Healing Shame: A Gestalt Perspective

Kenneth R. Evans

Abstract

A case example is used to describe the phenomenology of shame, its origin in early childhood, and its maintenance in adulthood. Shame is viewed as a defense against an abuse of power in the original infant-caretaker relationship. Healing may be realized through an emotionally corrective relationship based on dialogical Gestalt therapy which emphasizes a horizontal (equal) relationship between therapist and client. Gestalt and dialogic encounter are described in terms of three major characteristics: inclusion, presence, and commitment to the "between."

The shy person . . . is physically and constantly conscious of his body, not as it is for him but as it is for the Other. . . . We often say that the shy man is "embarrassed" by his own body. Actually this is incorrect; I cannot be embarrassed by my own body as I exist in it. It is my body as it is for the Other which embarrasses me. (Jean-Paul Sartre, cited in Mollon, 1984, p. 212)

Definition

Shame and guilt are, in part, different ways of perceiving the other with regard to the use of power. With guilt, the other is seen as the injured party with the self causing the injury. With shame there is a sense of inferiority in which the other is perceived as more powerful and capable of inflicting injury on the self, usually via scorn, contempt, or humiliation. Submissive behavior is probably the most important social adaptation that human beings have developed in order to survive in the presence of a more powerful and potentially dangerous other (Chance, 1988). In order to minimize the possibility of threat, a person sends nonthreatening signals to the more powerful other, for example, avoiding eye contact, physically shrinking back, withdrawal, and hiding. A shame response is thus a creative way of adjusting (surviving) in a threatening environment.

The following case example is used to illustrate the phenomenology of shame, how it develops in early childhood, and the ways it is maintained in adulthood.

Development

From the age of ten weeks to four years, Tom spent most of the day in a children's swing which was suspended from the kitchen ceiling and constructed so that he could not fall out when left unattended. In this way his mother could keep an eye on him. Tom was an unplanned baby born into a poor coal-mining family. His maternal grandparents lived in the house next door and disapproved of his father, who spent long hours at work. Tom's mother, an anxious and inadequate woman, was caught in the cross fire between her husband and her parents and tried to please both sides. At her wit's end, her resentment and frustration were often displaced onto Tom. With a face contorted with hate, she would unleash her pent-up fury on him by shrieking verbal insults—threats of violence and abandonment—if he "made demands of her." Imprisoned in his swing and under the relentless spotlight of his mother's hatred, Tom developed what in Gestalt is referred to as a malevolent Top Dog and looked on himself with disgust. For Tom, shame was experienced as an inner revulsion against his own existence.

I wish to acknowledge the teaching of Gary Yontef, Ph.D., a leading exponent of Gestalt as a dialogic method. This article was originally presented at the joint International Transactional Analysis and USA TA Association Conference in Minneapolis, Minnesota, October 1993.

Shame develops prior to cognition and is the result first of osmosis and then of isolation. (Introjection requires a more advanced level of self-other boundary that develops with cognition.) *Osmosis* may be described as the passage of a strong solution to a weak solution across a semipermeable membrane in such a manner as to equalize their concentration. As a baby, Tom did not have a sufficient self-other boundary to resist mother's onslaught. In Gestalt, this symbiotic relationship is referred to as *confluence* (Figure 1).

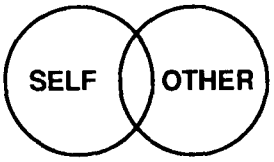

Figure 1
Confluence

Tom defended himself against being overwhelmed by internally withdrawing from mother behind a wall of adaptation (submissive behavior). In Gestalt, this process is called isolation (Figure 2).

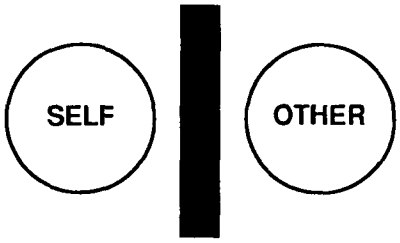

Figure 2
Isolation

From the defense of isolation, shame is born. In hiding from mother, there is—phenomenologically speaking—no other to differentiate from and be defined in relation to. In isolation, Tom overcame this problem by creating a split inside himself and developing a relationship between parts of himself. In Gestalt, this process as referred to as *retroflection* (Figure 3).

Through retroflection, a person does to himself or herself what he or she really would like to do to someone else, for example, "I am angry with myself," as if "I" and "myself" were two different people.

A shame-based system is said to be complete when retroflection and projection operate

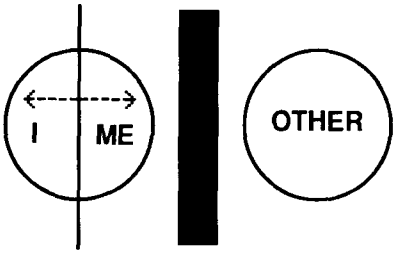

Figure 3
Retroflection

simultaneously, that is, when I think about myself and feel toward myself what I imagine the other person is thinking and feeling toward me (e.g., contempt, loathing, disgust, etc.). I look at myself as if there were a mirror in front of my eyes. I think I am looking outward into the world, but I am reflecting back my own imaginings (projection) and then punishing myself (retroflection).

Description

Physically, Tom experienced shame as a sudden implosion, as though the pit of his stomach were collapsing in on itself. This was accompanied by blushing and sweating. In such moments, what Tom most wanted was for the ground to open and swallow him up, that is, he wanted to hide, but at the same time he felt he was transparent to all around him. Furthermore, Tom had no conscious awareness that what he was experiencing was shame, and so he felt stupid and hopeless, believing there must be something fundamentally wrong with him. Early defenses like freezing and turning away are experienced psychologically and affectively because they develop prior to cognition and therefore appear incomprehensible (Fraiberg, 1982/1983).

Tom attempted to defend against his shame through achievement and pursued a successful professional career. However, he felt any kind of criticism deeply and strove for perfection. If he made the slightest mistake in public, he quickly and unmercifully reprimanded himself before anyone else could do so. In the event of feeling foolish, he would make himself the butt of a joke—in case someone else made a fool of him. Tom's self-criticism and self-mockery were probably more ruthlessly

humiliating than anything anyone else might have inflicted on him. The importance of self-humiliation, however, was that it gave Tom some control over a situation that might otherwise have felt overwhelming.

Treatment

Tom's story reveals four major factors that are associated with shame:

1. An abuse of power, usually by the primary caretaker.
2. Withdrawal or isolation on the part of the child, usually behind a defensive wall of adaptation.
3. A feeling of disgust and contempt toward oneself or, conversely, a lack of love toward self.
4. Incomprehension.

Shame develops in relationship, and its healing may be realized through an emotionally corrective relationship that addresses all four of these factors.

Gestalt as a dialogic encounter seeks a relationship in which power is horizontal (equal) rather than vertical, and that treats the other as a person and not as an object to be manipulated or controlled (Yontef, 1991). It emphasizes a mutuality of contact that gently and respectfully calls the person out of isolation. As the person's inner self comes out of hiding and emerges into awareness, self-loathing is gradually replaced with curiosity, excitement, and eventually love. This is a consequence and not a goal of Gestalt therapy.

The goal of Gestalt therapy is to enhance awareness, not to directly seek change. The Gestalt theory of change is that the more one attempts to be what he or she is not, the more one stays the same (Beisser, 1970). Thus, the therapeutic task is to enhance awareness of what *is* through the dialogic I-Thou relationship and by utilizing phenomenological focusing. The goal of awareness is a process goal—not a goal of content or direction. The focus in Gestalt therapy is on an exploration of what is, and this includes accepting that being stuck, frustrated, or sad, IS! Accepting what is leads to accepting the entire person, and it is with this kind of support that a client may begin to emerge from hiding.

At some point in therapy—usually later—it is important to name or label the emotion of shame to bring it into cognitive awareness. In the ancient world, to discover the name of one's enemy was believed to grant power over the enemy. Shame may be called the "enemy within." To understand what one is experiencing brings some understanding over what otherwise seems incomprehensible.

Dialogic Encounter

Dialogic encounter is a form of relating based on Buber's I-Thou contact (Hycner, 1985). Contact between people requires the appreciation of difference, that is, the ability to acknowledge what is self and what is other when moving toward connecting with the other and when moving toward separating from the other.

Between self and other are boundaries. A boundary is a process of connecting and separating and not a fixed entity. At one extreme, a closed boundary is like a brick wall inside that the person closes to the outside; after doing so, the individual moves toward self-nourishment (isolation). At the other extreme, a boundary that is too open results in the individual being overwhelmed by the other so that the flow of connecting and separating is lost (confluence). Healthy boundaries are permeable enough to allow in nourishment, but closed enough to maintain sufficient autonomy and to keep out what is toxic. In isolation a person habitually withdraws from the boundary and connection is avoided, whereas in confluence the separating aspect of contact is lost and there is only fusion. In both confluence and isolation, there is no appreciation of difference so there can be no true meeting of two separate people, that is, no contact.

In order to make contact, a person must show as much of himself or herself as meets his or her needs and the demands of the moment. Other needs are kept in the background. As his or her needs are satisfied, or the situation changes and those needs move into the background, other needs come into awareness. Awareness may be likened to a ball floating on the sea. As the water moves, so the ball moves around and what was on the surface goes below. Moving toward and away from the other requires, over time, a sharing of different aspects of oneself. Without movement, some aspects of oneself will be kept in the background and unavailable for sharing with the other. It would be as if the water surrounding the ball froze: Movement in and out of

awareness would also be frozen. With no movement, there can be no new awareness, and contact is replaced by rigid and habitual behavior.

With true contact, boundaries need to be flexible enough to go from one degree of openness/closedness to another. The regulation of the boundary along the open/closed continuum (confluence/isolation) requires awareness, and the medium through which awareness is enhanced and the person restores natural organismic regulation (lost developmental momentum) is the I-Thou dialogic relationship.

Power

The I-Thou relationship is a highly sophisticated form of human interaction. The "I" may be the "I" of an I-Thou, or the "I" of an I-It. The "I" of an I-It relationship addresses another person as "he," "she," or "it"; that is, the other is not related to as a person. The "I" of an I-Thou speaks to "You," and the other is directly related to as a person. The attitude of I-Thou is that the other is entitled to respect and should not be treated as an object to be manipulated or as a means to an end. "It" relations are vertical whereas "Thou" relations are horizontal.

The medical model, in which a sick client receives interventions directed solely by the therapist, is an example of a vertical attitude. In such treatment, something is done to the client, who is then not left with a sufficient notion of how to foster his or her own growth. The client is infantalized, and the therapist achieves power at the client's expense. When someone is treated as an object to be analyzed, that person is being treated as an It. In I-Thou relating, both client and therapist speak the same language of present-centered relatedness, and they work together as equals. In classical psychoanalysis, client and therapist speak a different language. The client speaks the language of free association, whereas the therapist speaks the language of interpretation. Power is not equal.

The therapist, like the client, is not a means to an end, but is also seen as a person. The therapist is not simply a vehicle for the client's self-realization. If this were so, then the therapist would not be present as a real person. His or her presence would be reduced and thus the opportunity for true contact would be diminished.

Mutuality of Contact

The horizontal relating at the heart of the dialogic relationship is a direct challenge to the abuse of power in the original infant-caretaker relationship. It is further enhanced through a mutuality of contact that has three important characteristics: inclusion, presence, and commitment to the "between" (Yontef, 1991).

Inclusion: Inclusion means living at the pole of the other in the I-Thou polarity (Buber, 1947/1965) and at the same time retaining one's own identity, that is, trying to experience what it is like to be the other as well as staying in touch with oneself. The therapist enters the phenomenological world of the client and attempts to see the world through the client's eyes. Thus, one simultaneously forms a relationship with the client and begins to understand him or her. The Gestalt therapist puts aside his or her own values and appreciates the validity of the client's beliefs without judgment. The client is seen and accepted, and gradually this allows him or her to show a little more of himself or herself to the therapist. As often as not, the client finds more of himself or herself in the very process of sharing. That which was hidden from the world and the self begins to emerge into awareness. This process is enhanced through the therapist being really present.

Presence: When practicing inclusion, the therapist maintains enough of his or her own identity to be able to reveal himself or herself to the client. If the therapist is frightened but tries to look strong, or angry and tries to look caring, or bored and tries to look interested, then he or she is only giving the impression of being present and is not being genuine. Clients with a shame-based system easily pick up inauthenticity and will simply withdraw. This may go unnoticed at first, even by the more sensitive therapist, because the client is particularly skilled in appearing to be present when he or she is not. Contact will sometimes mean giving accurate feedback even when it may not be wanted. In a dialogic relationship, caring includes being honest, although not in a brutal way. By modeling self-disclosure, the therapist encourages the client to be who he or she really is.

Commitment to the "Between": Mutuality of contact requires the practice of inclusion, presence, and a commitment to the "between." This means both therapist and client relate what they experience of self and other and respect

what the other experiences in turn, allowing the outcome to be determined by the "between" rather than it being controlled by either person. Letting go of solitary control means that each is affected by the differentness of the other; there is an allowing of what arises "between" to direct the process. Showing oneself rather than pretending to show oneself and allowing that which is "between" to control is an act of faith in the process that is confirmed by clinical practice. It is also an act of love. This is true both for the therapist and the client. Each time the client responds to the therapist with an attitude of I-Thou, the client grows a little in trust and self-acceptance. Over time, the malevolence of the Top Dog diminishes, and the client increasingly looks at himself or herself with affection.

Qualification

This level of mutual contact requires that both parties be available for and able to support themselves. This is rarely possible for the client in the early stages of therapy. It usually evolves after preparatory work involving, for example, phenomenological focusing and the acknowledgment of resistance, after which clients may have enough self-support to be sufficiently themselves and thus to connect and separate—that is, to sustain contact. During the early stages of therapy, the client will usually have less awareness than the therapist. Indeed, if the client saw the therapist as accurately as the therapist saw the client, then there would be no possibility of working through any transference distortions in the relationship. Even in the latter stages of therapy, mutuality of contact is never complete, because the therapist's task remains his or her own. The contract is to focus on the client, and it is the therapist's responsibility to come to the therapy hour prepared to set the climate for dialogue, practice inclusion, share his or her presence, and commit himself or herself to dialogue. Anything less is exploitation. However, although there is a differentiation of task, no hierarchical system is intended or encouraged; the relationship seeks to be horizontal, not vertical.

Conclusion

In a recent book on countertransference, Maroda (1991), writing from within the psychoanalytic tradition, said that if we are committed to facilitating long-term treatment, then "our level of expertise can only be as great as our level of self-awareness and our capacity to bear being seen realistically by others" (p. 65). This is particularly true in working with clients who suffer from shame. Shame is a closed system because it leads to isolation and hiding, which, in turn, enhances the feeling of shame. Therapists can rarely, if ever, successfully take clients through what they have not gone through themselves. This being so, it is necessary for therapists to face their own "enemy within" if they are going to be able to facilitate clients to a greater level of self-awareness and "capacity to bear being seen by others."

Personally, I do not believe I can ever be fully "cured" from experiencing the emotion called shame. Facing the enemy within has meant my accepting this enemy, which has greatly diminished the enemy's power—I am no longer ashamed of being ashamed. It is an emotion I can choose, when appropriate, to disclose to my clients along with anger, fear, sadness, and joy.

Kenneth Evans, B.Sc., Dip. Soc. Admin., Dip. G.P.T.I, is director of the Sherwood Psychotherapy Training Institute, Nottingham, England, an associate of the Institute for Integrative Psychotherapy in New York City, and President of the European Association for Psychotherapy. Please send reprint requests to: Sherwood Psychotherapy Training Institute, Thiskney House, 2 St. James Terrace, Nottingham NG1 6FW, United Kingdom.

REFERENCES

Beisser, A. (1970). The paradoxical theory of change. In J. Fagan & I. L. Shepherd (Eds.), *Gestalt therapy now: Theory, techniques, applications* (pp. 88-92). Middlesex, England: Penguin Books.

Buber, M. (1965). *Between man and man* (R. G. Smith, Trans.). New York: Macmillan. (Original work published 1947)

Chance, M. R. A. (1988). A systems synthesis of mentality. In M. R. A. Chance (Ed.), *Social fabrics of the mind* (pp. 37-45). London: Lawrence Erlbaum.

Fraiberg, S. (1983). Pathological defenses in infancy. *Dialogue: A Journal of Psychoanalytic Perspectives, Fall,* 65-75. (Original work published in *Psychoanalytic Quarterly, 51,* 612-635, 1982)

Hycner, R. (1985). Dialogical Gestalt therapy: An initial proposal. *The Gestalt Journal, 8,* 23-49.

Maroda, K. J. (1991). *The power of the countertransference: Innovations in analytical technique* (Wiley

Series in Psychotherapy and Counselling). Chicester: Wiley.

Mollon, P. (1984). Shame in relation to narcissistic disturbance. *British Journal of Medical Psychology, 57,* 207-214.

Yontef, G. M. (1991). Recent trends in Gestalt therapy in the United States and what we need to learn from them. *The British Gestalt Journal, 1,* 5-20.