The Way a Shame Posture Impacts Emotions (And How to Bring Clients Out of It)

Dr. Buczynski: When a client slips into a posture of shame, how can we help bring them back?

Dr. Peter Levine has studied the many ways we manifest feelings in our body.

One thing he found is that posture can have a direct effect on how a person experiences emotions.

Here, Peter shows how shame transforms the body, and a practical way to release it.

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Dr. Levine: What you see in shame is a very particular body posture and autonomic pattern, which is fairly similar to what you see in trauma.

I don't think people really appreciate how important this is – whenever a person is traumatized, even if it wasn't in an interpersonal dynamic or interpersonal relationship, the posture of collapse is very similar in trauma as it is in shame.

Shame and trauma fit together. You also see with both an aversion of gaze, of looking away, of not wanting to be in contact with another person, because the pain of the shame or the trauma is so devastatingly intense.

Actually, there's some recent data… I was just teaching a class together with Bessel van der Kolk here in Zurich and there's a very interesting fMRI…

If you show a person a picture of a friendly face, it lights up in the prefrontal cortex. In other words you say, "OK, that's a friendly face – that's nice – that feels good."

Now, if you play that same face to someone who's traumatized, or is in shame, the prefrontal lobe actually shuts down, and the periaqueductal gray in the brain stem lights up, and that's the part of the brain stem that's associated with fear and terror and paralysis or immobility.

This is a mistake that often psychotherapists make. They'll see that the client is in shame, and they try to be kindly – they try to be supportive – try to somehow make them feel better.

If you look back at that study, you'll see that when you do that, clients just shut down even more and go even further into the shame. As the therapist tries even more to get them out of the shame, it forces their clients back into the shame.

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It's a difficult situation, and without understanding that, therapists can easily increase the level of shame.

What I generally do when I work with a client, is I work with two chairs, and they're kind of facing out at a 45 degree angle.

The client can either be completely in their own space, or if they choose, they can make contact with me, but they're not forced to do that – if you're looking face to face, there's no way of getting away from that.

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It's important for therapists to be aware of how they arrange their seating and to be aware then of what happens if they try to make contact with a person who's in a state of shame.

There are so many approaches to shame, but the most relevant and beneficial has to do with the posture of shame.

When I started to think about shame and how to work with it, it was about 1972 or 1974, and I spent a lot of my life at the graduate library at UC Berkeley in they call the catacombs – the stacks – this, of course, was way before computers.

I came across a book by a woman named Nina Bull called The Attitude Theory of Emotion[1], and what she showed was remarkable, and when I read this, I said, "My god, that's exactly what I am seeing with my clients," as I was beginning to develop the SE (Somatic Experiencing) work.

She would give a person a particular emotion like fear or anger. They would either visualize or even just say the word.

Then the person would report what they were noticing – what sensations they were noticing in their body. There was also an observer present who was writing down what they observed in the person's posture.

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She would put the person in an emotion, and then she would lock in that emotion in something like hypnosis – I would call it action imagery or motor imagery or postural imagery.

As long as the person was locked in that posture, you could give them any other emotion and they would not be able to feel it… If they were in fear and you gave them joy, or anger or surprise... whatever you gave them, they could not feel that emotion as long as the posture was locked in the emotion, for example, the state of shame.

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I started to realize that when a person is in a posture of shame, the shame aspect will continue until you've changed the posture.

So, here's what I would do. I would, again, not face the person, and often I wouldn't even say anything about the shame.

I might start by saying, "I'd like to do a little exercise with you, if you're willing, and here's what I'd like to have you do. I'd like you to follow me – follow what I'm doing with my body."

So, I would feel the quality of shame and allow my body to fall into this helpless collapse.

Then, I would encourage them to see if they could very delicately increase that posture, but then to noticewhere it seemed to rest, and maybe even wanted to come back to the other direction.

They would be in a shutdown posture like this, and the experience of that is no energy – they're hopeless and helpless.

They would very slowly move… Again, it's not a matter of getting up – a lot of times people with shame try to change their bodies in such a way that they won't be feeling the shame, but the shame is there all the same and you see it in, for example, narcissistic individuals.

By just slowly moving out of the posture (of shame) – the person starts to notice, "Oh my god, I'm feeling better. I feel energy coming back. I feel more sensible, alive, and a little tingly."

The polarity of shame is pride or triumph, and when you gradually have the person come into this new posture, as with Nina Bull's experiment, the chest opens – you feel a sense of pride, a sense of goodness, and a sense of triumph.

Then, from that vantage, you can look at the shame and dissect it – you can work with it.

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Dr. Buczynski: Peter made a comment early in his talk – a warning about not approaching a client's shame with kindness. It's a small adjustment that can have a tremendous impact.

To get some more perspective on this, let's hear from Dr. Ron Siegel, Dr. Kelly McGonigal, and Bill O' Hanlon.

Dr. Siegel: My friend Chris Germer uses the term backdraft to refer to what goes wrong here – it comes from firefighting. When a firefighter opens a door to a room where there's a flame, oftentimes that opening of the door lets in oxygen and then there's a huge conflagration and things get quite out of control in that moment.

I think we therapists run into that a fair amount of the time, where we move toward the pain. And we run into it particularly around shame because, while ultimately air and light is what will cure shame, in the short run, when you bring air and light into shame, it flares up because it is so painful for people to be seen as being in their shame.

Eventually I think we move to a point where we can feel it, acknowledge it, and bathe it in self-compassion and compassion from the therapist, others, and air and light as healing. But we've got to pace ourselves.

Dr. Buczynski: Yes. The idea of something that we normally train ourselves and our graduate students to do being inadvertently harmful is a really important point to talk about.

In addition to wisdom and compassion, I would add timing. I think timing really matters. And sometimes the experience is overstimulating for someone, as well as making them feel vulnerable and weak at a time when they maybe aren't able to feel that and don't have a good enough rapport.

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Dr. Siegel: Yes. I've heard Marsha Linehan talk about this also. When it comes to treating people who are very emotionally volatile (folks who might have borderline personality disorder), a big frustration of Marsha's is that therapists are most comfortable leading with love.

But this can be destabilizing for that population. And it kind of makes sense – that population typically has a lot of trauma history and not a lot of secure attachment history.

Dr. Buczynski: Right. Ruth Lanius used to talk about people who have early childhood trauma and neglect had a hard time with eye contact – that if you look at them in the eye, they feel known and disgusted, and they really find it way too hard to tolerate.

So I guess it makes me think that anyone who thinks they can do therapy without the training really is unwise because there are so many ways that "a good idea is a good idea when it's a good idea…" and not at other times.

Dr. Siegel: And this is where Peter Levine's structural intervention of, "Let's sit at a 45-degree angle" is a very nice idea because it allows more flexibility and allows the client to take the lead in showing us just how much intimacy they would like at this moment.

Dr. Buczynski: Right. And yes, they can control the space.

Dr. McGonigal: The function of eye contact in supportive or positive social interactions is that it starts to trigger the release of oxytocin and other neural hormones that help people bond. That doesn't always happen with people who have a history of trauma or abuse – but it's more likely to happen with an animal than with a human.

I think about these great studies showing the benefit of gazing at a dog or gazing in a horse's eye. Can you make eye contact with both of a horse's eyes at the same time? I don't know – I haven't worked with equine therapy.

But it makes me think about what a powerful practice that is for many people who've experienced abuse or trauma – that the ability to accept a loving or accepting gaze could come from an animal first.

Mr. O'Hanlon: I've had experience with this. I had a client who was really deeply ashamed and felt inadequate in almost all situations. I don't want to say the specifics of it, but she was in a position where everyone expected things from her, and some of them were bound to be disappointed.

That would just drive her deeply into shame. And then she would function less well, and she'd get more criticism. So it was a really bad spiral she was in. She was in danger of losing her job because of it. I didn't realize it at first, but after I had seen her for a few weeks, she used to go into this kind of withdrawal where she would sit in the chair in the therapy room, and she would almost go into an infantlike withdrawal.

She would just pull into herself – she wouldn't suck her thumb necessarily, but it looked like she was doing that.

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She was just going back to almost infancy, kind of protecting herself when we would talk every once in a while. And then it would take her a few minutes to come out of it, and it would really interrupt the therapeutic flow.

After about three or four weeks I realized something I was doing was triggering that. It was that I'm a fairly optimistic person, and I tell stories, as I mentioned. And my stories all had this structure: somebody was having great a difficulty; they would struggle; and then they would find themselves in a better place.

And right after I told the story, maybe three or four minutes, she would start to pull into herself and go into

that very fetal kind of thing.

I said to her, "I think that my stories are triggering this for you." She hadn't realized it. She just felt it.

And then she said, “I think you’re right, because as soon as I hear one of those stories, I think ‘I’m not going to be a good enough client for you. I’m not going to be like those people. I’m never going to get there, and you’re going to be disappointed in me,” and it would trigger her shame.

So I started telling stories about people who were stuck and people who weren’t doing well. And she straightened right up and felt really good.

I thought, I have to adjust my style, because somehow, inadvertently, even though I was trying to support her, I was triggering the shame in some way. I had to adjust my usual style.

And that was a great learning for me, that what usually works with people — because for most people, that’s really helpful — was the exact opposite with her. She was so driven by and hurt by shame, that anything I said that she could compare herself to would drive her deeper into shame.

Dr. Buczynski: I appreciated those different views on safe ways to approach a person’s shame. Now, a shame posture can also be connected to trauma.

In the next module, we’ll look at one unconventional way to work with trauma-based shame.

I’ll see you then.

1. Bull, N. (1951). *The Attitude Theory of Emotion*. Nervous and Mental Disease Monographs, 1951.