

Transforming Shame and Self-Loathing

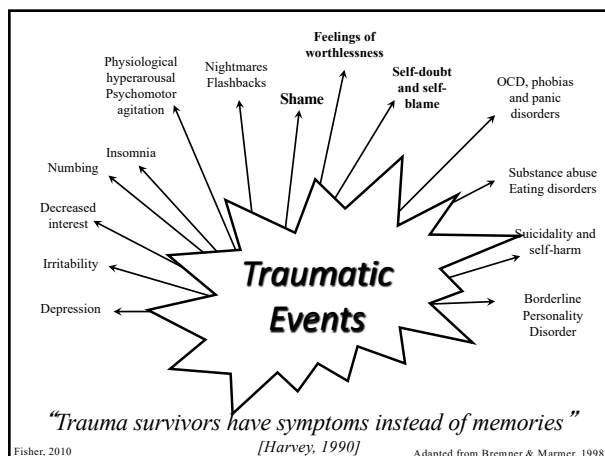
Jack Hirose Seminars

Webinar Series Module One

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Shame acts as a barrier to
resolution in trauma treatment

- The persistence of shame responses even after years of treatment poses a barrier to final resolution of the trauma. **Full participation in life, pleasure and spontaneity, healthy self-esteem are counteracted by recurrent shame states and intrusive thoughts**
- Shame** is not only **triggered** by criticism, normal mistakes, and less-than-perfect performance but also **by success, being 'seen,' self-assertion, self-care, asking for needs, and feeling proud or happy**

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

- **Shame is a survival response**, as crucial for safety as fight, flight, and freeze when submission is the only option

- **Shame is driven by the body and reinforced by meaning-making** (“You should be ashamed”) that re-activates the body responses and intensifies the shame

- While fear focuses on the source of threat, **shame feels personal**: it’s about “me”

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

Fisher, 2010

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The Role of Shame in the Context of Trauma

*“[When] a relationship of dominance and subordination has been established, feelings of humiliation, degradation and shame are central to the victim’s experience. **Shame, like anxiety, functions as a signal of danger, in this case interpersonal or social danger.**”*

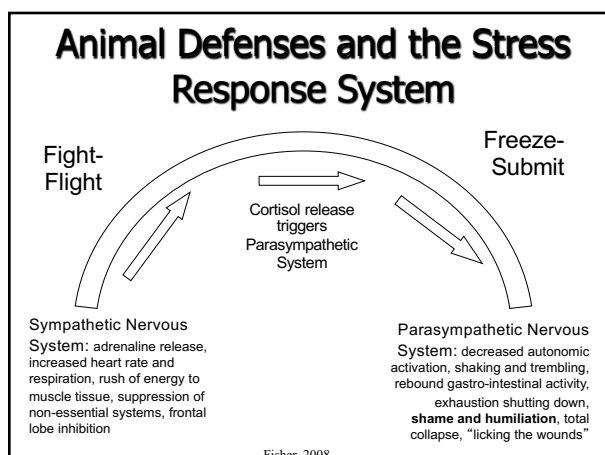
Judith Herman, 2006

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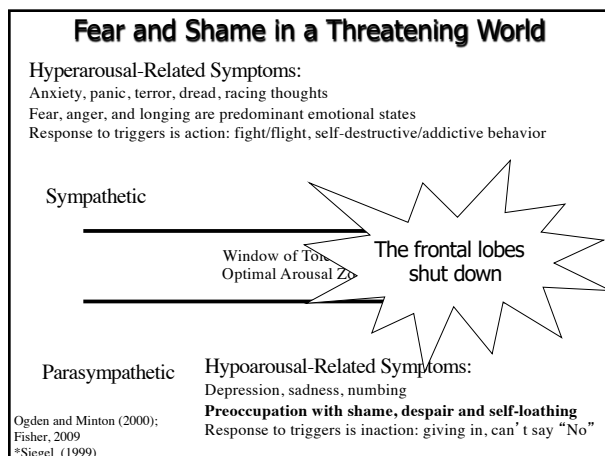
“Like anxiety, [shame] is an intense overwhelming affect associated with autonomic nervous system activation, inability to think clearly, and desire to hide or flee. Like anxiety, it can be contagious.”

Herman, 2006

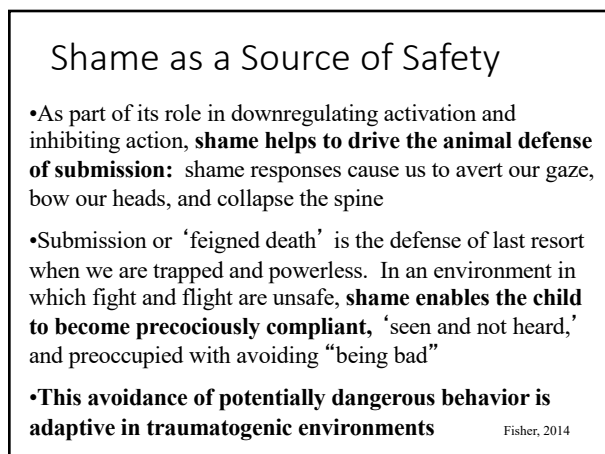
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Shame as a Survival “Resource”

*“In conflict situations, there are just two basic choices: to escalate or de-escalate. . . . The inhibitory functions of shame suggest that **shame functions as a defensive strategy** which can be triggered in the presence of interpersonal threat. . . .”*

Gilbert & Andrews, 1998, p. 101

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

Gilbert and Andrews, 1998, p. 102

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After the trauma is over, we ‘remember’ with our bodies

•Brain scan research demonstrates that traumatic memories are encoded primarily as bodily and emotional states rather than in narrative form

•But, when trauma is “remembered” without words, it is not experienced as memory. These implicit physical and emotional memory states do not “carry with them the internal sensation that something is being recalled. . . . **We act, feel, and imagine without recognition of the influence of past experience on our present reality.**” (Siegel, 1999)

Fisher, 2009

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Implicit memories are situationally evoked, not recalled

- The human body instinctively reacts to the **anticipation** of something bad happening. We call this response “triggering” or “getting triggered”
- All danger signals it has known before become stimuli of implicit memories:** times of day or year, particular people and places, colors, smells or sounds, weather, tones of voice, body language, disappointment, aloneness
- When implicit memories are triggered, we experience **overwhelming feelings, sensations, and impulses. This feeling of danger is misinterpreted as meaning “I AM in danger,”** not “I am remembering danger”

Fisher, 2014

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Client Trigger Lists

(Alta Mira Recovery Centers, May 2015)

Being surprised	Being threatened
Having to wait	Suicide in the news
Being alone	Feeling guilt, shame
Failure to follow through	Being watched
Anger and angry expressions	Feeling trapped
Parents yelling at their children	Being told what to do
Disappointing people	Change (bad or good)
Dark rooms	Witnessing others being hurt
The ‘silent treatment’	Heights
Being happy/unhappy	Confrontation
Being asked a lot of ?s, especially by authority figures	Being center of attention
	Feeling inferior

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Traumatic ‘implicit’ memories are experienced as:

- Ashamed, depressed or submissive states: numb, spacy, paralyzed, hopeless and helpless, self-loathing
- Feelings of desperation, despair, yearning to die
- Feelings of panic and terror, dread, apprehension
- Yearning for contact, painful loneliness, and a felt sense of abandonment
- Fight-flight responses: feelings of rage, impulses to run or “get out,” violence turned against the body
- Body sensations: rapid heartbeat, constricted breathing, tightness, shakiness, physical collapse, nausea

Fisher, 2008

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“When the images and sensations of experience remain in ‘implicit-only’ form. . . , they remain in unassembled neural disarray, not tagged as representations derived from the past . . . Such implicit-only memories continue to shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment. . . ”

Siegel, 2010, p. 154

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Neurobiological Purpose of Shame

[Schore, 2003]

•By toddlerhood, before the development of greater “top-down” control, **children need for their own safety to respond quickly to inhibitory cues**. From an evolutionary perspective, this is a dangerous time. **Mobility exposes the child to potential dangers because the frontal cortex is not developed enough to act as a “brake.”**

•Without a prefrontal cortex that exercises top-down control, children are action-oriented and impulsive. Allan Schore suggests that **shame develops at this stage as a neurobiological regulator** that serves the purpose of helping children inhibit potentially dangerous behavior.

Fisher, 2013

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*“Where no corrective relational process takes place, pathological variations in the attachment system can develop. . . . The child is torn between need for emotional attunement and fear of rejection or ridicule. She forms an internal working model of relationship in which **her basic needs are inherently shameful.**”*

Herman, 2007

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Shame as a neurobiological “brake”

“[Shame] perhaps more than any other emotion is intimately tied to the physiological expression of the stress response. . . . This underscores . . . the function of shame as an arousal blocker. Shame reduces self-exposure or self-exploration.”

Schore, 2003, p. 154

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Purpose of Shame, p. 2 [Schore, 2003]

•Shame and the parasympathetic system do provide an effective ‘braking system’ that can be protective---but only if parents soothe and transform shame states

•In the animal world, submissive behavior elicits approach behavior from fellow members of the group. **When there is good “repair,” exploration, willfulness, and social engagement can contribute to healthy self-development and increase the capacity to self-regulate. But that requires that limits are set in ways that do not frighten or shame the child and good repair is available for the disruption**

Fisher, 2012

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The Purpose of Shame, p. 3 [Schore, 2003]

•When these shame experiences are “repaired” by the parent through soothing, hugs and kisses, clarification, and reassurance, research suggests that **resilience increases** (Tronick)

•But, in unsafe environments, **shame must be over-used to down-regulate emotions, needs, and any other behavior unacceptable or unsafe in the environment.** Under conditions of neglect and/or abuse, shame states are not repaired by the caregiver, **decreasing resilience**

Fisher, 2011

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Safety requires adaptation to external demands or messages

Adapted from Ogden, Fisher, 2007

<ul style="list-style-type: none"> • “I don’t really want you” • “I don’t have time for you” • “You must do what I say” • “Your feelings don’t count” • “Be strong, not needy” • “It’s your fault I’m unhappy” • “You have to perform” 	<ul style="list-style-type: none"> • “You are loved and safe” • “You are special to me” • “You have choices” • “Your feelings are important to me” • “You can depend on me” • “You are not responsible for my upset” • “You are loved just the way you are”
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Shame and self-doubt are reinforced by powerlessness

- **Children ultimately have no control over the acts of caregivers:** experiences of safety, autonomy or mastery are fostered by attuned parents who use their control wisely
- **When the caregiver is the source of threat,** rather than comfort, **children are over-exposed to experiences fostering shame and self-doubt**
- Without ‘repair,’ these experiences of excruciating shame and blame come in time to feel “true” or “just who I am”

Fisher, 2010

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Shame problems are brain problems

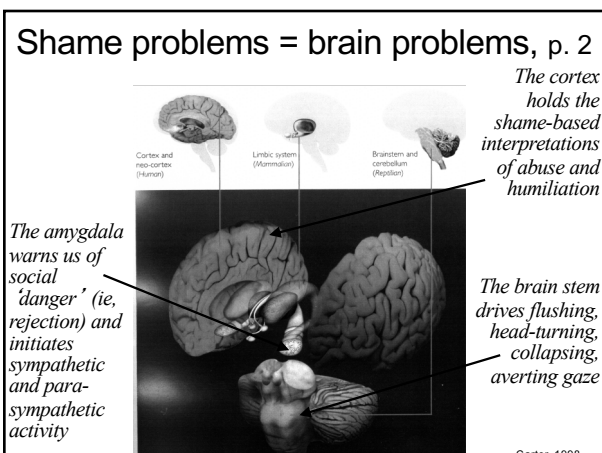
The cortex is responsible for how we interpret events and manage our reactions

The limbic system governs emotional arousal and attachment behavior but is also our emotional memory center

The brain stem is responsible for instinctual responses such as fight, flight, freeze or submission

Carter, 1998

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Addressing Shame from a Neurobiological Perspective

- Each area of the brain communicates and functions differently. We cannot 'reach' the brainstem using language. The limbic system, too, functions nonverbally
- **To address brain stem reactions, we need to work at the level of movement:** inhibiting impulsive responses or increasing movement, facilitating empowering action
- **To address the limbic system, we need to 'down-regulate' the amygdala** so that it does not respond to environmental cues with alarm. Both require learning to work "bottom up" rather than "words first" Fisher, 2020

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"Annie A." on the topic of shame:

"When I was young, my parts built their own little world that explained what was happening to them."

And what was their explanation?

"They thought, 'if I wasn't so bad and ugly and if I didn't cause other people to be angry, these things wouldn't be happening to me.'"

What were the advantages of that explanation?

"It limited how much people could get to them. If something is wrong with you, you can work on you. You don't have to try to figure out why the bad things are happening because you already know."

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Persistent Patterns of Response Reflect Procedural Learning

- **Procedural memory is the implicit memory system for functional learning:** skills, habits, automatic behavior, conditioned responses.
- Driving a car, playing an instrument, swimming or playing tennis, riding a bike, shaking hands and making eye contact, are all examples of procedural learning.
- **Procedural learning allows us to respond instinctively, automatically, and non-consciously,** increasing efficiency at the cost of a loss in reflective, purposeful action

Fisher, 2006

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*“The neural substrate for procedural learning appears to develop prior to the capacity for declarative learning. **This means [that] templates for habitual behaviors may be acquired, and the behaviors become relatively automatic and routine, before the child has an episodic memory system capable of remembering the events that produced these behaviors.** [Thus,] very young children are likely to experience a kind of learning . . . that is dissociated from the content.”*

Grigsby & Stevens, 2002

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Trauma-related Procedural Memory

- **Social behavior:** difficulty making eye contact, asking for or accepting help, expressing feelings in words
- **“Default settings:”** tendencies to automatic self-blame, shame, anger, shutdown, dissociation
- **Behavioral responses:** impulsive acting out, isolation and avoidance, help-seeking, inability to say ‘no,’ collapse
- **Emotional expression:** emotional disconnection, cathartic expression, overwhelming intrusive emotions
- **Interpersonal behavior:** gets too close too quickly and expects too much from others, becomes the caretaker, or avoids closeness, dependency

Fisher, 2014

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Procedural learning facilitates
automatic responding to
unconscious future predictions

*"[Procedural] memory shapes how we
experience the present and how we
anticipate the future, readying us in the
present moment for what comes next
based on what we have experienced in
the past."*

Siegel, 2006

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***"Long-lasting responses to
trauma result not simply
from the experience of fear
and helplessness but from
how our bodies interpret
those experiences."***

Yehuda, 2004

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Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from the work of Alan Schore, Bessel van der Kolk, and Daniel Siegel. **Sensorimotor work combines traditional talking therapy with body-centered interventions that directly address the neurobiological effects of trauma.**

By using the narrative to evoke the trauma-related bodily experience and making that the primary entry point in therapy, **we attend first to how the body “remembers” the trauma and secondly to emotional meaning-making**

Ogden, 2002; Fisher, 2006

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Noticing rather than narrating, playing rather than ‘working’

In collaboration, therapist and client “study what is going on [for the client], not as a disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded. The whole endeavor is more fun and play rather than work and is motivated by curiosity, rather than fear.”

Kurtz, 1990, p. 11

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“Small gestures and changes in breathing are at times more significant than the family tree”

(Christine Caldwell, 1997)

- **Sensorimotor Psychotherapy is less focused on the narrative of what happened then**
- **Instead, events are used to evoke the implicit memories connected to them: autonomic responses, movement impulses, postural changes, emotions, beliefs, etc.**
- **The therapist looks for patterns, for habits of response: too much or too little affect, movement or stillness, negative cognitions, patterns of gesture or movement**
- **We observe the client “right here, right now:” how is the client organizing internally in response to the narrative? How is the memory being expressed somatically?**

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Sensorimotor Principles of Treatment

•**Regulation of arousal is a prerequisite for successful treatment.** When clients are hyper- or hypoaroused, their frontal lobes shut down instinctively, interfering with therapeutic collaboration and integration. Whatever intervention we are using, it must regulate arousal

•**Keeping the frontal lobes ‘online’ must be a priority.** Both mindfulness and psychoeducation facilitate this.

•**Procedurally learned patterns must be identified as the “culprits” keeping the trauma ‘alive’** in the client’s body. Whether we identify those to the client or not, they must become the focus of treatment

Fisher, 2010

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“The most direct way to effect change is by working with the procedural learning system, rather than with declarative memories”

[Grigsby & Stevens, 2000]

We can address “procedural learning” in two ways:

•“The first is to ...**observe, rather than interpret, what takes place, and repeatedly call attention to it.** This in itself tends to disrupt the automaticity with which procedural learning ordinarily is expressed.”

•“The second therapeutic tactic is to engage in activities that empathically but directly **disrupt** what has been procedurally learned” and create the opportunity for new experiences

(Grigsby & Stevens, 2000, p. 325)

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A mindfulness-based model rather than a narrative model

“Change happens through discovering how a client [has learned to] organize experience and then changing how that experience is organized. . . .”

Ogden, 2005

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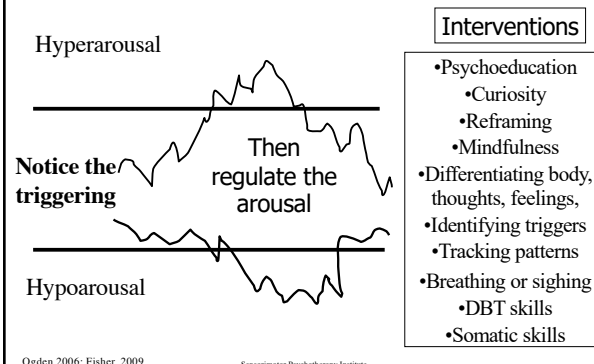
Assumptions of Neurobiologically-Informed Trauma Treatment

- **Under conditions of trauma and neglect, the human body becomes self-protective:** defensive responses of fight-flight-freeze-submit-attach are **automatic** under stress
- **The emotions, sensations, and impulses triggered by traumatic reminders,** divorced from their original context, **are misinterpreted as indicators that the individual is still in danger,** still powerless or helpless. Though the client may be safe now, the body doesn't know that
- Another consequence is that **human beings, including therapists, feel threatening or shaming, rather than comforting or calming**

Fisher, 2009

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Teaching the Skills to Regulate Arousal Within the Window of Tolerance



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Experimenting with Somatic Resources for Traumatic Reactions

Traumatic Reactions:

Shaking, trembling
Numb, dazed
Wanting to run
Mobilized for "fight"
Collapsed, helpless
Armoring, "on guard"
Pulling back, pushing away

Resources:

Deep breath or sigh
Grounding
Lengthening the spine
Slowing pace
Making a movement
Exaggerating response
Clenching/unclenching

Ogden, 2000; Fisher, 2005

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Shame without Words

“The subjective experience of shame is of an initial shock and flooding with painful emotion. Shame is a relatively wordless state, in which speech and thought are inhibited. It is also an acutely self-conscious state; the person feels small, ridiculous and exposed. There is a wish to hide, characteristically expressed by covering the face with the hands. The person wishes to ‘sink through the floor’ or ‘crawl in a hole and die.’ ”

Herman, 2006

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How Shame Experiences Become Cognitive Schemas

•“Shame is a relatively wordless state, in which speech and thought are inhibited.” (Herman, 2007) **Words put to non-verbal shame responses reflect the bodily experiences** of feeling small, exposed, overpowered, degraded, disgusting.

•**With repetition, our attempts to making meaning become belief systems that explain subsequent experience.** As both good and bad life events occur, each is interpreted through cognitive schemas of defectiveness and worthlessness inextricably linked with affective and bodily states of shame. **Each time, the shame and self-blame feel confirmed by this new “evidence”**

Fisher, 2011

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Putting words to experiences of shame exacerbates the intensity

•When we begin to attach words to early experiences, we echo what we hear from caregivers. For **our clients, these were words of blame:** “You stupid idiot—how could you be so dumb?” “You’re disgusting” “Loser!”

•**The words of blame serve to re-evoke the shame and submission responses,** self-enforcing the compliance we need to avoid punishment and preserve attachment.

•**But, sadly, children ‘believe’ the words of blame as truth about themselves.** The self-loathing does its job at the cost of their self-esteem

Fisher, 2010

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“Post-traumatic stress is a disorder of non-recovery” [Meichenbaum]

Donald Meichenbaum identifies **three variables most highly associated with non-recovery**:

- **Developing a ‘self-defeating story’** to explain what happened
- **Ruminating**: “chewing” on that story until it feels increasingly true
- **Isolating**: avoiding experiences that could contradict the self-defeating story or distract the individual from rumination

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Cognition and the Body

• **The body responds** not only to physical and emotional stimuli (sights, sounds, touch, facial expressions) but it also reacts **to words and the tone in which they are spoken**

• “It was my fault” evokes a different bodily response than “I did the best I could.” “I hate myself” has a different impact than “I hate when I do that. . .”

• In order to ‘treat’ the body aspect of the shame response, **we need to help clients notice the vicious circle between the words they use and the body responses evoked**

• **And we have to help them experiment with new words** that have a different impact on body experience

Fisher, 2011

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Sensorimotor Interventions [Ogden, 1999]

If the issue in shame is loss of the ability to speak or to hold up one’s head, then the remedy has to include action

• *“Notice what happens to the shame if you lengthen your spine just a little bit . . .”* The action of lengthening the spine increases energy and feelings of solidity. If the client is numb, lengthening the spine counteracts numbing

• *“Then orient to the room by turning your head and neck and slowly looking all around. What happens?”* The actions of orienting and scanning increase perceptual contact with the environment and increase optimal levels of arousal. Attention is turned away from the shame

⁴⁸
Fisher, 2007

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More Sensorimotor Interventions

- “Let’s notice what happens if you assume that the shame belongs to a part of you . . . Does that feel better or worse?” Techniques in which the shame is studied as a part of the personality ‘disrupt’ automatic shame-related patterns

- “Let’s study what happens to the depression when you repeat those words, ‘I’m a hopeless case.’ Does it go up or go down?” “Notice what happens when you say the words, ‘I’m doing the best I can. . .’?” Experiments facilitate changes in emotions, body, and negative cognitions. Notice the experiments interrupt automatic responses of self-flagellation

Fisher, 2010

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Shame acts as a “wet blanket” to decrease other emotions

- **In the context of trauma and neglect, some emotions are safer than others.** Any emotion that provokes or triggers abusive or neglectful parents is not safe.

- When abuse evokes anger, shame down-regulates the anger so that it doesn’t endanger the child. When tears come, shame stops them in their tracks. When happy feelings evoke impulses to smile, shame stops them cold

- Because both positive and negative feelings can evoke anger in caregivers, **the child may learn to respond to most if not all affects and arousal states with bodily and affective shame reactions**

Fisher, 2010

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Shame and Blame

- Annie F.: **“‘Blame’ and ‘shame’ are best friends. When my parts blame themselves for what was done to them, they are saying that they did ‘something’ wrong. And that ‘something’ had consequences.... such as that my body was bruised, or eyes swollen from crying, or hair messed up and tangled, and even a fat belly from a rape. That ‘I’ was to blame for looking and feeling so badly was just the beginning of my shame.”**

- Annie F.’s epiphany describes blame and self-loathing as essential ingredients of shame as a survival response. The blaming thoughts instigate shame responses followed by automatic submission responses

Fisher, 2010

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Self-Blame is also a ‘Brake’

•**Self-blame serves the purpose of putting the brakes on behavior that will be punished by others.** In self-blame, we yell at ourselves, inducing shame. We warn ourselves never to do that again; we silence ourselves; we withdraw.

The key here is that shame is active and protective

•Internalizing the punitive role ensures safety and a greater sense of control—at the cost of punitive introspection. **But self-hatred is a small price to pay for greater safety.**

•**Once self-hatred is procedurally-learned and encoded in the body and mind, it feels “true.”** It continues to exert an influence on self-esteem and healthy self-assertion long after its job is over

Fisher, 2012

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Previously adaptive responses encoded in procedural memory are challenging to modify

*“[The procedural memory] system involves a relatively slow, incremental learning process. . . . With repetition, performance of procedurally learned processes becomes increasingly automatic. . . . **Procedurally learned behavior may be altered, albeit slowly, [but] it is relatively ‘resistant to decay’.**”*

Grigsby & Stevens, 2000, p. 93

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The Compass of Shame [Nathanson, 1992]

Donald Nathanson describes four procedural patterns or “scripts” associated with shame:

Attack the Self: the client regulates through self-blame. “I should be ashamed of myself—I’m so stupid—”

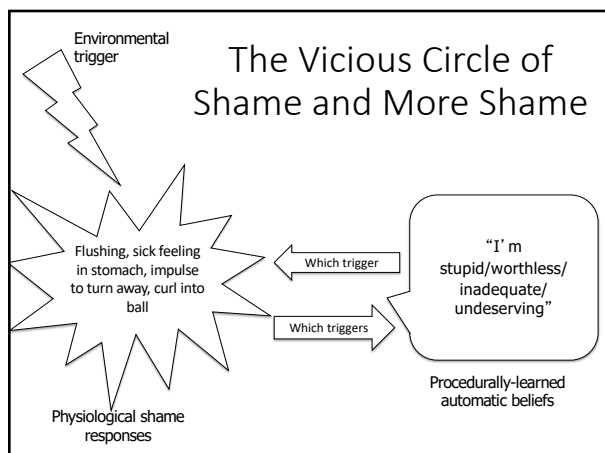
Attack Others: ‘they’ are the problem, not the client. The shame is externalized and disowned.

Withdrawal or Isolation: the shame is accepted as true, evoking anxiety about exposing one’s defectiveness

Avoidance of Inner Experience: dissociation, distraction, shutting down, avoiding affect

Fisher, 2014

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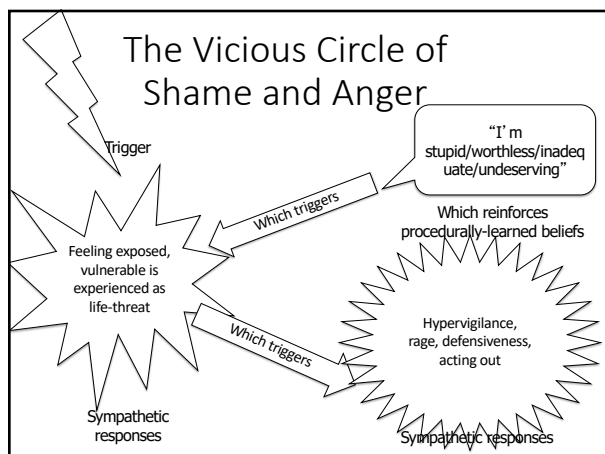
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Myths and Facts about Shame [Tangney & Dearing, 2002]

- The "shame and more shame" cycle is associated with **poor interpersonal skills and impaired empathy.**
- Caught in a cycle** in which the body is collapsed, has no energy, and feelings of shame are reinforced by beliefs of defectiveness, clients tend to withdraw, misperceive their effect on others, and become ruminative and self-involved.
- Often misinterpreted as poor self-esteem, attempts to 'increase confidence' backfire, leading to more shame.

Research shows that **self-esteem is connected to our evaluation of what we do; shame is about who we are.**
(Tangney et al, 2001) Fisher, 2013

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Myths and Facts about Shame, cont.

[Tangney & Dearing, 2002]

- Researchers were surprised that, contrary to their expectations, “shame-prone” subjects in their study were quicker to anger than withdrawal. **Shame-proneness was associated with anger, impaired empathy, addictive behavior, and with the inability to appreciate one’s effect on other people.** Males especially tended to lash out when they experienced shame; females tended to displace shame-related anger by blaming others or themselves (Tangney et al, 2001)
- When shame is associated with unsafe situations, it is not surprising that it triggers a sympathetic fight response,** which we experience as the client’s “anger.”

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Shame versus Guilt

- Guilt** = is what we feel when we break a ‘rule.’ For example, ‘it is bad to lie,’ ‘it isn’t OK to be angry at your mother’ or ‘to ask for what you want’
- Shame** = is what we feel about ourselves. There is no specific rule we have broken. Beliefs like “I am stupid” or “It was my fault” don’t tell us what we did specifically; they tell us that we are inadequate
- Healthy guilt and shame** = spontaneous healthy reactions to mistakes and poor choices that energize us toward needed change

Fisher, 2013

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Shame versus Guilt, cont.

- Much to the surprise of researcher, **moderate guilt is associated with better interpersonal relationships and motivation.** Perhaps because we have broken a rule, we try harder to change our behavior.
- Shame is about “our being:” we are “wrong and bad” in our essence.** And because shame is autonomically activating, it shuts down the prefrontal cortex and interferes with our ability to think. **Shame interferes with new learning, whereas guilt facilitates it.** This implies that we need to be very careful to avoid shaming clients whose behavior we would wish to change

Fisher, 2013

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The Role of Perfectionism

- **Perfectionism is ‘safety insurance:’** if mistakes are punishable and therefore frightening, perfectionism acts to limit mistake-making
- **Perfectionism is also superstitious:** the belief that perfect performance” will enable safety offers a sense of control
- If neglect or maltreatment are equated with fault or inherent defectiveness (as most children seem conclude), then the antidote is perfectionism
- Coincidentally, **perfectionism is also hypervigilance:** it enhances safety by decreasing the likelihood of behavior that would trigger parental acting out

Fisher, 2011

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*“The imprint of the
trauma is . . . in our
animal brains, not our
thinking brains.”*

van der Kolk, 2004

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Harnessing Neuroplasticity

“Neuroplasticity is the term used when connections [in the brain] change in response to experience”

Siegel, 2007, p. 30

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How to Facilitate Neuralplasticity

•**“The way an individual willfully focuses attention has systematic effects on brain function, amplifying activity in [those] brain circuits.”** (Schwartz & Begley, 2002, p. 334)

•For that reason, rumination on shame and worthlessness **increases** the likelihood of feeling more shame or engaging in shame-driven behavior

•Neuralplasticity is fostered by **inhibition of old responses coupled with repetition of new, more adaptive responses.** “Attending to one sense . . . does not simply kick up the activity in that region of the brain. It also reduces activity in regions responsible for other senses.” (p. 333) Fisher, 2009

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Principles of Neuroplastic Change

•The first principle is that **neuroplasticity is “induced by changes in the amount [and kind] of sensory stimulation reaching the brain.”** (Schartz & Begley, 2002, p. 16) The therapist needs to be very aware of what stimulation the client’s brain is getting now

•**The second principle is that neuroplasticity has to be “directed:”** repetitive new patterns of stimulation are necessary to obtain specific changes in the brain.

•**Third, neuroplasticity requires focused attention.** Concentration stimulates neuronal firing in the areas we wish to restructure and helps the brain to retain the new learning

Fisher, 2010

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*“The discovery that neuroplasticity cannot occur without [focused] attention has important implications. **If a skill becomes so routine you can do it on autopilot, practicing it will no longer change the brain.** And if you take up mental exercises to keep your brain young, they will not be as effective if you become able to do them without paying much attention.”*

Siegel, 2010

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Principles of Neuroplasticity, cont.

•Perhaps the most important principle is that **neuroplastic change requires inhibition of old responses coupled with intense repetition of the new, more adaptive responses.** “Attending to one sense . . . does not simply kick up the activity in that region of the brain. It also reduces activity in [other] regions . . .” (Schwartz & Begley, 2002, p. 333)

•In Sensorimotor Psychotherapy, we encourage **neuralplastic change by asking clients to pause and inhibit old responses by asking them to “notice what is happening **right now** in your body as you focus on this thought/feeling/sensation”**

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What does this mean for clinicians?

•It means heightened awareness that **talking about shame-related feelings, thoughts, memories, or behavior may actually reinforce the neural circuits holding them**

•Alternatively, **each time we ‘disrupt’ old patterns by inhibiting their repetition, we amplify new patterns**

•Remember that **new responses may be more important for effective therapy than talking about old events or responses.** Rather than trying to be good listeners, it may be more effective to interrupt!

•Lastly, this suggests a need for **increasing emphasis on and use of active, directive mindfulness-based therapies** rather than ‘listening’ therapies

Fisher, 2010

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Challenges to Shame and Self-hatred

•**Mindfulness:** helping the client to **notice** the shame rather than “be” it. *“What happens in the body when those thoughts of worthlessness come up?” “Notice what it’s like to observe the shame just as body sensation . . .”*

•**Dis-identification:** challenging the identification with the shame as “who I am.” *“Thoughts are just theories—let’s be curious about this theory that you’re stupid. How would that theory have helped you survive?”*

•**Reframing the shame:** attributing meaning and purpose to the shame as a “survival resource” (Ogden et al 2006). *“The shame was the hero of your story. . .”*

Fisher, 2011

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Challenges to Shame and Self-hatred, cont.

•**Shame as Memory:** *“Those shame memories are so strong, aren’t they? It’s amazing how easily they get triggered—but maybe that helped you survive. . .”*

•**Redefining shame and self-loathing as child parts:** *“That little boy still remembers the humiliation, doesn’t he? Is he judging himself right now? Or is some other part judging him?”* Typically, shame reflects a relationship between two parts of the self: a part that judges and a part that feels judged. When the critical part echoes negative messages heard in childhood, younger parts feel the same sense of shame as if it were “then.”

Fisher, 2011

71

A mindfulness-based model rather than a narrative model

“Change happens through discovering how a client habitually organizes experience in response to selected stimuli and then changing how that experience is organized. . . .”

Ogden, 2005

72

Mindfulness Skills

- “Notice . . .”
- “Be curious, not judgmental. . .”
- “Let’s just notice that reaction you’re having inside as we talk about your boy friend”
- “Notice the sequence: you were home alone, bored and lonely, then you started to get agitated and feel trapped, and then you just **had** to get out of the house. . .”
- “What might have been the trigger? Let’s go back to that day and retrace your steps” Fisher, 2004

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Facilitating Mindful Awareness

- **Mindfulness in therapy depends upon the therapist becoming more mindful:** slowing the pace of thinking and talking, refraining from interpretation in favor of observation, helping the patient begin to focus on the flow of thoughts, feelings, & body sensations
- **Curiosity is cultivated as an entrée into mindfulness:**
“Can we be curious about the shame? Amazing to see it coming up right here, right now . . . Is it OK to just notice it as body sensation? Could we be curious about how it’s trying to help you? Notice what the shame makes your body do. . . Do you stand up straighter or does your body collapse? Do you have more energy or less?” Fisher, 2012

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Focus on Cultivating Curiosity

- **The therapist must also listen with a mindful, curious ear:** We have to hear the client’s distorted beliefs as “just” thoughts, the intense shame as “just” a feeling, the retreat or avoidance as “just” action. We can make it feel safer to **be curious about intense feelings or impulses**
- **Communicate curiosity in your voice and body language:** “Can you feel the shame right now? How is your body telling you that you’re ashamed?”
- **Help the client notice patterns of response with excitement:** “Isn’t that amazing? When you set that boundary, your body didn’t feel strong and capable—it went into shame! Wow. . .” Fisher, 2012

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*“Although mindfulness is often seen as a form of attentional skill that focuses your mind on the present, [we can also see] mindfulness as a form of healthy relationship with oneself. **That is, mindful awareness is a form of intra-personal attunement. Being mindful is a way of becoming your own best friend.**”*

Dan Siegel

76

Differentiating Thoughts, Feelings, and Body Experience

In traditional talking therapies, we tend to treat thoughts, feelings, and body sensations as if they were one and the same. But when clients say, “I feel ashamed,”

- The words could convey a **cognition**: “*I believe that I am defective--inadequate*”
- They could communicate an **emotion**: “*I’m feeling painful emotions*”
- They could reflect **bodily sensation**: “*I feel flushing—a sick feeling in my stomach—want to hide*”

Fisher, 2007

77

Mindful versus Empathic Language

Empathic Statement	Statement in Mindfulness
“Your father can be very shaming—it’s difficult to be around him”	“I notice when you talk about him, you get very still and quiet. . .”
“You want to run out of the house to hide. . .”	“Notice what happens next when you imagine that. . .”
“Then you feel that it’s all your fault . . .?”	“So, the thought comes up: “It’s all my fault,” and then what happens?”
“ <u>You</u> feel ashamed—even though you know that he wasn’t appropriate?” <small>Ogden 2005; Fisher, 2011</small>	“At that moment, all you experience is the feeling of shame and the thought, ‘It’s all my fault.’ The fact that he was not appropriate isn’t even in your awareness, then, huh?”

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Increasing mindful concentration: offer a menu of possibilities

- “When you feel the shame come up, what happens? Do you feel it in your stomach? Your face? Or is it more like a physical urge?”
- “As you feel that anger, is it more like energy? Or muscle tension? Or does it want to **do** something?”
- “When you talk about feeling ‘nothing,’ what does ‘nothing’ feel like? Is it more like calm? Or numbing? Or like freezing?”

Ogden 2004

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Making mindfulness even easier: ask contrasting questions

- “Does that [thought/feeling/action] feel good or bad? Is it more pleasurable or unpleasurable?”
- “Does that danger feel like something that will hurt you from the inside or the outside?”
- “When you say those words, ‘It was my fault—there must be something wrong with me,’ do you feel better or worse?”

Ogden 2004

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Ingredients of Mindfulness

[Creswell et al, 2002]

- **Noticing:** awareness of sensation, thought, emotion, movement, external stimulus
- **Detachment:** noticing without ‘participating’ in it or getting swept away by thoughts, feelings or body
- **Labeling:** putting neutral language to what is noticed (e.g., “I’m having a thought—some emotion is coming up”)
- **Mindfulness can be directionless or directed:** we can follow the flow of thoughts, feelings and body response as they unfold **or** we can deliberately choose to direct our concentration away or toward something

Fisher, 2009

81

Combatting shame states by regulating the nervous system

Hyperarousal-Related Symptoms:
If shame evokes hyperarousal responses of flushing and panic, we can help clients lower their arousal

Hyperarousal

Window of Tolerance*
Optimal Arousal Zone:

Hypoarousal

Hypoarousal-Related Symptoms:
If shame perpetuates hypoarousal symptoms of hopelessness and worthlessness, we can help clients increase their arousal

Ogden and Minton (2000);
Fisher, 2009
*Siegel (1999)

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Combating Shame Through the Body

- If the shame is reinforced or exacerbated by body experiences of collapse, loss of energy, feelings of revulsion, curling up or turning away, then **shame can be mitigated by changing body posture**
- Lengthening the spine and grounding through the feet both challenge shame.** If the client's head is bowed or averted, bringing the head up or asking the client to begin to slowly turn the head and lift the chin can begin to increase feelings of confidence and fearlessness. If these movements are triggering, they can be executed piece by piece over time

Fisher, 2009

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Using the Body's Resources to Overcome Shame

Shame-related Reactions:	Resources:
Flushing	Deep breath or sigh
Head averted	Orienting movements
Eyes closed: "I'm invisible"	Therapist closes eyes
Collapse in the spine	Lengthening the spine
Self-blame, judgment	Hand over the heart
Ruminations re. worthlessness	"Dropping the content," practice of new words

Sensorimotor Psychotherapy Institute
Ogden, 2000; Fisher, 2011

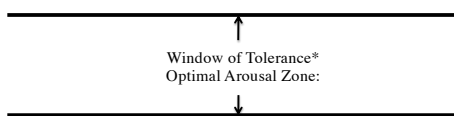
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Strategies for raising/lowering arousal

Hyperarousal-Related Symptoms:

Slowing the pace, increasing curiosity
Hand over the heart, movement (turning away or toward)

Hyperarousal



Hypoarousal

Hypoarousal-Related Symptoms:

Increasing the pace, increasing curiosity
Humor, playfulness, movement, lengthening the spine

Ogden and Minton (2000);
Fisher, 2009
*Siegel (1999)

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Mindful Experiments=non-threatening change interventions [Ogden, 1999]

•Rather than make suggestions or plan coping strategies, the sensorimotor therapist uses “experiments” to test out new options. **The experimental approach encourages thoughtful “trials” of new skills or responses and non-judgmental observation of their impact.**

•**Experiments are inherently mindful:** they are conducted without investment in a particular outcome. “Right” and “wrong” answers irrelevant: only curiosity and an open mind are important. Once the decision is made to try an experiment, therapist and client “run” the experiment in the office first to observe its effects

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Resourcing vs. De-resourcing Thoughts

•Some of our thoughts are creative, enlightening, expansive, encouraging. Some thoughts activate procedurally-learned body responses that “de-resource” us

•**A resourcing thought** creates a sense of greater aliveness, lightness of being, solidness, confidence, playfulness. **A de-resourcing thought** feels heavy, suffocating, numbing, anxiety-provoking, and automatic

•Clients can learn to notice thoughts and to label them as “resourcing” or “de-resourcing” depending upon their impact on the body. Resourcing thoughts can then be practiced and de-resourcing thoughts “dropped”

Fisher, 2011

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“Dropping” Negative Thoughts

- An important Sensorimotor skill for decreasing shame is learning to **“drop the content:”** i.e., focus away from shame-based thoughts, interpretations and feelings and focus toward something neutral or regulating
- For mindful clients, dropping the content and shifting focus to internal body awareness can be regulating. For less mindful or more unstable clients, letting go of the “content” is only possible when they focus on something concrete, such as their feet
- **Dropping the content to focus on the body challenges negative cognitions:** the words lose their power

2008

Fisher,

Sensorimotor Psychotherapy Institute

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Re-framing Shame

- Capitalizing on the neurobiological assumption that every symptom is a valuable piece of data about how the client survived, **shame can be challenged by reframing it as a valiant attempt to cope in a dangerous world**
- **Look for what the symptom is still trying to accomplish now:** Maintain compliance? Combat anger and assertiveness? Keep the client from being “out in the world? Cement relationships by fueling compliance and self-sacrifice. Admire the shame as a survival resource!

Fisher, 2007

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Curiosity is Enhanced by Re-framing the Symptoms

- If the therapist responds as if **every symptom or part is valuable data about how the client survived**, rather than a sign of defectiveness, curiosity is fostered
- We can use psychoeducation to make educated guesses about the meaning of each symptom or part: **is it a part having a feeling memory? Or trying to self-regulate?**
- **Look for what the part is trying to accomplish:** Increase hypoarousal? Decrease hyperarousal? Regulate feelings of emptiness or loneliness? Restore a sense of power and control over one’s own experience? **Admire the part as a survival resource!**

Fisher, 2009

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Re-framing Builds Trust and Safety

•In childhood, our clients' "mistakes" were punished harshly, sensitizing them to both negative and positive feedback.

Their defenses go up, interfering with new learning

•**Re-framing provides a way of noticing procedural patterns as adaptive, creative, ingenious, inherently positive** and inviting the client to be curious about them.

Defenses go down, increasing client availability

•Is the ashamed part trying to establish control over feelings that once would have been unsafe? Or trying to demonstrate submissive behavior? **Perhaps s/he is trying to make sure she doesn't threaten authority figures:** that the little parts are never so vulnerable to any human being ever.

Fisher, 2013

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Transforming Shame and Self-Loathing

Jack Hirose Seminars

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Separating Self from Symptom

•When we confuse **who we are** with **symptoms or triggering**, we inadvertently exacerbate them. Suicidal patients do better when the suicidality is defined as the aim of one **"part"** rather than coming from their whole being

•Hopeless clients do better when the hopelessness is attributed to just a **part**, as do ashamed clients or clients abusing substances. But if we don't explicitly use the language of parts, then clients will pick just one feeling or impulse as "who I am" or "me"

•**Parts language also makes it easier for clients to take responsibility:** part of the client would choose a healthier course, but another part didn't or couldn't

Fisher, 2010

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Trauma \Rightarrow Alienation from One's Self

•To survive, human beings need psychological distance from overwhelming events. The sense of self must also be kept separate from the ongoing trauma

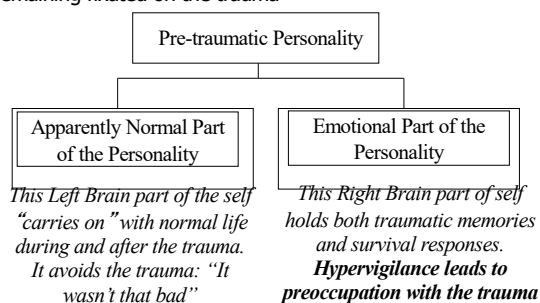
•Disowning “the bad child” or “wounded child” (the child who endured the abuse and humiliation) is a survival response: it preserves self-esteem, motivates us to be the “good child,” helps us go to school and do our homework

•We also disown the trauma by disowning/rejecting the traumatized parts: the most wounded parts, parts that carry the shame, the needy parts, and, most of all, the angry, vengeful parts

Fisher, 2009

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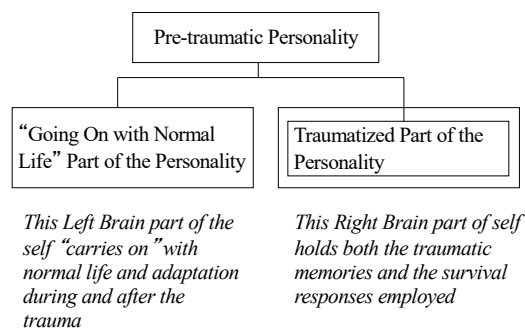
Structural Dissociation: even a single incident trauma leads to a divide between “keeping on” and remaining fixated on the trauma



Van der Hart, Nijenhuis & Steele, 2006

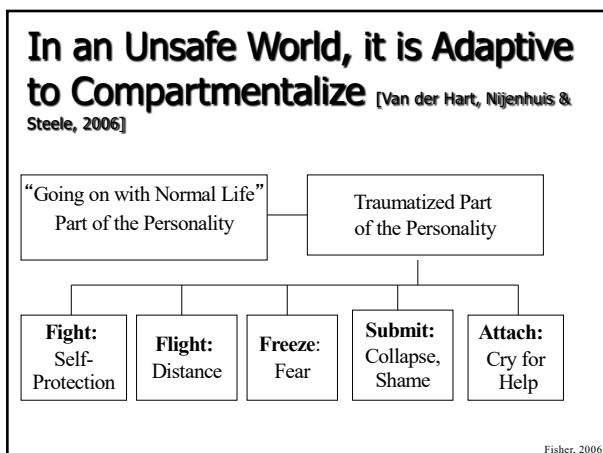
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Client-Friendly Language

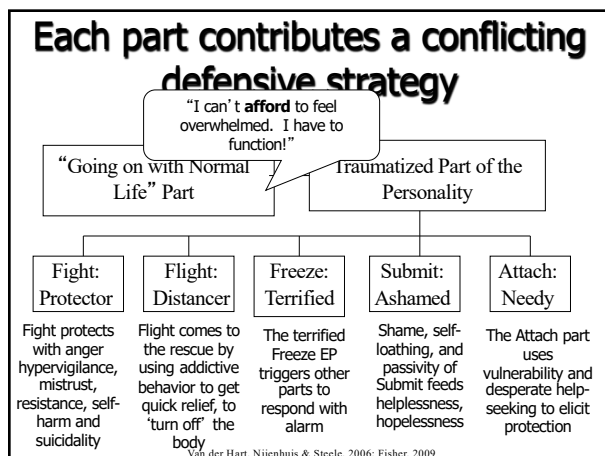


Van der Hart, Nijenhuis & Steele, 1999

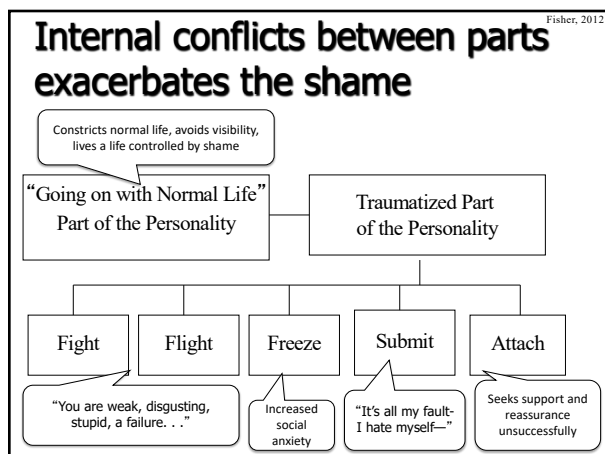
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99

Re-framing Shame as a Part

•When the client expresses shame or worthlessness, the therapist asks: “When you say the words, ‘I’m stupid,’ is that an accusation? **Is it the critic? Or the child who feels humiliated by the critic’s words?”**

•**If the client is confused by the question, offer some psychoeducation:** “Shame is the outcome of the relationship between an internal critic and a child part who remembers the feelings of humiliation--between the shamer and the one who feels shamed.”

•Most clients recognize that relationship: it feels true to their internal experience

Fisher, 2020

100

Awakening an observer

•**Evoking curiosity** by re-framing habitual responses as having been adaptive for survival: “the internal critic was just trying to shape you up before something happened”

•**Providing psychoeducation:** empowering clients by offering a psychoeducational understanding of the structural dissociation model

•**Increasing mindful differentiation of thoughts, feelings, and body sensations:** “When you say, ‘I’m so alone,’ is that a thought or belief? A feeling? Or more of a gut sensation?” “What part is feeling so alone?”

•**Helping the client achieve mindful distance from the symptoms:** using the language of parts in response to expressions of shame and self-doubt

Fisher, 2018

101

Noticing ‘who I am’ moment to moment

•**We assume that ‘we are what we feel:’** but the repercussions of trauma complicate that assumption. What “I feel” could be a spontaneous response to the present moment, **OR** the implicit memory of a part, **OR** a survival response. Further, what we feel gives rise to meaning-making which affects what we feel about what we feel

•**Mindful curiosity:** what is happening right here, right now, in this particular moment? **Ask the client to avoid interpretation in favor of just noticing with curiosity. What part feels nauseous? Which part feels angry? Whose words is the patient voicing?**

Fisher, 2014

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“De-coding:” identifying “parts”

- **Signs of internal conflict:** inability to make decisions, stuckness, trying to stay safe alternating with acting out, alternating sobriety and relapse
- **Emotions:** intrusive, overwhelming and out of proportion
- **Noticeable shifts in mood or behavior:** e.g., from neutral or fearful states to anger and acting out; asking for extra appointments, then not showing up; trust alternating with mistrust
- **Autonomic arousal patterns:** collapsed, numb, passive states versus angry or desperate or suicidal states
- **Cognitions:** “I am worthless and hopeless,” “I know you are going to leave me,” “I can’t trust you,” “I trust you completely”

Fisher, 2014

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“Speaking the Language” of Parts

- Using the “language of parts” increases mindfulness and challenges the phobia of disowned parts
- **“Relentless reframing”** helps us to de-construct internal struggles and distress into their component parts. When the client says, “*I hate myself*,” the therapist responds, “*So there is a part of you that hates you? or does that part hate the feelings?*”
- **“Relentless reframing”** encourages clients to step back and notice rather than react to their thoughts, feelings or impulses. When they notice mindfully, when they have that distance, their interest, curiosity and compassion naturally increase

Fisher, 2012

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Choose Language that Acknowledges the Parts

- “When you say those words, ‘I am so ashamed,’ **I hear the depressed part** of you that hates herself so much”
- “It feels like **a very young part of you** is in the room. . .”
- “When you say, ‘I am so alone—no one cares about me,’ **I hear the voice of a very young, lonely little girl.** . .”
- “I’m curious about **the part of you that didn’t want to come** today . . .”
- “So **there’s a part of you that wants so much to be loved and a part that doesn’t trust** that it’s safe to let anyone in close to you . . .”

Fisher, 2013

105

Advantages of using the language of “parts”

- **Parts language is a way to cultivate mindfulness**, which allows the client to have a wider Window of Tolerance and prevents highjacking
- **It helps clients to differentiate** scared or ashamed or unsafe parts from their competent, resourced selves
- **Parts language helps clients dis-identify from the symptoms** (“I am not depressed, but parts of me are”) and re-frame them as parts holding survival strategies
- **It increases self-compassion and self-care**
- It allows the client to utilize the resources of their adult selves on behalf of their younger wounded selves Fisher, 2012

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How the Parts Dominate: “Blending”

[Schwartz, 2001]

- When the client identifies with or “blends” with a part, **the thoughts and feelings of that part feel like “me.”**
- **“Unblending”** refers to decreasing blending and increasing the ability to hold multiple perspective/parts in mind.
- Because the client has no awareness that blended feelings come from parts, **it becomes the therapist’s job to initiate the unblending:** *“So, there is a part of you here today that feels utterly defeated and worthless.”*
- **Unblending is facilitated by awareness of other parts:** *“When the defeated part feels so worthless, how does that affect the part that is so ashamed?”* Fisher, 2013

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“Unblending” [Schwartz, 2001]

- **As feelings, thoughts, or body reactions come up, we re-frame them as parts and help clients “unblend” from them:** *“When the hopeless part collapses, notice that the annoyed part that pops up.”* Or *“When the word ‘hopeless’ comes up, I notice your head sink . . .”*
- **The therapist’s job is to both name the parts and foster empathy for them:** *“Yes, that annoyed part is really worried about the hopeless part ruining everything, huh?”* *“Fight was really trying to help by lashing out, wasn’t it?”*
- **As the therapist communicates compassion, calm, and acceptance**, the client often becomes more mindful and less blended, increasing the somatic sense of safety and calm Fisher, 2010

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Clinical Advantages of Working with Shame as a Part

- When we re-frame shame or self-hatred or schemas as a “part” of the self, **we interrupt procedurally-learned automatic shame responses and increase curiosity**
- The language of parts also increases mindfulness:** “I” is the first word in a narrative about the shame, while the language of parts encourages noticing internal experience
- If the client can notice parts that hold shame and parts that judge, s/he has a part that ‘sees’ those other parts (an observing ego).** As soon as the client can observe the shame as an “it” instead of as “me,” a dent is made in the procedural learning

Fisher, 2011

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Helping clients relate to their shame as a child part’s feelings

- Client: *“I feel so ashamed. I don’t want to face you”*
Therapist: *“So, there is a **part** of you that is feeling shame right now because you’ve told me something so very personal. Could we be curious about that **ashamed part**?”*
- “Is there **another part** that is shaming the **ashamed part**? A **part that judges** you or other parts? Or is the ashamed part remembering being judged?”* (Where there is an ashamed part, there is generally a part that shames it.)
- The therapist’s job is to help the client ‘separate’ from the shame and name it as a child part**

Fisher, 2011

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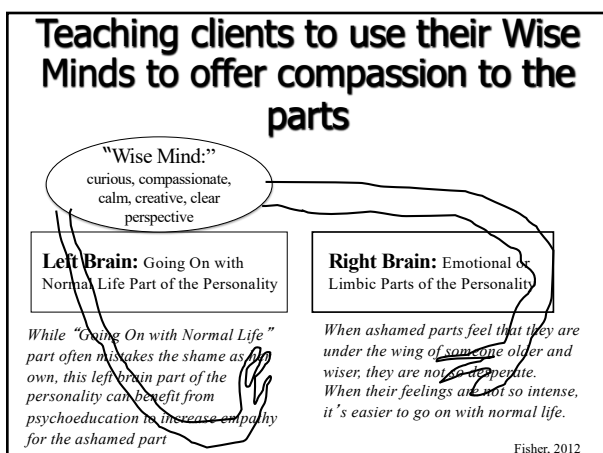
Engender Compassion for Parts

Each part “tries to fix things its way” (Annie)

- Suicidal symptoms:** “Fight keeps a parachute or “bailout plan” for you, like the samurai soldiers ready to die before defeat. Fight would rather die than feel powerless and overwhelmed”
- Cutting or self-injury:** “The part that hurts the body learned to stop the overwhelm and get some relief that way—and it worked because it triggers your body to produce adrenaline and endorphins”
- Mistrust and paranoia:** “Fight learned the hard way that it was safer to assume the worst in people . . .”
- Shame and self-blame:** “The Submit part figured out when you were very young that blaming herself was much safer than the Fight part blaming your parents.”

Fisher, 2008

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What do ashamed parts need?

- In Sensorimotor Psychotherapy, we ask: **what is the client's "missing experience"?**
- Be curious: what does the ashamed part need?** To feel proud of how he protected the other parts?? Or to hold her head high? To replace passivity with action? The therapist may be drawn to offer the missing experience directly to the client, but rarely does that seem to work. As we say, "You have nothing to be ashamed of," the client answers, "You don't understand!"
- To believe we are OK requires a connection between our wise minds and the part's shame and self-doubt,** our adult resources and our young emotions

Fisher, 2012

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Working with Ashamed Parts

- Ask the client to assume that negative beliefs are held by parts:** "What part might believe she is worthless and undeserving?" "What part might believe it isn't safe to trust people—that they will just humiliate him?"
- Increase the client's mindful curiosity:** "How would it have been adaptive for that part to be convinced that she was worthless and undeserving? How did that affect your/her behavior in your family environment?"
- Explore its role in how the client survived:** how did this part serve to regulate fear? Or anger? It couldn't stop the perpetrators, but how did it protect the child? Did it support the child "being seen and not heard"?

Fisher, 2009

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Working with Ashamed Parts, cont.

When re-framed as survival beliefs held by young child parts, shame-based cognitions lose their power. **“How did it help** that the ashamed part believed that she deserved the abuse?” **“What would have happened** if she had believed **he** was wrong? What would have happened then? Imagine if you had listened to the angry part . . .”

•Most often, clients can quickly see how **the belief served a defensive function as a survival resource**. They are aware of the dangers once posed by assertive behavior. “Yes, the ashamed part is the hero of your story, isn’t she? She kept you safe. . . **What happens as she takes that in?**”

Fisher, 2013

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Establishing relationships between adult self and parts

•Trauma alienates us from ourselves and our parts from each other. **To combat shame requires “welcoming” ashamed parts and evoking mindful curiosity about their feelings, thoughts, and impulses.**

•Bringing them alive naturally enhances empathy: *“How old might this part be? Very young? Middle-sized? A teenager?”*

•As curiosity challenges the automatic animosity toward parts and they come to be better understood, the therapist can ask an Internal Family Systems (Schwartz, 2001) question: **“And how do you feel toward that part now?”**

Fisher, 2012

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Establishing relationships with parts, cont.

• **“How do you feel toward this part now?”** (Schwartz, 2001) automatically invites compassion and is also a litmus test for mindfulness: **does the client have enough mindful distance to feel curiosity or compassion for this part?**

•If the client responds with hostility, we can assume that she is “blended” (Schwartz, 2001) with parts that judge the ashamed part as “weak” or “shameful.” If the client responds, “I feel badly for her” or “I want to help him,” we know that a relationship is beginning to form.

•**The key to establishing compassion for ashamed parts is the appreciation of their role in survival**

Fisher, 2012

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Internal Communication

- **Ask the client to focus on the distressing thoughts and feelings and assume that they belong to a part.**
- Ask the client to notice **what thoughts, feelings, or beliefs is this part communicating?**
- **Next, encourage some curiosity:** what kind of part would feel or think this way? A very young one? An elementary school child? A teenager?
- **Then, ask the client to connect to that part just by letting it know s/he is there:** “Perhaps you might want to tell this part that you’re here and listening—that you will take the time to listen to whatever she has to say.”

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Internal Communication, p. 2

- **If the client is too blended, then he or she can ask the part to 'sit back a bit'** and make room for the “Normal Life Part.” This step can be repeated whenever the patient becomes 'blended' with parts or starts to report confusion or overwhelm.
- **States of confusion, disorientation, overwhelm, and anxiety should always be re-framed as parts**—and also depression, shame, sadness, anger, dread, guilt, and self-criticism. Once the patient feels less 'blended,' i.e., less confused or anxious or overwhelmed, we go back to Step 1: establishing awareness of and interest or curiosity in the part that is currently most activated.

119

Internal Communication, p. 3

- **The therapist next facilitates an internal dialogue by asking the client to “ask inside,”** focusing on a series of questions designed to cultivate greater understanding and compassion for the part. Some clients understand the term, “Ask inside,” easily, while others will need help.
- **“Asking inside” can be taught as a skill:** “Let’s find out more about this part: did you know you could just ask her questions? All you have to do is just think the questions inside your mind and body.”
- **The best starting place for most clients is to ask the part in distress what s/he is “worried about.”**

120

Internal Communication, p. 4

- **Next, ask the Adult to report the exact words the part has said**, rather than give an interpretation because these can be a way of distancing from parts.
- The Normal Life self is asked to ask the part, "What do you need from me right here, right now to not be so afraid of _____?"
- In most cases, the answer the part gives is some variant of the following: "I need you to be there," "I need you not to be afraid each time I get afraid." "I need to know that you will be there—that you won't go away."

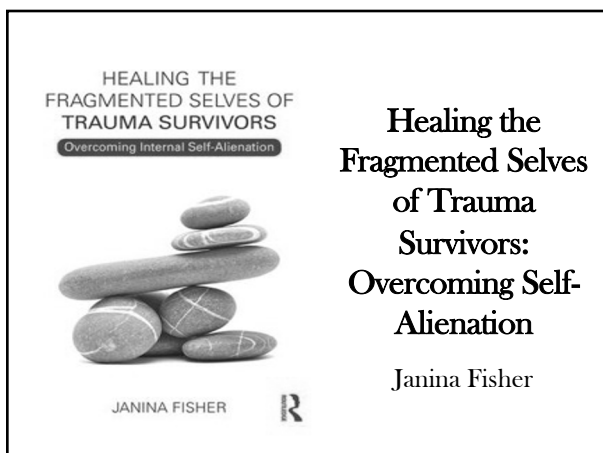
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Annie: *"Until today it didn't seem possible that the ashamed parts would ever feel any respite from the searing embarrassment caused by any mention or reference to the kinds of crimes committed against them as children. In the minds of the parts, they were complicit in the acts against them. . . And I wasn't helping those ashamed child parts because I was blended with them. . . ."*

122

"Shame is a powerful weapon that the abusers counted on. I can see that now. How different it feels in my body to acknowledge submission as a survival tactic that was smart and courageous of my young parts to access! Their submission and subsequent shame may be the reason we survived. So, now there is more hope for healing. Every time I "hang in there" with my back straight and my feet firmly planted on the ground, the parts that feel so much shame will see that they are really the heroes."

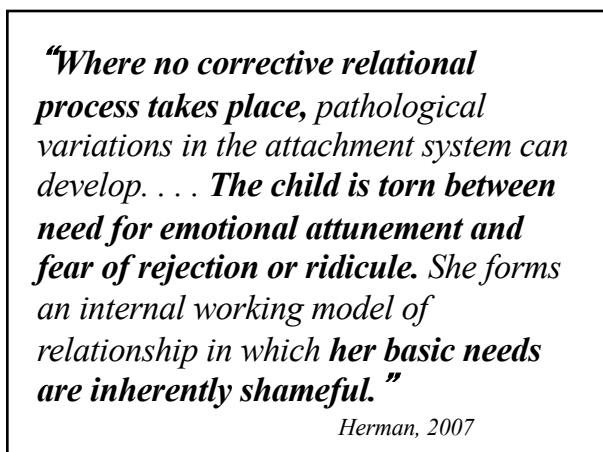
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The good news and the bad news is
that therapy and the therapist
stimulate the attachment system

“Contact itself is the feared element
because it brings a promise of love,
safety, and comfort that cannot
ultimately be fulfilled and that reminds
[the patient] of the abrupt breaches of
infancy.”

L.E. Hedges (1997, p. 114)

Ogden, 2002

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Stimulation of the attachment
system \rightleftharpoons stimulation of the
fear/shame system

*“To be known or recognized is
immediately to experience the other’s
power. The other becomes the one who can
give or withhold recognition: who can see
what is hidden; who can reach, conceivably
even violate, the core of the self.”*

Benjamin, 1994

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How Therapists Trigger Shame

- For clients who survived through shame, **the wish to be liked by the therapist can be triggering**
- Unconditional positive regard can be triggering—and **positive statements** about the client even more so
- **Empathy** can be triggering: “that shame must be very painful” can suggest that we agree with the client that s/he is worthless and defective, empathy that increases connection to affect can also evoke shame
- Self-reflection or the invitation to be ‘seen’ can be triggering. And so can the therapist’s warmth and kindness

Fisher, 2020

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Interactive neurobiological regulation in psychotherapy

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

Schore, 2001

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Being a “neurobiological regulator”

- It doesn’t mean that the therapist is responsible for convincing the patient “not to be ashamed”
- What it means is that the therapist “regulates” or “repairs” the shame**, just as healthy parents should have done: i.e., experiments with making contact with the patient in some way that mitigates the shame, such tone of voice, energy level, empathy vs. curiosity, providing psychoeducation, waking up the frontal lobes, re-framing the shame as active and heroic
- It means a shift in the therapist’s focus from affect expressed in words to a focus on moment-by-moment regulating of the client’s internal state

Fisher, 2014

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Co-regulating Shame States

- In an interpersonal neurobiological model, the emphasis is less on affective expression or problem-solving and more on “co-regulation”**
- Co-regulation in therapy describes the moment-by-moment interaction between the nervous systems of the therapist and that of the client:** e.g., the therapist’s anxiety goes up as his client is silent and unresponsive. That anxiety is contagious, further dysregulating the client. As the client expresses hopelessness about the therapy, the therapist’s nervous system drops into hypoarousal, too
- But if the therapist intentionally re-regulates his/her arousal, ‘contagion’ then benefits the client

Fisher, 2011

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Like a parent, co-regulation
begins with the therapist

“...the therapist resonates with the patient’s internal state of arousal dysregulation, modulates it, communicates it back prosodically **in a more regulated form**, and then verbally labels [the client’s] state experiences.”

Schore, 2003b, p. 30

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Increasing capacity for social engagement in
the therapy is a precursor to repairing
attachment patterns

•In the therapy hour, **the therapist must make use of his or her own social engagement muscles**, making sure to utilize facial expression, head movements, intonation, and gaze to evoke the client’s social engagement system. Talking about social engagement does not in itself engage the ventral vagal system

•**The social engagement system is body-oriented:** it relies upon the “muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds.” (Porges, 2004, p. 21)

Ogden, 2004; Fisher, 2007

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*“Not only is the therapist . . . unconsciously influenced by a series of slight and, in some cases, subliminal signals, so also is the patient. **Details of the therapist’s posture, gaze, tone of voice, even respiration, are [unconsciously] recorded and processed.** A sophisticated therapist may use this processing in a beneficial way, potentiating a change in the patient’s state without, or in addition to, the use of words.”*

Meares, 2005, p. 124

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Neurobiologically Regulating Shame States

- Does the client need help noticing the relationship between shame and particular triggers? Notice that the shame is evoked by both positive and negative triggers
- Does the client need help dis-identifying from the shame-based cognitions? Use psychoeducation to decrease “believing” the cognitions and to evoke greater curiosity. Name the shame as “body memory” or “default setting”
- Does the client need help shifting states? Notice what happens if you use humor?? Or encourage movement?
- Is the shame connected to relational triggers? Invite the client to collect data on “what the shame accomplishes” relationally?

Fisher, 2014

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Neurobiologically Regulating Shame States, cont.

- Does the client need to change postural and autonomic patterns that reinforce shame? Use therapy sessions to help client practice new postural and autonomic patterns.
- Does the client perseverate on shame and blame or perfectionistic anxiety? “Disrupt” client’s obsession with the shame by empathically interrupting ruminations. **Don’t let the client dig the shame deeper and deeper!** Challenge, disrupt, re-direct
- Does the client need help identifying the shame as a child part? Don’t be afraid to be “relentless” in helping clients notice the shame as either an ashamed or judgmental part. To change the patterns of shame and self-blame, they need to be in a mindful relationship to them

Fisher, 2014

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*“Any [therapeutic] remark
made while [the client] is in
a state of traumatic
consciousness will only be
understood in the
[traumatic context]. . .”*

Meares, 2005

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Use 'co-regulation' to communicate

- **Co-regulation is moment-by-moment right-brain-to-right-brain 'contingent communication.'** Does the client resist your interpretations or explanations? *Try using humor or language that sounds less like a therapist? What happens if you give the client the lead?*
- Does the client look uncomfortable when you empathize? *What happens if you universalize it? Or validate it?*
- When clients fight to hold on to their shame and self-hatred, *what happens if you re-frame it as a part? Or a memory?*
- Is the client not processing our new information? *Simplify your next response. Is the client responding irritably? Try lightening your tone or increasing humor*

Fisher, 2013

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Like a parent, experiment!

- If the client is subdued, shutdown, non-communicative, **experiment with letting go of your need for something to happen and try instead to 'meet' or 'befriend' the shutdown state.** What is that state 'accomplishing'? Try laughter or admire its power. Don't shut down yourself!
- **If the client is hopeless or ashamed, experiment with increasing your energy** in some way. Try to find something to admire in either state
- **If the client is angry or irritable or complaining, see what happens if you 'befriend' that state.** What is that state accomplishing? Increasing energy? Counteracting shame? Pushing people away? What does it want?

Fisher, 2011

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Russell Meares' Conversational Model (2001)

- **"Identification of traumatic consciousness:"** noticing signs of triggering, noticing the shame as a trauma response, disrupting client's normalizing of it
- **"Restoration of [present] consciousness,"** help the client 'be here now,' using co-regulation, mindfulness, somatic resources, psychoeducation, playfulness
- **"Setting the scene:"** rather than being biased by the client's interpretations, the therapist tracks patterns of thought, emotion, body language, triggers, or parts and points them out to the client as 'interesting' or 'important'

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Russell Meares' Conversational Model,
cont.

- **"Playing about:"** evoking curiosity in the client, delighting in the exploration of moment to moment experience, "playing detective," having fun
- **"Changing the script:"** implicitly or explicitly changing client's story in some way (eg, proposing that it is a story about parts, a story about body memory or procedural learning)
- **"Changing the narrative of self:"** eg, how the ashamed part only took on the shame to ensure survival, how the judgmental part reflects fear (not criticism), how wise and ingenious the body to have offered such protection!

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We must communicate faith in the
client's capacity for growth

*"If I accept you as you are, I will
make you worse. If I treat you as
though you [already] are what
you are capable of becoming, I
will help you become that."*

Johann Wolfgang von Goethe

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Make use of the Social Engagement
System [Porges, 2005]

•The **'social engagement system'** regulates movements
of the eyelids, facial muscles, middle ear muscles,
larynx, and head tilting and turning movements

•The development of an infant's social engagement
system is dependent upon the caregiver's ability to
stimulate and interactively regulate social interaction

•When clients have had abusive and neglectful parents,
social engagement was usually absent, and they come to
therapy with an inhibited or shutdown social engagement
system and dorsal vagal dominance

Ogden, 2006; Fisher, 2007

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The Social Engagement System of the Therapist

•**Amplifying the capacity for self-compassion** and loving feelings towards all parts of us **requires a therapist whose social engagement system responds to all parts**

•**As the therapist's voice exudes compassion for the ashamed part**, once humiliated by parent figures and now by the judgmental part, **the client's body will respond with increasing warmth or openness**

•When we are not afraid of the suicidal part but respond with smiles and warmth to its determination not to lose control and dignity, the client's body will relax—and thereby suicidal intensity will lessen

Fisher, 2012

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The Social Engagement System of the Therapist, cont.

•As our “sparkling eyes” communicate that all parts are welcome and valued, **the client will begin to increase the capacity to turn “sparkling eyes” on younger selves**

•The Adult self's “inside information” about the parts' unmet needs, integrated with the therapist's empathy for them, increases intuitive understanding of parts: “She isn't afraid to be alone; she's afraid that she'll be rejected”

•**As our faces soften and our voices become warmer, the client begins to soften as well**, relaxing the body and creating a pervasive sense of warmth. **Our acceptance becomes internal acceptance.**

Fisher, 2012

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Increasing capacity for social engagement in the therapy, cont.

•To stimulate the client's social engagement system, **the therapist can make use of his or her social engagement muscles**, making sure to utilize facial expression, head movements, intonation, and gaze to evoke the client's social engagement system

•**When shame is an issue, we must avoid drawing attention to these patterns directly and focus instead on co-regulation.** Each time we respond to shame, self-blame or hatred with a change in expression or body language that evokes curiosity or a relaxation effect, we facilitate deeper change than we can with words

Ogden, 2004; Fisher, 2014

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“Mirror Neurons” [Gallese, 2000] and the Practice of New Actions

- The theory of “mirror neurons” proposes that we have a type of motor neuron that doesn’t just fire when we actually move but also when we perceive others executing a particular action or if we imagine an action that we might want to execute
- Mirror neuron research began with studies of monkeys and not has been extended to human beings.
- Many experts believe that mirror neurons are the “active ingredient” in empathy: when we resonate to someone’s experience, it is because our mirror neurons are firing in response to theirs

Fisher, 2020

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Mirror Neurons, cont.

- This concept offers an intriguing avenue for psychotherapy
- It suggests that we can capitalize on the action of mirror neurons by providing our clients with opportunities for observation, visualization, and practice of new actions. Rather than “talking about” using new skills, the therapist’s demonstration or modeling will stimulate the mirror neurons, even if the client is resistant to trying them
- It means that we can potentially alter our client’s internal state by changing our own states!

Fisher, 2020

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“Not only is the therapist . . . unconsciously influenced by a series of slight and, in some cases, subliminal signals, so also is the patient. Details of the therapist’s posture, gaze, tone of voice, even respiration, are [unconsciously] recorded and processed. A sophisticated therapist may use this processing in a beneficial way, potentiating a change in the patient’s state without, or in addition to, the use of words.”

Meares, 2005, p. 124

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Strategies for neurobiologically regulating clients

- **Varying voice tone and pace:** soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- **Energy level:** very “there” and energetic versus ‘wispy’
- **Empathy vs. challenge:** how does the patient respond to empathy vs. challenge? Does s/he need limits or permission?
- **Amount of information provided:** noting the effect of psychoeducation or therapist self-disclosure vs. neutrality
- **Titrating vs. encouraging affective expression:** “too much” affect or shame-based ruminating can be dysregulating
- **Speaking in ways that connect clients to their resources:** intellectual, spiritual, sense of humor, ability to nurture

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Maximizing positive states, not just repairing negative ones

“... The earliest phase of [attachment formation] involves calibrating the infant-caregiver relationship in regard to maintaining a positive state for the infant. **The parent’s role in regulating negative arousal during the first year is** not simply to respond with comfort when the infant is disturbed, but **to avert distress by maintaining the infant’s interest and engagement in a positively toned dialog** with the social and physical environment.”

Hennighausen & Lyons-Ruth, 2005

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“The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

P = playfulness

A = acceptance

C = curiosity

E = empathy

Hughes, 2006

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“Leavening” Distress States with Positive States

“Playful interactions, focused on positive affective experiences, are never forgotten . . . Shame is always met with empathy, followed by curiosity. . . . All communication is ‘embodied’ within the nonverbal. . . . **All resistance is met with [playfulness, acceptance, curiosity, and empathy], rather than being confronted.**”

Hughes, 2006

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Transforming Shame and Self-Loathing

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Recovery = ‘Re-establishing ownership of
body and mind’

Four aspects to achieving this goal

1. “Finding a way to become calm and focused;
2. Learning to maintain that calm [despite stimuli] that remind you of the past;
3. Finding a way to be fully alive in the present and engaged with the people around you;
4. Not having to keep secrets from yourself, including secrets about the ways you have managed to survive.”

Van der Kolk, 2015, p. 203-204

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Learning to Think “Bottom-Up”

[Bruce Perry, 2010]

• **“The hardest parts of the brain to change are the lower levels. . . . Cognitive processing works when there is mature cortical and limbic development but not with early neglect and trauma.”** (Perry, 2010)

• This is the case **because “the brain’s biological imperative is the stress response.** Though repetition, strong [trauma-related] synaptic connections develop that need very infrequent re-activation to maintain them.”

• Because sensory input from the environment is perceived in the lower levels of the brain, **“by the time input gets to cortical levels, it’s too late.”** We have already reacted!

Fisher, 2011

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Bruce Perry’s Recipe for Trauma Treatment

• To address these challenges, we need trauma treatments that are:

- **Relational** (i.e., create safety in relationship)
- **Relevant** (developmentally matched)
- **Repetitive** (patterned)
- **Rewarding** (pleasurable)
- **Rhythmic** (resonant with neural patterns)
- **Respectful**

Fisher, 2010

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• **Relational** does not mean what feels relational to **US** but what enhances the client’s felt sense of safety and attunement: e.g., what does ‘relational’ mean to the client?

• **Relevant**: ‘talking about it’ is not always relevant to clients afraid of ‘it,’ overwhelmed by it, ‘forced’ to tell

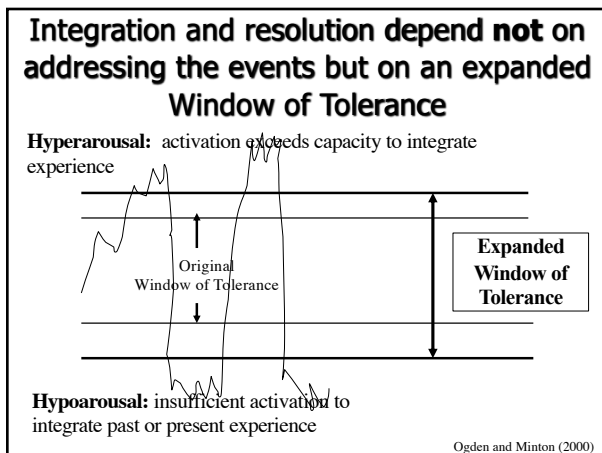
• **Repetitive**: the “Goodnight Moon” principle. Repetition is comforting and regulating to all of us

• **Rewarding**: choosing interventions that feel good, eg, interweaving distress with lightness, laughter, playfulness

• **Rhythmic** is regulating: trauma is not rhythmic

• **Respectful**: respecting the dysregulation, believing that all symptoms = the best possible adaptation

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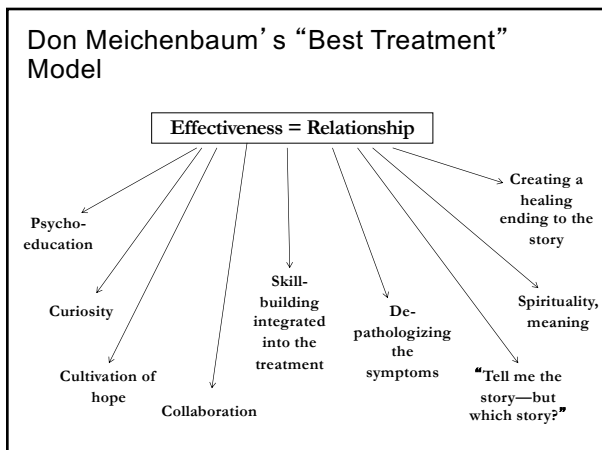


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“The biggest change in our understanding of trauma treatment is its goal. What is important is not the telling about the terrible things that happened but **the development of a healing narrative** with which the survivor can live now. . . ”

Donald Meichenbaum, 2014

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Neuralplasticity: changing the brain instead of the story

- **“Neuralplasticity** refers to the ability of neurons to forge new connections, even to assume new roles. In shorthand, [it] **means rewiring the brain.**” (Schwartz & Begley, p. 15)
- **“Plasticity is induced by changes in the . . . sensory stimulation** reaching the brain,” i.e. on what the client focuses cognitively, emotionally, perceptually, etc.
- **“With [directed attention and] neural firing, the potential is created to alter synapses by growing new ones [or] strengthening existing ones . . .”** (Siegel, 2007, p. 30). If old procedural learning is no longer helpful, therapy can be used to identify and practice new, more adaptive patterns that will eventually become new brain structures

Fisher, 2011

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What does neuralplasticity have to tell us about how to work?

- When you encourage clients to talk about their unresolved traumatic experiences, be aware of the risks, not just the benefits. **Remembering activates the body and reinforces the neural circuits holding the shame or fear**
- **Each time you interrupt** the client to ‘disrupt’ an old pattern, **you inhibit old neural circuitry** and give the client an opportunity to ‘grow’ other areas of the brain
- **Don’t be afraid to be repetitive!** Intensive repetition of new responses is of critical important for effective therapy. Rather than trying many things, it may be more effective to **do fewer things consistently and repetitively**

Fisher, 2010

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What else can neuralplasticity tell us?

- **“Doing is more important than talking.”** It’s important that we not get so caught up in our client’s stories that we miss opportunities for challenge and “doing”
- Most psychotherapies emphasize attention to one’s feelings, but neuralplasticity research cautions us to **be impeccable about mindful noticing of thoughts, feelings, and body**
- **Attention to empathic attunement should not prevent us from interrupting** to inhibit maladaptive patterns
- Catharsis provides temporary relief, but it doesn’t change brain structure or muscle memory. **Only repetition with focused attention actually results in physical change**

Fisher, 2011

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Teaching clients to inhibit old responses

- An important sensorimotor skill for helping clients to inhibit habitual responses is called **“dropping the content”** or **“letting go” of dysregulating thoughts and feelings** in order to choose a different focus of attention, one either neutral or resourcing
- For some clients, it can be helpful to **shift the focus away from the symptom or belief to the body**. For the less mindful, “dropping the content” should be followed by focusing on something concrete, such as their feet
- **Dropping the content challenges and inhibits obsessive focus on negative cognitions and emotions**. Practiced over and over, it results in neuroplastic change Fisher, 2008

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What does that mean for clinicians?

- It means having heightened awareness that **focusing on shame-related feelings and beliefs may reinforce the neural circuits holding them rather than resolving them**
- **Each time we ‘disrupt’ a shame pattern, we inhibit the old neural circuitry and create an opportunity** to amplify activity in other areas of the brain
- **Intensive repetition of new responses is crucial but very difficult to achieve with clients** whose shame is an automatic response. Shame may require more consistent disrupting and more frequent challenges
- In neuralplasticity-oriented treatments, **the therapist must provide more direction and less listening** Fisher, 2011

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Mindfulness of shame is a gentle challenge

- **Mindful concentration is associated** with increased activity in the medial prefrontal cortex and **decreased activity in the amygdala**, thereby regulating arousal and widening the window of tolerance
- Helping clients notice the physical sensations of shame separate from the beliefs and behavioral responses is mindfulness. The more mindful detachment from an emotion, the less overwhelming it is and the less likely to be acted out
- **Mindfulness discourages the negative self-talk** and cognitive distortions that exacerbate shame. In a mindful relationship to our symptoms, we don’t judge them Fisher, 2020

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*“Although mindfulness is often seen as a form of attentional skill that focuses your mind on the present, [we can also see] mindfulness as a form of healthy relationship with oneself. **That is, mindful awareness is a form of intra-personal attunement. Being mindful is a way of becoming your own best friend.**”*

Dan Siegel

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The “Flow “ of Psychotherapy

•**Focus first on ‘dyadic dancing:’** a therapeutic alliance requires an ability to “dance” with the client in a way that will either enhance or disrupt treatment. **How does s/he want us to dance?**

•**Become the client’s neurobiological regulator** so that both of you gain confidence in your ability to stay attuned and guide the client back into a regulated state as needed

•**Take on the Consultant Role:** become a teacher or guide more than a ‘therapist.’ “This is what your symptoms mean as an expression of trauma—yes, you got really triggered, and you didn’t know it—most trauma survivors struggle this way.”

•**Cultivate curiosity and mindfulness** first and foremost: only a mindful patient will make progress!

Fisher, 2004

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Make Sure to Have a Frame

•**A “frame” is the concept or theme around which all sessions are organized.** With frontal lobes that under-function or are often inhibited, ashamed clients need simplicity and repetition to integrate the work. To get integration, we have to work methodically step-by-step

•**A frame might be:** regulating autonomic arousal, increasing the ability to observe patterns instead of judging or interpreting them, challenging “stuck” patterns, building resources for modulating arousal, awareness of parts, unblending from parts, internal communication, growing a Wise Self, nurturing young parts as a way of alleviating distress

Fisher, 2009

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The “Flow,” cont.

•**Have an ‘end in mind’**: How can I help this client have a different experience of him- or herself today? How can I help him be “here” instead of “there”? “How can I stay curious and mindful? How can I let go of **my** need for this to be different?”

•**Prepare the client** for whatever needs to be done: use psychoeducation to set the stage, to develop somatic resources and top-down coping skills, increase confidence, expand the Window of Tolerance, substitute mindful awareness for judgment

•**“Put a toe in the water:”** is this the right time for this intervention? Use experiments to determine the client’s readiness AND ability to integrate the work you want to do

•**Challenge**: Don’t wait for the client to **BE READY!** Challenge habitual patterns: point them out with empathy and humor, use psychoed to explain the need for practice of new responses. Fisher, 2008

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“The Flow,” p. 3

•**Cultivate curiosity and compassion**: your own as well as the client’s! If the client reacts negatively, get more curious and more compassionate. How does it make sense?

•**Timing is everything**: Cultivate the ability to sense the client’s points of readiness. At the right time, after enough challenging of the habitual patterns, you can make that right intervention you have always wanted to make!

•**Prepare for backlash**: Progress almost always triggers backlash in trauma survivors. Change is threatening; the unknown is threatening; success or pleasure is even more threatening. Normalize the backlash: “Now watch for the next wave . . .”

•**Keep the focus on the present moment**: insist that patient avoid over-focus on the past or the future Fisher, 2009

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The ‘Negativity Bias’

•Presented with negative and positive stimuli, **the human brain is biased to attend to the negative**. While the emotionally neutral left brain is biased toward the positive, the more emotional reactive right brain is biased toward the negative, as is the amygdala, two thirds of whose cells are dedicated to scanning for negative or threatening stimuli

•Hamlin et al (2010) observed that **the negativity bias is operative at ages as early as six months of age**

•When limbic activation “highjacks” higher levels of the brain, the prefrontal cortex can no longer dispute the negativity bias with logical data, leaving the limbic system “in charge” of our perceptions Fisher, 2013

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The ‘Negativity Bias,’ cont.

- With a ‘better safe than sorry’ bias, **“locked and loaded dedicated circuitry”** (Hanson, 2014) in the brain **stimulates automatic over-reactions to normal stress** via increased cortisol production, irritability in the amygdala, and emergency alarm responses.
- When limbic activation “highjacks” higher levels of the brain, **the prefrontal cortex can no longer dispute the negativity bias with logical data**, leaving the limbic system unmanaged and “in charge” of our perceptions
- We need to help clients “take in the good” by teaching them to deliberately internalize beneficial experiences and encode them as implicit rather than explicit memories Fisher, 2015

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“While we are failing to install positive states, negative mental states are rapidly being converted into traits via the negativity bias. The negativity bias includes loss aversion, greater motivational focus on the negative, hyperfocussing on and/or scanning for negative stimuli, and over-reactivity to negative stimuli versus positive.”

Hanson, 2014

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Five Essential Components of Trauma Therapy [Barrett, 2014]

- **Attachment:** connection to therapist, self, other; cultivation of curiosity and compassion
- **Safety and empowerment:** predictability and consistency, structure, skill-building
- **Value:** feeling valued, collaboration, re-valuing of the story and cognitive schemas
- **Skills:** new learning and practice
- **Hope:** our hope = the client’s hope

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The Challenge of “Giving Up” Shame States

- If the shame state once felt “safe,” then **it may be frightening to be without it**. The client may feel less safe
- Chronic hypoarousal creates affect intolerance**: even a little bit of emotion can be experienced as overwhelming. If the client “gives up” the shame, s/he will feel more
- If the shame has helped the client to be more invisible, to “fly below the radar,” **lifting of the shame may cause increased anxiety about visibility**
- And if the shame represents a communication from a depressed Submit part, **efforts to “treat” it can backfire** if these appear to be a way to ‘shut up’ Submit

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The Challenge of “Giving Up” Shame States, cont.

- If the client’s body has historically felt safer in a shame state, it is a sign that we have to move slowly in therapy**
- Psychoeducation about the role of shame or the ashamed part in the client’s survival can increase his/her curiosity—less threatening as a new feeling state
- We have to clients about what they will lose if they give up their shame**: will they feel too visible? Too relaxed? Are they afraid to feel deserving? What would it mean if they were not at fault? Will their bodies rebel?
- Creativity may help**: what if the client asked the part to give up 10% of the shame? Or 5%?

Fisher, 2020

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In the face of stuckness or resistance,

- Become even more curious**: how is the stuckness protecting the patient? What would s/he lose if progress was made? What might be threatening about that in the light of the trauma?
- Let go of your need for their progress**: cultivate the ability for ‘radical acceptance,’ not needing the patient to do more or different. It is OK for patients to choose stuckness.
- Consider attachment issues**: is the shame attachment-related? Would the client be disloyal if s/he gave up the shame?
- Look for internal struggles between parts**: stuckness often = gridlock. Parts holding different survival imperatives cannot trust each other or agree on a common goal: e.g., judgmental parts keep child parts ashamed while the client struggles to feel better

Fisher, 2008

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Principles of Trauma Treatment

- “The symptoms tell the story better than the story”
- “*Slower is faster*”
- If it isn’t working, we’ve given the client “too much to chew”—make it smaller or smaller yet
- *Simplicity is the key to complexity*
- Repetition facilitates new patterns
- Remember: “*The goal of trauma treatment, no matter what modality we employ, is to be ‘here’ instead of ‘there.’*”

(van der Kolk, 2002)

Fisher, 2009

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Trauma is overcome through practice, not redemption

*“I believe that **we learn by practice**. Whether it means to learn to dance by practicing dancing or to learn to live by practicing living, the principles are the same. . . . Practice means to perform over and over again in the face of all obstacles, some act of vision, of faith, of desire. **Practice is a means of inviting what is desired.**”*

Martha Graham

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