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Healing Shame

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This article presents a theory of shame and the healing journey of a client with serious shame issues. Shame is defined as a 2-step process that can be healed by understanding early childhood development from 4 points of view: the need for an other to gather the sense of self, the idea of either–or thinking, secure and insecure attachment, and the capacity to make comparisons within the family. Then the importance of the therapeutic relationship is discussed, including the authenticity of the therapist. Several holistic techniques such as somatic awareness, touch, and imagery work are included as part of the healing process.

> Only in an open, nonjudgmental space can we acknowledge what we are feeling. Only in an open space where we're not all caught up in our own version of reality can we see and hear and feel who others really are, which allows us to be with them and communicate with them properly.
>
> Pema Chodron (1997, p. 78)

Maria (not her real name) is the only daughter of immigrant parents. At the time we met, she was out of control—she felt driven by her impulses, she was desperate to get rid of her cyclic depression and there was "no one" inside making choices or setting priorities. Although she is very intelligent and articulate, her words expressed old stories, true stories but nonetheless dead stories. Maria had tried various medications for her depression and experienced no relief.

Maria's family lived the American dream of becoming financially successful and joining middle-class life. But her mother was never satisfied. Her mother railed at her father, who never fought back. Her mother wanted to live a life of beauty and luxury—anything less was a failure. She wanted Maria to succeed for herself and to be elevated by Maria's success.

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Like her mother, Maria is tall and attractive. Her brown eyes are usually soft, almost longing for approval or connection; when they harden, she is focused on the numbers of a real estate transaction where her quick intelligence shines. Typically her breathing is shallow while her face is intense, giving the impression that all of her aliveness is in her head.

Maria attributed part of her depression to the overwhelming pressure to succeed beyond the economic and social status of her family of origin. She felt empty and driven—driven to make more money, to have more stuff, to get her husband to take better care of her and make her feel whole, good, and loved. Maria had spent a great deal of her life-energy creating enough wealth to be financially independent. This was motivated by the desire to make sure she would never have to "be under anyone's thumb" (i.e., controlled by the bad mother as was her father). Having achieved this goal, she still suffered from depression and inferiority. She entered therapy confused about why she still felt that way. She believed that this financial superiority would vanquish her inner feeling of inferiority.

During one session Maria used a word to express how she feels about herself: "defective." When we explored what that meant to her we discovered that she believed that other people have something she does not have or know something that she does not know. Her use of the word defective affected me very deeply. My perspective on Maria's depression and impulsiveness changed because I finally realized how great is her sense of inferiority. She is always *less than* in the contest she calls life. She is deeply ashamed of her very being and no amount of outer reassurance or material wealth touches this early childhood wound.

Maria is always in inner conflict. She articulates that she wants to feel "Zen," her word for inner peace and tranquility. She has powerful moments of feeling creative, but those moments happen when she is alone. She is very much in touch with her capacity to self-actualize and longs for wholeness (Maslow, 1968). However, that longing is constantly thwarted by her inner shaming, critical voices. Maria and I agree that wholeness includes connection with others we love and enjoy being with, not only the wholeness of the creative moment. But for Maria, relationship is always dangerous; you can be shamed or left. For me, relationship is crucial to the therapeutic process.

This article presents my understanding of our journey together over several years of weekly therapy. First, I talk about shame as an experience and from the point of view of several theoreticians. Then I talk about a developmental theory of gathering a sense of self and how that sense of self can become imbued with shame. I discuss this from four points of view that seem particularly relevant to shame: the need for an other to gather self, the idea of either–or thinking, secure and insecure attachment, and the capacity to make comparisons within the family. Then I discuss healing shame in a therapeutic relationship, including several holistic techniques.

THE EXPERIENCE OF SHAME

Shame has been a recognized experience since Adam and Eve. Each of us has felt hesitant to express our thoughts and our feelings because we feared exposure, vulnerability, attack, or ridicule (Karen, 2001), therefore, each of us knows the inner experience of primary shame (Morrison, 1989; Nathanson, 1992). Many people suffer from a far more debilitating experience.

We have several words to describe the feelings associated with shame: humiliation, embarrassment, mortification, all stemming from feeling exposed or betrayed. We talk about being embarrassed when we are self-conscious about an aspect of ourselves. Usually, we use the word humiliation when someone we need or love criticizes or attacks us (even if only in imagination) in some way. Other events are mortifying because we can never live them down. Our sense of self is "killed" by them. We feel shame when something unacceptable and private about us is discovered. We typically respond to shame by trying to mask the reaction altogether. We associate survival of the self with hiding from the internal or external judges. Sometimes we hear the shaming voice from inside ourselves and sometimes from the other (Kaufman, 1992). We need to hide our shame, our blush, our thoughts, and the parts of us that have been exposed. A key aspect of the shame sequence is this hiding. Internally it feels urgent that the other does not find out about this hidden part of our lives or personality.

It follows that the experience of shame is among the most negative and disruptive feelings. The experience fragments our going-on-being (Winnicott, 1965, 1992), and stops our innate capacity to self-actualize (Maslow, 1968). Our body language, learning capacity, and communication significantly change when we fall into the experience of shame. Often there is an identifiable sequence to shame (Hastings, 1998; Nathanson, 1992):

- The first sign is a shift in eye contact. We lower our eyes and break off our gaze. We lower our heads and droop our shoulders.
- Second, our ability to perceive reality shifts. We become unable to see, or hear clearly, what is going on around us.
- Third, shame interferes with thinking and we automatically defend ourselves in various ways. We try to get away from this noxious feeling to the extent that we cannot think, cannot problem solve, and certainly cannot be creative.
- Fourth, shame interrupts our emotions and emotional communication, limiting intimacy and empathy. Shame can interfere with anything and everything from the joy of sex to the joy of ideas.

At the most severe level of shame, we are afraid of any kind of self-expression because to be seen is to be seen as dirty, disgusting, worthless, and unlovable. To be

exposed is to be endangered. In this self-system the only safety lies in withdrawal and isolation because "everyone knows or sees that I am completely worthless." This degree of isolation makes an individual feel "not real" (Winnicott, 1992).

For some people the power of shame is always this intense, unbearable, and disorganizing. The mere act of initiating from one's inner authority produces immeasurable shame. These individuals cannot move beyond their inner world of thought into expression because the fear of exposure, attack, and ridicule is too great.

Maria suffers at this unbearable level. When her drive and needs are thwarted in some way, she falls into a terrible, painful state of depression, defectiveness, and withdrawal. She does the minimum at work and spends most of the day at home. There she retreats into her bedroom or office and stays completely away from family life, sometimes not even appearing for dinner. Her husband encourages her to reach out, to talk to him or even phone some of her closest friends, but for her this is not possible. "There is nothing to say. No one would want to listen. No one could understand or possibly help," is what she tells her husband. What she tells me is that it is too dreadful to talk about; she has no right to feel so bad with such a privileged life. It is too shameful to mention depression or despair or hopelessness to others when your outer world looks OK. Only withdrawal is safe. "It's the best I can do," she reports. "At least I am not inflicting myself on anyone else." But of course, this intense withdrawal dramatically affects her nuclear family—much more than if she could talk about her state of being

SHAME AS A TWO-STEP PRIMARY AFFECT

Shame can be conceptualized in a number of ways (Gilbert, 1998), but I have found the work of Nathanson and Schore most helpful. Nathanson (1992), along with Schore (1998), makes a strong case for shame as a part of the very early repertoire of the infant. In his model, following Tomkins (1987), the baby-as-body falls into the shame affect with any kind of self-generated failure (reaching for something and not getting it) or interpersonal failure (displeasure on mother's face). For him, shame is a two-step process: wanting something positive, followed by something negative. It cannot be induced without the positive impulse or the wanting preceding the failure.

For the first 6 months of life, the baby ideally is simply enjoyed and taken care of. His[1] sense of himself develops in the context of another who values him, holds him, takes care of him, and so on. As the baby gains mobility, first by crawling, then walking, the parents become "no-sayers," and often induce shame as part of

[1]I have alternated between masculine and feminine pronouns in various sections to avoid gender preferences.

their socialization strategy. The child, who has enjoyed nothing but the gleam in the mother's eye, is now faced with a very different face—the face of disapproval, of "no," of "you are bad." He expected to see her delight, and instead found her disapproval. For the young child this is a very stressful situation and forms the basis of a negative sense of self. It is often this two-step process (I expected the positive, I got the negative) that creates the experience of shame.

As adults, we know this in subtle ways. As I walk down the street in my town, I imagine I see a friend up ahead (I want it!) and then, just as I am going to yell out, I realize it is not her and I turn away, avert my eyes and pretend that nothing happened. This is not a terrible experience, but it is part of the internalized shame continuum.

On the other side of the infant's development of self is the primary affect of pride or success (Nathanson, 1992). These experiences tell the infant's forming self-system that he is OK. Pride affect involves the pleasure of competence plus excitement. Observers clearly see this in neonates anytime the baby tries something "on purpose" and is successful. There is a "me" who is excited and interested in achieving the goal and who relaxes into the pleasure of the accomplishment. These positive experiences become integrated into the sense of self, self-identity, and self-esteem. This me is coordinated, organized and is the root of my competent self (Demos, 1988).

We also know this in adult form. When we complete something positive, even something small, we feel good about ourselves and often want to share it and even get positive feedback for it. We experience an energetic or emotional component with the completion of the task that could be called primary pride and that enhances our sense of self and self-worth.

Pride is truly the energetic opposite to shame. While shame is contracting and isolating, pride is expansive, connective, and infectious. When in shame I want to hide, to disappear, to never be seen again. In the moment of pride I want to be seen in my success and judged favorably. Pride lets me connect and be seen as valuable and worthwhile.

Maria knows this sequence only too well. She wants a lot. Her drive is to generate wealth with each business move. She is extremely vulnerable to a business failure. When a deal she is certain about falls apart, she will feel worthless and doubt that she will ever be able to trust her judgment again. She will obsess about the failure, go over and over each detail—not to anyone else, only to herself and to me. Then she will sooth herself by adding up her net worth, reassuring herself that she has made good deals in the past and no one can take that away from her. In these bad moments, she believes that everything could be taken away from her at any moment and that poverty is just around the corner. These are moments when it is possible for her to fall into her personal black hole of despair, shame, and depression.

SOURCES OF SHAME IN EARLY INFANT DEVELOPMENT

To understand and heal Maria's debilitating shame response I have needed to be familiar with the preverbal world where we gain our sense of self through bodily sensations. Only through this understanding have I been able to heal such early developmental deficits. Therefore, my thinking has been strongly influenced by Winnicott's theories (1965, 1992) on the inner workings of the child's mind. Winnicott was first a pediatrician and always kept a pediatric practice. Additionally I have learned a lot from the current researchers Daniel Stern (1985), and Beatrice Beebe and Frank Lachmann (2002). All of them present evidence that the infant slowly gathers his sense of self, his sense of agency, his "going-on-being" through interactions with others. I have chosen to focus on four aspects of early development as these aspects relate directly to Maria's developmental deficits:

- Gathering a self through the care of others.
- Either–or world.
- Attachment and mirroring.
- Impact of comparisons within family structure.

All of these strands (and many more) interact to create an adult sense of self.

Gathering a Self Through the Care of Others

We are increasingly clear that the infant's brain is literally formed in the crucible of the nuclear family. Neurons connect due to experience and the brain is transformed (Schore, 1994, 1998). This happens throughout life, but it is crucial in the early first years as the pathways are formed that will be strengthened and used over and over again. At the beginning, when babies are hungry they fret or cry and food comes. Their brains have not developed enough to distinguish exactly what happened. At the sensorimotor level, discomfort changed into comfort. They are not aware that another must meet their needs and that they are truly helpless (Stern, 1985).

When the baby's state of being is changed from discomfort (hunger) to comfort (full) we believe that his whole world is changed. In a general sense he changes from not-OK or bad to OK or good. Ideally, the baby has many, many experiences of being taken care of in a timely fashion. This generates a sense of self that includes the power to affect his environment and the inner sense that "I am worth being taken care of." Of course, each baby has some experiences of not being taken care of in a timely fashion and this generates a sense of "I don't have much power in the world" and "I'm not worth much." I am suggesting that these ideas correspond to primary shame and primary pride.

Over time the toddler learns more about taking care of himself (e.g., I'm hungry and it is time to find some food). But due to our intensely social nature we also always need some of our feelings and moods managed by others (Lewis, Amini, & Lannon, 2000; Schore, 1994; e.g., I'm angry and want to tell someone about it, I'm scared and need contact, a great thing happened and I want to share it). This combination of being able to manage many of my feelings by myself and having others to share with leads to a healthy sense of self, an inner continuity of being, with a sense of a "me" inside my skin.

Maria feels that her mom failed her in many basic ways, leaving her vulnerable to losing her sense of ongoing being and unclear about her own boundaries. Her mom made no effort to meet Maria's emotional needs or understand her feelings. Instead, as a young child Maria felt it was her job to make her mom happy. Of course she failed, for Mom conveyed over and over that only more money, a grand apartment, art, and jewelry would make her happy. So today Maria feels good around wealthy people: "If I am near them I am finally wealthy (safe, OK) too." Living in a wealthy neighborhood and talking to clearly wealthy people confirms for her that she has made it into the world of money and safety. For her, the outside controls the inside much of the time.

This permeable boundary also works when she is around less fortunate people. One day at the playground a homeless man sat down next to Maria. She told me this made her very uncomfortable. She had to take the children elsewhere to play rather than sit on the bench together. When we talked about it, she knew something was off in her response to the situation, for she was *compelled* to leave the playground; she had no choice. But she couldn't put into words what was wrong with being near the homeless man. Only as we talked about it did her fear and lack of boundaries become clear—that somehow this man's poverty would rub off on her, would take something away from her and all that she has accomplished.

Either–Or World

At birth, the newborn has no sense of time in the way adults experience time as a flow (Stern, 1985; Wilber, 1980). The newborn lives in an eternal now. What she is experiencing at this moment is all that there ever has been and all that ever was. In this condition each state of being is totally absorbing; if she is full and comfortable, then physiologically and psychologically she experiences pleasure in her whole being. We believe that at the very beginning of life she doesn't remember being hungry or empty and she doesn't know she will be hungry and empty again. What she is experiencing now is all that matters.

When things get experienced together she will learn that they go together. This capacity, like many others, is part of her inherited potential. For example, she will learn that footsteps mean Mom is coming and comfort (being picked up, being fed)

is coming. So in a few months, footsteps mean I can quit crying, quit protesting. A sequence has been learned just as classical conditioning theory would predict.

We also believe that subjectively the infant experiences a different Mom when she is comfortable from the Mom she experiences when she is uncomfortable. Further, we believe that she has a different sense of herself in these different states. She is EITHER comfortable OR uncomfortable and it takes many months to realize that she is the same baby-as-body in both states. The 4-year-old can still say with full conviction to Mom (as my grandson recently did), "I hate you and I never loved you!" It is only as the brain grows and develops that full inner continuity is possible (Schore, 1994). This process of gathering inner continuity is long and for some people it has not happened even in adulthood.

For these people, this innate capacity to sequence was stopped because the pairings were unbearably painful (Fonagy, 2001; Winnicott, 1965). What if the footsteps mean I'm going to be yelled at, increasing my upset? It's not possible that the Mom who loves me and takes care of me is the same Mom who yells at me, so this baby might keep an inner world of separate Mom's and separate senses of self into adulthood.

Maria sometimes struggles with a lack of continuity within herself and in her experience of others. If someone mistreats her, she immediately cuts off contact with that person, believing that she has discovered that person's true colors. For example, she worked with a vendor for 5 or 6 years and then they had a money misunderstanding. Maria refused to bring up the topic, instead, she simply dropped the vendor. It came up in our work as an example of how people betray her and cannot be trusted. As we explored her experience, it became clear that there had been absolutely no conversation between her and the vendor about the problem. When a payment did not arrive when Maria expected it, Maria had concluded that this person was not reliable, despite many years of positive experiences. Once that conclusion had been reached there was nothing to talk about. To bring it up now, more than a year later, was too hard in her mind, and would bring up painful feelings of shame and being defective. It took her several months to challenge her own belief system on both levels: that the person had betrayed her (rather than made a mistake) and that talking about it a year later would be devastating in some way. When she finally did have a conversation with the vendor, she was shocked to learn that the vendor had a totally different memory of the agreement, and that the vendor was delighted to be back in connection. They now work together again and it seems that the rupture has been repaired.

Maria also experiences herself in a discontinuous way. At the beginning of our work together, she experienced her black holes as a total state of being. They were not feelings or moods. Rather, the state of defectiveness was all that mattered; there had never been any state of being other than this state of being. As we have discussed this over and over, she has slowly gained the perspective that she has different internal self-states, moods, and feelings. She can talk of herself as having a bad

mood or a bad day, rather than discovering that she is a bad person, worthless in every way, who must hide from the world in fear of being discovered.

Under family stress, she often finds herself in the either–or world. She acknowledges it often around raising her own children. She sadly and shamefully realizes that she only loves them when they are behaving. When they are noisy or displease her, she finds ways to spend absolutely no time with them, announcing that they are selfish and disgusting. Then when they do something well at school or sports, she is proud and loving. She longs for more flow and connection but is unable to sustain it. She understands she is repeating the pattern started by her mother who spent time with her only when she was performing in ways that pleased her. This awareness is only slowly increasing her ability to tolerate and be with her children.

Attachment and Mirroring

The infant spends half of his waking life as a baby-as-body, exploring his world of floating shapes, light–dark contrasts, tactile experiences and sounds. The other half is spent in the interpersonal world of me-with-other, whether with a caregiver or a curious sibling. Paradoxically, it seems that he has a sense of the other from the beginning of his life while at the same time views everything as an extension of himself (Stern, 1985).

Attachment is life itself for the baby (Bowlby, 1969; Fonagy, 2001; Winnicott, 1965). We need relationship at the beginning of life to survive and relationship for the rest of life to thrive (Lewis, Amini, & Lannon, 2000). We also need to feel that the other wants the relationship with us. We need to feel that we are not a burden but are desirable. If the baby did not experience someone loving taking care of him, he will carry a great deal of shame in his self-system. Winnicott (1965, 1992) did not use the word "shame" in his papers. But he was very clear in his work with children and adults that each baby needs not only to have had "good enough" care, but that the caretaker needs to find delight in giving that care. Our sense of well-being and capacity to hope and thrive come from that exchange.

The young child needs to idealize his parents—they are big and powerful and will take care of him—and to have his emotions and needs mirrored (E. Kahn, 1985; M. Kahn, 1991; Kohut, 1977). It is critical that an adult face reflects "I see you in your pleasure and in your upset." When the young child's needs are not met he always assumes there is something wrong with *him*, not his parents. He falls into shame (Karen, 2001).

Like all children, Maria had to attach to her parents. After all, they did their best to take good care of her and had dreams and expectations for her. However, that attachment was not secure. She could never rest in it and feel appropriate dependency and relaxation. By adolescence, she did her best to avoid being around her mom (at the same time, became very much like her), and was very ambivalent about her father whom she experienced as kindly yet ineffective. To this day, she

struggles with asking directly for what she needs from her husband and close friends and at the same time feels terrified that those close to her might leave her. This kind of ambivalent or avoidant attachment is very painful, for she feels ashamed of her needs and separateness. She is damned from both sides.

Maria never felt seen or mirrored by either of her parents. Her mother was the powerful one but she was never available. She was ambitious for herself and her daughter, but unable to provide any kind of consistent care. Her father was the weak one, and his kind regard did not matter. Unfortunately, that was true until several years after his death, when she finally felt the pain of rejecting him all her life and began to appreciate his ways of being in the world. Maria was left on her own, lonely and driven to find some way of being good enough in her mother's system of values. She left home feeling defective in her core and driven to hide that defect behind power and wealth. She used her intelligence and precocious development to hide her sense of being unable to meet her mom's expectations for wealth and her own need to be valued unconditionally.

Being Compared in the Family System

The human brain is organized to recognize patterns. Research from child development suggests that infants can compare and contrast from the moment of birth (Stern, 1985). The child continues the process of comparing and learning as she gathers more of an ongoing sense of self. Along the way, she and her family compare her to others around her. This may take very benign forms or very malevolent forms. Almost all adults will say to a child something like "how big you are" or "how pretty you are." The young child knows that big and pretty are good; therefore small and ugly are bad. She can tell this from the tone of voice, the smile, and the light in the eyes. She does not have to be taught explicitly. So the child hopes that she is big or pretty or whatever is desirable. Each family values certain body shapes and sizes, mental attributes, and morals. The child hopes she has the right attributes to fit in and to be a member of the family group.

Inevitably, the child fails to live up to all the comparisons made by the environment and internally. These failures support the formation of her contracting shame system. If internal failures outweigh successes, her self-system can become so distorted that she will continually measure herself against some other person or ideal of perfection and come out on the losing side. This is a root of low self-esteem, self-defeating behavior, and even depression (Nathanson, 1992). In healthy development, the unnecessary comparisons lessen with time and authentic limits and failures become more acceptable.

Maria often compares herself unfavorably to her husband. He has better instincts around people, is more empathetic, and has stronger friendships. Maria uses these comparisons to prove to herself that she is no good and to confirm why things do not work out for her. She also compares herself to people who have more money

than she does. She craves being around wealthy people and often creates that possibility. However, she is extremely sensitive and registers the smallest slight as proof that either she is inadequate or they are snobs. Historically, she spent little time with people whom she perceives as having less money than she does—they are not very interesting! Increasingly, she is challenging these patterns and wants to spend time with the parents of her children's friends—"salt of the earth" people who want to spend time with family and friends. She recognizes that an evening spent with kids and a pizza is more satisfying than an evening of name-dropping and glitz. Over the winter holidays she had several of these different experiences to compare and we talked about which felt better and which her mother would have enjoyed and want her to attend. Finding and trusting her own feelings without comparisons to others or to her mother's values is a new way of experiencing the world for her.

HEALING SHAME

I have found the maps created by Wilber (1980, 1986) to be most helpful in understanding that intrapsychic and interpersonal conflicts fall along a continuum of levels of development from early childhood to transpersonal oneness. Maria is an example of living along this continuum of early childhood deficits, adult strengths and weaknesses, and transpersonal longings and experiences. I fully understand that intense psychotherapy is a creative, generative process in which my presence is the critical component (Bugental, 1976). However, like E. Kahn, (1985) I have needed the depth provided by British and American developmental psychologists and psychoanalysis to help me understand and transform early issues. In working with Maria, I needed to continually mirror her feelings and piece together the issues for her (deficit work) for her to experience my care and connection (Morrison, 1989). It took a long time before there was enough safety for me to disagree with her (i.e., two adults in the room) or suggest techniques that were strange to her but might be helpful (e.g., touch on her transpersonal connections).

Over 40 years ago, Rogers (1961) gave many of us the ground rules for being with others in ways that facilitated growth and change. Rogers suggested that we look into ourselves and become dependable and trustworthy (nonshaming) to the other. I have found that this is the most helpful basic stance I can take in healing shame. To become trustworthy I have had to search myself to find my weaknesses and my own places of wholeness and connectedness. I need to convey this possibility of wholeness to my clients through who I am, not by words and techniques. Rogers did not directly suggest bodywork or imaginal journeys as part of psycho-spiritual healing, but much of his work pointed in that direction.

About that same time, Maslow (1968) gave us a philosophical ground for clinical exploration. Maslow postulated that our inner nature is good or at the very least

neutral and if that inner spark is permitted to lead us, we will lead fulfilled lives. He created a psychological way of looking at people that was not based on drives or operant conditioning. However, he did acknowledge that this inner nature is not strong, rather it is "weak and delicate and subtle and easily overcome by habit, cultural pressure and wrong attitudes" (Maslow, 1968, p. 4).

This latter acknowledgement is certainly true for Maria; she knows she has that inner spark but experiences herself as fragile and easily thrown off course and off center. So much of our work—as noted before—has been to create enough safety in the relationship to expose, explore, and begin to heal those developmental deficits that left her so vulnerable.

As I sat with Maria in the first year of our working together, we pieced together many of her self-destructive patterns. She is very intelligent and could use the many insights we explored. She catches herself in her reflexive either–or stance and can recognize the difference between a mood and a black hole of worthlessness. As our work deepened, our relationship has also deepened. Increasingly I am a real person to her—one who cares for her but sometimes disagrees and challenges her. This is no longer taken as proof that I will betray her. She still struggles with ambivalent and avoidant attachment issues, but there are definitely people who she now feels are trustworthy even if they make mistakes. As she comes to trust our relationship more, she is better able to enter into holistic ways of working. She knows that her fine mind and great sense of logic and insights will only take her so far.

Another theme we continually struggle with is forgiveness (Karen, 2001). Forgiveness would be a healing antidote to Maria's shameful sense of self. However, since her mom did not attend to her in ways that would give a child a sense of being loved and valued, she still speaks of hating her. Maria left home with a clear message: to be ordinary was shameful, only being on top had any value. Maria knows that if she were to accept her mother more fully, she could accept herself more fully. Mom died many years ago; sadly, forgiving her is still far away.

THERAPIST MUST FACE OWN SHAME ISSUES

To deepen the work with a client like Maria, we must first face our own shame issues. All of us have been shamed and have had to integrate these experiences into our being. Since all of us experienced some shame from our parents we need to acknowledge how we have passed that on to our partners, children, and other loved ones. We have been shamed and we have shamed. Shame, like pride, is woven into the fabric of our being. It is a part of us that cannot be cut out; we must accept shame to transform it.

Having been in therapy is a prerequisite to doing therapy, but one's own therapy is only the beginning. Doing psychotherapy is a lifelong commitment to personal growth. Each client will bring up new personal issues for the therapist if the rela-

tionship is really alive and intense. When the therapeutic relationship is not going well, it is very likely that the therapist will experience shame. We can leave a session and judge ourselves as any number of negative things: stupid, inadequate to the task, impotent. All of these are variants of feeling ashamed: "I don't know what's going on," " I'm not doing a good job." When our shame reaction is clear, we know it—I feel humiliated, embarrassed, and so on. But more often, our response is subtler, what Lewis (1971) calls "by-passed." We feel an inner jolt, a body sensation, but do not put it into specific shame words; rather we feel amorphous things like *uneasy, confused, weird, helpless*, and so on. It is very helpful to know that when those words cross my mind, I am probably in the realm of shame. If I do not recognize I am carrying shame about the potential failure of the relationship, I am more likely to create the "healthy-therapist–sick-patient polarization" sabotaging the opportunity to create a truly human relationship (Retzinger, 1998).

Maria's emphasis on wealth has brought up very powerful issues for me. She has made it clear that to be on an hourly fee schedule is "very dumb and that you cannot get ahead that way." I had never thought about it that way before, but once she brought it to my attention I could only agree with her! I would never get ahead in the sense she meant it. I would never have the things she has, like warm winter vacations at elegant resorts or a second home. Inadvertently (or perhaps not so inadvertently) Maria made me doubt my life choices and feel I had made a serious mistake. Over time, I realized that I did not really want many of the things she wanted (well, maybe that $10,000 gold watch!) so the inner issue was not envy. Rather it was that I *could not* have the things she has and she *knows* I cannot have them. It is that combination that has generated the sense of shame that I have had to manage internally.

I use supervision and self-reflective meditation to keep my personal systems in balance. Both have reminded me of my personal reality: I have enough in the material world. From the place of knowing that I have enough, I can challenge Maria on her chronic need for more without making her bad for feeling empty or for having shamed me. We can talk about her need for more wealth as a defense against shame and defectiveness without the additional burden of my unresolved shame issues around money.

THE HEALING RELATIONSHIP

The sense of "brokenness" we carry was created in relationship and so must the sense of being healed come through relationship. Each therapist must find ways of creating a relationship that is safe enough and strong enough to bear witness to all that is inside, including some very unpleasant feelings. This containing relationship must support both parties to stay present for the exchange and not enter denial. All of us have needs to be known and needs to keep some things private. We have

needs for intimacy and needs to be safe, inside, internal, and separate. This applies to therapists and clients alike.

Some clients need a lot of space, silence, and patience to grapple with what is going on inside and to come up with their own words. Other clients need very active engagement, lots of dialogue and aliveness or else the therapist is experienced as too far away and as not caring. We know that for growth to happen the client must be willing to become self-reflective, experience what he is feeling and share those experiences with the therapist. To become self-reflective is very scary if one expects some inner form of shaming, like emptiness or badness, to result. The client may never share if she experiences being shamed from the outside during her first attempts at communication.

These boundaries can be difficult to negotiate. We have to pay attention to the polarities and to repair our mistakes as quickly as they are known. Failures are inevitable and necessary for the healing journey. A perfect understanding would be a fusion or an imitation. Two living beings cocreating a relationship must include mistakes and repairs.

Maria needs very active engagement with me. If I am quiet she wonders if I disapprove in some way. I tend to ask her a lot of questions about her current state of being. These questions are based on my read of her face and mood in the moment (and my theoretical understanding of her developmental journey). She can get very impatient when my question or suggestion is off. To this day, she wishes I could read her perfectly, and of course I cannot. This rhythm of mistake and repair is very important, humanizing both of us.

One way we each create this caring relationship is through being present and attuned, creating mirroring or empathy (Bohart, 1991; Kohut, 1977). We convey that we know how the other feels by facial gesture, body language, and tone of voice; verbal communication is not enough, the nonverbal is critical. This capacity for empathy is built in neurologically (Nathanson, 1992). Parents smile when their baby smiles and suffer when she suffers. Lovers love being totally in tune with the beloved. People stay connected through this mirroring and resonance. Therapists must use this built-in ability to deeply connect with the client, giving the felt-sense of being seen and cared for.

When this is missing, connection is broken. The shame-based client picks up on the least bit of inattention or boredom. A glance at the clock or a sigh is enough to close down the communication. The more shame-based the client, the more he or she scans the clinician's face for the least sign of disapproval or disagreement. When this is found, these clients withdraw for safety. Now Maria will ask me directly what I think about what she just said, particularly if it is something she finds difficult to share. Can I care for her when she has done things that are shameful like ignoring her kids until she screams at them to be quiet? She still cannot assume my care but she longs for it and hopes for it.

I lose my empathic connection with Maria most easily around her treatment of her children. One time I said to her, "You really hated him at that moment, didn't

you?" She visibly winced at this "attack." While it was true, it was certainly not helpful. I immediately asked her what happened for her when I said that:

> "That's way too big for me to hear. That I hate my own child. That's too much."
>
> I said, "I'm sorry for the tone and the word. It was too strong. I'm sorry for pushing too hard. How are you feeling toward me right now, having pushed and hurt your feelings?"
>
> "OK, but not really safe; I need you on my side."

Maria and I survived my attack, and many other mistakes. Each time we go through such a small rupture, she builds the capacity to see me as human, capable of making mistakes and apologizing for them. That way we stay out of the either–or world where one of us could be damned and cast out of the relationship.

When a client like Maria can express a historically forbidden need like longing for my care it is important that I acknowledge the need and the courage to express the need. By living through these experiences, Maria feels truly cared for and valued. In those moments we are cocreating the context that is the critical healing medium, much more than the insights and ideas. The words, insights, and other techniques pass back and forth in this medium of attention and care. Once this medium becomes trustworthy, the content becomes richer and richer.

Eye contact is another important barometer of safety. When we can maintain eye contact neither of us is ashamed to be seen, and therefore we can create space to be known. Some very shame-based clients need lack of eye contact for a long time. I have had many clients who only glanced at me once during entire hours of therapy. I had one client who came with a CD player in his hands, the headphones dangling around his neck (not on his ears), and the music on. He told me it was important to be able to get away, to tune me out when he needed to. The music was his safe space. At the beginning of our work, he barely looked at me. It took several months for the CD player to simply disappear as he gained confidence in our connection. Maria still spends a lot of time looking out the window, glancing at me for connection and even approval.

Once the relationship is begun, the context established, certain techniques become useful. For me these techniques may include different kinds of bodywork, including touch, and various kinds of imaginal work. Over the past few years Maria has felt safer and become more self-reflective allowing us to experiment with these holistic possibilities.

USING THE BREATH

The stress reduction techniques of the West and the Yogic traditions of the East both depend on paying attention to the breath. It is vital to developing somatic awareness, as it is the only bodily process under automatic and conscious control.

Fast shallow breath connotes anxiety, even panic. Long slow breath connotes peace and relaxation. As Thich Nhat Hahn (1987) has taught us, when we smile in a simple meditation, the physical act changes our emotional sense. We can generate emotional well-being and wholeness by starting at the bodily level.

One of the things Maria and I now do regularly is to focus on her breath and the movement in her chest engendered by breathing. She needs ongoing help to find those sensations that help her slow down and stay soft and open to her love feelings. Maria's normal breath pattern is shallow with almost no movement of her rib cage. Changing this pattern provokes anxiety in her. When she slows, deepens her breath and pays attention to her inner sensations she often connects with an emotion. This immediately upsets her, no matter what the emotion:

> "I'm afraid of my anger coming out and destroying everything."
> "Are you feeling angry?"
> "No, but it might be there."
> "But what *is* there, what are you in touch with right this moment?"
> "I wish things were different."
> "But what is real and true right now?"
> "I feel sad, longing to feel loved, particularly by (her husband). I hate that needy place. I hate needing him and feeling empty."

The pattern of shallow breath keeps her in her old story of "never get close to another because that person can always shame you or leave you." Once she gets in touch with her softer sensations she might or might not shed a tear, and then she feels a better sense of connectedness and wholeness in her body. Feeling better allows her to feel stronger and then we might also focus on her spine. I will have her focus on the strength of each vertebrae and how collectively they hold her upright with no effort on her part. She can feel her backbone and feel how it supports the structure for her whole frame. When she focuses on her spine, Maria reconnects to her center, her emotional place of wholeness and courage. I have found that breathing in this way not only gets Maria in touch with her softness but also her strength, allowing her to leave a session more optimistic about her capacities to meet life without shame.

IMAGERY

Imagery is another powerful therapeutic tool for Maria and one that I have used in my practice for many years. By this I am referring to our capacity to imagine an object or journey that is not perceived by the senses at this moment.

> This realm lies behind that ordinarily perceived by our senses and is a world as real as the one we usually refer to as objective reality. It is here that one can see the whole

> since in the act of apprehending imaginal reality linear logic is suspended and gestaltic perception is opened up (Epstein, 1980).

It is now believed that imagery processes use the same neural substrates as perception, allowing the individual to have a new experience that evokes the same possibilities of an actual experience (Cappas, Andres-Hyman, & Davidson, 2005).

When I work with imagery, I prefer that the image come from my client: perhaps it is a dream fragment or a bit of fantasy Maria had while driving to my office. If she does not have an image, I offer one that we have worked with before. I often use an image that my colleague, Judith Schmidt, calls the "cave of the heart" and this has been very powerful for Maria. My variation of it might go as follows:

> Close your eyes and get in touch with your breath. Pay attention to the breath, particularly the out breath. Make the out breath long and slow, taking away from you everything that you don't need right now—your stress, distractions from the outside, anything that would keep you from paying attention to the sound of my voice and to your inner images. Then allow yourself to be in a landscape with a cave-of-the-heart in it, a cave-of-the-heart carved into rock, a cave-of–the-heart with a wonderful vista in front of you. The cave is shelter, it is protection, it is safety. Tell me what you are experiencing in this cave right now. Take your time and really feel the safety and the beauty.

Once we have created the refuge of the cave-of-the-heart, I will encourage Maria to stay there as long as she wishes, enjoying the whole experience. Then I will ask her if she wants to do anything else in this inner landscape. Usually, she will then want companionship in that inner world.

> So who do you wish were with you?

Usually, it is her husband, but if they are having a particularly difficult time, she will mention a close friend or one of her children.

> So allow that person to join you, send a light band of connection to him, and feel the effect in your body and emotions. Feel the goodness of the connection, head to head, heart to heart, (and pelvis to pelvis if the imagine person is her husband). Allow intimacy and safety to reside together in your body. Stay there as long as you want, allowing the cave-of-the-heart to expand and contract with each breath, holding both of you in its safety.

These kinds of imaginal journeys are profound for Maria. She often reports back the next session that the images played out during the week and describes

whether or not she was able to reconnect to the positive ones. Sometimes I suggest that she deliberately recreate a part of the image, for example just before seeing her husband at the end of the day. She reports that that is helpful as well, an internal reminder to be in her softness as well her strength.

TOUCH

Touch is another powerful medium for Maria (Field, 2003). In our society, it is impossible to escape some shame around our bodies and sexuality (Hastings, 1998). Between her low self-esteem and her personal distaste for her body, Maria does not think of herself as very touchable. At the same time she is starved for touch. Over time, we have established the pattern of a hug at the end at each session. She is taller than I am and is very careful not to overpower me. At the same time she so craves the warmth and acceptance of that hug that she almost leans into me just before we part. When she has had a bad week, she remarks on how important it is that we make physical contact, that it makes her feel more acceptable to herself and supports her to be who she wants to be.

IN CONCLUSION

Like most people in deep process, Maria has changed many aspects of her life and some things remain almost untouched. Perhaps most importantly she is no longer so isolated either personally or professionally. She no longer bullies her husband; they make important decisions together, like where to live and whether to let the nanny go and how to coparent their children. She is very conscious of wanting to change the multigenerational patterns. Perhaps her biggest opening has been to become more empathic to her children. Both of them still yell at the kids a lot, but Maria can also apologize and explain, not just repeat her mother's pattern of withdrawing in disgust.

At work, she has created a team rather than doing everything impulsively and alone. Decisions are now made jointly with people she respects. We both know that this has happened in part due to her increasing inner strength and in part because she has created enough wealth to finally feel safe.

Internally, she now recognizes that life is a process and seeking permanent perfection is a recipe for shameful failure and depression. The depressions still come but with less frequency and intensity. Exercise helps and she has a routine that works pretty well for her. As I write this she is considering trying yoga or meditation to gain further relief. She is resistant to both for different reasons, but has bought tapes for meditation and found a schedule of yoga classes she could attend.

Perhaps another door will open for her. She talks openly of needing connection and meaning in her life, not just wealth and freedom.

Maria's use of the word *defective* brought me to much study and many conversations with her. For this I thank her.

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