

# The Body of Shame

## *Listening for the Longing*<sup>1</sup>

Danielle Tanner

### ABSTRACT

This paper seeks to explore the issue of embodied shame through a clinical vignette from the perspective of a relational body psychotherapist. Through this therapeutic journey, key themes became evident. First, the body of shame develops in response to familial patterns of behavior, relational rifts, and social shaming. Second, the body of shame can also have a transgenerational impact and, in this case, extensive and damaging consequences.

In the relational turn, there is a departure from the classical psychoanalytical paradigm, which views shame as a sign of immaturity. This paper will contribute to a growing body of relational psychotherapy theory and praxis that suggests that, in order to heal, the body of shame requires external support, a neurobiological approach in psychological treatment, and an internal validation of desires.

**Keywords:** shame, pain, body, relational, neurobiological

Received: 03.11.2018

Revised: 07.09.2020

Accepted: 09.09.2020

International Body Psychotherapy Journal  
The Art and Science of Somatic Praxis

Volume 19, Number 2,  
Fall/Winter 2020/2021, pp. 32-42

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

© Author and USABP/EABP. Reprints and  
permissions: secretariat@eabp.org

*You left and I cried tears of blood.  
My sorrow grows.  
It's not just that You left.  
But when You left  
my eyes went with You.  
Now, how will I cry?*

Rumi

According to Freud, shame is an “affect” or “reaction-formation” – a defense mechanism to defend against the incursions of libidinal impulses. That is, shame functions to control instincts that are “perverse.” Freud posited that shame occurs at the developmental stage when we stand up on two legs, exposing our previously concealed genitals to the world, and shame therefore serves to protect them. The traditional psychoanalytical view was based on the philosophy of the nature and function of shame, which Aquinas took from Aristotle. In that context, shame is an appropriate response in a child or adolescent, as it provides restraint against socially unacceptable behavior. Yet in adulthood, shame implies a moral imperfection or immaturity that is incompatible with the notion of “virtue,” and because the mature person determines his own course of action without too much concern about the approval or disapproval of others (Hazard, 1969). Current relational literature views shame as a fragmented sense of self, where shame is “an experience of one’s felt sense of self, disintegrating in relation to a dysregulated other” (DeYoung, 2015: xiii) that requires a relational approach to facilitate neurobiological affect regulation and the development of self-compassion to heal.

In this case, I found that the relevant issues revealed over the process of therapy contributed specifically to themes of embodied shame and transgenerational transmission of body shame, which I hope this paper will show can be healed by a modality based in a relational, neuropsychological approach and touch. My client in this study, Grace, was very flexible and amicable to this

<sup>1</sup> “Listening for the Longing” was conceived by Robert Lee in 1995 regarding shame.

method. I believe that an individualistic strategy that changes according to the evolving needs of the client is the most appropriate way to work.

Both shame and guilt are experienced in interpersonal relationships, and the adverse events that generally cause them are similar. Tangney and Dearing (2002) reported that these emotions are very close in nature, but also differentiate them from each other, based on specific characteristics. For example, shame involves the negative evaluations of the global or whole self (*I made a mistake*<sup>2</sup>), whereas guilt involves the negative evaluation of one's behavior (*I made a mistake*). Guilt often includes feelings of tension, remorse and regret, which can be physically or emotionally painful, but guilt does not affect our core identity. In contrast, shame is an acutely painful emotion that can make us feel exposed, worthless, and powerless. Another critical distinction is that people who feel shame are concerned with evaluation by others, whereas people who experience guilt are concerned with their effect upon others. Finally, a desire to hide and escape is a typical motivational feature of shame, while with guilt, people want to apologize or confess and take reparative action (Lewis, 1971, 1987; Tangney, 1995, Tangney & Dearing, 2002).

Lewis (1987) concluded that shame often results in feelings of anger and hostility, combined with a tendency to project blame outward. This can be seen in the dynamics of Grace's marriage, which will be discussed within the clinical vignette. Tangney (1995) further emphasized the link between shame and anger by noting that shame-prone people are not only likely to experience more anger, but are more likely to manage their anger in maladaptive ways, such as acting out their particularly hostile intentions. Shame-prone people may experience resentment and feelings of being unappreciated or humiliated, which contribute to hostility, hypervigilance, and volatile expressions of anger. Additionally, shame-prone individuals can often believe that these angry feelings were likely to result in negative or destructive long-term consequences; thus, they may suppress or hide their feelings or intentions.

## The Shame of Grace: A Clinical Vignette

Grace is a sixty-six-year-old woman. She sports a head of short, tightly-curled hair. She is organized, articulate and well-educated. She speaks with animation and smiles often. Grace spent her entire career in social work with families and children. She shows warmth, empathy, and compassion for others, and appears to be naturally reflective, insightful, and curious about movement towards "feeling more comfortable in my own skin." I enjoy being with her. We have worked together for three years.

---

<sup>2</sup> Italicized for emphasis..

At the beginning of our therapeutic relationship, she had a desire to explore issues that had become pertinent in her marriage. Her constant criticism, irritation, and frequent angry verbal outbursts towards her husband had become detrimental to their relationship. Over time, we uncovered several pivotal traumatic events that had led her to a "seething stalemate" with her husband. Most recently, her beloved dog had died, and her sorrow had immobilized her. She was unable to share her profound grief, and the projected fear of ridicule or rebuke, that someone would say, "It's just a dog." She had become frozen and socially withdrawn. Her already tumultuous relationship with her husband had dramatically deteriorated further.

## A Personal Reflection

During initial supervision, I had noticed my own internal apprehension when we engaged in sessions. I had embodied a sense of urgency for change, to solve this "dilemma" quickly. Through reflection with my supervisor, I began to identify the transference anxiety that I had, inadvertently, adopted. I determined to slow the process down. Instead of halting the flow, we were both able to relax, as I held onto the internal idiom, "We have all the time in the world." This phrase became a crucial locus as we began to uncover the subconscious drives that underpinned her anxiety that "time is running out." She had moved into retirement, and what she regarded as the end of her "usefulness." She had become painfully aware of the aging process in the human body as it affected her and her husband, and mortality through the death of her most beloved dog. The specter of death had become very real, as she felt it was "just around the corner."

Over time, her desire to please, both in the therapeutic alliance and in the outside world, became evident. With this identification, there came a liberation. We both spoke with increased candor and directness, as our rapport became established and our therapeutic intimacy deepened. However, our emphasis shifted from her marital relationship to her relationship with her body.

## Shame and the Body of Pain

After several months of working together, I could see that she was in pain as she shifted, with some discomfort, in her seat. Her back was straight and stiff, and as she began to speak of the pain in her stomach, her shoulder girdle became rigid. Her breath became shallow, then more ragged and rapid, and she began to swallow. As her eyes widened, I too began to feel a rising panic in my own body as I resonated with hers. "Oh, this pain," she said, as she moaned softly.

Over time, we began to explore her experience in her body. For a long time, her body had been in some considerable pain. It started with sudden “horrific” and debilitating “attacks.” Then daily, she experienced “excruciating” pain, nausea and diarrhea. Eventually, after many attempts to find a solution, she was told by a consultant that she had microscopic colitis, and the inflammation was covering her entire bowel, “straight the way through.” No effective cure was offered, and it would have to be “managed.”

Since this diagnosis, she had developed severe hypertension, and become asplenic, which entails a significantly increased risk of severe sepsis. Additionally, she became hypothyroid due to Hashimoto’s, an autoimmune disease in which the body attacks the cells of the thyroid tissue. However, with all of these potentially life-threatening diseases, the one that she was primarily concerned with was her stomach pain. “I’ve been trying very hard to manage the problem, but I’m frustrated and depressed,” she said quietly, her eyes downcast and her shoulders hunched. She looked utterly defeated.

## The Effects of Trauma and Stress on the Nervous System and the Gut

Inflammatory bowel disease (IBD) is a result of disordered immune activity in the gut. Emotions profoundly influence, and are intimately involved, in the nervous system. Emotional influences acting through the nerve and immune pathways of the psychoneuroimmunology (PNI) system can create inflammation. Chronically stressful emotional patterns could induce inflammatory disease (Ainman, 1996)<sup>3</sup>, and adverse life events and chronic stress increase the likelihood of relapse in people with quiescent IBD (Mawdsley and Rampton, 2005). The gut is more than an organ of digestion. It is a sensory apparatus with a nervous and ecology system of its own, connected to the brain’s emotional centers. Emotionally upsetting events can be “gut-wrenching,” and many of us intuitively understand this, or can recall experiencing the “sore tummy” of an anxious child. “Gut feelings” help us to interpret what is happening in our environment, as to whether it is safe or not. Nausea and pain, or a warm, comforting feeling in the gut are sensations that orient us to the meaning of events.

Thus began the somatic narrative of Grace’s IBD. After some reflection, we determined that the pain started almost immediately after her daughter had suffered a distressing ectopic pregnancy. Her daughter had miscarried in a bathroom cubicle in a public toilet, while her family had been dining at a restaurant. Grace had been called in to attend to her daughter and faced “a room full of blood,” which they just “cleaned up,” even

though her daughter was later told by the medics that “she had nearly lost her life.” Although the incident had happened nine years previously, Grace had never reflected further on it. In the last three years, she had also witnessed her husband’s journey through bladder cancer, seen the blood in his urine, cleaned his post-operative wounds, and helped the district nurse with his dressings.

She told these stories in a pragmatic tone, yet her body and face were frozen and still. Her eyes were wide, her voice barely audible, and her breath shallow. The dissonance between the narrative and her body-story was striking. I was acutely aware of the quiet trauma hidden within the narrative.

Nourishment had become intrinsically merged with blood, pain, and loss, which made self-care and nurture almost inaccessible for Grace. She had lost her resilience and the ability to nourish herself: “I don’t eat properly...” “I had to eat it, even though I knew it was wrong, that it would cause me pain...make me tired,” “I just wanted something nice.” Grace recounted how she was “ashamed to say” that she would secretly eat chocolate bars in her car, and hastily dispose of the evidence.

## Shame and its Relationship to Self-Care and Nourishment

In a society full of shaming behaviors, we are social beings who are deeply vulnerable to its undercurrents that dictate much of our behavior. Grace felt shame for not practicing the self-care that she thought she should or wanted to engage in, but was caught by a more insidious shame that quietly questioned whether she actually deserved care and compassion in the first place. Shame became a toxic bedfellow to self-care, and a powerful accelerant of self-loathing.

In thirty-five years of social work, Grace had never taken a day off sick. With great courage and passion, she had become “the neglect expert,” gathering “concrete, factual evidence” to protect children. She was a mother, wife, and social worker – a nurturer of humanity, and yet she had forgotten how to nurture herself, which we came to believe had contributed to her illness.

Utilizing her words, I was instrumental in building and developing a metaphor in which she likened her human body to the soil. Excessive ploughing and unmindful practices by farmers ruin the life and health of our earth. She spoke of how land is left “barren, exposed, degraded” and stripped of its life-giving power. This means that when hard times strike – like a severe drought – the once nutrient-rich soil becomes lifeless dirt. The earth is devoid of any nourishment, and without en-

<sup>3</sup> In clinical trials of medication for IBD, placebos can affect a positive response in up to 60% of patients. This does not suggest that the disease was “all in the mind,” but that when these patients felt that they had agency over their disease, this enabled the neurological and chemical process in their body to be activated to allow for healing (Hershfield, 1997).

richment, nothing can grow. There is no resilience, and humanity has the potential to starve.

Her spiritual ecosystem, if you will – the soil of her soul – had become exposed to negativity and constant self-doubt. She recognized how she was repressing her emotions, and no longer felt that she could innocently and authentically respond to events. Instead, she was driven by her constantly unfolding anger. We began to explore how she could cradle and accommodate her own sometimes extreme and erratic emotional responses, rather than relying on external objects. In her instance, “busyness” and the predetermined judgments of others that she had internalized to “get on,” “don’t make a fuss,” “be useful,” “don’t fall apart...” Through the soil metaphor, she came to see how she risked ending up living in a “dust bowl” of self-judgment, hopelessness, and cynicism. I frequently returned to this metaphor in our sessions to explore dialogues around self-care. She also came to see that her disease had its roots in anxiety and stress, created by her innate perfectionism. She had faithfully passed on this perfection, imbued from her own mother, to her daughters. “They never stop; B. just keeps going with her hectic life, she’s a lawyer... and she has children, and she’s in pain every day, riddled with awful endometriosis. I really worry about her.”

I resolved to ensure that within our sessions, we would not repeat her patterns of failure to attend to her pain, and we would actively engage in self-nourishment. Whenever Grace came into the session with pain in her body, we would sit and silently attend to the pain. Our work style changed from talking therapy and became more centered around breath work, grounding, and bodywork (touch and movement). This happened over a year, when Grace and I felt more comfortable with negotiated touch, a broader modality, and a more dynamic approach.<sup>4</sup> Gradually, we would explore the feelings around the pain. We came to the agreement that we would attend to ourselves first, as an act of mutual self-care. She would sit and breathe into the area of pain, and I too would attune to my own body, then resonate with her body and the intersubjective field between us. We would attempt to *feel* what was “behind” a flare-up. Eventually, she identified that the only “feeling” there, behind the pain, was a “withdrawing,” “cringy,” self-flagellation and a “desperate and angry” anxiety. Whenever we explored her body sensations, she said, “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful towards her body. However, gradually, she identified her self-hatred as a reflection of her auto-immune disease – which is essentially the body attacking itself.

During one session she was recounting how, during a social outing to the cinema, she became upset that she could not eat an ice cream at the break. She had become grumpy and belligerent, “quite unlike myself.” She spent several minutes scolding herself for her “shameful” behavior. It was then that I felt we could begin our exploration of her shame, which became a central theme in the therapeutic journey.

## Grace and her Shame

Shame is a universal feeling, and also one of the most potentially disorganizing of all affect experiences (Wheeler, 1995). Shame had shaped many of Grace’s adult experiences. She primarily felt shame that she had had an affair with her second husband, and that their first daughter had been the product of her first marriage, not of her current husband. She clarified that she did not feel guilty, but ashamed.<sup>5</sup> She felt crushed by the weight of her shame, and unable to take any reparative action.

In the initial event, she had not admitted to her first husband that she was having an affair, but it was discovered. She had gone to meet her lover in her car, and had parked it beside the lake. As she had the opportunity to spend a few days with him, she had left her car there. The car was spotted by the local police, who felt moved to investigate. As her husband did not know her whereabouts when questioned, her parents were informed that she had disappeared, and the police suspected foul play. Eventually, she returned home, to her parents, who were “worried sick” that she had either drowned or been abducted. “Shame-faced,” she had had to explain where and with whom she had been. In this moment of abject humiliation, she felt unable to speak, as she was so confused and disoriented. Her desire had met an unwanted limit in a sudden, overwhelming, physical experience of shame – of sweat, racing heart rate and diffuse anger. This powerful affect was the beginning of her journey with chronic shame.<sup>6</sup>

This shame was compounded when, upon leaving her husband for her lover (soon to be her second and current husband), she discovered she was pregnant with her first daughter, the conclusive result of a union between her and her first husband. She decided to conceal the truth (“so wished she wasn’t blonde, and so glad when she had to wear glasses like the rest of us...”) and did not inform her daughter for over twenty-five years. This augmented and embedded her sense of shame. The whole scenario also highlighted her fear of conflict and negotiation.

<sup>4</sup> There was a consideration of ethics and safety in that the touch was consensual. Each time we engaged with touch, there was a renegotiation.

<sup>5</sup> Despite her “retirement,” she occasionally worked both as a paid facilitator with the social restorative justice team, and in a voluntary capacity as an “appropriate adult” (AA) for vulnerable youth in police custody. She often spoke and educated others about shame and its adverse impacts on restorative justice. She spoke eloquently on her understanding of the difference between self-blame and self-responsibility, and the difference between guilt, shame, and remorse.

<sup>6</sup> Nathanson (1992) and his mentor Tomkins (1963) both describe the very concrete physiological affect of shame.

Grace felt that there was nothing she could have done to redeem herself and had no opportunity to change her parents' diminished (as she perceived) opinion of her. They both passed away without her having had the chance to address it with them. "They didn't say anything, but I could see in their faces how disappointed they were with me, and I had caused them so much distress. Imagine how it must have been for them to think I was in that lake, and I still don't know what damage I have done to my daughter."

She had experienced both direct social shaming and the concomitant withdrawal of support from her first husband's family, as well as uneasy feelings of anticipatory shaming from her parents. She felt she had let them down, as well as experiencing her own internalized shame. She felt humiliated by the whole experience, and her growing belly of pregnancy was a testament to her shame, which she felt should be concealed. Society has often held up women's bodies as markers of sexual immorality, in that women are supposed to be paragons of purity and virtue. Therefore, female sexual transgression can often be condemned or punished harshly (Fischer, 2016). We discussed the politics of gender and shame in our sessions, and later her "belly shame."

I had to be sensitive to my client in our ongoing dialogue about her embodiment of shame. Offers of support can themselves lead to feelings of shame, which could be seen in her conversations in therapy; "Why aren't I managing this better? Why aren't I finding a creative way out of this?" It took time and careful, attuned negotiation to move through her own condemnation of herself, of not "quite measuring up" and of not being "good enough" – phrases she frequently used, which all exemplified her own feelings of perceived personal inadequacy and shame.

## The Crucial Element of Support in the Journey Through Shame

Grace and I then began a new phase of therapy together. The therapeutic journey subsequently became a discovery of how crucial support, and its absence, are in the experience and development of shame.

I was aware that this area could prove to be challenging for the shame-prone client. Because the psychotherapy situation can easily provoke feelings of inadequacy and perceived moral judgment, shame-prone clients often blame or feel blamed concerning the issue of whether they are functioning satisfactorily in treatment. They may explicitly blame themselves for failing to improve, or they may blame the psychotherapist for their lack of improvement, as a defense against a devalued self-schema. I wanted to be mindful to avoid countertransference and handing the "blame" back.

By paying attention to shifts in my own self-evaluation, I remained sensitive to a projective identification of devalued self-schemas, as advocated by Goldstein (1991).

The shame-prone client is vulnerable to feeling deflated in the course of delving too rapidly into various aspects of an experience. Therefore, I was careful with the pacing of our engagement together, as I was mindful of the emergence of my client's devaluing-other internalization; when this arose, it became a signal to employ a "tactful slowness," a process described by Horowitz (1989), to re-establish or deepen the alliance between us. In the case of projective identification of this devaluing-other agency, the therapist may be caused to feel and behave toward the client in accord with an internalized, and often covert, critical agency. Negative countertransference reactions with shame-prone clients often signal instances in which the therapist is pressured to accept a disapproving stance toward the client, and function as a spokesperson for the client's self-contempt. Understanding this function enabled me to maintain a supportive stance, while reflecting and encouraging an exploration of those self-critical attitudes that the client generally turned toward herself.

The therapist, in response to this scenario, might feel pressured to accept projections as a disapproving parent criticizing their client's self-schemas. This enforced positioning may allow us to understand better, when we briefly become the "spokesperson" for the client's self-contempt, which may have resulted from an accumulated experience of a critical caregiver. However, it is another tactful dance that requires skill (and probably a few therapeutic mistakes) of not colluding with the client's degrading self-beliefs, while still offering support.

Grace would berate herself for engaging in a damaging internal dialogue and admonish herself further for "not knowing better." It took time to assume a supportive role where I was not colluding with this dynamic. Instead, I challenged her by gently reminding her whenever she was berating herself. However, within this interaction, I became the critical parent; loving and warm, but also critical. It was only by making this double-bind as transparent as I could that we were able to examine the impact her shaming behavior was having on her sense of self-worth. We began a conversation around shame and shaming behavior, self-deprecation, and internalized shame ("we even shame ourselves for shaming ourselves"). We attempted to counteract these shaming behaviors with playfulness, and a stance of open curiosity.

These feelings of shame had led to her chronic stomach pain; the indigestibility of her shame had led to inflammation and feelings of vulnerability and powerlessness over her digestive system. She often minimized her discomfort, tried to conceal it from others, and felt that she had no control over her symptoms. "When I'm out in the open, exposed to others, I don't want them to see me like that." Her condition was robbing her of her own sense of strength and agency, two traits that she believed had been an integral part of her self-identity. Her shame had created a field in which she could not "face others" in her position of weakness and powerlessness:

thus, the close connection between these feelings of shame and her sudden disorganized outbursts of rage, turned against herself, her husband, and the world.

Shame was not merely manifest in her stomachache, but also in her averted eye contact and her hunched shoulders. When she spoke of her disquieting sense of shame, she could not bear sustained eye contact, and it became “intolerable.” Eventually, it rendered her silent, her speech dried up, caught in the light of exposure, and she became inaccessible. She felt that in these moments, the examination of herself created a self-consciousness that was “paralyzing.” Shame had become the source of many of her complex and distressing internal states: her depression, her feelings of alienation, isolation, perfectionism, and deep-seated feelings of inadequacy and loneliness.

### Touching the Body of Shame

Grace and I decided to move onto a floor mat to explore the pain in her “belly.” She would often sit stiffly upright or move away when she was in pain. We looked at how we could make her as comfortable as possible. She looked at me warily, and then shyly as I passed her blankets, cushions, and covers to support and cover her. She lay down and spoke of her pain. Drawn to touch her, I asked if I could put my hand on her belly. She stiffened, but acquiesced. Feeling her reluctance, I explained that I felt moved to pay attention to the pain in her belly, she carefully pulled up her top. Gently, I placed my hands on her she froze, and I waited as the musculature in her abdomen softened. When I eventually followed the impulse to place my hand on her “sore belly,” Grace instinctually reached up with both of her hands as if reaching out, grasping into the air, and then pulling her closed fists towards herself. Her breathing slowed, and she closed her eyes. I noticed that she smiled. It was a closed-mouth smile, but her body movements appeared young and playful.

As I slowly stroked Grace’s belly, my concentration became single-pointed, and my hands soft and warm. I felt maternal and loving toward Grace. I felt a state of being for the other, in which there was a sense of responsibility, and vulnerability. The sensation felt so reminiscent of the moments when I stroked my young daughter’s back and she, enraptured, would soften under my touch. All my attention was focused on Grace’s breath, and her shy smile and the softness of her belly. I felt engaged and entranced in the simple movement. Grace’s body relaxed under the longed-for touch that she was unable to ask for directly. At the end of the session again, I could see her shyness re-emerge when we spoke about the touch. Still, she talked of how she felt transported back to the moments when her mother had “rubbed her tummy,” of how good it felt, and how difficult it was for her even to acknowledge that need, let alone ask for it to be met.

I was familiar with the various interpretations of the movement of reaching out in somatic psychology. This action of reaching and grasping is explored in the five fundamental developmental movements (Bainbridge-Cohen, 1997; Aposhyan, 1998). Reaching is an action that supports going beyond the sense of self. It is a way of extending out towards others or objects. Psychologically, reaching manifests as curiosity, desire, longing, and compassion. This action may, however, expose one to risk-taking and a sense of vulnerability.

### Reaching for What We Want: A Recognition of Longing

This movement of grasping began another phase of our exploration: that of desire or longing. Shame has a “modulator affect” (Tomkins, 1987, Haufman, 1963) in that it has a protective mechanism to modulate or regulate our desire or excitement for an object or state in the outside world. We place ourselves into a state of vulnerability when we extend ourselves towards that which we desire, and shame can be the warning light that can reel us back from exposure. As we reach out, when we need something, we are dependent upon the field, and dependency has an inherent vulnerability. The dynamic interplay between the protective mechanism of shame and Grace’s desire or need then became our focus in bodywork. Theoretically, this therapeutic approach is a movement away from the individualistic paradigm of classical psychoanalytical ideology, which sees shame as an immaturity (Hazard, 1969). From a more relational field perspective, rather than shame being a deficiency, the person may not be receiving enough external support.

To understand what was underpinning the rage that she felt, I began to question Grace about her felt sensations around external support. At first, when I questioned if she felt she received ineffectual support from her partner, there would be a series of protests and then she would deflect or become dismissive. However, over time, this dialogue changed; she would no longer discount this as a possibility. I attempted a different dialogue, exploring whether she felt supported, affirmed, held, or seen the way that she wanted. She became curious. When we engaged with more direct felt experience, she was able to engage: “What does it feel like in your body to be affirmed? Who would do that? Who does that for you now? Where do you remember receiving that before in your life?” It became clear that she yearned for more support and connection.

### The Loneliness of Shame

Grace began to recognize that her shame subsumed her sense of longing. She longed for a deeper intimacy with her husband, to be seen and held tenderly by him. However, her core belief was that to be seen as dependent on anyone was “needy.” Grace was aware that she and

her husband were in the autumn years of their life together. Nevertheless, her sense of dissatisfaction was further preventing her from acknowledging and naming her desires. She took these realizations back home. She entered into a dialogue with her husband, first through an admission of her loneliness, then by disclosing the realization of how she had used this hurt, defensively, against her partner. Gradually, she began to transform her firmly-held conviction that she was alone in this desire. By acknowledging and talking about her need for greater intimacy, her need became a shared challenge that was beginning to form into an intimately-held desire by both partners. Her husband decided to enter into his own psychotherapy, having mocked it for many years. She was no longer alone, and they were no longer legitimizing their long-held belief in hyper-autonomy.

Through our exploration, she realized that, as a result of the deep shame she had experienced at the inception of the relationship, she had become overly self-reliant. She had no-one to regulate herself against; she was ostracized by her family at a time when she was at her most vulnerable, and, unknown to herself at the time, also pregnant. She felt alienated from those closest to her. Her “loving” parents could not understand their daughter or her behavior at a time when she needed their emotional attunement and regulation. She left her familiar home environment to begin a new life and family with a man who “looked like he was shell-shocked.” In her own words, “We just had to pull ourselves together...we barely had time to look at each other.” She experienced a visceral experience of herself disintegrating in response to an acute and then sustained misattunement from her parents. Her sense of self was fragmented with shame.

Her high-octane performance at work (“the only criticism I received was that I never took time off”) and as a doting, attentive mother who still makes multiple trips a year to look after her grandchildren, all put distance between her shaming experience. However, she still harbored the thought that underneath it all, in her belly, lay a shameful creature of rage, bitterness, bile, and desire. Her negative self-belief allowed her only to be seen one way, while disowning all those aspects she believed would be unpalatable. Therefore, the loneliness seemed to stem from the fact that by disowning parts of our self that we deem unacceptable, no one can truly know who we are.

Initially, Grace would become defensive when I asked her about feelings of longing, and would retort with, “Well, I live with my husband, we see each other every day.” However, I became aware of her sense of loneliness that often accompanied her shame. She was devastated by the loss of her dog, and upon closer examination of her bodily sensations of grief, we came to see how her loneliness stemmed from her separation from

her mother, and her perceived emotional loneliness (Weiss, 1989) from her husband: “If only we felt closer...if only he could talk to me.” Grace was not physically alone in her relationship with her husband, and she had dependable and long term friendships. However, loneliness is a subjective experience. It does not necessarily equate to social isolation (Peplau & Perlman, 1982).

One highly significant event that had a profound effect on Grace was when her husband suffered with bladder cancer, and she saw his penis “pissing out blood.” She was traumatized by this, and it had long-lasting effects on her sense of intimacy with her husband. It had been deeply shocking to her, and she responded with dissociative professionalism, rather than as a wife and lover. It had so shocked her to the core that even the words she used were so dissonant from this well-mannered and articulate woman that they sounded like an alien language passing from her lips. Trauma had lent itself to dissociation.<sup>7</sup> Together we tentatively explored how the familiarity of bodily horror had destroyed their intimacy.

In terms of therapeutic outcome, there has been progressive improvement within her relationship with her husband. By entering into his own therapy, they have found another shared commonality and language. They spend time together, she feels less irritated with him, the emotional outbursts have lessened, and she feels better able to manage her temper. Her inflamed bowel, however, had not disappeared; there was a transmogrification in that she no longer used words like “my bloody stomach,” and she no-longer attached to the word “pain,” but had replaced it with “hunger” as a somatic experience. She began to identify her body sensations as an internal barometer, which educated her on her own needs and desires.

Over a few weeks, I encouraged Grace to keep a journal of her bodily or somatic experiences to build on this felt understanding. Using this journal in our sessions allowed her to become more compassionate, empathic and even curious about the sensations she was experiencing and how to attend to them. Her greater body awareness allowed for more pain-free days. Her semantic dialogue about her stomach pain changed, and she was able to make the cognitive link between her somatic experience and her hunger for more adventure and higher risk-taking; to engage with the “unlived life” that she so wanted to experience.

Like other negative social emotions, shame, guilt, and loneliness may arise from early relationships (Leary, Koch, and Hechenbleikner, 2007). However, I was also aware that in Grace’s journey, I could not entirely match my client’s reality with theory. I was alert to any signs of trauma in Grace’s early childhood which would have predisposed her to shame; however, at each turn I was presented with a loving and sensitive family unit. According to attachment theory, the interaction between

<sup>7</sup> Herman (2011, 2012) and Schore (2012) cite studies that find significant correlations between PTSD, shame-proneness, and dissociation.

the infant and primary caregiver predicates how a child develops working models, including judgments and evaluations of the self and other people (Bowlby, 1969, 1988). Shame and guilt are defined as moral affects, so parenting practices and discipline styles can shape the emotional and moral functioning of children (Baumrind, 1979, Hoffman, 1998). However, Tangney and Dearing (2002) also emphasized that throughout children's developmental process, family interactions may not, directly, model guilt and shame behaviors, but rather reflect general interactions within the family system. This statement suggests that shame and guilt may be more intensely affected by the socialization process than by attachment relationships. Grace felt that her shame revolved around her affair as an adult, not through a narrative of childhood shaming.

Towards the middle stage of the therapy, during one session, I suddenly noticed the semantics of her pain, her "sore poorly tummy." It was an unusual phrase for her to use, strikingly childlike in its language and tone. I asked her old she felt as she spoke it. "Oh, I don't know... quite little...maybe 3 or 4..." Placing her hands on her abdomen on the area that was so painful, we explored this simple phrase. She smiled and looked up at me. It was a phrase that her parents had used; it brought to mind the warmth and comfort of her parents. "I have to say it in a Scottish accent...like my mum," she said. Her parents were strict Scottish Presbyterians, but Grace described them as warm and often indulgent. She remembered her mother rubbing her "tummy" when she was not well, and spending hours massaging it when she had painful menses as a young teenager. When the pain was severe, her mother would send her father to the next room and install her daughter into their bed, so she could sleep with her mother, and be soothed if she needed attention during the night. She commented that she remembered that her father "wouldn't mind being turfed out" of the marital bed.

I introjected, "So you were placed above all others." "Yes," she affirmed, and she began to cry. "I never cry, but thinking about my mother and how kind she was to me, it felt so good, so warm, so loving...and my stomach ache has stopped." Not only did Grace never cry, but she had never seen her mother cry, and her father only cried at her mother's funeral.

In coming to a clearer understanding of the somatic presentation of trauma, I was surprised when my client's pain stopped; it was an extraordinary experience. It is rare to experience such a clear clinical picture, and to be able to make so many connections, and even rarer for the symptoms to, simply, go away.

It was here, in the later stages of Grace's therapeutic journey, that we became more aware of the transgenerational link. Grace yearned for the love and affection that her mother, who had been dead for over 30 years, had given her; she wanted someone who would rub her "poorly tummy" all night. I was aware that mothers became a pertinent theme in our understanding. Grace, as a child and later as a teenager, had been attended to by her mother for her "sore poorly tummy." Grace, in turn, attended to her own daughter as she witnessed her first daughter's traumatic miscarriage. Her daughter, at that time, was also pregnant with her first child; she was a mother, with a "poorly tummy."

Slowly we explored these connections. Supported by the insight of my supervisor, we saw the interconnection with her first daughter, the shame that she had embedded around her parentage, and how the "poorly tummy" had been passed down to her – first through her miscarriage, and then her severe endometriosis that had come after the birth of her own daughter (Grace's first grandchild) following her miscarriage, and finally with the removal of a large teratoma tumor, which, like a horror film, contained hair and bone tissue. In direct opposition to Cartesian dualism, Grace's shame had become embodied, particularly with respect to her experience of pain, and, eventually, through her child's body, it became material. Embodiment is experienced twofold, lived as well as material.

I began to see the link between Grace as a little girl with her stomachache who, even as she moved into her adolescence, continued to have her "tummy" rubbed for her menstrual pain. Though supervision, we identified the little girl who does not know the difference between the womb and the intestines; it was all the homogenized "tummy."

### Sources of Shame: The Body, Sex and Food<sup>8</sup> or "What I Take in or Keep out"

Through my reflexive practice, I became aware of what I had left out in the countertransference. Initially, I did not discuss, either in supervision, or in the first drafting of this case, the "penises." I had not let the penises in. I will elucidate what I mean.

In my psychotherapy practice, I often talk about sex, and how our sexuality or sexual activity can change or acclimatize to the landscape of our bodies in sickness and the aging process. Aware of how often I discuss alternative sexual acts to women after menopause, I noticed that I had omitted to discuss this with Grace. Following her husband's operations and the resultant impotence that

<sup>8</sup> The self-conscious emotions (SCE) of guilt, shame, pride, and embarrassment are moral emotions, which motivate adherence to social norms and personal standards, and emerge in early childhood following the development of self-awareness. Shame and gender are inexorably linked within our society. Gender stereotypes of emotion maintain that women experience more guilt, shame, and embarrassment, but men experience pride more often. Gender differences in SCE about domains such as the body, sex, and food or eating tended to be larger than gender differences in SCE about other domains. (Else-Quest, et al., 2012)

*“Shame is most importantly a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others.... There is a loss of the sense of empathic possibility, others are not experienced as empathic, and the capacity for self-empathy is lost.”*

(Jordon, 1997: 147)

had occurred, and the difficulty he had in achieving an erection with the prescriptive aids (penile prosthesis implants), together with the added complication of her own dyspareunia, they were “no longer having sex.” My supervisor appeared surprised that I had not addressed this, or discussed sex without penetration. Grace’s desire for deeper intimacy with her husband had been an essential aspect of our relational work. However, she had not spoken of how they were circumnavigating their changing bodies, their sexual intimacy, and how she may not be letting her husband in, penis or otherwise. Why had I left this out? The answer is simple – shame and embarrassment.

Through my recognition of my own internal shaming, of my own self-imposed limitations guided by what I believe will be acceptable to people, I was again reflecting Grace’s narrative of choosing what I take in or keep out. Had I finally met my edge, my own internal shamer? Also, I was aware that in writing my case, I was presenting my work to external agencies, and inhibition had come in. I was concealing my own practice from organizational structures, with the belief that if they knew all of me, I would be unacceptable/marginalized/excluded. This countertransference replicated Grace’s own struggle. She wanted to be the kind of person who says “poorly tummy,” but she was also the woman who rages and “bays for blood.”

Reflexivity involves coming as close as possible to an awareness of the way I am experienced and perceived by others. It is the ability to stay with personal uncertainty and hold onto critically-informed curiosity as to how others perceive things as well as how I do, while maintaining the flexibility to consider changing deeply held ways of being. The role of a trusted other, my supervisor, has been vital in understanding how I relate with others, and how we, as psychotherapists, can shape organizational realities through shared practices and language. If I conceal part of my practice, this can detrimentally affect my profession. I believe that reflexive thinking, this critical focus on beliefs, values, professional identities, and how they affect and are affected by the surrounding cultural structures, is my social and political responsibility.

## Conclusion

We have explored multiple issues in this paper. We have looked at Grace’s convoluted therapeutic journey from her marital conflicts, aging, the grief of losing her dog, her husband’s cancer, her daughter’s miscarriage, endometriosis, and tumor, as well as Grace’s experience of having an affair and falling pregnant. We have seen

how Grace’s somatic-emotional system presents many physical symptoms, including various bowel and immunological issues, as well as some sexuality issues. However, we explored three main themes, which were nourishment (self-care), shame, and loneliness.

At the outset of our therapeutic journey, Grace was shattered by her shame, as her sense of a coherent self had disintegrated. Shame is experienced in response to a perceived (or inferred) devaluation by others (Tangney & Dearing, 2002). There had been little relational reconnection with her parents, and this continued into her relationship with her husband. Her ensuing struggle for coherence was, paradoxically, causing her to physically and emotionally come apart at the seams. Grace’s shame had a relational origin, and the unbearable pain of her shame had been pushed away, deep into her “tummy.” I came to see the importance of the need to be compassionately and viscerally present with her body of shame throughout the time of our exploration.

In the course of therapy, there has been a transformation from self-inhibition and internal disorganization into new self-development and growth. Grace has developed a greater awareness of self-care; she no longer dismisses her symptoms as “nothing,” or engages in comparative suffering – “Well... there are so many other people in the world, with so much more pain than I have, experiencing so much more suffering.” She has become more attuned to her pain, its causal connection with stress, and the care or nourishment that she requires, as illustrated in her journals.

Our work encompassed a movement from the idealized self to an acceptance of her real self in relation to another. The relational emphasis enabled a repair of Grace’s fragmented sense of self within a relationship of empathic attunement. In line with Schore’s (2012) affect regulation theory, shame was not healed by words alone, but we also repaired this relational rift through right-brain language, with appropriate eye contact, voice tone, rhythms of response, body language, and consensual touch.

Shame and longing are evident in Grace’s body, beliefs, emotions, and behavior. Grace’s body shame was centralized in her belly, and this was evident in the present as well as in many times in her past. She yearned for a deeper, more supportive, and loving connection with her husband, but felt unable to ask for it. As a result of buried and undischarged emotional stress caused by incidental events and periods of her life that had been overwhelming, her body’s response was to store the trauma and tensions within her tissues – namely her belly. The physical symptoms presented themselves as

chronic pain and complex immunological syndromes. Her psychological symptoms were resentment, uncontrollable anger, dissociation, and depression. Grace came to understand the role of her pain as an indicator in her somatic-emotional system and in her relationships, and how her belly holds shame and longing. She realizes that her pain is an attempt by the body to call for healing.

Grace was adamant that her early childhood was not involved in her somatic experience of shame, but instead felt that it began with her shame about her affair and the pregnancy. Grace talked about her experience as a child and adolescent getting loving attention for her stomach pain, and then losing parental support during her divorce and pregnancy. When entering the prototypical shameful state of mind, the individual has a sense of an exposed, vulnerable, devalued self being scrutinized and found wanting in the eyes of a devaluing other. In Grace's case, this was in the eyes of her parents. She responded to their silent withdrawal in her adulthood by internalizing the pain of her shame back into her belly, but without the ability to call for her "tummy" to be rubbed better by a loving parent.

Touch is central to the resolution of the pain, both throughout her life and in therapy. The seeming miraculous resolution through touch of Grace's stomach pain seems like the climax of this therapeutic journey. However, the pain did, gradually, return, and Grace is currently undergoing treatment for two small tumors found in her small intestine. She feels that the legacy of a lifetime of shame has finally become material. I am saddened by the weight of her shame and its long-term consequence.

Nevertheless, both Grace and I felt that this touch intervention provided a key to her understanding. Grace spoke of how, after that moment, she felt enlivened and hopeful, that she could find resolution to her physical pain, and she believes it was instrumental in her seeking further medical help. Through exploring her longing for her mother's attention and "being placed above all others," she became enabled to find her voice in asking for what she needed without explosive rages, whether this was asking for help, nurturing, or for emotional support from her husband. Reparative and engaged touch has affected her emotional, relational, and behavioral responses and her physical symptoms. Unlike the state of shame, which is alienating and lonely, she has begun to feel able to connect to others, and to see others as sources of comfort and support, and that she deserves that.

Finally and consequently, the isolation and loneliness that Grace had been experiencing as a result of her shame could be acknowledged. We explored appropriate expressions of anger, rage, and grief and, finally, relational support. She was incredibly independent and self-reliant, and imbued these characteristics into both of her daughters. However, she now acknowledges that "I see that sometimes they are a little too much like me, and like me have brushed away events, and got on with things, events that I now recognize as traumatic." She now feels that she has become more honest with herself and others, and is better equipped to heal the loneliness in her relationships with her husband and her family, and she hopes to pass on a better model of self-nurture and connectivity to her daughters.



**Danielle Tanner** is a mother of three children, a wife, and a body psychotherapist. She works in private practice in Hebden Bridge, West Yorkshire, UK. She trained with Silke Ziehl, of the Entelia Institute at The Open Centre, in Deep Bodywork and Postural Integration (PI). She furthered her training with Dr. Asaf Rolef Ben-Shahar in Integrative Mindbody therapy (IMT) and relational hypnotherapy. She has the deepest gratitude for her teachers, Silke Ziehl, and Dr. Asaf Rolef Ben-Shahar, and her supervisors, Nick Totton and Emma Stewart.

Email: [psychotherapydanielletanner@gmail.com](mailto:psychotherapydanielletanner@gmail.com)

## REFERENCES

- Aposhyan, S. (1998).** *Natural intelligence: Body-mind integration and human development*. London: Lippincott Williams and Wilkins.
- Bainbridge-Cohen, B., & Conrad-Da'oud, E. (1997).** *Groundworks: Narratives of embodiment*. Berkeley, CA: North Atlantic Books.
- Baumrind, D. (1979).** Parental disciplinary patterns and social competence in children. *Youth and Society*, 9, pp. 239-276.
- Bowlby, J. (1988).** *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

- Bradshaw, J. (1994).** *Healing the shame that binds us*. Deerfield Beach, FL; Health Communications.
- De Young, P., A. (2015).** *Understanding and treating chronic shame: A relational/ neurobiological approach*. New York: Routledge.
- Else-Quest, N.M., Higgins, A., Allison, C., & Morton, L.C. (2012).** Gender differences in self-conscious emotional experience: a meta-analysis. *Psychology Bulletin*, 138(5), pp. 947-81. <https://doi.org/10.1037/a0027930>
- Fischer, C. (2016).** Gender, nation, and the politics of shame: Magdalen laundries and the institutionalization of feminine transgression in modern Ireland. *Signs: Journal of Women in Culture and Society*, 41(4), pp. 821-843. <https://doi.org/10.1086/685117>
- Goldstein W. N. (1991).** Clarification of projective identification. *American Journal of Psychiatry*, 148, pp. 153-161.
- Hazard, P. A. (1969).** Freud's teaching on shame. *Laval théologique et philosophique*, 25(2), 234-267. <https://doi.org/10.7202/1020145ar>
- Herman, J. L. (2011).** Post-traumatic stress disorder as a shame disorder. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 261-75). Washington, DC: American Psychological Association.
- Herman, J. L. (2012).** Shattered shame states and their repair. In J. Yellin & K. White (Eds.), *Shattered states: Disorganised attachment and its repair* (pp. 157-70). London: Karnac.
- Hoffmann, M. L. (1998).** Varieties of empathy-based guilt. In J. Bybee (Ed.), *Guilt and children* (pp. 91-112). Boston, MA: Academic Press.
- Horowitz, M. J. (1989).** Clinical phenomenology of narcissistic pathology. *Psychiatric Clinician North America*, 12, pp. 531-539.
- Jordon, J. (1997).** Relational development: Therapeutic implication of empathy and shame. In J. Jordon (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 138-61). New York, NY: Guilford Press.
- Kaufman, G. (1980).** *Shame: The power of caring*. Rochester VT: Schenkman.
- Kaufman, G. (1989).** *The psychology of shame*. New York: Springer.
- Leary, M. R., Koch, E. J., & Hechenbleikner, N. R. (2007).** Emotional responses to interpersonal rejection. In M. R. Leary (Ed.), *Interpersonal Rejection* (pp. 145-166). New York: Oxford University Press.
- Lee, R. (1995).** Gestalt and shame: The foundation for a clearer understanding of field dynamics. *British Gestalt Journal*, 4, pp. 14-22.
- Lee, R., & Wheeler, G. (1996).** *The voice of shame*. San Francisco: Jossey-Bass.
- Lewis, H.B. (1971).** *Shame and guilt in neurosis*. New York: International Universities Press.
- Lewis, H.B. (1987).** Introduction: shame, "the sleeper." In H. B. Lewis (Ed), *The role of shame in symptom formation*. Hillsdale, NJ: Erlbaum.
- Mawdsley, J.E. & Rampton, D.S. (2005).** Psychological stress in IBD: new insights into pathogenic and therapeutic implications. *Gut*, 54 (10):1481-1491. <http://dx.doi.org/10.1136/gut.2005.064261>
- Nathanson, D. (1992).** *Shame and pride*. New York: Norton.
- Peplau, L. A., & Perlman, D. (1982).** Perspective on loneliness. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A sourcebook of current theory, research and therapy* (pp. 1-18). New York: John Wiley & Sons.
- Schore, A. (2012).** *The science of the art of psychotherapy*. New York: Norton.
- Tangney, J. P. & Dearing, R. L. (2002).** *Shame and guilt*. New York: Guilford Press.
- Tangney J.P. (1995).** Shame and guilt in interpersonal relationships, In J.P. Tangney & K.W. Fischer (Eds.), *Self-conscious emotions* (pp. 114-139). New York: Guilford Press.
- Tomkins, S. (1963).** *Affect imagery consciousness: Volume II: The negative affects*. New York, NY: Springer.
- Tomkins, S. (1987).** Shame. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 133-161). New York: Guilford Press.
- Wheeler, G. (1995).** Shame in two paradigms of therapy. *British Gestalt Journal*, pp. 76-85.
- Wheeler, G. & Jones, D. (1996).** Finding our sons. In R. Lee & G. Wheeler (Eds.), *The voice of shame* (pp. 61-100). San Francisco: Jossey-Bass.
- Weiss, R. S. (1989).** Reflections on the present state of loneliness research. In M. Hojat and R. Crandall (Eds.), *Loneliness: theory, research and applications* (pp. 51-56). London: Sage.