Chapter 9

Working with Shame and Trauma

Not only does the literature attest to the high levels of trauma among displaced populations, research in the past decade has increasingly revealed the hidden yet pervasive role that shame may play in posttraumatic symptomatology. As defined by Wilson and colleagues, “in the posttraumatic self, shame develops from traumatic experiences that render the victim fearful, powerless, helpless, and unable to act congruently with moral values” (Wilson et al., 2006, p. 127). In the context of forced migration in particular, both trauma and shame are ubiquitous, pervasive, and contagious.

Despite its omnipresence, shame is ashamed of itself. Shame activates shame. The mystifying dualism of shame is that it is at once an isolating, intimately intra-psychic phenomenon seeking concealment, yet remains deeply embedded in a visual and public interpersonal space where the self is violently and unexpectedly exposed to the critical gaze of the Other (Womersley et al., 2011). Unlike guilt (typically related to a particular action or behaviour), shame taints the entire landscape of the individual—colouring the very sense of self. Shame is therefore considered to be a more complex intra-psychic process than guilt because it involves processes concerning attributes about the core dimensions of the self, identity, ego processes, and personality (Wilson et al., 2006). Inasmuch as it lies within the interactional space between self and other, at the divide between the intimate and the public, the individual and society—it tries to hide itself by its very nature. As such, it often remains unnoticed. Its powerful yet seemingly invisible impact may be hidden behind a myriad of emotional cloaks—anger, dissociation, blame, resentment... even more so in the context of clinicians working with migrant populations, where a plethora of differently nuanced cultural cloaks may further obfuscate this noxious affect. However, ethically, clinically, professionally, humanly, we cannot ignore it. This is particularly true of work within multicultural contexts, where relations are so typically marked by power differentials in terms of race, class, nationality and socio-economic status. It is here, in this matrix of identities, that shame is located. Therefore, new approaches are needed for clinicians (both researchers and academics) which

consider the interactive effects of shame and trauma within sociocultural context among such vulnerable populations.

Migration and Post-traumatic Shame

Shame significantly shapes the migration experience, linked particularly to extreme feelings of powerlessness, degradation and humiliation. It may emerge as a result of the many forms of torture, sexual violence and other atrocities experienced in the country of origin, yet is equally exacerbated by degrading and humiliating asylum procedures, having to accept a new and often devalued social identity of being an asylum seeker, and the embarrassment of not meeting culturally-informed expectations to financially support the family. Shame pervades the experience of no longer being “at home” at home, of being cast out of one’s country, of having to metaphorically knock on the door of a potential host country and beg to be accepted, only to be met by significant social discrimination, scrutiny and disbelief at one’s claim to asylum.

The process of migration may therefore be in and of itself a shameful experience, wherein individual and social identities risk being negated through the systemic trauma associated with legal and social practices of exclusion (Goldsmith et al., 2014). The bureaucratic systems and procedures with which migrants are faced upon arrival in a host-country may echo feelings of powerlessness and helplessness experienced throughout the migration journey. Indeed, the very status of “victim,” of “asylum seeker” may be inherently shameful to some. The outright expulsion of many migrants, the deterioration of living conditions, the uncertainty regarding legal status, the deprivation of rights and the implementation of mechanisms designed to prevent the construction of social links has arguably lead to a shameful “construction of invisibility” (Sanchez-Mazas et al., 2011). Administrative provisions may often make the very presence of migrants as subjects within a State no longer accepted and “this translates all too quickly in the fact that the person as such is no longer accepted” (Torre, 2016). The physical, social and political isolation so typically experienced upon arrival to host countries serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015).

Furthermore, the stressful experiences that many asylum seekers and refugees are exposed to during forced migration, and during the resettlement process, make them vulnerable to mental health conditions. As a consequence, the prevalence of psychological distress and mental disorders in asylum seekers and refugees as reported in the literature appears to be generally high, with significantly elevated rates of PTSD being found among this population (Li et al., 2016; Turrini et al., 2017). Traumatology research over the past decade has seen the development of the concept of “posttraumatic shame,” with key authors stressing the importance of shame as a social emotion that impacts the severity and course of PTSD symptoms (Hecker et al., 2015; Maercker & Hecker, 2016; Wilson et al., 2006). Indeed, the experience of shame has even been revealed to potentially hold the same properties as traumatic

events involving intrusions, flashbacks, strong emotional avoidance, hyper arousal, fragmented states of mind and dissociation (Matos & Pinto-Gouveia, 2010). Shame and trauma are inextricably linked.

Torture in particular represents an extraordinary exception in the psychopathology field—with significant implications for the shame-trauma nexus. The particularity of torture as pathogenic is linked to the fact that the act itself is taught, organized, elaborated, and perpetrated by humans against other humans (Sironi, 1999; Viñar, 2005a). Arguably, the aim of the perpetrator is to shame, to disrupt the connection to all that makes us human (Viñar, 2005a). As such, torture is not an individual act, but a social one. It is an inherently shameful experience, damaging different spheres of an individual including body, personality, hope, aspirations for life, identity, integrity, belief systems, the sense of being grounded and attached to a family and society, autonomy, community relationships, and a sense of safety (Womersley et al., 2018). Humiliation thus arises from torture experiences where the survivor is abused, dehumanized, and made an exhibition for others, essentially representing a profound loss of dignity and power (Wilson & Droždek, 2004; Wilson et al., 2006). In particular, the dual shame inherent in being both a victim of torture as well a refugee is related to a myriad of losses, human rights violations, shifting power dynamics and other dimensions of suffering linked not only to torture experienced pre-migration, but to different forms of violence experienced during and after migration as well (Hodges-Wu & Zajicek-Farber, 2017).

Cultural Manifestations of Shame and Implications for Clinicians

The source of shame can never be completely in the self or in the Other, but is a rupture of what Kaufman (Kaufman, 1989) calls the “interpersonal bridge” binding the two. In thus theorizing shame as being located at this bridge, we understand the important role it plays in community life through promoting socially acceptable or desirable behaviour. It exerts a force that inclines individuals to adapt to socially sanctioned values, rules and beliefs—an integral component of the promotion of cultural ideals (Swartz, 1988). A significant source of shame is the loss of continuity in upholding culturally defined values, norms and respected patterns of behaviour—and the self-consciousness over disappointing others within one’s social network and embedded within one’s culture (Wilson et al., 2006). We may therefore understand the importance of the sociocultural context in determining its various manifestations. This has been highlighted in the plethora of cross-cultural and anthropological literature paying attention attesting to the variety of culturally diverse forms of shame (Wong & Tsai, 2007).

This has significant implications for professionals—both clinicians and researchers—working with populations from a variety of cultural backgrounds. A large potential for misunderstandings between clinicians and traumatized individuals

is not only because of a language barrier; very little is known about the concepts of illness and treatment expectations in these patients (Maier & Straub, 2011). Furthermore, shame-related cultural codes of behaviour might prevent migrants from directly reporting earlier traumatic experiences, from trusting the professional or from even attending appointments. As noted by Wilson et al. (2006), “the powerful emotions of posttraumatic shame are associated with a broad range of avoidance behaviours: isolation, detachment, withdrawal, hiding, nonappearance, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others” (p. 138). These signs are easily misread.

The interpersonal dynamics of this clinical encounter may not be so different from the context of research interviews, similarly marked by power asymmetries (Salazar-Orvig & Grossen, 2008). Here, the individual migrant is placed in the role of a patient-participant object, in the face of an arguably more socially powerful professional subject aiming to scrutinize the most intimate details of their life history. It risks being an inherently shameful encounter, exacerbating extreme feelings of powerlessness, degradation, and humiliation. However, as noted by Wilson and colleagues (Wilson et al., 2006), shame is a two-way street; it can exist in the patient and therapist at the same time in different intra-psychic configurations. Working with the complexities of shame in the posttraumatic self, both patient and therapist (and arguably, participant and researcher) share a common ground of human vulnerability whose management likely determines the quality of outcome. As we have illustrated elsewhere in the case of research among survivors of sexual abuse (Gail Womersley et al., 2011), shame pervades the entirety of the relationship. It is contagious. All are affected. As much as the identity of a victim, an asylum seeker, an oppressed ethnic minority may be shaming for the migrant, the identity of the oppressor, the colonizer, the privileged ethnic elite, may be shaming for the clinician or researcher.

We need to consider shame in the context of work with vulnerable migrant populations—not only because it may influence our professional work in profound yet often barely perceptible ways, it is our ethical duty as human beings to reflect on these intersubjective encounters. In order to reflect on some concrete case examples of the ways in which shame may manifest in such encounters, and on some applications in dealing with shame constructively, I draw on my work with asylum seekers and refugees in a centre for victims of torture in Athens.

Case Study One: Research Among Displaced Victims of Torture in Athens, Greece

The case study also appears in a chapter entitled “A Sociocultural Exploration of Shame and Trauma Among Refugee Victims of Torture” in a book entitled “The Bright Side of Shame,” edited by Claude-Hélène Mayer and Elisabeth Vanderheiden (Womersley, 2019). As the migration “reception crisis” continues unabated, Greece

remains one of the first ports of sanctuary. While the country is still gripped by one of the worst financial and societal crises of the past 40 years, little attention or funding is available to provide mental health and psychosocial support to refugees (Gkionakis, 2016). Many torture survivors in Greece, only some of whom having been identified as vulnerable, are still trapped on the islands, a context characterized by a lack of specialised medical care and poor living conditions. Other torture survivors who have moved to the mainland without permission have also found themselves in limbo, unable to proceed with their asylum claim. The complex asylum system and the many barriers in accessing basic services in Athens and across the country have only increased their hardship (Kotsioni, 2016). Furthermore, according to Mentinis (2013), Greece itself has been diagnosed as being in a never ending crisis of identity; a conflict between two traditions, a hovering between the East and the West. For many Greeks, the major influx of immigrants brings even further challenges to their national identity, because until recently Greece was a very homogeneous society, inhabited by an overwhelming majority of ethnic Greeks who speak Greek and who belong to the Greek Orthodox Church (Voulgaridou et al., 2006). The sources of shame within this context are many: from the Greek citizens themselves who may be ashamed of the poor reception conditions, of not being able to do more to help, of the inadequate institutional structures and hostile reactions to foreigners on the part of their compatriots, of not being up to “civilised” Western European standards; to the asylum seekers suddenly finding themselves in an incredibly precarious and vulnerable position, having lost many aspects of their valued social identity linked to their country of origin.

In this particular context, I conducted participative research in a centre for victims of torture in Athens. This involved three months of participative observation with the medical team of the centre: participating in the team’s daily morning meetings and group therapy activities, facilitating psycho-education sessions for the beneficiaries of the project, and teaching English in the centre twice a week. My research also involved conducting qualitative interviews with beneficiaries, the health professionals themselves as well as “community representatives”—leaders of the various refugee communities around Athens. It was thus a complex mixture of being both a clinician and a researcher, requiring an on-going negotiation of these multiple identities.

The beneficiaries of this particular project were identified as “vulnerable”—victims of torture in their countries of origin and in particular need of multidisciplinary care. They came from all over the world, notably regions affected by conflict. The team, offering mental health support, physiotherapy, and medical care, worked in collaboration with social workers and lawyers who were assisting the beneficiaries in their request for asylum. The needs were many, varied yet interrelated. An accompanying team of cultural mediators was required—not only for translation but as mediators of this new and complex medico-legal system with which people were confronted.

The use of the term “beneficiaries” to refer to the individuals coming to the clinic, as opposed to others such as “patients” or “asylum seekers” or “victims of torture” was a deliberate one. When the project opened, all individuals would all be presented

with a “patient” card, that is until one individual refused to take his. It was, he said, not how he chose to identify. The word “patient” evoked a deep sense of shame. He felt that it implied a victimizing and humiliating identity. He was neither, he had insisted, a patient nor a victim—but an individual in his own right.

It became apparent, during the course of my time as a participant researcher in this context, that it was not only trauma, but also shame, which pervaded the space—with significant and potentially destructive implications for the micro-interactions among the various actors. It was present in the daily meetings, where professionals kept expressing a feeling that they were not “good enough,” not doing enough to help the beneficiary find work or shelter, not feeling experienced enough to handle the complexity of the needs of the vulnerable population with whom they were working, ashamed of belonging to a country where the structures supposedly in place to assist the migrants were not meeting their needs. The result appeared to be either an increased or decreased commitment to the work, a feeling of anger which incited a call to action, to respond to the need in front of them—or a resignation, a feeling that they had very little power to effect concrete changes in the lives of the beneficiaries.

As for the beneficiaries of the project, the shame was even more apparent. Finding themselves at the clinic, unable to help themselves and at the mercy of the team of professionals there to help them, ashamed of not being able to support their families financially, of not having met their aspirations of “succeeding” in Europe, ashamed of the humiliating and horrific experiences which they had endured, of how they may have compromised their perceived moral integrity in order to survive, of not being able to fully master the language nor the cultural nuances of their new environment ... this was the shame in some way linked to the identity of “victim.” The result, often, was a need to hide oneself, to not want to be seen entering the clinic for fear of the stigma attached to being a victim of torture, to mask aspects of their narratives, to not want to answer the professional’s questions directly for fear of certain aspects of their lives being exposed or not believed. It resulted in different versions of their life story being told to different professionals. It resulted in many not wanting to see the psychologist as a result of the shame of being identified as “crazy.” It resulted in quiet waiting rooms, where the silence among the various beneficiaries may have been out of respect for shame—for not wanting to expose each other as victims.

Shame was similarly present within the intersubjective space between myself, the health professionals, and the beneficiaries/participants. As noted above, I came as both a researcher and a clinician, an active participant in the space. I was both part of the team, yet in many ways a detached third party observer. Other aspects of my identity were similarly present, becoming more or less salient within the micro-interactions. I am South African. Therefore, as so often raised by the beneficiaries of African origin, I am “an African sister.” One of “us.” Yet, unlike the rest of “us”—I have White skin, I am not subject to the same degrading or humiliating micro-instances of racism so many experience when coming to Europe. Unlike them, I am “legitimized” in my right to be there, to pass unnoticed in the streets, to move freely around Europe. I am in the privileged position of the professional—I have the right to observe, to direct, to interrogate, to pose questions. I am also a woman, like some and not others. As we have explored elsewhere in reflecting

on working with South African survivors of rape (Womersley et al., 2011)—the shame linked to the similarities and differences across marks of identity, so boldly and unavoidably expressed through our bodies, is a fundamental part of the interaction between researcher and researched in the context of qualitative interviews being conducted, particularly among vulnerable populations and particularly when exploring the sensitive topic of trauma.

To explore the myriad manifestations of shame—not belonging to the Self or Other but in the intersubjective space between all of these actors—I present a case study of one beneficiary with whom I had multiple interviews over the course of a year. I intend this to be an illustrative case study which may allow us to track the manifestations of shame as it arose in the interactions between us. It is representative of many of the interviews conducted during this period, and, hopefully, representative of so many qualitative interviews being conducted by qualitative interviewers in multicultural settings across the world. Reflecting on these micro-instances of shame, being able to first of all track it and second of all, through this awareness, allow this reflexivity to influence the way in which we interact with the participants whom we interview in qualitative research, is an ethical obligation. It is our responsibility as researchers, and as human beings.

Applied Approach to Dealing with Shame: The Case of Sylvain

Sylvain is a 35 year old refugee from the Ivory Coast, a beneficiary of the centre for victims of torture in Athens and a participant in my research with whom I conducted five qualitative interviews over the course of the year. Our work together is presented as a study on the myriad of ways in which shame was both manifested, and subsequently transformed, during this period. To analyse the case, instances of manifestations of shame in our interaction were identified in the transcripts, and subsequently grouped according to emerging overarching themes. Four identified sources of shame are presented, accompanied by some reflections on implications for transformation.

The Shame of Dependence

During our first interview, Sylvain described his situation as the following:

Often we are confronted with strangers, and they mistreat us... when he can help you today, it is in two or three weeks that he will help you. They like to play with people, come and go... You go there and you are told to come back where you left first. It is not easy. But we understand them, we have to accept them, otherwise, it's dangerous [...] but we have to accept it is life, it hurts, it's stressful, it's hard, but when you're out there, we have to accept.

His shame appeared to have been related to being in the vulnerable position of dependence on the help of others, others who may well “mistreat us.” Interestingly enough, the “mistreatment” to which he referred was not related to the many instances of racism he reported, nor to the fact that he was handcuffed by the police and thrown in prison without apparent just cause. Rather, he referred to the people who “play,” who “come and go.” In other words, the mistreatment he referred to is that which he encountered among those meant to “help”—humanitarian aid workers, state social services, medical professionals etc. This, in turn, evoked in me a sense of shame of being somehow related to those who help “when he can.” Despite my role as an independent researcher, I was still connected to the clinic where he came for assistance. I was aware of this throughout my fieldwork in Athens. In 2015 and 2016, it was a context characterised by a plethora of well-meaning humanitarian workers coming to assist refugees for short periods of time. So many of the asylum seekers with whom I spoke referred to this phenomenon of “trauma tourism”—painting a picture of people arriving, asking questions, offering to help, and then leaving without fulfilling promises of further assistance.

Implications for Transformation

Sylvain’s words offer a sobering reminder of the way in which the shame associated with being dependant on the assistance of others may be transformed through simply being (a) attentive to and aware of the possible impact of shame and (b) aware of the responsibility to avoid “playing” with vulnerable populations, to not just “come and go.” I would argue that part of the transformation of Sylvain’s shame, particularly shame related to this experience of being dependant on external aid, came through the consistent relationships he was able to form with staff at the centre over a period of two years. In our own relationship, it was linked to the fact that I kept to our agreed meeting schedule and consistently returned over the period of a year. It lay in simple details, such as allowing him to choose the time and place of our meetings together—a change compared to the treatment he reported encountering in his dealing with bureaucratic state institutions where he was often left to wait for hours, only to have the appointment delayed by months. Such basic signs of respect seem to have had a transformative impact on his own shame.

The Shame of Social Discrimination

Throughout our five meetings together, Sylvain reported feeling ashamed at the way in which as an asylum seeker he way he was treated as a “criminal” by a variety of actors, including the police:

We start from a good one to frustrate you somewhere, and we fled the violence in Africa, arrived in a country where we say there is the human right, you come to sleep in the things that... I am in Greece I have known handcuffs, it is in Greece I have known handcuffs [...] Because they say I don't have papers. Is an unregistered person a criminal? [...]

it's the things we keep in our hearts, in the prison, the police can hit you...

He also noted facing discrimination by not only local Greek populations, but other migrant communities. In reflecting on this, he highlighted my identity as a white person:

You're South African, where we are sitting, a lot of people think you're European. So you see, but me seeing myself [...] You go to immigration, they say, you wait and give priority to others.

Despite us both being African, a fundamental difference is the colour of our skin. I am able to pass as European, he is not. His words are testament to the very present psychic consequences of shame and the accompanying feelings of envy seen in the context of deprivation and powerlessness as well as in the ubiquitous (and often unspeakable) presence of racial trauma (Harris, 2000).

Implications for Transformation

In outlining his experiences of racism and discrimination encountered in Europe, Sylvain stated the following:

He [a European] does not distinguish you, he says, "The immigrants." But it's not just immigrants.

His words hint at the shame of a loss of individual identity in favour of being seen as "an immigrant." He contested this notion of being "just immigrants," in favour of being "distinguished"—in other words, of being seen and recognised as a complete and complex individual self. I would argue that the implications for transforming shame related to such social discrimination lie in the need for individual aspects of identity to be made visible, recognised, and valued. In exploring this, we similarly cannot ignore our own sense of shame related to being in a position of social privilege. Here, what seemed to have had a transformative impact on Sylvain's shame was my recognition of it. I needed both to be aware of my own shame linked to social privilege, and to recognise and respect his shame related to social discrimination.

The Shame of Being Unemployed

Throughout the year in which we met, Sylvain referred multiple times to the shame he felt at not being able to provide for his family back home who were waiting for his financial assistance. The shame he felt at not being able to meet their expectations

eventually got to the point where he stopped answering their phone calls. He did miss them, he explained to me, but he couldn't face the shame of being unemployed and unable to help:

Tomorrow when you succeed, you will be the pride of the family: the family and the whole village. But when you become a delinquent, it's [a shame for] the father and mother. These are things you don't really want to talk about.

He reported feeling frozen in time, unable to move on with his life and contribute as a productive member of society. Jobless, he felt "worthless," a delinquent who eventually turned to illegal activities in order to make money:

The situation in Greece here, if you're not morally strong, it can make you do some bad things. It is not easy. We live like we never existed [...] I'm starting to do bad things. When you become envious, you're exposed to everything. And the easiest thing in Greece is selling drugs.

The shame of being unemployed was therefore double-edged: not only was there shame around being "useless" to society, in other words a "delinquent" family member unable to provide—the situation as an in-existent *persona non grata* lead him to conduct himself in "shameful" ways which previously would have been unthinkable. The behaviour seems to have been judged as immoral not only by others but by himself, a deep source of shame at the interpersonal bridge between himself and his social world. He was led further and further into the metaphorical shadows of society.

Implications for Transformation

Sylvain eventually did find legal work, and the transformative effect on his mental health was remarkable. Not only had his material conditions improved, he felt somehow more legitimate in his environment. He had become an active contributor to society, able to take the bus in the morning along with others heading to work, able to share the little that he had with friends and family, able to "show his face" in public. The fact of being employed seemed to lessen his sense of shame more than any other factor. As concisely and poignantly stated by Buggenhagen (2012), "money takes care of shame."

The shame surrounding Sylvain's unemployment serves as important reminder of the embeddedness of this emotion within a socioeconomic context. In my role as researcher, my primary focus was evidently on his psychological state of mind. However, it became abundantly apparent in interviews, with him and other asylum seekers, that this was significantly dependant on his social and economic environment. His sense of self-worth, relationship with family, socioeconomic status and the material conditions in which he found himself, all mutually reinforced the sense of shame about which he spoke so openly. We may not always have the capacity to effect changes in the socioeconomic lives of the people with whom we interact as

clinicians and researchers. We can, however, reflect on this shame in our interactions. This could mean, for example, breaking our professional/ethical codes of conduct to accept gifts which we know individuals can ill-afford but for whom it is a point of pride. It means having the courage to address the sensitive topic of money when raised. Practitioners and researchers working with this population cannot ignore this incredibly salient aspect of shame. To do so risks, in many ways, reinforcing a social silence that so often fosters shame.

Case Study Two: Female Survivors of Sexual Violence in Cape Town, South Africa

The case study also appears in a scientific article published in *Qualitative Inquiry* (Womersley et al., 2011). Shame lies at the heart of the traumatic experience of rape—it is the experience of the body being exposed as inherently damaged or defiled and the consequent disconnection of the self from society. While descriptions of rape commonly identify “shame” as something with which abused women often wrestle, the form of the affect may depend on the value systems of particular communities (Bennett, 2000; Gavey, 2013). Much of the South African literature regarding the stigmatising and shaming effects of rape emphasises how the damage, devaluation and deviance of rape survivors is shaped by underlying contextually-specific patriarchal structures which position African women as moral guardians for their respective cultural values and traditions (Dawes & Donald, 1994; Kiguwa & Hook, 2004). As a result, the attitudes of the police, the medical establishment and the criminal justice system continue to reflect a deeply shaming undercurrent to reactions to rape survivors, contributing to what is referred to in the literature as “secondary traumatisation” (Artz, 1999; Artz & Smythe, 2008; Koss, 2000; Posel, 2005; Steyn & Steyn, 2008).

The pervasive threat of contracting HIV after a sexual encounter adds a further dimension to the shame of the South African rape survivor. The South African context is characterised by an unrivalled rape pandemic as well as having one of the highest HIV infection rates in the world. It is therefore unsurprising that there have been attempts to link the two pandemics conceptually, mediated by the myths and traditional beliefs surrounding female sexuality and its relationship to the virus (Chisala, 2008; Motsei, 2007). Thus, the rape survivor’s profound shame lies not only in her experience of the humiliating and degrading event itself, but in the subsequent appraisal processes undertaken by herself and others in an attempt to make sense of the event.

Next to children, black women in South Africa are most vulnerable to ongoing traumatisation on a number of economic, physical and psychological levels, and are also the victims of the majority of rapes reported in the country (Maw et al., 2008). Within this context, it is impossible to consider the shame of the gendered, sexual body without linking it to the shame inherent in racialised identities, which

themselves are deeply enmeshed in a complex matrix binding gender, class and socio-economic status (Harris, 2000). Butler (2003), for example, has marked the body as the stage on which traumatic disconnection unfolds. She constitutes the body as a public phenomenon situated squarely in the social sphere, the site of abuse and political oppression reflecting our social identities:

Each of us is constituted politically in part by virtue of the social vulnerability of our bodies – as a site of desire and of physical vulnerability, as a site of a publicity at once assertive and exposed. Loss and vulnerability seem to follow from our being socially constituted bodies, attached to others, at risk of losing those attachments, exposed to others, at risk of violence by virtue of that exposure...the body implies mortality, vulnerability, agency: the skin and flesh expose us to the gaze of others, and also to touch and to violence (p. 10).

Butler here is not referring directly to the affect of shame. However, her allusion to the exposure of the self to the Other, manifested in the body, speaks directly to processes underlying the shame following violence and bodily abuse. In the context of white women researching gender-based violence among black women in South Africa, there is an added dimension of shame which carries a particularly racialised and politicised dimension. As Burman and Chantler (2005) argue, any investigation of violence or abuse within oppressed communities “faces charges of fuelling racism by perpetuating widespread cultural stereotypes that these groups are more oppressive to women than the dominant culture” (p. 71). This dimension is further highlighted by Mama’s (2007) understanding of the role of psychological research in the “construction of African subjects as the objectified Other of the European imagination” (p. 18).

Shame is manifest on the micro-level of our daily interactions and cannot be separated from the complex matrix of gender, ethnicity and socio-economic class informing our public identities, which are so boldly reflected through our bodies. In order to further explore what shame DOES on the micro-level of our daily encounters, the analysis below tracks the affect of shame within the context of a qualitative research interview as a demonstration of how significantly the interview was shaped by the affect.

Presented below is a case study of a particular researcher-researched relationship within the context of qualitative, feminist research in South Africa. It is an analysis of the dialogue between Maria and me, which formed part of a study conducted in order to research the psychological impact of rape in survivors within 72 h of the event. Maria was interviewed at the Thuthuzela Care Centre in the Western Cape, which provides forensic, clinical and counselling support for survivors of rape—the site of the research. A semi-structured interview schedule was used and the conversation was therefore guided by broad, open-ended questions aimed at eliciting a narrative of her experience of the event, including the details of the rape itself, her emotional reaction and her feelings towards the institutions who were dealing with the rape.

The transcript of this dialogue has been analysed as part of this original research, with the focus being on an analysis of the dominant discourses which shaped the narratives of the survivors I interviewed. However, I have subsequently become aware of the pivotal role of shame, which profoundly coloured the exchange between us.

This interaction is therefore presented as a case study in order to delineate the various manifestations of shame which arose in the intersubjective space between us.

In order to track the development of shame as it was co-constructed within this intersubjective field, the analysis follows the interaction from the beginning of the interview to the end. However, specific pieces of dialogue are highlighted as marking particularly salient moments where shame was activated and passed between the two of us. Following the example of Miller (Miller, 2013), who demonstrates an inferential identification of shame themes in interview data, the selection of such moments was based on a triangulated model of data analysis dictating the tracking of the affect—namely based on the form of the conversation, the content of our dialogue as well as my own emotional memory of the event.

Analysis

The analysis offered here illustrates the various manifestations of shame which arose in the interaction between myself and a research participant, Maria. The case illustrates the effects of shame as it is mediated by my identity as a 22 year old, Jewish, middle-class female researcher and Maria's identity as a 32 year old female Coloured rape survivor living in the socially and economically oppressed Cape Flats. Our dialogue is testament to the very present psychic consequences of shame and the accompanying feelings of envy seen in the context of deprivation and powerlessness, as well as in the ubiquitous (and often unspeakable) presence of racial and gendered trauma (Harris, 2000).

The first contact I had with Maria was in the waiting room of the Thuthuzela Care Centre, which forms part of G. F. Jooste Hospital in Mannenberg, Cape Town. She had been brought in by the police, had been seen by a doctor, and was sitting in the waiting room. I approached her to ask whether she would be interested in taking part in my research by speaking to me about her feelings surrounding her experience of having been raped. From the very start of our meeting, our interaction was bound by a potentially shame-inducing social structure. The interview began with Maria expressing her anger and confusion at being raped:

Now I'm feeling very angry. I feel so confused. I feel that there's no hope. It's almost like I'm trapped. I can't get out. I feel like no one understands, nobody cares. I can't trust even myself. Or even cry...I can't even cry. I don't know what to do. And the most important thing of all that I feel is that I don't feel anything. I feel like nobody cares ... I won't even be able to look at myself and I've lost everything.

Maria's sense of "not being able to look at myself" speaks immediately and directly to the shame felt as a result of being raped by her husband, and the subsequent severance of her own sense of self from her social environment, a rupture of what Kaufman (1989, p. 22) terms the "interpersonal bridge" binding self and Other. Her words communicated a sense that the rape has taken away an acceptable form of self from her, and in its place stood a self which even she could not tolerate. At this stage

of the interview, her feelings of rage dominated her narrative. She went on to tell me that she was so angry that she could “kill someone, really hurt someone.” She outlined the thoughts she had of pouring boiling water over her husband’s feet: “he would have gotten so much pain. And all his skins, all his bones would have hanged on him. But most of all he would have had pain...and I wanted him to feel that pain.”

Maria then began expressing her sense of helplessness and confusion at the time of the rape: “You can beg, you can scream but they will still hurt you. Nobody will help you. No person...but when I really wanted to, I couldn’t end it. But I have to get up from the floor and show no emotions, no feelings.” The assumption implicit in her statement is that any display of emotion is strongly equated with a feeling of vulnerability and of being situated in a lower social position (“on the floor”). The rape has tainted her body as spoilt, compromising her social position in the eyes of the Other (Paul Gilbert, 1997; Paul Gilbert & Andrews, 1998; Paul Gilbert & Miles, 2014) and has taken away her own sense of personal agency by placing her in a situation which rendered her powerless to act. Morrison (Morrison, 2014) suggests that the “searing” (p. 113) quality associated with descriptions of shameful experiences reflects a sense of helplessness in the face of an inability to alter the state of the compromised self.

This feeling of unworthiness, of social undesirability, of helplessness leads to a shattering of the core self of the survivor (Herman, 1992), which may lead to a paralysing self-hatred, as illustrated in Maria’s subsequent words:

I know I’m beautiful, I know myself. I’m someone who likes to look in people’s faces when I talk to them. I like to look in their eyes. But now I could never look in someone’s eyes. I could never look into my own eyes because I’m just lying to myself. I will never see that part of me again. Ever. I will never look another person in the eyes again.

Maria’s words suggest that the rape has disconfirmed her previously held positive self-beliefs in her own beauty (Lee et al., 2001), and has replaced this with a shame so paralysing that she is unable to look people in the eyes. As Morrison (Morrison, 1998) notes, “to feel shame, we do not need the presence of an actual shamer or a viewing audience; we need only those internal figures who have become part of who we are” (p. 16).

She went on to say, “I’m in a corner, I can’t move. I don’t know how to get my life back in order again. I’m a cripple.” As Morrison (1998), suggests, “a lack of acceptance by self and others is...a central narcissistic quandary, related to the deeply felt shame of the narcissist” (p. 82). This quandary places the shamed self outside of known relational and contextual structures in the interpersonal field (Broucek, 1991), a significantly disabling position.

She thus described her experience of rape placing her in a lowly social position, her words serving to highlight my relatively high social position as researcher in contrast—a position wherein I could construct my own interpretation of her experience and pass judgement by subjecting her to the scrutiny of my own disciplinary surveillance. My own shame at this juncture in our interaction was significantly informed by a feeling of having forced Maria into this vulnerable position against her will, purely to cater for my own academic needs, or what is referred to in the

literature as Guimaraes (Guimaraes, 2007) refers to as “holidaying on someone’s misery.” In response, I remained silent in order to distance myself from “other” authoritarian figures (in this case not only the police and the medical staff at the hospital, but the numerous white researchers attempting to represent the experiences of black women) who I imagined may have pushed her to expose her experience of being raped.

Maria went on to tell me the story of her first born child, who died on her third day of school at the age of six years old. She told me of how she has come to terms with this death, and how she has been blessed with another child: “Now God gave me another child, He gave me a second child. A Barbie child. That child is so perfect that when I cry, she wipes the tears away.” Here there is a striking association of perfection with Barbie—an icon which arguably celebrates the feminine ideal, both in terms of her (white) bodily perfection as well as the middle-class lifestyle she represents. The image of the perfect child reverberates with the projective phantasies of perfection and omnipotence seen as the underside of shame (Hollway, 1989), a defensive identification with the admired Other (Morrison, 2014).

When she uttered these words, I couldn’t help but consider the significance of it being this “Barbie child” who was able to alleviate her pain. The allusion resonated with images of the many attempts by powerful white supremacists propelled by humanitarian ideals to “fix” Black and Coloured people (Cushman, 2000). As Maria continued to recount this distressing narrative, she began to cry. She went on to say, “I don’t want to be a cry-baby. Growing up, I was told, “Don’t you cry, Grown-ups don’t cry.” At this stage I was made acutely aware of her inability to look me in the eyes. Her head hung low and she avoided my gaze, an indication as to her degree of shame at crying, at being so exposed and placed in such a vulnerable position (Exline & Winters, 1965).

Maria continued by saying, “because what happens if you cry, people slam your face against walls. They take away your dignity, they take away your pride.” Her use of the ruthless metaphor of having one’s face slammed against a wall, exemplifies her feelings of anger towards the people in her life who have shamed her. The metaphor served as a vivid, concrete example of what such severe feelings of shame might have felt like for her, particularly when one considers its violent depiction of the fragmentation of self.

Maria continued by asking me, “How can someone sleep with you without asking? How can someone just do that to you?” The fact that Maria chose to engage in the use of the second person participle “you” as opposed to the first person singular “I” seems significant on various levels. It was firstly indicative of her desire to remove herself as the subject of the narrative, or indeed as the shamed object of scrutiny. Secondly, it highlighted the salience of our shared gendered identity and thirdly served as an invitation to me to place myself in her position, of imagining myself having been raped by someone who has slept with *me* without asking.

Maria’s questions elicited in me a feeling of shame related to my own internal thoughts of immunity to rape, a narcissistically imagined invincibility due to the fact of my own whiteness. Rape doesn’t happen in my neighbourhood, specifically not to nice Jewish girls. What rose in the space between us was a recognition of these

thoughts, which Maria was able later to expose in a way with her comments that having a nice car will not necessarily prevent me from experiencing similar trauma.

Maria's need for similarity and identification on the basis of a common gendered identity was fighting for space with my own defensive need for distance and difference. I was ashamed that my own silent belief in immunity had been revealed, and was therefore unable to answer her question. Here, my silence acted as an admission of defeat, of acknowledging the shame that I carried which was so deeply connected to notions of my whiteness having marked me as being immune to domestic abuse. Thus, shame in this particular instance served to create blocks in the interaction, potentially obscuring a more natural and spontaneous engagement.

Maria went on to tell me that there was no one else to be trusted "because people talk behind your back. But I do know that there are people out there who care about me." She recounted the ways in which she had been ostracised by many members of her community for being in an abusive relationship, marking her as inferior, unruly and deficient (Ussher, 2006). She told me of the many ways in which she was "not herself," "not the same person I used to be." The experience of being raped, and the subsequent severation of herself from her community had tainted her identity irrevocably, the shame serving to obstruct certain pathways to her social world. She began to cry, turning to me and saying:

I used to be like...when I look at you, as a young person, we're about the same age and I think, I hope...I hope that you don't have to go through so much pain. It really hurts. I hope you don't have to. I hope nobody kicks you around. Because there's no mercy, no mercy for a poor woman. You can have the car, you can have nice clothes, but don't let anyone take that away from you...don't let anyone do it.

Her words marked a turning point in the interaction between us. I felt as though Maria had turned the tables in a way, positioning herself as the advice-dispensing expert holding significant power and authority, and myself in the position of the shamed and abused. I felt pinned down, trapped, "in a corner" in Maria's words. Her marking my nice clothes and my nice car spoke directly to the reality of my socio-political background, "responsible for the material disadvantage of the majority of South Africans" (Kometsi, 2001, p. 15).

Maria said that were she to go home, that she would not let her husband know that she had been at Thuthuzela, "I would say that I've been at someone else." This provided me with insight into the shame felt by herself, and presumably many other women who came to Thuthuzela Care Centre, at having to come to a hospital centre to receive medical and psychological help. I was only able to imagine the response of Maria's husband, and other important people in their lives, in discovering that she had been there. The sense of silence and secrecy surrounding the space in which we were located mirrored the shame, silence and secrecy which so commonly shroud women's experiences of abuse. Maria told me of how she had waited at the police station for hours the day before in order to get an interdict against her husband:

And when I came home, I left all those papers at my friend's house because I know that he will take that away from me. They can take my clothes away so that I can't go anywhere. They did take my clothes away, I can't go anywhere. And sometimes they take my stuff,

my money, my clothes...he always has his brother helping him. And he gave his brother a smile: 'Listen, take my wife's clothes' Take my personal stuff. And anyway, ummm...I went home.

As she said this, Maria pointed to the hair on her head, indicating how her husband had grabbed her hair whilst chasing her. I was immediately filled with a sense of rage at the cruelty of her husband's actions, unable to fully conceive of the sense of utter helplessness and humiliation I assumed must have arisen out of being so mercilessly objectified (Broucek, 1991). It would be possible to suggest that the shame evoked in Maria by such an encounter was significantly informed by a sense of having been objectified by her husband, that her literal nakedness spoke to a much deeper sense of being mercilessly exposed and publicly shamed. At this point in the interview, I was aware of the fact that Maria was not looking me in the eye, and that I too was feeling somewhat disabled by her narrative. My own shame resonated with hers. I was led by a strong desire not to put her any more into a corner, not to appear as yet another judging critic. I felt unable to respond to her shame in a way which was deservedly respectful and thus remained silent whilst she continued to recount her experiences:

And then he pushed me down on the floor. That is why I had this bump here. It's almost like he forced me down. And he held a screwdriver, an orange screwdriver, against my throat and he said that the more I screamed he would just stab me in the throat. Because I was already so tired and mixed up. I couldn't push him away or anything. And he just forced himself on top of me....and then he had sex with me.

She relayed the narrative with her head down low, avoiding eye contact and evidently distressed. Her shame was palpable. My own silence at this point in the encounter was due in part to a feeling of being overwhelmed with the depth of her pain and feeling a need to limit my identification with her distress and vulnerability. This resonates with the observations of Burman and Chantler (2005) who, upon reflecting on their work researching domestic violence, noted that researchers themselves "might have often felt "shamed" because of their lack of engagement, and/or knowledge, or feelings of being overwhelmed both with issues of abuse and specifically in relation to minoritised women" (p. 390).

Maria then looked up, turned to me with some pride in her voice and said,

And then I feel, for a second, that I wasn't going to have it. And then I said to myself, "No Maria, remember you have your interdict. You did something" And then, "Don't stop." I wanted to stop, I wanted to get out...This morning I just got up and I just left. I just said to him, 'You will never touch me again' And I left.

Horney (1991) relates pride directly to shame, "pride and self-hate belong inseparably together, they are two expressions of one process" (p. 109). From this perspective, Maria's pride in leaving her husband was an attempt to regain a sense of autonomy and control, a way in which she could reclaim the situation and alleviate her shame.

Maria went on to say:

Thank you for listening, and I hope that you keep up with what you're doing. I know myself, I know that I can do it. God is all I have because God has put me here. I'm here for a special reason. And I hope that you will make something of your life. That's the kind of person I used to be, talking to people. I can't take your confidence away, I can never put you down.

Maria went on to explain that "because I'm Muslim, I don't have any rights towards the husband," further marking the socio-cultural and religious differences between us. She expressed a sense of powerlessness which she perceived as being inherent to her own identity as a Muslim wife, and all the duties and obligations which that seemed to entail for her. She felt that as a Muslim wife, "they take your money away...because if it's his T.V. it will stay his T.V." Thus, the acknowledgement of religious difference brought with it an acknowledgement of the socio-economic implications of that religious difference, an expression of the meaning which she attributed to her own cultural and religious heritage.

Maria went on to speak about her work as a hairdresser and the sense of autonomy her employment gave her: "I don't depend on him financially to support me. That's the one thing he can't take away from me. I can support myself ... I've got my own tools." She explained that being financially independent was of huge significance for her in reclaiming a sense of pride in moments of the most acutely felt shame, because.

When he hits me, all crumpled up, all hurt, he kicks me, he's injured me, he gives me the ... I feel I have no hope. But I pick myself up and I blow someone's hair.

At this stage of our interaction, Maria seemed to have regained a stronger sense of control, as was exemplified in her subsequent comment that "from this point to that point, it's all up to me." She continued by comparing her own physical appearance to mine:

You look nice with your pink jersey...you like a woman that's in control of her life. That's what I want to look like, not like you, or be you. I can't be you, you are you. I just want to be like you. Just be so confident. Just go somewhere. Just treat people with respect and be like a human being, not like a hoender been [chicken bone]. A hoender been you eat and then you throw it away.

It can be argued that in her construction of me as "confident" and "in control," Maria imbued me with a power which she referred to as having been "stripped away" from her by her husband. Morrison (2014) refers to the interaction between envy and shame, suggesting that "envy leads to the identification (via projective identification) with the powerful object" (p. 108). Seen from this perspective, her words mark me as the powerful object worthy of respect, which sits in stark contrast to Maria's own depiction of herself which positions her as a less-than-human chicken bone. Interestingly, the respect her words mark me as deserving, is intrinsically linked to my "nice pink jersey"—possibly signifying material wealth and thus indicating the link between socio-economic status and immunity from shame.

I replied by acknowledging how difficult it could be for people to talk about their experiences like she had done. The motivation for my words was two-fold. Firstly, in that moment I had become acutely aware my own shame in perceiving myself

not to be the caring, ideal Other and of my subsequent desire to detract attention from the uncomfortable feeling of being idealised so overtly by placing her as the subject of our co-constructed narrative, a subject worthy of praise and admiration. Secondly, through the expression of my own admiration for Maria, I was attempting to acknowledge that the potentially shaming experience she may have been going through in having to recount the rape to me, thereby attempting to provide some alleviation from the shame pervading the intersubjective space we had created in order to replace it with a sense of pride and of accomplishment. This led Maria to reflect on how ashamed she had initially felt in the beginning of our interaction:

At the beginning you feel like, how can you cry to a stranger? I mean, I don't know you. I don't know where you come from. So I don't know if I can trust you. I don't know if I hate you! I expected you to chase me away, but you didn't....so I can just lift up my eyes.

This acknowledgement of the strangeness of the situation (and allusion to associated shame) served to further emphasise the marked differences in our identities, "where we came from." It is evident that Maria's sense of shame for having cried was significantly compounded by our distinct differences in identity—"how can you cry to a stranger?" A reflection on the degree of devaluation which occurred as a result of the abuse can be seen in Maria's following words:

I don't know if I can ever look at people again but after the crying and tears, I can look up and I can say, 'You don't deserve it.' Nobody does, but when I look down I can't face a person. I feel that I can chase you and hurt you the way that I am hurt.

It is striking that the alleviation of such shame, expressed by Maria as a feeling of being able to look someone in the eye again, was only made possible "after the crying and the tears." Despite the fact that this was not the aim of our meeting, her words indicate that the journey which we had taken together had been a psychologically beneficial one for her. At this moment the shame resonated between us, facilitating a deeper level of engagement through trust. It is evident that to unpack the impact of shame is a complex process. Shame indeed served thus far in our meeting to hide, obscure and prevent, yet also to facilitate. The sense of hopefulness which dominated the tone of the narrative in that instance may indeed have served to metabolise and remediate some of the shame within the space which we had created, a way for both of us to have constructed a psychologically more coherent and bearable space in which to part.

Shame was certainly making itself felt, both in my own silence and in what Maria was choosing to share and to hide. In retrospect, my comparative silence throughout the interview may be attributed to both my own shame regarding my relatively privileged position in relation to Maria, but equally to a sense of the silence as an appropriate indication of respect for her in making space for her voice to be heard. Ironically, it is her voice which dominated the dialogue throughout our interaction, yet her story remains spoken through my own strong interpretive voice as author.

Our parting was strongly informed by a tension between the various manifestations of shame which had arisen in the space between us, and a need to counteract it through reclaiming a sense of pride and hopefulness for the future. This was reflected in

Maria's parting words, which spoke to a self which had been shattered by shame, and a presumably deeply-felt desire to reclaim a socially acceptable, coherent self:

In my community, I am not a person that's weak. I'm a person that people look up to. If they could see me now, they'd never believe it. They would just shake their head. And I want that back. I want me back. The way I used to be.

Conclusion

Shame is an individualistic, subjective response to a uniquely constructed experience. However, certain categories of experience may predictably lead to acute feelings of shame connected to both its public and private triggers (Morrison, 1998). Rape is one such category. The shame which attaches itself so strongly to rape, framed the interaction between myself and Maria on numerous levels by opening up a veritable Pandora's box of shameful feelings. However, despite the rape itself having acted as a metaphorical magnifying glass underscoring the shame between us, it only served to highlight a pre-existing shame inevitably framing our interaction.

A consideration of shame is particularly pertinent given the renewed interest in a wider "reflexive turn" in the emotional politics of feminist research which considers the research interview as the point or moment of contact at which subjectivity is formed, negotiated and manoeuvred about (Burns, 2003; Jensen, 2008; Rice, 2009). Given the return of the body and emotions as a site for feminist and psychological inquiry, and a focus on the "emotional geographies" of the research relationship (Burman, 2003, 2006, 2014; Burman & Chantler, 2005), what is called for is a reflexivity that takes into account an acknowledgement of the ways in which we 'affect' the data collected and how our own (powerful) subject positions are implicated in research. As Flax (2004) argues, "content, interpretation, and mechanisms may be partially effects of particular relationships and contexts" (p. 914). From within this paradigm, vigilant ethical practice can be seen a function of the researcher's own self-awareness (Ponterotto, 2010).

I would echo this call to reflexivity by suggesting that qualitative researchers have an ethical responsibility to be aware of the role of shame within the research relationship, both in terms of its potentially traumatizing impact on research participants as well as on the way in which it necessarily impacts data. However, there is similarly a need to challenge discourses of transparency which invite researchers to subject themselves to the scrutiny of others through an incitement to confession. I would argue that such subjugation is, ironically, also motivated by the shame of our limitations as researchers. Indeed, particular perceptions of reflexivity are becoming the index for judgements regarding what is "good" and what is "bad" research (Finlay, 2002; Gray, 2008), leading to a retreat of the privileged researcher into inaccessible and insular "ivory tower angst" (Langhout, 2006, p. 272), "navel-gazing" or an "impasse" of research underlined by fears of (mis)representation (Sultana, 2007, p. 375). Rather, reflexivity should therefore be widened from a self-centred exercise to consider the critical relations which shape academic work (Doucet, 2008).

Shame is a powerfully communicating affect with potentially paralysing effects. Alleviating its noxious effects requires an awareness and acceptance of its ubiquitous presence in our lives, as well as the conditions in which shame plays an important part (Morrison, 1998). We therefore need to reflexively and consciously locate the shame within our racialised, gendered and institutionalised research relationships, and to wrestle with the implications this has for research validity, meaning-making and embodied subjectivity.

Shame is manifest on the micro-level of our daily interactions and cannot be separated from the complex matrix of gender, ethnicity and socio-economic class informing our public identities, which are so boldly reflected through our bodies. What did shame obscure, prevent or facilitate within this space between myself and research participants? What are the implications of this noxious affect for reflexive research, particularly with displaced populations? The above reflections intend not only to shed some light on the role of shame in the research relationship which unfolded but to consider the way in which it was intrinsically linked to the representations of our multiple and constantly shifting identities (Burman, 2006; Gray, 2008). It is clear that both the psychologist and the client's individual shame, as well as the shame which they co-construct within the intersubjective space, play an integral part of the therapeutic process. Similarly, reflexive qualitative research should also take into consideration the powerful impact of this affect within the research relationship.

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