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This article provides the clinician with an overview of how narrative thought can create spaces for possibilities and hope midst shame. As a part of an integrative practice, it is important for the therapist to acknowledge the impact various ideas have on the people who consult them. This testimony and other literature will be used to make a case that the existence of shame is contingent on structural assumptions of the self.

KEYWORDS: family therapy, narrative therapy, narrative assumptions, shame

A Testimony View

The steps that the postmodern domain of Marriage and Family Therapy (MFT) has taken away from pathology in positing that the problem exists in the system rather than the individual largely drew me to the field. In my first semester of graduate school I wrote a case study of my family from a non-structural lens. Through this healing process, I realized that the welcoming of Michael White and David Epston's (1990) non-structural assumptions into the field of MFT was yet another step taken away from pathology. The problem was now viewed as the problem rather than the relational dynamics of the family (White & Epston, 1990). I have continued to develop these understandings over the last year and will provide a testimonial perspective of the impact non-structural understandings have had on shame in my life.

Relevance of Shame and Narrative Assumptions

There is plenty of literature on both shame and narrative therapy individually; however, it comes as a surprise that the literature is sparse on the topic of how narrative therapy's assumptions and practice impact shame. One explanation for this may be the perspective that some narrative therapists have on research. Combs and Freedman (2015) suggest that narrative therapy approaches positivist research that uses population-based statistics to prescribe what happens in psychotherapy with unique people in their subjective settings skeptically.

One can observe the prevalence of shame in our society by the popularity of the shame researcher Brené Brown. According to Brown's (2006) interviews with 215 women who experience shame, shame was distinguished as there being something wrong with one's self as opposed to guilt being the idea that one did something wrong. Shame is a problem that is experienced by culturally diverse populations (Castilho, Pinto, & Duarte, 2017; Cheung, Gilbert, & Irons, 2004; Matos, Pinto, & Gilbert, 2013; Pinto-Gouveia & Matos, 2011; Taihara & Malik, 2016). Literature suggests that early shame experiences contribute to a life story and identity filled with shame (Pinto-Gouveia & Matos, 2011). Pinto-Gouveia and Matos (2011) also conclude that the centrality of shame memories predicts external shame (i.e. the belief that others think one is stupid, wrong, incapable, or not good enough) and internal shame (i.e. the belief that one's self is wrong, incapable, stupid, or bad). Folks whose shame memories are central to their construction of narratives display more depression, anxiety, and stress (Pinto-Gouveia & Matos, 2011).

Additionally, Hallman, Yarhouse, & Suarez (2018) found that identity confusion and internalized shame are strongly related.

Shame is seemingly dependent on the existence of a core self. The idea of a concrete, essential, or core self is based in structural assumptions (Derrida, 1978). White (1998) presents the importance of an analysis of the impacts of structural assumptions that most theories in the fields of psychology, social work, and marriage and family therapy are rooted in. The following testimony will provide an example of how non-structural assumptions can be used as a tool in the development of possibilities that counteract shame.

The Development of Shame in my Youth

Some of the stories that shame has and does tell me include: I am not good enough, I am not smart enough, there is something deeply wrong with me, and if I were only like *this* I would meet the mark. Throughout my youth, in response to these stories, I would distance myself from others and experience isolation and loneliness. I could never be *normal* like my peers because of my deficits, so I was better off just avoiding them. I had these intense experiences of shame; however, I did not have any contexts (i.e. relationships with friends or family) where I thought it was acceptable to talk about this problem. When people did listen to my stories, I remember experiencing much excitement. I now believe that this excitement existed because of all the important lived experiences I had, that I wanted to share but did not think would be accepted.

The shame that developed in my childhood contributed to experiences of depression, anxiety, isolation, loneliness, anger, and embarrassment. I remember a number of specific instances in grade school where I viewed myself as not good enough when thinking about my peers, teachers, and adults in my life. I believed that there was something deeply wrong or deficient about my core self.

Shame existed in my familial relationships as well. In my relationship with my Dad, the narrative of not being good enough developed roots. As a child I developed the understanding that my Dad was always "right" at the end of the day. Upon reflection it seems as though shame grew in this relationship because of ageism and patriarchy.

Towards the end of high school and into college shame told me that I was not smart enough. When conversations with classmates would enter into the realms of philosophy, theology, or politics this message would keep me from learning and/or engaging with these ideas. Additionally, shame would tell the story that I was bad with names and in turn I would experience a lot of anxiety and shame around forgetting people's names. This further reinforced the overarching narrative of not being good enough.

The dominant societal narratives I grew up with contributed to the growth of shame in my life. These narratives around toxic masculinity, academic achievement, athletic achievement, social ranking, financial success, and other ideals also added to the strength of shame. Although I had some understanding of these dominant narratives and their falsity in my youth, they still had a significant impact on the stories I told myself and in turn the prevalence of shame I experienced. White and Epston (1990) suggest that no one can escape the grasp of these dominant discourses. This was certainly true for me, no matter how well I did, I could never meet the mark set by these dominant stories. In response to the weight of shame, I did not experience much hope and depression started to prevail in my life. I ended up giving into these dominant narratives and did what they expected of me to avoid discomfort. When I look back, I believe that I was lacking

relationships where I could develop preferred understandings of my identity and directions I wanted to head in life (Freedman & Combs, 2016).

In my youth, my solution to shame was largely to avoid *it*. As Fisch, Weakland, and Segal (1982) suggest people's solutions to problems often maintain or exacerbate the problems they are trying to rid themselves of. Having grown up as a white, upper class, cisgender male in the 21st century, I did not experience much discomfort and so I took the easiest path possible which was to avoid shame. Unfortunately, this only strengthened shame's hold on me.

The zeitgeist I grew up in led me to believe that I ought to rely on the "expert" (e.g. the doctor, dentist, psychologist, researcher, teacher, or pastor) for the answers to problems in my life. This reliance on the expert, based in positivist and mechanistic assumptions of the existence of a right and wrong in all situations played a tremendous role in me questioning the validity of my understandings of my experience (White & Epston, 1990). The development of shame in my life, caused by dominant social narratives and "expert knowledge" was based in positivist and structural understandings of the self (White & Epston, 1990).

First Therapeutic Experiences

The first therapist I saw in college was in the internship phase of her doctoral program. Although she was new to practice, I was deeply impacted by the Rogerian approach she took to our relationship. The unconditional positive regard she used provided a context where I could express feelings I had neglected and explore problems in my life (Wilkins, 2000). However, the cognitive behavioral understandings that influenced her work did not serve me. I was taught that I had cognitive distortions and that changing the ways I thought would rid me of depression and shame. Although I put much effort into altering these cognitive distortions, this pathology-focused approach resulted in more shame. According to White (2011), "Normalizing judgment is the core activity of modern operations of power" (p. 25).

The second time I entered into therapy was to do premarital work with my wife. Having studied Bowenian theory, I believed that uncovering patterns that had been passed down the multigenerational family system would allow me to increase my level of differentiation and be a better spouse, friend, and family member. These sessions were useful and although I did address shame in this work, it still had a strong hold on my life. At this time, I was working as a field guide at a wilderness therapy program with adolescents who for the most part did not want to be in wilderness therapy and were required to attend by their caregivers. I would be in the backcountry with these students for eight days at a time and shame kept me from being fully present in these groups. I also experienced some of the worst anxiety of my life prior to going on these expeditions because shame told me that I was not well equipped to work with these students.

During this period our therapist helped us step away from viewing each other as the problem and rather to focus on the problematic relational dynamics. Collaboration was fostered in these sessions as I developed a deeper understanding of my wife's experiences. I also valued how this therapist held a metaphorical mirror up to me at times and challenged me to look at problems related to patriarchy that were not on my radar. There were a few times she directly confronted me; however, I now see that she aided me in moving toward a preferred understanding of my identity outside the influence of patriarchy (Hare-Mustin, 1994).

Thanks to close relationships and my first experiences with therapists, I was able to make significant headway around putting shame and the depression that came along with it at bay. As I began to share shame's stories, I experienced much comfort, freedom, joy, and liberation from the

grips of shame. Close friends made comments on how they appreciated the listening, courage, commitment, and thoughtfulness I brought into our relationships.

Up until my graduate studies I told the story that what was helpful for me in my early therapeutic work was excavating repressed emotions. The metaphysical Freudian notion that I had repressed drives and emotions core to myself that resulted in pathology seemed true to me at the time (Derrida, 1978). This was evidence that I had not resolved what was essentially wrong with me and that I needed an expert to guide me to insights that would free me from these problems.

Healing with Non-structural Assumptions

I was first introduced to how non-structural assumptions might be applied to psychotherapy prior to my graduate studies by Chris Hoff's interview of Harlene Anderson on the Radical Therapist Podcast (Anderson & Hoff, 2016). I was struck by Hoff and Anderson's (2016) focus on honoring the client's subjective understandings and moving away from "expert knowledge." It had been a number of years since my undergraduate studies, and Anderson's work struck a chord with me. This humanizing dialogical discourse served as a catalyst in me applying to MFT programs; however, it was not until I wrote a paper on an analysis of my family system from a narrative lens that I truly began to experience the freedom post-structural assumptions had to offer (Anderson & Hoff, 2016).

In hindsight, my early experiences in therapy were largely therapeutic because I was able to put language to significant experiences I had never talked about. These experiences were with me; however, I was alone in bearing them. It was empowering to come to understandings of these deep experiences I had not shared for so much of my life. White (2007) talks about the therapeutic value of storying experiences which have not been shared.

I was taking steps away from blaming family members for not doing enough of their own work and thus perpetuating the life of criticism in my family. In the same stride, I was taking a stand against shame in a manner that allowed for more curiosity and creativity. Historically, I had not exercised much creativity because I had developed the story that I was not creative growing up, although there is much evidence to the contrary.

Non-structural understandings have allowed for more possibility in my life and relationships. Rather than dismissing the fringe ideas of others, I now have more receptivity to subjugated ideas and those who present them (Vargas, 2018). Additionally, there are many past experiences I have had that I am now beginning to bring to life via the construction of preferred narratives. Inspired by White's (2007) work I am engaged in expanding on the unique outcomes of courage, grace, humor, creativity, persistence and joy that the dominant shame saturated story in my life has kept me from embracing.

Concluding Reflections

In light of these ideas I question whether shame can exist in a society with non-structural assumptions. It is possible to conceive of shame existing in a community with non-structural assumptions in terms of shame around the community being wrong, bad, or not good enough. However, it is hard to imagine the ideas about there being something wrong with one's self without the structuralist notion of an essential self.

There is currently a movement to go back to traditional ways of living and eating. One of the pioneers of this movement was a dentist and researcher named Weston A. Price (2003) who

documented indigenous groups who had not been touched by the foods of modern commerce. In his work, he found that these communities had straighter teeth, less tooth decay, higher immunity to tuberculosis, and overall better health. There is emerging discourse from medical doctors and academics that these subjugated practices help heal the modern body from diseases prevalent in the West such as diabetes, heart disease, cancer, autoimmune disorders, A.D.H.D., A.D.D., autism, depression, dyslexia, schizophrenia, and dyspraxia (Pollan, 2016; Campbell-McBride, 2010). This is not to say that traditional practices are a panacea; however, there has been unnecessary pain due to the loss of various subjugated knowledges around relationships, growing food, preparing food, and ways of living.

White (1998) was one of the pioneers of this comparable movement in the field of psychotherapy by suggesting that non-structural assumptions could be useful in psychotherapeutic work. White (1998, 2007) is clear about the possibilities, shared values, dreams, commitments, and hopes that can arise from non-structural thoughts. White (2007) discusses the importance of creating contexts where folks can get in touch with subjugated experiences and knowledge that dominant discourses have prevented them from being in touch with. In White's (1998) work with indigenous communities he noted that some of these aboriginal people did not have a word for self. Did these individuals have a conception of shame? Can shame exist outside of structural assumptions of the self?

I urge those practicing psychotherapy to continually grapple with the intersect of structural and non-structural approaches. These ideas underlie all of our work with individuals and have a profound impact on people's lives. Additionally, our field would do well to engage in dialogue and research around the relationship between shame and structural assumptions.

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