Working with the Neurobiological Legacy of Trauma 2015-16

Working with Shame and Self-Loathing
Janina Fisher, Ph.D.

Shame becomes a “completion barrier” in treatment

• The persistence of shame responses to a variety of stimuli, both good and bad, often acts as a barrier to final resolution of the trauma. Full participation in life, including pleasure and spontaneity and healthy change, are prevented by recurrent intrusive shame.

• Criticism, normal life mistakes, less-than-perfect performance, or even performance itself can trigger shame responses, but so can healthy self-assertion, self-care, success, being ’seen,’ asking for needs, feeling proud or happy about one’s self.

Why does shame stick like ‘glue’ for decades after the trauma?

• Shame is a survival response, as crucial for safety as fight, flight, and freeze.

• Shame, however, feels ”personal:” by its nature, it feels as if it is about “me.”

• Shame is a body response accompanied by cognitive schemas that can also trigger shame and create a vicious circle of shame.

• Shame is often reinforced by other cognitive schemas, such as “It’s not safe to succeed—to be self-assertive—to have needs—to be happy.”

Fisher, 2010

Fisher, 2010
How can we better understand trauma and shame?

“[When] a relationship of dominance and subordination has been established, feelings of humiliation, degradation and shame are central to the victim’s experience. Shame, like anxiety, functions as a signal of danger, in this case interpersonal or social danger. Like anxiety, it is an intense overwhelming affect associated with autonomic nervous system activation, inability to think clearly, and desire to hide or flee. Like anxiety, it can be contagious.”

Judith Herman, 2006

**Autonomic Arousal Drives Emotional Responses**

<table>
<thead>
<tr>
<th>Hyperarousal:</th>
<th>Fear, terror</th>
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<tbody>
<tr>
<td>Rage, anger, frustration</td>
<td></td>
</tr>
<tr>
<td>Excitement, euphoria</td>
<td></td>
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<tr>
<td>Overwhelming grief</td>
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</table>

High Arousal

"Window of Tolerance" Optimal Arousal Zone

<table>
<thead>
<tr>
<th>Hypoarousal:</th>
<th>Flat affect, numb, alexithymic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame, disgust</td>
<td></td>
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<tr>
<td>Sadness</td>
<td></td>
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<tr>
<td>Depression</td>
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Low Arousal

Ogden and Minton (2000)


**However, Anxiety is Sympathetically-Mediated**

- **Activation of the sympathetic nervous system** drives hyperarousal symptoms, such as elevated heart rate and respiration, hyperactivity, hypervigilance, easy startle, and emotions of fear, terror, and panic, all serving the biological purpose of sounding the alarm and warning of danger

- Core beliefs driven by sympathetic activation have to do with safety: "I’m not safe," "I’m a marked woman," "you can’t trust anyone."

Fisher, 2006
Shame is a Parasympathetically-Mediated Symptom

**Activation of the parasympathetic nervous system is associated with autonomic responses of dissociation or disconnection, vegetative depressive symptoms, emotional numbing, decreased heart rate, and emotional responses of shame, disgust, despair, and guilt, all of which serve the function of facilitating submission responses and thereby maintaining connection to attachment figures.**

Parasympathetic activation drives such core beliefs as “I’m worthless/helpless/hopeless.”

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“Shame signals (e.g., head down, gaze avoidance, and hiding) are generally registered as submissive and appeasing, designed to de-escalate and/or escape from conflicts. Thus, insofar as shame is related to submissiveness and appeasement behavior, it is a damage limitation strategy, adopted when continuing in a shameless, nonsubmissive way might provoke very serious attacks or rejections.”


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Shame and Self-Doubt are Magnified by Powerlessness

- Children have no control over the acts of their caregivers: experiences of satisfying autonomy or mastery are fostered by secure attachment and absent in disorganized attachment relationships.

- When the caregiver is the source of threat, it is not surprising that, instead of experiences of age-appropriate mastery, children are over-exposed to experiences fostering shame and self-doubt: “I can’t do it—I have no control—I’m little and helpless and insignificant.”

Fisher, 2007
Neurobiological Purpose of Shame

- Allan Schore believes that shame serves the purpose of helping the child inhibit behavior. When shame down-regulates excitement and impulsivity, the child is able to restrain from doing whatever action the parent just forbid.
- In a healthy, safe environment, these normal experiences of shame are repaired by the parent so that shame inhibits but then is mitigated by soothing and clarification.
- In an unsafe environment, shame must be over-used to down-regulate states of fear/anger or any behavior unacceptable in the environment. In these families, shame states are not repaired by the caregiver (Fisher, 2006).

Shame as a Source of Safety

- As part of its role in downregulating activation, shame helps to drive the animal defense of submission: shame responses cause us to avert our gaze, bow our heads, and collapse the spine.
- In an environment in which self-assertion is unsafe for the child, shame enables the child to become precociously compliant and preoccupied with avoiding "being bad.”
- This avoidance of potentially dangerous behavior and procedurally learned submissiveness is adaptive in traumatogenic environments (Fisher, 2006).

Cognition and Safety: the Theory of Competing Working Models

- Until the Piagetian stage of “formal operations” (around age 12), children do not have the cognitive capacity to hold in mind two contradictory working models, much less conceptualize and integrate the two.
- "He’s disgusting, and I’m disgusting," says the client as she remembers her grandfather’s sexual abuse. At age 5, she could not integrate the two working models to reach a more accurate conclusion: "He is disgusting, not me.”
- This phenomenon is thought to underlie disorganized attachment behavior: children cannot organize responses to a parent who is the source of fear and hope of safety (Fisher, 2006).
How Experiences of Shame Become Cognitive Schemas

- "The subjective experience of shame is of an initial shock and flooding with painful emotion. Shame is a relatively wordless state, in which speech and thought are inhibited." (Herman, 2007)
- The words put to these autonomic, non-verbal responses naturally reflect the experience of feeling small, powerless, and exposed. Over time, these become belief systems that explain all subsequent experiences.
- Trauma-related cognitive schemas are then inextricably linked with affective and bodily states of shame, resulting in vulnerability to shame and self-hatred. (Fisher, 2009)

Shame and Cognitive Schemas, p.2

- Meaning-making childhood begins in the body: an infant or small child can only make meaning at a body level. Then, as children develop language, they begin to attach words that seem to explain these emotional and body states.
- The words not only reflect the body states but can also trigger the body states each time they are used. A collapse in the body accompanied by hypoarousal and a heavy feeling in the chest may be ‘explained’ as “I’m worthless” or “I’m stupid.” Each time those words are repeated, the body feels heavier, more hypoaroused, more collapsed. Thereafter, the body experience and the cognition mutually reinforce and confirm each other. (Fisher, 2009)

Shame is a Procedurally-Learned Response

- "Procedural learning" refers to the acquisition of body memory for how to “do things, such as driving an automobile or riding a bicycle.
- In traumatic environments, children and adults alike depend on procedural memory to acquire adaptive physical and mental reactions, cognitive schemas, or behaviors that promote optimal survival.
- For the most part, procedural learning is characterized by automatic, non-conscious performance, making it more efficient and automatic. (Fisher, 2009)
“The neural substrate for procedural learning appears to develop prior to the capacity for declarative learning. This means [that] templates for habitual behaviors may be acquired, and the behaviors become relatively automatic and routine, before the child has an episodic memory system capable of remembering the events that produced these behaviors. [Thus,] very young children are likely to experience a kind of learning . . . that is dissociated from the content.”

Grigsby & Stevens, 2002

Shame and Procedural Learning

• Over time, procedurally-learned shame responses become automatic and unconscious: when threat stimulates terror, shame regulates the fear response.

• Eventually, the child learns to respond to most if not all affects and arousal states with bodily and affective shame reactions accompanied by negative cognitions.

• The cognitive schemas evoke both increased shame AND hope: “I’m stupid” provides hope of being smarter; “I’m ugly” gives hope for being an Ugly Duckling who grows into a Swan; “I’m not lovable” provides hopes for improving one’s lovability.

Fisher, 2007

“The most direct way to effect change is by working with the procedural learning system…” [Grigsby & Stevens, 2000]

• The first [type of therapeutic challenge] is to …observe, rather than interpret, what takes place, and repeatedly call attention to it.”

• Empathy is not helpful with shame: it reinforces identification with the shame, rather than challenging it. [Note: Observing the shame or the body can also trigger shame]

• “The second therapeutic tactic is to engage in activities that directly disrupt what has been procedurally learned.” But the disruption cannot be shaming to the patient: disrupting must be done more indirectly than directly.
Psychoeducation

Psychoeducation is a ‘good disruptor’ of shame:

• Psychoeducation about the ability of shame to inhibit unsafe behavior (Schore’s theory), emphasizing that shame is not a feeling. It is a body response.

• Psychoeducation about the role of shame in enforcing submission for the sake of safety. Submission must be understood as an ‘active’ defense at those times when fight and flight would be dangerous or impossible.

• Psychoeducation about shame and cognitive schemas: “The belief that you are worthless is a story you told yourself—it kept you alive” — Fisher, 2009

Re-framing Shame

• Using the assumption that every symptom is a valuable piece of data about how the client survived, shame can be re-framed as a valiant attempt to cope in a dangerous world.

• Look for what the shame is trying to accomplish now: Increase hypoarousal? Maintain compliance? Combat anger and assertiveness? Keep the client from being “out in the world”? Admire the shame as a survival resource! “You wouldn’t be alive today without the shame having protected you” — Fisher, 2007

“The pathogenic qualities of shame and self-criticism have been linked to two key processes. The first quality is the degree of self-directed hostility, contempt and self-loathing that permeates self-criticism (Gilbert, 2000; Wheeland & Greenberg, 2003; Zuroff et al., 2005). Second is the relative inability to generate feelings of self-directed warmth, soothing, reassurance and self-liking (Gilbert, 2000; Gilbert, Clarke, Kempel, Miles, & Inseva, 2004; Linehan, 1993; Neff, 2003a; Wheeland & Greenberg, 2003). Although reducing self-directed hostility is important to help high shame self-critics, [treatment must also focus] on developing abilities to generate feelings of self-reassurance, warmth and self-soothing that can act as an antidote to the sense of threat.

Gilbert & Proctor, 2006, p. 353
Other Challenges to Shame and Self-hatred

- **Mindfulness and self-study:** “Let’s be curious about what happens when those thoughts come up? “Drop the content, and notice the shame just as body sensation . . .” “Don’t attach to it or avoid it with disgust . . .”

- **Dis-identification:** “The thought, ‘I don’t deserve anything,’ is just a theory from when you were young, huh?”

- **Identifying shame and self-loathing as parts:** Typically, shame reflects a relationship between two parts: a part that judges and a part that feels judged. When the critical part echoes the negative messages heard in childhood, younger parts feel the same sense of shame as if it were “then.”

The biology of shame and parts

“**Thus one part of the self** (or one processing system) **may deliver a string of criticisms** (you failed again, you are no good, nobody will love you) and **another part of the self** (represented by a different processing system) responds to these putdowns as it might to external putdowns, with stress, anxious or depressive responses . . . These self-criticisms can be seen as a form of internal self-harassment, which can regularly stimulate submissive, anxious and depressive defences . . . We suspect that over time, with repeated use, these become highly sensitized and conditioned pathways and probably develop a retrieval advantage” (Brewin, 2006). . . .”

Gilbert & Proctor, 2006, p. 356

Treating Shame as a Child Part

“**So, there is a part of you that is feeling sick with shame right now because you’ve told me something so very personal. Could we be curious about that ashamed part?”**

“**Is there another part that is shaming the ashamed part? A part that judges you or other parts? Or is the ashamed part remembering being judged and shamed?”** (Where there is an ashamed part, there is generally a shaming part that judges and ridicules any behavior that would have been unsafe when the client was a child)

**The therapist’s job is to evoke the client’s empathy for the ashamed part, rather than shame it further**

Fisher, 2009
Using a Parts Approach

<table>
<thead>
<tr>
<th>Adult Stephanie</th>
<th>Ashamed Child</th>
<th>Critical Part</th>
<th>Suicidal Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of control over parts, teenage children</td>
<td>&quot;No one cares about me unless I'm doing it all&quot;</td>
<td>&quot;You don't deserve to be cared about—why should they care?&quot;</td>
<td>&quot;What's the point in living if no one respects you?&quot;</td>
</tr>
</tbody>
</table>

These threats re-trigger the child part and re-ignite the cycle.

Fisher, 2006

Engaging compassion for one’s parts

Compassion abilities [involve] a number of key abilities [and processing systems] . . . the desire to care for the well-being of another, distress sensitivity/recognition related to the ability to detect and process distress . . ., sympathy related to being emotionally moved by distress, distress tolerance related to the ability to tolerate distress and painful feelings ‘in another’. . ., empathy related to intuitive and cognitive abilities (e.g., ‘theory of mind skills’) to understand the source of distress and what is necessary to help the one distressed, and non-judgment related to the ability to be non-critical of the other’s situation or behaviours. All these require the emotional tone of warmth.”

Gilbert & Proctor, 2006, p. 358

A Solution for the Shame

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</thead>
<tbody>
<tr>
<td>&quot;I’m overwhelmed—I’m all alone now—no one cares&quot;</td>
<td>&quot;You’re just ungrateful! You owe your family for all they’ve done for you!&quot;</td>
<td>&quot;It’s OK—I’m here for you. You’re not alone. You haven’t failed—your family just doesn’t know how to be nice.&quot;</td>
<td>Not needed now, the Suicidal part can be on “stand by” alert status</td>
</tr>
</tbody>
</table>

Fisher, 2006
Working with Shame and Self-Loathing

Combating Shame Through the Body

- If the shame is reinforced or exacerbated by body experiences of collapse, loss of energy, feelings of revulsion, curling up or turning away, then shame can be mitigated by changing body posture.

- Lengthening the spine and grounding through the feet both challenge shame. If the client head is bowed or averted, bringing the head up or asking the client to begin to slowly turn the head and lift the chin can begin to increase feelings of confidence and fearlessness. If these movements are triggering, they can be executed more slowly, piece by piece, over time.

Fisher, 2011

“Dropping the Content”

- An important sensorimotor skill for regulating emotions and arousal is learning to “drop the content” to focus away from dysregulating thoughts, interpretations and feelings and instead to focus attention toward the body sensations OR just external stimuli.

- For less mindful or more unstable clients, letting go of the “content” is only possible when they focus on something concrete, such as their feet, as an alternative.

- Dropping the content to focus on the body challenges negative cognitions: the words lose their power when they are deliberately ignored. Clients can be taught to ‘drop’ the parts’ shame or judgments or their own.

Fisher, 2015

Self-Compassionate Content

- Self-compassion is difficult for trauma survivors for a variety of reasons: fears of the softening it causes and the greater sense of vulnerability, fears of giving up the safety of self-hatred, fears that “I’ll be lying to myself.”

- If self-blame and self-attack provided safety, then it will be hard to give up and still feel safe.

- It is important that we begin with what is believable: “You are a good person” is not believable; “You’re doing the best you can” is. “Your shame saved you from being visible and a threat” is also believable. “You have worth” is not, but self-compassion for how we survived is easier to take in.

Fisher, 2015

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| “The therapist must act as an auxiliary cortex and affect regulator of the patient’s dysregulated states in order to provide a growth-facilitating environment for the patient’s immature affect-regulating structures.” |
| Schore, 2001 |

| Being a “neurobiological regulator” |
| • It does not mean convincing the patient “not to be ashamed.” Our well-meaning attempts to encourage clients to believe in themselves are often dysregulating. |
| • What it means is that the therapist “regulates” or “repairs” the shame, just as healthy parents do: i.e., experiments with making contact with the patient in some way that mitigates the shame, such tone of voice, energy level, empathy vs. curiosity, re-framing the shame as active and heroic. |
| • Effective neurobiological regulating of shame also requires a commitment to not letting clients “go there:” interrupting the thoughts earlier, consistently challenging the cognitions, re-framing over and over again. |

| In the face of stuckness or resistance, |
| • Become more curious: how is the stuckness serving the patient? What would s/he lose if the client felt worthwhile? What might be threatening about feeling proud or deserving? |
| • Let go of your need for their progress: cultivate the ability to just keep challenging the shame. It is hard for us to hear self-hate, but understandable that they feel safer ashamed than proud. |
| • Consider fear or attachment issues: did they have to use shame to maintain attachment bonds with caregivers? Or does the shame indicate a phobia of active, assertive, emotional expression? |
| • Look for internal struggles between parts: stuckness often = gridlock. Parts holding different survival imperatives cannot agree on a common goal: the internal critic keeps attacking needy or emotional parts, and shame shuts it all down. |
Ending: What Next?

• The Australia Level II webinar begins in September! Information will be sent out very shortly about the dates and topics.

• Conferences: check my website periodically to see if there are going to be conferences or workshops in your area. I will send out an email announcement as well.

• Trainings: Sensorimotor Psychotherapy trainings are scheduled to begin in New York, Chicago, St. Paul, Grand Rapids, Berkeley, Seattle, and Vancouver, as well as in the UK, Ireland, Italy, France, Australia, and Norway—if they have not already started. (Go to www.sensorimotor.org and click on Upcoming Trainings to see what might be starting in your area.)

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