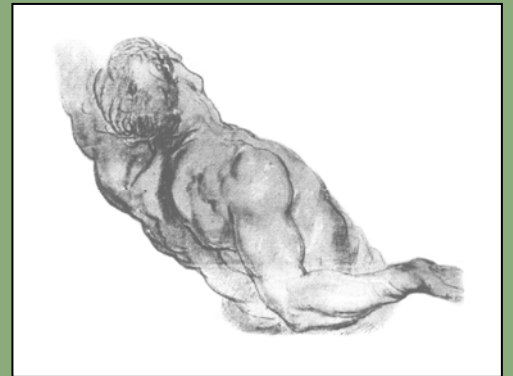


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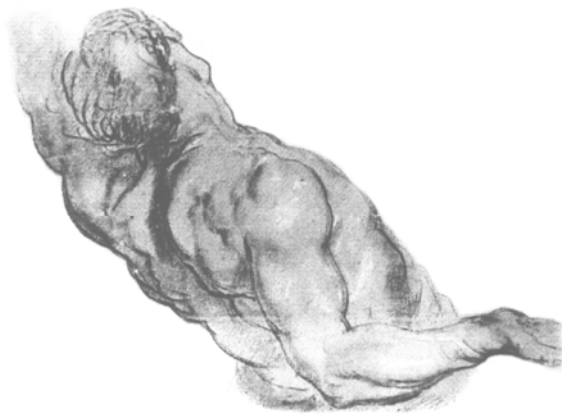
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USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humani

The Experience of Shame in Human Development and Psychotherapy

Yudit Mariah Moser, MA, CPC, SEP

Abstract

The experience of shame plays an important role in human development and the renegotiation of developmental issues in the therapeutic process. Shame has many negative associations but in the last decade, researchers like Allan Shore and Daniel Siegel have distinguished between the positive role shame can play in the social learning process and the negative effects it can have if not resolved appropriately. This distinction has come to be known as “healthy shame” and “toxic shame.” The lingering effects of toxic shame can be challenging for both those who suffer it and therapists assisting clients to reframe their experience and to move past shame-centered dynamics. This paper first reviews the distinction between healthy shame and toxic shame, then explores how shame can be addressed in the therapeutic setting with attention to both physiological and relational cues.

Keywords

Shame and self-regulation – Toxic shame – Disguises of shame – Physiology of shame

The positive socializing function of shame: “We don’t do this”

Cozolino (2006) described shame as a mechanism for child rearing and socialization. Parents concerned with teaching their offspring the rules of their cultural and social environment seek to help the child internalize the norms of their environment and uphold them even during the absence of parental control and guidance. According to Cozolino, shame has a positive role in the development of consciousness and social responsibility and therefore assures the cohesiveness of our social unit. Shame can therefore be seen as a self-conscious emotion, an inhibitory, biologically based response that evaluates our own actions from the viewpoint of the other.

In his groundbreaking work on self-regulation, Allan Shore (1999) pointed out the importance of a healthy shame experience to build neurological and social resiliency. According to Shore, in the stage between 12 to 18 months of age, an infant develops a sense of expectancy for sharing positive affect with the caregiver, which is the foundation for shame development. During the second year of life, with increased motor coordination and exploratory drive, the toddler meets more disapproval and disappointment. The parental role has shifted from a primarily care-taking style to a socializing function and mis-attunement between caregiver and child occur more frequently. In the face of this surprising negative feedback, the child experiences what Shore called a “rapid state transition” (p.241), that inhibits excitement and causes a rapid shift in the autonomic nervous system: very quickly, the energy-mobilizing sympathetic functioning shifts to a withdrawn, energy preserving, parasympathetic response.

Shore (1999) recommends differentiating between shame and guilt. Shore sees shame as a developmental precursor of guilt. While shame is primarily a visceral experience, based on preverbal imprints, guilt on the other hand is language-based, more complex, and therefore less permeating. In essence, guilt is experienced as a rejection of our behavior, whereas shame is experienced as a rejection of our self. The guilt experience signals a rejection of undesirable behavior, which motivates our reparative capacity. Shame is rooted in our hard-wired need for attachment, and rejection is experienced as a more devastating threat to the self. Shore emphasized that deflating experiences of shame need to be followed by relational repair and re-attunement. The parent reaching out to the child as part of the relational dance is crucial for psycho-biological health. The child experiences that it is possible to tolerate deflating shame affects and come back into relationship and equilibrium. The experience of negotiated state transition eases the stress response and the shame experience can be metabolized and regulated. This process of short-lived shame, followed by repair, benefits the social-emotional development of the child and further stimulates the maturation of the orbito-frontal cortex (Shore). Repeated experiences of returning to attunement solidify the trust in positive outcomes of difficult social interactions and therefore supports affect regulation capacities. The experience of repeated immediate repair creates visceral, sensory, motor, and emotional memory imprints (Cozolino, 2006).

Toxic effects of enduring shame: To make a mistake versus being a mistake

Given that shame is a powerful, preverbal and physiologically re-organizing experience, the question arises: What happens when parents shame the child excessively and fail to support the child’s affect regulation by not welcoming the child back into relationship? Siegel (1999) argued that sustained shame and lack of repair is toxic to our brains. When shame is internalized, it alters our sense of self and becomes part of our self-perceived identity. In our own eyes, we become flawed, not good enough, and not lovable. Our ability to differentiate is compromised; we see ourselves as being a mistake rather than making a mistake. In this sense, the toxic effects of prolonged shame, held in the imprints of our early parent-child interaction, have been shown to have a negative impact on our right hemisphere and limbic system network development (Cozolino, 1996). The shame-prone child becomes hypersensitive to perceived criticism, reinforcing a lack of self-worth and sense of

disconnection from the world. Over time, shame may also be experienced as an inner, critical voice—an internalized script that keeps the cycle of shame alive. Enduring shame might be connected to the deep pain of loss of love and unity. Sylvan Tomkins has captured the experience of shame with these words:

If distress is the affect of suffering, shame is the affect of indignity, transgression and of alienation. Though terror speaks of life and death, and distress makes the world a valve of tears, yet shame strikes deepest into the heart of man...shame is felt as inner torment, a sickness of the soul...the humiliation when one feels himself naked, defeated, alienated, lacking in dignity and worth.

Expressions of—and defenses against—shame in therapy

Early unregulated and pervasive shame is at the core of many psychological problems. Psychotherapy offers an opportunity to renegotiate early shame imprints. The work with developmentally based shame dynamics is sensitive territory that calls the therapist to become familiar with the body language and disguises of shame. Cozolino (2006) described shame as a visceral experience stimulating the same areas in the brain as those activated by physical pain. The primitive, nonverbal nature of the shame experience frequently makes it difficult for clients to articulate the experience and name what is happening. Cozolino (2002) described the body posture of submission— averted gaze, rounded shoulders, hanging head— as a possible indicator for shame (p194). In my observation as a therapist, when shame emerges, clients tend to lose muscle tone and vitality throughout their whole body. Energetically, they step out of contact and appear to shrink or diminish. This experience is frequently described by my clients as feeling heavy or small, wanting to "fold in on myself" and an urge to disappear and hide. As my clients allow shame to move, they may have a visceral experience such as nausea and skin irritations.

By its nature, the shame experience triggers feelings of acute vulnerability and deep discomfort. Consequently, the attuned therapist must watch for possible masking behaviors like nervous laughter and disproportionate anger towards a social situation, as well as the role of shame in transference enactments. Badenoch (2008) examined the close ties between shame presentations and defensive responses. She asserted that clients may not be able to tolerate or witness shame experiences and may instead go directly to the expression of anger or rage. The impact of dysregulated anger in this shame-rage dynamic makes it very difficult to track the origin of the experience. Other clients may avoid the unbearable humiliation of shame by isolating themselves socially. Irrational beliefs often are at the heart of toxic shame presentations. A common dynamic is the child who finds it easier to tolerate a shame identity of being flawed than the unbearable sense of feeling betrayed by the very people who were suppose to love and protect her. Through the lens of the shame-prone client, it is easy to see criticism, rejection, and abandonment in nearly every interaction as he or she struggles to achieve perfection.

Reflections on processing the shame response in therapy: Ashamed but connected

In addition to recognizing the body language and possible masking behaviors of shame, the conscientious therapist is called to remain differentiated when shame enters the relational field. To witness intense shame can, in itself elicit shame. As therapists, we must stay present and track our own responses in the moment, which means we first must have explored our own shame history and become familiar with any of our own unresolved shame-related issues.

In my experience, the completion of the shame response requires surrender into the physiology. Change occurs when we are able to endure and wait with one another for the movement of shame and the desire to engage socially. It appears that the earlier the shame experience, the more the viscera will be involved in its imprint. Shame often elicits the sensation of nausea; a sense of needing to expel what is not inherently ours through coughing and spitting. The repeated process of balancing parasympathetic shame states with positive emotions within a relational context of 'feeling felt' loosens the debilitating grip of toxic shame and frees up more capacity for joy, creative expression, and compassion. Because shame is rooted in preverbal imprints of mis-attunements that have lingered unresolved, it is essential to keep language simple and to stay in contact with a sense of ease, humor and compassion when shame emerges.

Conclusion

Great strides have been made recently in our understanding of the role of shame in society and what clients need in order to move past unresolved shame imprints. While many psychotherapeutic processes elicit shame responses, shame itself can be a silent and unrecognized emotion, often blocking the psychotherapeutic process. To use the emotion of shame for developmental resolution, therapists must understand its dynamics: the regressive and visceral nature of shame, resistance to the shame experience and shame's association with various defense mechanisms, and the simple ways by which lingering shame issues can be transformed by naming it, normalizing it, and helping clients move their shame experience to both physiological and psychological completion.

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Biography

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