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Parental Misattunement and the Production of Shame of Existing: How to Address the Shame of Existing Through an Intersubjective Systems Approach

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Parental Misattunement and the Production of Shame of Existing:

How to address the Shame of Existing through an Intersubjective Systems Approach

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This paper is dedicated to the loving memory of Dr. Peter Buirski, whose passion for intersubjectivity and the therapeutic relationship inspired the topic of this paper. I will forever be grateful for his mentorship and supervision, specifically for the case presented in the paper. Dr. Buirski inspired me with his genuine passion for therapy, and taught me the true value of the therapeutic bond. Without him, the success of this case, and the strength of the therapeutic relationship, would not have been possible.

Abstract

Shame is at the root of many commonly encountered psychopathologies. Its development has often been attributed to early childhood emotional misattunement. In severe cases, individuals can develop an extreme form of shame called the "shame-of-existing". This paper primarily intends to contribute to the limited research about the shame-of-existing, which includes psychoanalytic perspectives from 1950-1990s, and theoretical analysis in 2014. The concept of shame of existence will be explored through an in-depth case study analysis of a 31-year-old, heterosexual, cisgender, white male who presented to psychotherapy with low-self-worth, and shame in acknowledging his own emotions and needs. This client was treated using an intersubjective systems framework, given its focus on misattunement in the parent-child relationship and the reparative power of validating attunements within the therapeutic relationship. Further, this paper will explore how to address and treat shame-of-existing utilizing an intersubjective approach.

Introduction

Shame is a universal emotion that presents in varying degrees of intensity and significantly affects one's ability to relate to themselves and others. However, shame is one of the least understood emotions. The APA Dictionary of psychology defines general shame as “a highly unpleasant self-conscious emotion arising from the sense of there being something dishonorable, immodest, or indecorous in one’s own conduct or circumstances.” Though there is this universal definition, it fails to encapsulate how shame has various components that affect its depth, severity and impact. The phenomenon of shame is at the core of many issues within the field of psychology. Given its ubiquity, scholars have long examined the development and prevention of shame. Emotional misattunement in early childhood has been revealed to be a primary causal factor. The APA Dictionary of Psychology defines emotional misattunement as “a lack of rapport between infant and parent or caregiver such that the infant’s efforts at communication and expression are not responded to in a way that allows the infant to feel understood.” Imagine a child playing on the monkey bars, falling and scraping their hands and knees. Overwhelmed with pain and fear, the child starts crying, and runs to their caregiver for comfort. The child is told to stop crying, and that they are not actually in pain. The child automatically feels ashamed of their emotions, rejected by their parent, and becomes mistrustful of their own emotional experience.

The lens of intersubjectivity can be a useful and ideal starting point for addressing shame with individuals, given its focus on the parent-child relationship. Intersubjectivity in case conceptualization and treatment specifically considers how the caregiver environment responds to a child’s emotional needs. Through this lens, shame can develop when a child is not getting their

emotional needs met and begins to blame this reality on a belief that they are fundamentally unlovable.

When evaluating and treating shame, its severity is a crucial consideration. If emotional misattunement is severe and persistent within the parent-child relationship, it can lead to a particularly extreme form of shame known as the "shame-of-existing". While shame has been widely researched and discussed, there is a significant gap in literature about this specific form of shame. Shame-of-existing is an extreme form of pathological shame which underlies or informs many kinds of severe psychopathology. Identifying shame-of-existing within patients is important because the "shame-of-existing has a specific meaning and concealed dynamic of its own, and readily escapes notice" (Willie, 2014).

Existing scholarship has primarily examined the shame-of-existing through the theoretical lens of psychoanalysis. There is extensive literature about the concept of shame from object-relations theory, self-psychology, attachment theory, intersubjectivity, and psychoanalysis. However, there has been no clear understanding of the shame-of-existing specifically, and no guidelines on how to best assess or treat it within these frameworks.

Shame Research

In initial psychoanalytic literature, shame was discussed as a component of narcissism, and was associated with emotions of grandiosity, pride, guilt, self-blame, and self-esteem. The experience of shame was seen as the result of one's failure to live up to the narcissistic standards of the ego ideal. (Fishkin, 2016). Additional literature on shame has focused on the early developmental roots of shame, and the impact parental responsiveness and attunement have on the development of shame. Parental emotional attunement, specifically the role of empathy, is vital to the development and formation of the self. In order to conceptualize shame, it is important to

understand the inborn attachment functions of the infant and their interplay in optimal infant-caregiver relationships in the first year. In *The Role of Attachment Functions in Psychotherapy* (2000), Spiegel, Severino, and Morrison explain how "in mutual gaze interactions, the caregivers' facial expressions stimulate and amplify the positive affect, the joy, of the infant." This mirroring experience creates an experience of interpersonal oneness, where the infant feels unified with the caregiver and seen by the caregiver. Spiegel, Severino, and Morrison suggest that interpersonal "oneness" in positive emotions such as joy provides confidence, strength, connection, and vitality for the child. The child seeks to experience this emotion in their future interpersonal experiences, which makes them feel loved, seen, and confident in their connection to the other individual. A lack of empathic attunement creates a sense of uneasiness and confusion for the infant, and they no longer experience excitement and joy from the caregiver relationship. The infant ceases eye contact, activity, and exploration. This leads to a mistrust in the caregiver, viewing them as a stranger and themselves as deficient for not being responded to and attuned to (Spiegel, Severino, Morrison, 2000). In severe cases, parental misattunement can become a form of interpersonal trauma.

These experiences of misattunement are understood as shame experiences, in which the infant's shame is rooted in awareness that they are being responded to in a way that is different than they anticipated, and different from others in their environment. This can lead the child to feel embarrassed and responsible for their parents' response. The child then views themselves as unworthy, unlovable, helpless, and confused, and is unable to differentiate themselves from the misattuned caregiver who is core to their concept of self, which leads to a self that is defined by shame. These early experiences create a model for how an individual behaves in and interprets

future interpersonal encounters. They ultimately shape how individuals relate to themselves and others.

Origins of Shame-of-Existing

The shame-of-existing specifically has primarily been understood as a symptom of moral masochism. In *The Widening Scope of Shame*, Wurmser defines inner or moral masochism as "tormenting, berating, and shaming as mostly carried by the conscience and directed against the self," (Lensky & Morrison, 1998). This form of shame is described as developing from the patient's earliest experience, when every wish and expression of their own was treated as evil, especially by their mother. Markson describes how moral masochism "stems from the child experiencing oneself as a painful burden, rather than a source of pleasure." (Markson, 1993). This results in the early attachment experiences being suffused with pain rather than pleasure, resulting in a sense of object-loss as the parent fails to attune to the child's joyful and pleasure states. Any sort of happiness or joy is treated with indifference, annoyance, or incomprehension.

Shame-of-existing often involves lack of individuation from the parent, and the child's fear of complete rejection and abandonment if they assert their own needs. Wurmser described this as "shame about not having a self-guilt about wanting to assert (one)self, about saying no, resisting, because it is murderous" (Lensky & Morrison, 1998). In this context, loss of oneself to the caregiver, and submission of all needs and desires, is the only way to secure the attachment to the caregiver. The child would often rather have no self and be nothing to maintain their attachment than to be someone but have none. As such, having a self "is regarded as ruthless, omnipotently destructive, and as having robbed and depleted the parent of vitality" (Markson, 1993). The child believes they have no right to a pleasurable life of their own, or opinions of their own, and that in

order to be liked and accepted by others, they have to diminish themselves and surrender themselves to the welfare of others. The feeling of not being seen or acknowledged as their own person, with their own thoughts, feelings, and opinions, leads to an all-encompassing shame: shame-of-existing.

To further preserve the attachment with the caregiver, the child does not identify the parent as an aggressor, but rather views them as a victim. This also puts the child in a parentified position, in which they are the one in the relationship taking care of the parent and attending to their every emotion and need. Feeling needed in this way is confused with feeling loved and connected to the caregiver. This puts the responsibility on the child to maintain the relationship. When the child gets older, they continue to believe that if their relationship with their parent does not improve, it is their fault for not mending the damage within the relationship. This creates an internalization of blame, in which the child learns to believe they are inherently unlovable and bad, which justifies their parent's rejection and indifference towards them.

Defining Shame-of-Existing

Although there has been an increase in literature on shame, there continues to be a gap in the literature on the various degrees of shame, specifically the shame-of-existing. This extreme form of shame has previously been discussed within the psychoanalytic literature as a symptom of moral masochism. The most recent literature, by Robert Willie (2014), defines and understands shame-of-existing as "shame about existing as we are and especially at the fact that we are. It is accompanied by merciless and total rejection of the subject's self and by feelings of extreme worthlessness and inferiority coupled with the all-pervasive conviction that it would be better not to exist" (Willie, 2014). The shame-of-existing develops through disturbances in the parent-child attachment, which are created by a lack of physical touch and emotional attunement, and

inadequate mirroring by the caregiver, which negatively impacts the infant's development of self. The lack of physical touch also impacts the infant's development of awareness of the self and self-cohesion, (Anzieu, 1993; Bick, 1968; Brazelton and Cramer, 1991; Gaddini, 1987), and deprives them of sensory confirmation of their existence. The infant internalizes this lack of physical touch and emotional attunement as hate and rejection by the primary object, the caregiver. When the child is repeatedly subjected to emotional misattunement, the compounding effects lead the child to question whether they have the right to exist and take up space in the world.

The individual experiences severe shame for having needs or emotions, which are core aspects of survival and the human experience. This type of shame is not specific or directed towards a certain aspect of one's body, personality, emotional experience or being. It is generalized and undirected and is more concerned with one's existence rather than a specific aspect of one's existence. If the shame were concerned with a specific aspect of self, one would have a desire to change that specific aspect to get rid of the shame. Since this shame is all encompassing, the only release of the shame would be to disappear or cease to exist. This extreme form of shame pervades one's self-esteem and mental functioning. Willie (2014) explains that "in the shame-of-existing the rejection of the self is total, merciless and lacking in any nuance." The individual views their private, most vulnerable self as disgusting, something to be deeply ashamed about and hide as it is embedded with feelings of inferiority and worthlessness. The individual makes sense of their mistreatment and lack of acknowledgement by their caregiver by becoming convinced that they are inherently bad and were born incomplete. There is significant hate and contempt directed at oneself for being so unlovable that they could not get their caregivers attention. Willie (2014) suggests this self-hatred can lead to the individual engaging in extreme masochistic and submissive behavior, in which the individual is "often literally not permitted to occupy any space, give off any

smell or make any sound." Engaging in these behaviors would confirm the way they feel about themselves, in that they are disgusting and unworthy of existing. In a way, they are seeking an experience that reflects their internal experience and confirms their self-perception.

Development of Defenses

The way one views themselves not only impacts the way they relate to themselves, but shapes how they relate to the world. If the internal world is one of rejection, judgment, hatred, and hostility, then the external objects mirror that. This self-rejection is projected onto the external objects of the world. With such severe low self-worth, the individual believes that others view them with equivalent disgust and reject and despise their presence. The individual is rigid in their thinking and is unable to understand or see others' attempts to prove them otherwise and put the situation in perspective. Though it is not specific to the shame-of-existing to have one's perception be clouded by one's core beliefs, it is taken to extreme lengths in this situation.

The intensity of this shame often leads to significant social anxieties, phobias, and other forms of avoidance, as they experience the world and individuals in it as rejecting (Willie, 2014). In the eyes of someone experiencing shame-of-existing, the only way to survive a world rendered hostile by their projection is to become invisible. Another defense and effort to mask one's shame is to create a false self. Often, this false self is one who strives for perfection and objective measures of success as a way to try to control the way they are viewed by others, as well as convince both themselves and others that they are worthy. A third defense against this all-encompassing shame is by projecting the shame onto a specific quality or aspect of the self, which makes the shame much more tolerable. For example, one could reason that their partner broke up with them because of their physical appearance. Though this shame is still painful, it is more tolerable because it feels like it is something concrete within their control and is something they

can change. Believing they are rejected because of physical appearance is easier to digest than accepting that at their core, they are fundamentally and unchangeably unlovable. When individuals present to therapy, they may often present with this specific, less generalized, form of shame. The shame-of-existing unveils throughout treatment as the individual begins to lower their defenses and better understand their experience.

Assessment and Treatment of Shame

Defining Intersubjectivity

Given that emotional misattunement in the parent-child relationship has shown to be a significant factor in the development of shame, it is imperative to employ a therapeutic approach with this factor as the primary focus. Intersubjective systems focus on understanding how the interpersonal experiences within the parent-child relationship shapes the individual's view of self. *In Making Sense Together* (2020), Buirski, Haglund, and Markley define the intersubjective perspective as "a developmental perspective that presumes that experience is organized early in life with caregivers and continues to influence our self-experience as adults." Intersubjectivity is concerned with the lived experience originating from misattuned responsiveness by the caregiver and how this shapes one's experience of self, ability to regulate emotions, and ability to relate to others. This theory focuses on the way the caregiver environment responded to the child's emotional needs. Through these early caregiver experiences, an individual comes to form core beliefs about themselves, called organizing principles. These organizing principles form from the child's efforts to make sense of the way they are being treated by the parents.

The ways in which the child attempts to survive in this environment, such as internalizing the blame, are means of 'striving for health,' as they attempt to preserve the critical attachment to their caregiver and thrive in this unsupportive environment. The ways in which a child was striving

for health often becomes maladaptive in adulthood, as they are now protecting themselves in environments in which they no longer need protection. In therapy, these means of striving for health are often perceived as the psychopathology that led the client to seek treatment.

Goals of Intersubjectivity

The goal of intersubjectivity is to help the patient better understand how they came to relate to themselves and others by collaboratively examining their early relational experiences. This is accomplished by (1) attuning to their feelings; (2) labeling their emotions in order to better communicate and understand their emotional experience; (3) developing a caring, trusting relationship between the therapist and patient; and (4) co-constructing a developmental narrative which contextualizes the individual's childhood experiences (Buirski, Haglund, & Markely, 2020). Intersubjectivity highlights the therapeutic relationship as a parallel process to how the client relates to others and the world. The therapist addresses in-session interactions in the 'here-and-now' to help the client build perspective on how they relate to others, using it as a tool to heal those interpersonal wounds. These experiences provide a corrective relational experience, in which the individual feels cared for and understood in a way they longed for in their childhood. The hope is that through this experience, the individual will gain insight into how their mistreatment affected their emotional development. This includes understanding what led them to internalize the blame and how they developed the sense they were unworthy of being loved and cared for. Moreover, they will learn how to better recognize their emotions and communicate them to others, as well as how to better advocate for themselves and their needs. Ultimately, intersubjectivity seeks to understand how negative emotions developed in the context of the parent-child relationship and evolved into feelings of worthlessness and shame. Given its focus on the origins of shame, intersubjectivity is a natural and logical treatment approach for the treatment of shame-of-existing.

The Case of Drew

Drew is a white, heterosexual, cisgender male in his early 30s who presented for treatment with depression, anxiety and a significant sense of worthlessness. Drew sought psychotherapy after experiencing what he described as the "darkest time in [his] life." He had just turned thirty-years-old and was overwhelmed with the feeling of failure and worthlessness for not being where he thought he would be at this age: financially thriving, married, and with children. For the purposes of this discussion, case conceptualization will be conducted through the intersubjective lens.

Early Years

Drew was born and raised in Colorado and is the second of four children. He was raised in a devout Christian household but does not currently describe himself as religious and identifies as Atheist. Christianity played a predominant role in Drew's upbringing, specifically in his early childhood. Drew attended a Christian primary school, which was led by nuns. His sister, who was two years older than him, attended a non-religious, public elementary school. Drew did not receive an explanation from his parents of why he and his sister did not attend the same school. Drew felt confused as to why he was receiving a religious education, which he perceived as much more strict, structured, and disciplinary. Without an explanation, Drew started to question if there was anything in his behavior or personality that was a problem. He felt confused because he believed that he was an obedient, kind, well-behaved child. This made him question how he was being perceived by his parents, which led them to parent him differently than his sister in this regard. He began to create explanations in his mind to make sense of this experience. He came to believe that his parents thought he was a bad, unruly child, which required him to be parented and taught with

more discipline and structure than his older sister. This early experience led Drew to feel "othered" by his parents, and therefore less favored.

Furthermore, Drew struggled to feel accepted and accurately seen at school. He felt subjected to scrutiny for various aspects of himself over which he had no control, such as his name and his left-handedness. Drew was forced to learn how to write with his right hand, which made him believe the way he was born was unacceptable and needed to be changed. Drew was also shamed significantly for his name, which has a negative connotation in the Bible. The nuns sometimes called him "the devil," and would call his parents and say that "he cannot be trusted." Sometimes when he spoke at school, his teachers would yell at him and say he is not "speaking from the word of God." When he did not speak, he got the same response. These messages confused him and made him feel that nothing he did or said was right. Regardless of whether he contributed or not, or said the right thing or not, he was met with anger and rejection, which caused him to feel shame.

At home, Drew continued to feel othered and confused as to why he did not receive the same acceptance and positive attention as his sibling. This feeling was further exacerbated when his younger brother was born. Drew noticed his parents applauded his baby brother for doing the simplest of tasks, whereas he felt he never received recognition or applause for significant accomplishments. He said that for his brother simply "getting out of bed in the morning" was applauded. He felt frustrated and confused because he believed he was doing everything his parents expected of him, and yet, it was still not good enough. He was earning good grades, winning awards, and being an obedient son who did not cause trouble. He recalled a memory of winning an elementary school writing competition, for which there was a significant award ceremony with

the Governor of Colorado as the presenter. He felt immense pride and finally believed he did something worthy enough to receive his parents' attention and make them proud. He recalled hearing his parents debate in the hallway about who would attend the ceremony. He perceived them as being annoyed that they were obligated to attend. He was doing everything he could to be the perfect son and earn his parents' love, and he felt deeply saddened that not even this award warranted pride or recognition. Throughout his childhood, he did not recall his parents expressing their pride or love for him, and he did not recall ever receiving physical affection. He felt he was either met with indifference or rejection, both in moments of happiness and pain.

When Drew was in 8th grade, his father was involved in a severe car accident which left him permanently disabled. His parents did not have a conversation with Drew and his siblings about what had happened or how scary and sad this experience must be for them. They failed to attune to their sadness, and put words to their feelings to help them understand their emotional experience. This left Drew confused on how to respond, and unsure if his emotions of extreme fear and sadness were an acceptable or appropriate response to this event. He believed that since no one was outwardly expressing grief or fear, that he must be overreacting. This led him to be ashamed of his feelings and mistrustful of his emotions and ability to read a situation

Drew became parentified following this tragedy, as he was tending to his father's basic needs while his mother worked full-time to provide for the family. Drew hoped that by stepping into the caretaker role, he would finally be seen and appreciated by his parents. He saw his father in severe agony and pain, and felt confused by the demonstration of such severe emotions on his father's face. Whenever he got injured playing hockey growing up, his father would yell at him if he was crying and tell him to "stop being a baby." Drew was extremely confused, for instance,

when he witnessed his father crying, because of the messaging he had received about crying being an intolerable demonstration of weakness. His father was presenting with the exact emotional expression for which Drew was shamed, making him believe others' needs and emotions are acceptable and valid, but not his own.

Shortly after his father's accident, when Drew was starting high school, his parents divorced and his mother moved out. This was another traumatic experience which occurred without any conversation addressing the change and difficulty of the experience. When Drew's mother left, Drew chose to live with his father in order to take care of him. Drew's siblings decided to live with his mother, leaving him to help his father all on his own. Though his mother lived close by, Drew reported barely ever seeing her. Drew felt extremely disconnected from his mother and felt abandoned due to her lack of effort to maintain the relationship. Drew justified this by saying it was not her fault that she could not make time for him, since she was too busy working. He also blamed himself because he could not make the effort himself to go to see her even though he did not yet have a driver's license. Drew felt lonely living with his father, and angry about carrying the responsibility to care for his disabled father alone. Simultaneously, he felt useful and needed within his family by taking on this role. He believed he finally knew his role in the family, yet still felt so disconnected, unappreciated, and alone.

Peer Relationships

While in high school, Drew had one person by whom he felt fully seen and accepted. He considered this girl his best friend and his confidant. She was the one person with whom he felt he could be vulnerable, without any shame. His junior year, she was killed in a car crash. He recalled how his parents knew of the tragedy, but they did not bring the subject up to him or ask him how

he was doing or if he needed support. With the messaging he had received about crying, he did not dare cry or show grief in public. He was so devastated he could not contain his tears but would only allow himself to cry in the privacy of his own room. Drew explained that because his room was below his fathers, he had to be very silent because he did not want his father to hear him and shame him. Drew reported that the only person who supported him during this time was his older sister. However, shortly thereafter she went to college, and he was left to navigate his grief alone.

Feeling deeply unseen and unsupported now that his best friend and sister were gone, Drew sought out connection. Drew did have a group of friends in high school with whom he spent time, but believed they simply tolerated his presence rather than enjoyed it. Because he did not feel particularly connected to this group, he felt that every time they were trying to include him it was out of pity. This friend group all shared a religious identity that he did not hold, leading him to feel "othered" in this group. This pattern of feeling different and disconnected persisted with his friendships into college and throughout his adulthood.

Romantic Relationships

Drew had one relationship in his 20s which made him feel truly seen, loved, and connected in a way that he longed for. Drew was in this relationship for about three years and reported it was the second time he felt truly accepted by someone else. He did not feel judged in this relationship, and believed he could be vulnerable with this partner, unlike other experiences growing up. He felt understood by her in that they both shared similar interests and the same alternative style. With her, he did not feel like an outsider. Drew was certain his parents would judge his partner, given their similarities. He hoped his parents would accept his partner and support their relationship. He

felt disappointment and further rejection at his parents' neglect and ambivalent support of his relationship.

Drew finally felt loved by his first partner and did not want to risk losing her, leading him to avoid any conflict or tension which arose. Throughout their relationship, Drew's girlfriend was abusing alcohol. Drew consistently made excuses for her in social settings, and struggled to acknowledge the underlying problem or hold her accountable. Their relationship ended after he discovered her infidelity. This devastated Drew, because he felt he was finally loved and accepted by someone who ended up betraying him. After this relationship, Drew was even more convinced that he was unworthy of being loved or accepted. He finally was vulnerable and honest with someone, and the betrayal proved to him his belief that he is inherently unlovable. Drew experienced significant anger from this perceived betrayal, about which he felt guilty because it prevented him from continuing a relationship with her, even as a friend. A few months before Drew began therapy, he learned that his ex-girlfriend had died from liver failure, due to her alcohol abuse. This death brought up a flux of complicated feelings for Drew. He feared he abandoned the only opportunity he ever had to feel loved and feared he would never experience this kind of love again. Additionally, he struggled with his feelings of anger towards his ex-partner, and he felt compounded shame about these emotions.

Development of Survival Mechanisms

Because Drew never received a clear explanation for the rejection he experienced in early childhood, he was left with only one justification: something is inherently wrong with him. Drew internalized the blame in order to make sense of this misattuned environment. Drew received harsh criticism for even the simplest of tasks, such as sitting quietly or participating appropriately in

primary school. This led him to believe his mere presence was the source of this judgment and criticism. He thus tried to minimize his presence as much as possible and become physically and emotionally invisible to others so he would not be picked on. This was Drew's effort to survive and maintain some sense of personal agency and self-cohesion in the face of an oppressive, disorienting childhood environment.

Being invisible required an additional defense: denying his emotions and needs. In Drew's experience, acknowledging emotions and needs led to rejection and alienation. Within his caregiver environment specifically, his presence was not acknowledged unless he was being criticized for expressing his emotions and needs. This shaped a belief that his existence was fundamentally a burden to others. As an additional defense, Drew created a false self to protect against experiencing the depth of the shame-of-existing. He felt compelled to create a lighthearted, easygoing self to counteract his private self, which felt dark, pessimistic, and rejecting. This defense compounded Drew's shame-of-existing because his true, private self was vastly different from his false, public self. This further reinforced his belief of how shameful his private self was. Because Drew's shame-of-existing was all encompassing, it led to cyclical feelings of hopelessness about being loved and accepted. Parallel with his defense of internalization of blame, Drew began projecting his shame onto a specific aspect of his self to attain a necessary sense of control. This specific aspect was his physical body, and ultimately led to body dysmorphia. In sum, these defenses composed a global presentation of shame-of-existing.

Drew's childhood survival mechanisms shaped his present behaviors and relationship with self, summarized as his shame-of-existing. These defenses helped him survive persistently misattuned environments. As an adult, these defenses became maladaptive, as he was attempting

to protect himself in environments from which he no longer needed protection. Drew's shame-of-existing ultimately led to a significant disconnection from himself and others, making it difficult for Drew to feel valued and seen. Every aspect of his life was affected, including his relationships, self-esteem, and experience of the world.

Treatment Application

Drew's organizing principle of being unlovable led to the belief that the world would be inherently and consistently rejecting. He came into therapy with this worldview, which in turn affected his beliefs about and behavior within the therapeutic relationship. Drew's defenses had been reinforced throughout his 32 years of life, and required time, trust, and safety for these defenses to lower and reveal his most vulnerable, honest self.

The therapist attempted to make Drew feel seen and accepted from the beginning. Drew struggled significantly with the emotional intimacy which comes with this relational approach, because it prioritized his needs and acknowledged his presence in a way he had not previously experienced. As a result, Drew was very resistant to the therapist's attempts to attune to his emotions and acknowledge his value. This resistance presented during the first few months of therapy when Drew reported that he was experiencing suicidal ideation, and felt that his presence was a burden on others; he believed no one would notice if he was gone. He had no intention to act on those thoughts, as he believed that his death would be a burden on others as well due to the financial undertaking for funeral arrangements. The therapist applied the intersubjective strategy of acknowledging the here-and-now by speaking to the presence of the therapeutic relationship and verbalizing that she would notice if Drew were gone. Because this was early in their relationship and in Drew's progress, he was not able to genuinely accept or believe this. This

attempt from the therapist to connect and speak to the strength of the therapeutic relationship was premature, because it acknowledged value in his existence in a way he had long denied. Only with time and unfolding Drew's organizing principles, would he be able to genuinely believe that he was worthy of being cared for.

The here-and-now was also utilized to acknowledge his presence in the room, give him permission to take up space, and prioritize his needs. Drew initially denied the therapist's attempts to make him physically and emotionally comfortable in the therapeutic space. This presented as refusal to take off his winter coat in a heated room and not taking a tissue when it was offered. It was initially challenging for the therapist to not feel discouraged by her multiple attempts to create an attuned, supportive environment. In remaining faithful to the intersubjective approach, the therapist committed to consistent affect attunement, regardless of the client's resistance. Affect attunement did not initially resonate with Drew, because it was a completely foreign experience for him. Additionally, this approach highlighted his pain in a way he was not ready or comfortable enough to accept. In accepting this pain, he would be accepting emotions he had been told were shameful and made him unlovable and intolerable. Drew resisted attunement by justifying his parents' actions that had harmed him. Within the intersubjective experience, this phenomenon is known as "premature empathy." An example is when a client says, "they did the best they could," when discussing their parents and instances in which they felt neglected or mistreated. This avoidance is a way of protecting the caregiver attachment by not holding the parents accountable. This led to the realization that Drew would need to establish some sense of a secure attachment with his therapist before questioning his primary attachments.

Throughout the first half of treatment, Drew's ability to sit with discomfort slowly grew as the therapeutic relationship strengthened. He began to tolerate moments of silence after powerful

reflections, and openly expressed his emotions, as he knew his tears would not be rejected or shamed.

The therapist realized that Drew was finally responding to affect attunements when she realized that his understanding of what it means to be loved was beginning to shift. He started to understand what a caring, secure relationship looked and felt like. A powerful moment in therapy occurred when Drew mentioned his aunt, and how he felt confused that she hung her children's drawings on the fridge when he perceived them as ugly and unworthy of recognition. The therapist responded by highlighting "that is unconditional love," which left Drew in utter disbelief. It finally occurred to Drew that the only love he had ever known was conditional love. This came with a significant sadness, and grief for the childhood and love that he had not had but deserved. He had always reached for objective measures of success so that he would have something worthy enough of being placed on the fridge with pride. The idea that his aunt could simply love her children highlighted his shame in a way he had not been able to understand. He had believed that he was inherently unlovable because the love he had received had limitations and was inconsistent, hypocritical, and ever changing.

At this moment, the developmental narrative shifted in a way that he was able to see how he was the victim and that the mistreatment was not his fault. This started the process of him recognizing that he deserved better. With increased self-worth, he was able to hold other people accountable for how they had hurt him, thus removing the internalization of blame he had carried for so long. Through this, he was able to understand how his defenses were a means for survival, rather than a characterological defect. He learned how the ways in which he had been striving for health had led him to feel insecure, anxious, and disconnected in adulthood.

Drew had newfound insight into his childhood, which created a stronger sense of self and self-worth. The release of self-blame for his mistreatment, in conjunction with the language to understand and express his emotions, empowered him to take up space in the room. This presented in therapy by him disagreeing with the therapist openly at times and identifying frustration toward her. It was a pivotal moment in therapy when Drew was able to tell the therapist he was angry at her because he had always been scared to both feel and express anger, in fear he would be rejected buy her. Only after two and half years of therapy did Drew feel safe enough within himself to feel the anger within the therapeutic relationship. The therapist utilized the here-and-now to process what that experience was for him and what he feared as a result. Drew was able to hold someone else accountable without being abandoned, which provided him with a corrective relational experience.

After three years of treatment, Drew achieved functional self-advocacy when he verbalized a desire to terminate therapy. Drew specifically stated that therapy provided the only relationship in his present life in which he felt supported, believed in, and cared for. He reported that the security of this relationship provided him the confidence in himself to navigate the world on his own. He was also able to articulate specific ways in which he had grown throughout treatment, as well as identify aspects of himself about which he felt pride. Together, the therapist and Drew acknowledged the significance of Drew speaking positively about himself, unlike his inability to do so at the start of treatment. Drew was additionally able to believe the therapist when she spoke positively about him and his progress. Drew reported feeling confident in the therapist's support, knowing it would continue even after they stopped meeting. After building a secure attachment with the therapist, Drew was able to accept that his therapist genuinely cared for and believed in him.

Summary

The case of Drew demonstrates the strength of an intersubjective approach, as it addresses the importance of healing interpersonal trauma through the therapeutic relationship. In Making Sense Together (2020), Buirski, Haglund, and Markley explain how "trauma is not the particular event, but the experiencing of overwhelming affect in the absence of attuned others who could provide attunement and understanding." Because shame is affective in nature, it had been critical to address Drew's depth of shame through a therapeutic approach that places emotional attunement at its core. This experience of attunement allows clarification and validation of emotional experiences and promotes insight, which ultimately allows one to understand and slowly release their shame.

Conversely, a common behavioral approach such as cognitive-behavioral therapy fails to address the affective nature of shame, but rather focuses on manipulating thoughts (Fishkin, 2016). Behavioral approaches are also manualized for the short-term, as to be time-efficient and cost-effective. A brief intervention would not allow a patient with complex trauma enough time to develop a trusting and corrective therapeutic relationship demonstrated by the case study of Drew. Since the shame-of-existing is developed within an interpersonal context, it must be addressed and healed within one as well.

The case of Drew illustrates the intersubjective contexts from which his shame-of-existing developed. There was an absence of emotional attunement and complete rejection of his feelings that led Drew to believe that he is unlovable, worthless, and inherently bad. In order to preserve his attachment to his caregivers and strive for health, Drew learned that he needed to try to minimize his presence and prioritize the needs of others, and completely reject his own.

Through the therapeutic relationship, Drew was able to learn that he is worthy of taking up space and being cared for. He was able to learn that by expressing his emotions and showing his vulnerabilities, he would not be rejected, but rather, be accepted and strengthen his connection with someone else. Through an intersubjective systems approach, Drew was able to have a corrective relational experience, in which he was able to develop and strengthen his self-awareness and self-esteem in an attuned environment. Additionally, he acquired a new perspective on his life narrative that helped him release the internalized blame he held on to from his early caregiver experiences. For Drew, the release of this blame helped him slowly believe that he is worthy of receiving love, and that there was nothing inherently wrong with him to explain the mistreatment and misattunement he received from his parents. This liberated him from the significant shame that had dominated his life and sense of self, and it created space for new organizing principles to develop that focused on resilience and inner strength.

Conclusion

The shame-of-existing is an all-encompassing, annihilating form of shame, which significantly affects one's ability to relate to themselves, others, and the world around them.

The shame-of-existing develops in a misattuned environment, in which a child's emotions, needs, and existence are not attuned to or acknowledged. The child struggles to understand their own emotional experiences, because they do not have caregivers who put words to their feelings to help build self-awareness. Additionally, the child internalizes the blame for the disconnection in their relationship with their parent and begins to believe that something is inherently wrong with them in an effort to make sense of the mistreatment from their parents. They learn to believe that their own needs and emotions are the barriers to connection with their caregiver. Consequently, they begin to deny their own needs and emotions in order to preserve the attachment with the caregiver

and attain their love. This pervasive interpersonal experience shapes how the individual sees themselves in relation to others. It makes them see themselves as a burden on others and as invaluable.

Given the present gap in related literature, the psychotherapeutic field would benefit from further research examining the utilization of intersubjectivity to address the shame-of-existing. This research should consider shame-of-existing through a trauma-focused lens, given the traumatic and relational nature of this phenomenon. Ultimately, intersubjectivity has the potential to offer consistent, sustainable, long-term benefits for patients suffering from severe shame.

Due to its severe nature and significant impact on the development of self, it is vital to continue to improve our understanding of the shame-of-existing and how to treat it. The case of Drew demonstrates the pernicious and self-destructive realities of the shame-of-existing, as well as the potential for healing through connection.

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