consumed by self-condemnation and is certain that others would think similarly, it is reasonable that he or she might withdraw from relationships to avoid others' condemnation. Thus, the self-condemnation resulting from failure to reach an SRG then leads to painful emotions and ineffective behavior that can be destructive to relationships.

Stigma and Shame

It is widely asserted that stigma is a source of shame among sexual minority individuals (Kaufman, 1996; Neisen, 1993; Tangney & Dearing, 2002; Wells & Hansen, 2003). Stigma, unquestionably part of the sexual minority experience, is devaluation resulting from a difference (Herek, 2000b; Kaufman, 1996; Kaufman & Raphael, 1996; Meyer, 2003; Tangney & Dearing, 2002). In contrast, shame occurs when one condemns oneself. When shame is elicited by a perceived difference, it is because the person has interpreted the difference as a deficiency (Kaufman, 1996). In effect, stigma says, "Something is different about me that makes me not as good as others." Shame says, "I am different because I am inherently bad, and I must hide this difference from others." Theoretically, living in a stigmatizing environment can give rise to shame within oneself.

In spite of the presumed relationship between stigma and shame, there is a dearth of empirical evidence that directly links stigma and shame. The evidence that does exist suggests that negative internal cognitions may be one link in the chain between stigma and shame. If this is the case, there is reasonable hope that cognitive interventions can alleviate shame in sexual minority clients. We suggest that shame results when

stigmatization interacts with internalized negative cognitions. These internalized negative cognitions can arise from the interaction of a variety of factors, such as experiences, sociocultural influence, religious or personal values, personality factors, or mental health struggles. Stigma can also arise from a wide variety of sources.

A continuum of stigma. In an analysis of stigma sources (i.e., things that bring attention to a devalued difference), Meyer (2003) conceptualized stigma on a distal–proximal continuum. Distal sources of stigma are objective events and conditions that happen to an individual, whereas proximal sources are subjective attitudes and postures that come from within the individual. This conceptualization is useful, because it recognizes the role of negative internal cognitions and perceptions in stigma's impact on individuals. In the case of sexual minorities, distal stigma includes (a) societal oppression (e.g., heterosexism) and (b) individualized negative attitudes and beliefs (e.g., homophobia or sexual prejudice; Herek, 2000a). Proximal stigma is conceptualized by (a) internalized homophobia, which is characterized by negative beliefs about one's minority status taken on as one's own beliefs (Allen & Oleson, 1999), and (b) concealment, which is the internal decision to hide from others those aspects of oneself that make one different. In addition, Meyer suggested that stigma consciousness, the expectation of being treated according to a stigma (Pinel, 1999), would fall between the distal and proximal ends of the continuum. Differentiating and identifying how these types of stigma relate to shame in a sexual minority population can help counselors target the events and attitudes that are most amenable to change.

Distal stigma. It is interesting that a direct empirical link has not been established between distal stigmatic events and shame among sexual minorities. Clearly, a lack of empirical studies on the topic does not mean that distal stigma is not related to shame. For example, seeing one's partner fired from a job because of his or her sexual orientation may very well lead to the experience of shame (a sense that one's whole self is wrong and a fear that others will reject him or her if one's sexual orientation was known). However, psychological science cannot yet make this claim due to a lack of evidence.

A lack of empirical evidence linking distal stigma and shame can be due to any number of reasons. For example, studies focusing on distal stigma's impact on members of a sexual minority group have focused on psychological symptoms and/or disorders, such as substance abuse, rather than shame (Meyer, 1995). Focusing research on diagnosable disorders is understandable because disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000) are distinctly categorized and easily communicated among those in the profession. Shame is neither a diagnosable disorder nor a required symptom within a diagnosis, as is guilt within mood disorders, for example. It is, thus, more difficult to justify and fund research in this area.

In addition, a lack of research linking distal stigma and shame may be due in part to a difficulty defining distal stigma, which in turn may be a result of a change in terminology. *Homophobia*, *homonegativity*, *heterosexism*, and *sexual prejudice* are terms that have all been used interchangeably to refer to this phenomenon (Herek, 2000a). O'Donohue and Casselles (1993) noted the psychometric difficulties in the development of homophobia as a construct and called for a consensus on a definition. In addition, these authors suggested that such a definition should acknowledge the multidimensionality of the construct without unfairly deprecating moral beliefs, a concern shared by Rosik (2007a, 2007b). As a culture attempts to accept and value members of a sexual minority, views that do not condone same-sex sexual behavior are frequently evaluated negatively (O'Donohue & Casselles, 1993; Rosik, 2007a). These writers have debated whether constructs of distal stigma, such as sexual prejudice, are actually measuring distal stigma or shifting cultural values. It is possible that a lack of definitional consensus has limited research linking distal stigma and shame in sexual minorities.

Regardless of the reasons for the absence of studies in this area, there is reason to investigate whether proximal sources of stigma are related to shame. In studies that identify higher prevalence rates of mental disorders among individuals in the lesbian, gay, and bisexual community as compared with the general population (Cochran, 2001; Cochran & Mays, 2006; Gilman et al., 2001; Meyer, 1995, 2003), researchers often cite distal stigma (e.g., sexual prejudice) as the primary explanation of the discrepancy. However, Meyer (2003) suggested that both distal *and* proximal stigma mediate psychological distress among those with same-sex sexuality. That is, both external and internal negativity toward one's sexuality have an impact on one's mental health. If both distal and proximal stigmas are related to psychological distress and mental health, it is possible that they are both related to shame. In addition, Meyer's (2003) explanatory model takes only present factors into consideration; preexisting correlates may also influence distress. For example, women identifying as lesbians are 3 times more likely than their heterosexual counterparts to have been sexually abused as children (Laumann, Gagnon, Michael, & Michaels, 2000). According to a diathesis-stress model, historical factors could heighten vulnerability to problematic beliefs, which would then lead to psychological distress, particularly in the face of distal stigma events. Our theory is that if stigma and shame are related, the relationship is affected by internal cognitions.

Between distal and proximal stigma. Just as distal sources of stigma have not been directly linked to shame, the stigma construct that lands between distal and proximal extremes (i.e., stigma consciousness) has not been linked to shame. However, stigma consciousness shows remarkable likeness to shame. Stigma consciousness is the expectation (proximal stigma source) of being stereotyped (distal stigma source; Meyer, 2003;

Pinel, 1999). It describes the awareness of being different from others in a way that others might denigrate and the subsequent expectation that others will denigrate that difference. Shame is the emotional experience of condemning oneself (although not always because of a difference) and is certain others will condemn him or her as well. The two constructs are distinct in that stigma consciousness arises from the stigmatized difference, whereas shame can occur due to the exposure (private or public) of any aspect of the self. In addition, stigma consciousness focuses on that which makes the person different (e.g., gender, disability), whereas shame engulfs the whole self. However, stigma consciousness and shame have many similarities. Both constructs include an aspect of the person that is deemed unworthy, and both constructs include expectations of others' response to that unworthy aspect. The development of both stigma consciousness and shame is influenced by previous events that have occurred in an individual's life (Kaufman, 1996; R. J. Lewis, Derlega, Clarke, & Kuang, 2006). Both stigma consciousness and shame include negative internalized beliefs about the self. In addition, the related internal cognitions become self-perpetuating; once a person expects to be evaluated poorly, he or she often performs more poorly than he or she might have otherwise performed. Kaufman (1996) theorized that after a person faces sexual prejudice, the experience becomes an internal script that perpetuates shame, which "become[s] the source of all forms of internalized self-hatred connected to minority status" (p. 276). Thus, shame seems as if it could be related to stigma consciousness, but again, no research has tested this hypothesis. On the other hand, there is empirical evidence that shame is correlated with proximal stigma.

Proximal stigma. Although neither sexual prejudice nor stigma consciousness has been empirically linked to shame, internalized homophobia (a proximal stigma source) has been directly linked to shame (Allen & Oleson, 1999; Sherry, 2007). Allen and Oleson's (1999) study was the first that empirically linked a stigma construct to shame in sexual minorities. Unfortunately, the participants were limited to gay men who completed the Internalized Shame Scale (Cook, 1994) to measure shame, and there is some concern that this measure does not distinguish between shame and guilt (Tangney & Dearing, 2002). In addition, other measures were used that were not specified and cannot be examined. However limited the methodology, Allen and Oleson concluded that internalized homophobia and internalized shame are highly correlated in gay men. They also suggested a causal link between the two constructs, which was unfounded because of the correlational nature of their study.

Sherry (2007) overcame some of the limitations of the Allen and Oleson (1999) study by including a larger sample size of both gay men and lesbian women. Sherry used a psychometrically robust measure of trait shame, the Harder Personal Feelings Questionnaire–2 (Harder & Zalma, 1990), and reported a significant correlation between internalized homophobia and

trait shame in both gay men and lesbians. Although further research is warranted to determine the exact nature of the relationship between internalized homophobia and shame, it seems to be a real relationship. When a same-sex attracted individual has internalized negative attitudes and beliefs about his or her sexuality, that person is more prone to experience shame.

Concealment is another construct of proximal stigma in which a person decides to hide that which gives rise to stigma (Meyer, 2003). For example, a person who experiences same-sex attractions may decide to hide his or her attractions or sexuality because of the cultural stigma of such experiences. Of course, the decision to conceal one's same-sex sexuality is multifaceted with many complexities involved. Remaining "closeted" can be effective in maintaining relationships and/or social status that might be threatened otherwise. Therefore, nondisclosure can be motivated by the desire to avoid shame (Macdonald & Morley, 2001). However, concealment as a proximal stigma can also have negative outcomes. Frable (1993) showed that a concealable stigma led to stronger feelings of uniqueness. According to social psychology research, people attempt to live as somewhat unique, but not too different from others (Frable, 1993). Frable reported that individuals with concealable stigmas were more self-schematic to words connoting uniqueness than to words connoting similarity. That is, those with concealable stigmas had a self-perception of being unique more than both those who had visible stigmas (e.g., physical handicap) and those who were not part of a stigmatized group. Importantly, this sense of difference was especially the case when the person felt unable to change his or her stigmatized identity. Thus, being part of a sexual minority can lead to a perpetual state of feeling different. Although feeling different and unique could have positive connotations (e.g., being special), Frable, Platt, and Hoey (1998) concluded that the feelings of difference in this case led to negative self-perceptions, depression, and anxiety. Taken together, these two studies (Frable, 1993; Frable et al., 1998) suggest that concealing a stigma like same-sex sexuality can lead to feelings of uniqueness (I am different), negative self-perceptions (I am deficient), social isolation (I am alone), and depression and anxiety (I am powerless). Although neither study examined the relationship between concealment and shame, the combination of such factors associated with concealment points to the core characteristics of shame (Brown, 2004; Kaufman, 1996).

It seems logical, therefore, that stigma can cause shame for sexual minority individuals, but research cannot yet clearly make this claim. Shame has not been linked to stigma that happens *to* a same-sex attracted individual, such as in sexual prejudice or heterosexism. Though not correlated to shame per se, the interaction of distal and proximal stigma, as in stigma consciousness, appears to be similar to shame. What is more clear is that internalized homophobia has been correlated, though not causally linked, to shame. The more negative an individual's views are

of his or her sexual orientation, the more likely he or she is to experience shame. Of interest for counseling sexual minority clients who are mired in shame, the links that have been made empirically refer to the changeable nature of proximal stigma and thus shame. Although reducing prejudice in a society is a worthy and necessary goal, reducing the prejudice within oneself is more readily and feasibly reached. By targeting negative beliefs that have been internalized, counselors can help sexual minority clients reduce shame that is related to the stigma they experience.

Treating Shame in Sexual Minorities: Counseling Strategies

Perhaps due to its complexity or perhaps because it is not a specific diagnostic category, there have been very few outcome studies on the treatment of shame (Pattison, 2000; Rizvi, 2004). This lack of knowledge makes it difficult to design interventions that are known to be effective in reducing shame in any population, much less the population of interest discussed in this article. The goal of this section is to suggest counseling strategies to reduce shame in ways that are believed to be realistic and effective, according to empirical, theoretical, and clinical literature.

Treatment of shame is presented in four tiers: shame identification, affect regulation, cognitive restructuring, and therapeutic relationship. Cognitive restructuring is the heart of these strategies; after all, shame results from self-condemnation and the certainty of condemnation from others. In addition, cognitive identification of shame sets the stage for being able to reduce its presence. However, recall that shame is so painful that the experience prompts defensive, often destructive, behaviors. If not checked, these defensive behaviors keep an individual, and those in relationship with the person, far from the cognitions that prompt shame. The defensive behaviors must be addressed prior to restructuring cognitions, but the behaviors are present because they are the shame-inflicted person's means of surviving the shame. By adjusting defensive behaviors and changing negative cognitions, counselors can regulate shame's painful affect. Finally, to address the client's deep beliefs that others will condemn him or her, counselors can use the therapeutic relationship as a safe place to test more adaptive beliefs. Thus, counselors will first help a client identify when shame is occurring, and then teach skills to regulate the affect and to choose more adaptive behaviors in the midst of shame. Only then will counselors be able to guide clients in the process of restructuring negative internal cognitions, which can be tested within the therapeutic relationship.

Shame Identification

The cognitive identification of shame is strongly recommended in the literature. This requires that the person become conscious of the shame experience (Kaufman, 1996).

H. B. Lewis (1971) said, "At the moment that the person himself says: 'I am ashamed,' shame affect is likely to be diminishing" (p. 197). Indeed, H. B. Lewis wrote that the identification of shame, along with the knowledge of its sequelae, is a realistic goal of shame treatment. However, identification is easier said than done for several reasons. First, shame is based on automatic thoughts and core beliefs of condemnation; although the cognitions are present, the person experiencing shame is often unaware of the thoughts prompting the shame. Unawareness of the thoughts that shame is built upon may make it difficult for the person experiencing shame to make sense of the experience (e.g., "I am condemning myself and believe others will condemn me; I must be experiencing shame"). Thus, shame is often experienced as overwhelming affect, such as anger or anxiety. Second, the shame affect is so strong that it is often denied (Tangney & Dearing, 2002; Turner, 1998). Third, language fails to describe what is occurring in shame (Kaufman, 1996). Even when shame is defined, as it was above, it can be difficult to connect the cognitive definition with the experience of shame. The root meaning of shame is to cover or envelop (Lynd, 1958; McClintock, 2001); it is as if the very experience is covered up by the inability to express it. It takes sincere effort to identify shame.

Counselors can help a client identify shame by being cognizant of typical emotions, cognitions, and behaviors that suggest shame's presence, then wondering aloud if the client might be experiencing shame. Some emotions that are often present in shame are inferiority, worthlessness, deficiency, or inadequacy. Other more global emotions, like disproportionate anger, may also cue counselors to a shame experience. Thoughts that are commonly part of shame in same-sex attracted individuals might be "I am inadequate as a man" (Friedman & Downey, 1999), "I am defiled," or "God hates me" (Schuck & Liddle, 2001). Typical behaviors that suggest the presence of shame are averted gaze, lowered head, hunched shoulders, crying, and leaving the situation (Kaufman, 1996). In addition, the defensive responses to shame (e.g., blame, anger, withdrawal, and avoidance) may be revealing. These responses may show up in counseling as intellectualization, argumentativeness, or silence. The presence of compulsive behaviors and perfectionism are also indicators of shame.

Helping clients identify shame means helping clients learn how they typically experience shame. Do they typically feel panic and try to hide their flaws through perfectionism? Do they fall into despair and isolate themselves? It may be beneficial to have a list of shame-related emotions for clients to peruse and circle the ones that are familiar to their shame experience. It will also be important to have the client write out his or her condemning thoughts that prompt shame. Although there are commonalities to the shame experience, each person experiences shame in distinct ways. For example, an extroverted person may react with rage, but an introverted person may react more naturally with avoidance. A counselor can be pivotal in helping clients be able to identify their shame so that they can learn to manage it well.

Affect Regulation

A promising hypothesis in helping clients manage shame is the idea that individuals can learn to regulate their affect, including the affect of shame. The goal of affect regulation is to develop adaptive methods of releasing painful feelings (Adams & Robinson, 2001; Wells, 2003) so that painful emotions are not allowed to control behavior (Linehan, 1993). To summarize, regulating shame includes (a) withholding natural maladaptive reactions, (b) using self-soothing techniques to mollify the feelings of shame, (c) willfully refocusing attention outward (Kaufman, 1996), then (d) deciding how to act (Gottman & Katz, 1990). Dialectical behavior therapy (DBT), a cognitive-behavioral approach to therapy developed by Linehan (1993), offers affect regulation and distress tolerance skills that can be helpful for clients who are learning to regulate shame. For example, Linehan recommended using distraction (e.g., involvement in an activity) or engaging one's senses (e.g., soft music) in the midst of a painful emotional experience. In addition to teaching DBT skills, counselors can help clients willfully refocus their attention away from the shame. Shame is an affect that is entirely self-focused; it centers all of one's attention on the self. Refocusing attention is the skill of intentionally shifting the cognitions away from one's self. For example, one counselor instructed her client to get up, open the door, and look outside whenever he realized he was in the midst of a shame experience.

Counselors can also work with clients to identify alternate behaviors that are more adaptive than a typical defensive response to shame. Rizvi (2004) reported reduced shame in clients (especially regarding specific events, characteristics, or behaviors) by using the opposite-to-emotion action intervention, which is commonly used in DBT. Opposite-to-emotion action is built on the premise that effective interventions for emotional disorders often work because they reverse the expressive and action components of emotional responses (Linehan, 1993). Linehan (1993) described opposite-to-emotion action as acting opposite to the urge that an individual feels compelled to act upon in the midst of an emotion. As an example, a same-sex attracted male who experiences shame regarding his body shape (Martins et al., 2007) typically responded to his body shame by cowering away from the situation that triggered the shame and avoiding speaking to anyone about his self-image. Affect regulation skills would suggest staying in the situation (withholding the natural maladaptive reaction) and perhaps using a mindfulness exercise to reduce the intensity of the shame (soothing the affect). He might then refocus his attention away from his body shame and onto something in the situation at hand, such as the color of someone's clothes (refocusing attention). Finally, he could use opposite-to-emotion action to share his negative cognitions about his body shape with a safe person (deciding how to act). By taking these steps, this gentleman can contain the affect that in the past compelled him to act destructively. Once contained, the cognitions underlying shame can be addressed and adjusted.

Cognitive Restructuring

Many shame theorists recommend challenging negative cognitions as a part of successful shame treatment. In order for shame to recede over time, the client will need to challenge the thoughts that arouse shame. Shame is aroused when an individual holds self-condemning beliefs and fears of condemnation from others, particularly when the individual believes that he or she is failing to attain an SRG (M. Lewis, 2004). Restructuring cognitions includes identifying the condemning cognitions focused on the self; challenging the veracity of the beliefs; and helping clients replace them with positive, affirming cognitions (Adams & Robinson, 2001; Haendiges, 2001; Kaufman, 1974, 1996; Neisen, 1993; Talbot, 1996; Tangney & Dearing, 2002). For example, if a same-sex attracted woman with gender atypical behaviors (Haendiges, 2001) believes, "I am different from other women, so I am not meant to be a woman," a counselor can help her notice when she indicates this belief (it is rarely stated so clearly) and help her question whether or not this is true. It may be helpful to examine the SRGs that underlie the self-condemnation. For example, what are the client's standards for being a woman? A counselor can help a sexual minority client intentionally choose the standards that are important to her and intentionally negate the standards that she does not value. Furthermore, a counselor can suggest alternative beliefs, such as, "I am a woman with unique abilities to offer the world." Alternative positive cognitions can be based on religious/spiritual beliefs, the therapeutic relationship, or different appraisals of reality. The beliefs underlying shame can be entrenched and often require repetitive attention.

In addition, a client's beliefs regarding others' condemnation need to be identified, challenged, and replaced. The woman mentioned earlier in this article may expect that others will reject her because of her differences in dress or manners. The counselor can begin to note when the woman's actions or emotions belie a fear of condemnation, for example, when she becomes defensive about her choice of clothing. As the fears are identified, the client and counselor can work together to question the fears' accuracy and find alternate understandings. Specific to reducing shame in sexual minority clients is psychoeducation about the experience of stigma, such as sexual prejudice (Bobbe, 2002; Haendiges, 2001). The presence of sexual prejudice means that fears of condemnation from others can be realistic. There is a risk that friends, family members, work associates, and religious affiliates may reject the same-sex attracted client if he or she disclosed his or her same-sex sexuality. Increasing awareness about sexual prejudice and its psychological impact might have the effect of reducing internalized shame. For example, instead of concluding, "I'm unlovable," a client who is well informed about sexual prejudice might be able to conclude, "Others may not understand." Because the cognitions that give rise to shame are intertwined with a person's relationships, the therapeutic relationship is a powerful foundation from which a client can challenge difficult and very entrenched beliefs.

The Therapeutic Relationship

Although not considered an essential component of cognitive therapy approaches, a secure and supportive therapeutic relationship is believed to be key to helping a client reduce shame, particularly within a sexual minority population (American Psychological Association [APA], 2009; Gair, 2004; Haendiges, 2001; Kaufman, 1996; Sherry, 2007; Wells, 2003). Shame includes the deep belief that others will reject, abandon, or feel disdain toward the person if his or her flaw became known. It is hypothesized that the more secure a relationship is, the less threatened a client will feel, and the more likely he or she will be able to address and reduce shame in the context of counseling. In addition, the therapeutic relationship can be a testing ground to challenge the condemning beliefs that give rise to shame. If a client believes that he or she is unworthy of others' respect, but the therapist respects him or her, there is room to question whether the client's shame-inducing beliefs are actually true. Perhaps effective counseling with clients immersed in shame requires a relational approach to therapy to supplement cognitive interventions to reduce shame.

On the basis of a relational therapy approach (e.g., Jordan, Kaplan, Miller, Stiver, & Surrey, 1991), Brown (2004) stated, "Empathy is our best antidote for shame" (p. 35). Empathy, the ability to understand and experience another's feelings, could neutralize the effects of shame by (a) drawing the person out of isolation and self-focus, (b) communicating that the shameful flaw is understandable and acceptable, and (c) confirming that the relationship is not in danger of being lost. Unfortunately, individuals who are shame prone are less likely to receive empathy from others (Tangney & Dearing, 2002) and are, thus, less able to experience this powerful healing agent. The self-condemning cognitions of shamed individuals lead them to believe that they are worse than everyone else. Brown suggested that shame-filled people can attempt to gain others sympathy, which serves as "confirmation of their uniqueness" (p. 45). Unfortunately, sympathy negates and disregards the acceptance and connection offered via others' empathic efforts. It may be beneficial to specifically address barriers to receiving empathy when they arise.

Members of a sexual minority are especially prone to feelings of uniqueness. Many sexual identity development models include a stage wherein members of a sexual minority feel different from those around them (Cass, 1979; Coleman, 1982; McCarn & Fassinger, 1996; McDonald, 1982). In addition, as mentioned previously, others have noted the uniqueness experienced by members of a sexual minority who conceal their sexuality, perhaps due to the resulting social isolation (Frable, 1993; Frable et al., 1998). When a person holds a self-perception of being different from others, it is difficult to change this belief. Clinicians should be alert for a sexual minority client's attempt to prove his or her uniqueness in attempts to gain sympathy. For example, clients might deny similarity to others within their faith community

and might insist, "I will never fit in," "Others don't understand me," and "I could never fully be myself in this church." In these moments, when a counselor may feel the urge to sympathize with the client's situation (e.g., "You are right; this church is not good for you"), that counselor can instead empathize with the feeling of aloneness in such a way that the client understands that he or she is not alone. Then, reverting to cognitive strategies, the counselor can gently challenge the client's beliefs about never fitting in, not being understood, and not being able to be authentic in his or her church. Experiencing empathy from a counselor can open the door for a client to adjust negative self-evaluations.

Just as counselors provide a safe place to face shame and challenge its underlying beliefs, therapy groups offer a similar possibility. Several authors have strongly recommended the use of group therapy within the treatment plan of an individual struggling with shame (Adams & Robinson, 2001; Kaufman, 1996; Lear, 1987). This recommendation may reflect the presence of group cohesiveness, universality, and altruism within therapy groups (Yalom, 1995). Group cohesiveness reduces the threat of condemnation that shame so powerfully presents, universality reduces the isolation and beliefs of uniqueness that shame creates within its victims, and altruism combats the self-focus of shame cognitions. Thus, group therapy can provide a ripe context in which same-sex attracted individuals can confront the beliefs that propel them into shame.

Speaking specifically about the sexual minority population, Kaufman (1996) said, "Individuals experiencing conflict about sexual orientation can be worked with *as a group* [emphasis added] to facilitate the resolution of shame and the emergence of an integrated self-identity" (p. 246). Kaufman and Raphael (1996) suggested that "coming out" to supportive friends might be helpful in reducing shame. On the other hand, for same-sex attracted individuals who may not have adopted a gay or lesbian identity, it could be helpful to share with similar individuals that they have experienced attractions (Yarhouse, 2005). Regardless of the developmental trajectory one might take (Savin-Williams & Cohen, 2004; Yarhouse, 2001), a group made up of similar participants might reduce shame associated with being part of a sexual minority (APA, 2009; Frable et al., 1998).

Conclusion

Shame seems to be a central concern among members of a sexual minority. Given the severe psychological and social consequences of shame, it is important to understand the nature of shame in sexual minorities so that it can be combated effectively. It has been suggested that stigma associated with being a minority is a source of shame among same-sex attracted individuals. Empirical evidence has not established a consistent link between shame and the various constructs of sexual minority stigma. Future professional literature ought to reflect the hypothetical nature of the proposed link between

stigma and shame until research indicates otherwise. Certainly, more research needs to be done in this area. Correlational as well as causative studies are called for in order to determine the nature of the relationship between all types of stigma and shame among sexual minorities. In addition, developing and testing models (e.g., Meyer, 2003) can elucidate mediating factors between stigma and shame. When more is known about the relationship, mental health professionals can step more competently into the difficult task of reducing shame.

When empirical research has found a relationship between stigma and shame, that relationship has existed between shame and proximal stigma (stigma that arises from within the individual). Therefore, as suggested by cognitive theory, negative internal cognitions may be one link in the chain between stigma and shame, a link that can be targeted by counseling interventions to reduce the painful affect of shame. Many strategies have been suggested by theorists and clinicians, such as (a) identification of shame, (b) regulation of the shame affect, (c) restructuring of cognitions, and (d) use of therapeutic relationships. These strategies are believed to be helpful, but the treatment of shame (as a state, trait, or otherwise) has not been adequately researched. These strategies would be best tested using robust shame assessments (e.g., Tangney, Dearing, Wagner, & Gramzow, 2000), as well as assessments that are sensitive to changes in shame intensity over specific cues (e.g., Rizvi, 2009).

In addition to a lack of research, our review is limited because we focused on the understanding and treatment of shame largely within a cognitive framework. Shame is a global experience within an individual in that it affects emotions, behaviors, physiology, as well as cognitions. Other theories and theoretical orientations that offer frameworks on shame (e.g., affect theory, self psychology, and social constructionist) offer valid and rich insights that can broaden counselors' understandings and work with sexual minority clients. Nevertheless, it is believed that by targeting internalized negative beliefs, particularly surrounding their sexual identity, there is hope for sexual minority clients to reduce the shame that can so powerfully bind them.

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