Shame: An Integrated Approach to the Pre-verbal Becoming Verbal

Robert Shaw

This paper briefly examines some of the current debates on shame, and considers the body and its links with shame, concluding with a case study and client commentary.

Robert Shaw is a UKCP Registered Integrative Psychotherapist and a Registered Osteopath in Private practice. He is a trainer and clinical supervisor at the Sherwood Psychotherapy Training Institute, Nottingham, UK.

Shame begins as a largely wordless experience.
Kaufmann (1993: 19)

Only recently has shame been the subject of the psychotherapeutic gaze. This may be due to the elusiveness of shame. Kohut (Morrison, 1994) has used the term 'nameless shame', and yet, while shame seems elusive, it appears to be a common experience. Shame, therefore, presents psychotherapy with a paradox.

The aims of this paper are to review the current debate on shame, and to explore the pre-verbal nature of shame. This exploration will involve a theoretical integration of the work of Reich, the developmental theorists and the self-psychologists. I shall then develop these arguments by the introduction of shame as a pre-verbal phenomenon. This links to the phenomenological notion of lived-body experience. Thus, this paper will also discuss shame within the context of pre-verbal lived-body experience.

The employment of phenomenology will help develop my integrationist argument and provide an opportunity to move the discussion of shame towards the interpretative social science philosophies, which give significance to subjective experience. In order to highlight these arguments and extract the salient features of the discussion, I shall present a case study. The paper concludes with the client's perspective on our therapeutic work.

Review of the current debate on shame

There is, without doubt, an increasing interest in the construct of shame within contemporary psychotherapy. Shame appears

to be a ubiquitous human experience, and it seems to cross cultural and gender boundaries (Kaufman, 1993). The omnipresence of shame may account for the popularity of Silvan Tomkins's work which is frequently referred to in the literature on shame (Kaufman, 1993; Cornel,l 1994; Erskine et al., 1994; McClendon and Kadis, 1994; Nathanson, 1994; Gilbert et al., 1996). Tomkins views shame as one of the nine innate affects and thereby locates shame as a biological and universal phenomenon in one fell swoop. Although the use of the term 'innate' has echoes of some form of biological determinism, it can be argued that, by naming the affects, Tomkins has allowed for the possibility of describing and naming shame. This does help to solve Kohut's 'nameless shame' problem, and provides a framework within which to begin looking at shame.

If shame is a universal phenomenon, then perhaps the question to ask is how can it also be elusive? Kaufman (1993) provides us with the notion of shame-based syndromes as a potential method for answering this question. In this concept, shame becomes intrapsychically internalised. In the process of internalisation, shame is learnt and simultaneously experienced via relationship. Thus, the painful experience of shame within the therapeutic relationship is often very well defended, hence its elusive nature.

There would, therefore, appear to be two types of shame response: the first, an innate biologically driven affect and the second, a response learnt in relationship which becomes internalised. The first can occur only when in response to the here and now environment; the second can occur either within a relationship or when one is alone and can recall the internalisation that engenders pain and discomfort. It is this latter aspect of shame that has aroused the interest of psychotherapists, although it is interesting to note that the predominance of therapists who are currently exploring shame come from the humanistic psychotherapeutic traditions which emphasise the importance of the relationship in therapy. These authors fall into two categories: those from a psychoanalytic self-psychology school, and those from the existential humanistic therapies.

If we look at the first of these groups, much is made of the self-psychology work of Heinz Kohut. Morrison (1994) describes shame as being about the whole self, and links this to the work of Kohut, who was interested in the self's experience and the emergence of self object needs. Morrison (1994) goes on to suggest that shame results in 'a self buffeted or ignored by nonattuned, understimulating and inadequately responsive self objects'. In response to Morrison's paper, Lansky (1994a) and Fosshage (1994) underline the importance of self-psychology in helping to understand shame. Lansky views shame as a defence against awareness, and Fosshage suggests that more attention needs to be paid to the relationship between shame and narcissism. Fosshage also provides an argument for shame being a response to ward off others who may be experienced as

attacking, and asserts that shame is a clear message to care-givers that help is required. Thus we see the potential for misattunement, and see that this could provoke an internalised shame response.

Lansky (1994b) develops his argument with a connection to object relations theory by stating that 'the problem with shame is inextricably tied to the problem of what one needs an object for'. He therefore locates the potential for shame responses at an early development stage which, I suggest, must be pre-verbal. Lansky also makes the suggestion that narcissism is related to shame-proneness; thus, in order to try and redress the balance that shame may engender, grandiose styles of being may be employed. Lansky agrees with an earlier work of Morrison in which 'shame has been called the underside of narcissism'.

The writings from the humanistic-existential therapies see shame as a self-protective process (Erskine, 1994) which acts as a defence against an early abuse of power (Evans, 1994).

Thus, the argument is made that shame is an early developmental experience. Shame in this context starts via interpersonal relationships at a very young stage as an attempt to protect the care-givers; in this way, the infant internalises the misattuning environment and turns in on itself. Since this process is likely to occur very early in development, the lack of attunement may result in a lack of language that is related to affect and inner processes (Erskine, 1994).

English (1994) suggests that, owing to the primitive nature of shame, it is likely to be a non-verbal phenomenon, and goes on to suggest that guilt is more 'amenable to psychoanalysis' since it develops later with words. Shame, on the other hand, being non-verbal, presents a problem for therapies that depend on verbalisation. English (1994) suggests the therapist acts as a translator for shame. Other authors pick up on these themes and link shame to somatic illness (Hyams, 1994) and to developmental vulnerability (Cornell, 1994).

It is interesting that, within the humanistic-existential traditions, some authors strive to explain shame in mechanistic terms. Nathanson (1994) uses a computer model of human emotions, and McClendon and Kadis (1994) see affect as a pre-programmed neurophysiological response. Such biological determinism certainly seems at odds with existential philosophy, and the urge to reduce human behaviour to a mechanistic model seems to go against the tenor of humanism.

These are by no means all of the methods used to examine the concept of shame. Amati (1992) links the dynamics of ambiguity to shame. In this context 'ambiguity represents the most primitive psychical organisation. . . . a state in which the ego is not discriminated from objects and self is not distinguished from non-self'; thus, shame is seen as a signal to prevent ambiguity overwhelming the ego. Shame then becomes inextricably entwined with a sense of self or, as, Amati puts it, 'shame is connected with a dilemma of identity'.

The overriding themes of this review are that shame is becoming an increasingly important area for psychotherapy to study, as it is related to early developmental issues and is likely to be experienced as a pre-verbal phenomenon within the therapeutic relationship.

Integration

The current movement towards psychotherapeutic integration has emphasised the need to cast a critical eye over theoretical constructs. As a reaction to this movement, there has been a quest to discover how best to integrate differing theoretical outlooks. One method that has been suggested is that of looking for common factors that occur within therapy (Weinberger, 1993; Sechrest and Smith, 1994). An example of a common factor would be the therapeutic relationship.

So far in this paper I have identified shame as a ubiquitous phenomenon and linked it to another common factor, namely pre-verbal experience. The earlier review has highlighted how self-psychology can be employed to try and make some sense of the development of shame in relation to object needs and the yearnings of the self. The misattunements and consequent internalisation of unfulfilled wishes have a bearing on shame development, but also I would suggest that there is a somatic component involved in this process. It is here that the work of Wilhelm Reich has tremendous significance. He provides us with an account of how pre-verbal communication, when consistently ignored or misunderstood, can lead on to body armouring (Reich, 1983; 1990). This armouring, although a persistent feature of adult life, has its roots in pre-verbal experience. It was Reich's contention that body work (he used the term 'vegetotherapy') was required to give expression to this characterological armouring. He observed that 'there is a difference in the state of muscular tension before and after a severe repression has been resolved' (Reich, 1990: 340). This has been noted by other therapists (Randell, 1989; 1992; Frankl, 1990; 1994; Shaw, 1994; 1996a,b).

It was Reich who stated that 'psychic tension and alleviation cannot be without a somatic representation, for tension and relaxation are biophysical conditions' (1990: 340). With this assertion, he firmly puts the somatic component of therapy in the foreground as a phenomenon to be taken seriously. This acknowledgement of the soma is still uncomfortable for psychotherapy (Shaw, 1996b), but has great significance for contextualising shame within pre-verbal experience since, as a concomitant, the body becomes the means of living and experiencing shame. This notion is partially acknowledged by Tomkins (Kaufman, 1993) in that the face is seen as a primary site of the affects but, in so doing Tomkins ends up relegating the rest of the body to a secondary role.

However, from a Reichian perspective, the body is not reduced to primary and secondary locations for affect. Affect is represented throughout the whole soma. Thus, in the context of this paper shame may be seen primarily on the face, since that part of our body is vulnerable to inspection; but it is also and not unequally, a somatic phenomenon. This is of importance when relating shame to pre-verbal experience since, in the pre-verbal stage of life, it was the whole body that became involved in communication, not just the face.

The work of the developmental theorists is important at this point. Attachment theory (Bowlby, 1988) highlights the necessity of continual and appropriate attunement which implies a recognition and understanding of pre-verbal messages. This is also a feature of Winnicott's 'good enough mother' (Davis and Wallbridge, 1981), in that an understanding of pre-verbal material is consistently required. There is an acceptance and support for the infant which the good enough mother or care-giver will provide. The process of development, if appropriately encouraged and supported, leads to a sense of core self, which gradually begins to integrate a sense of others as well as self. This can begin within the first few months (Stern, 1985). Such an ability is mediated at least partly by pre-verbal communication. The work of the developmental theorists therefore provides a backdrop within which pre-verbal subjective experience can be viewed and contextualised and then linked to adult behaviour in relationship. This theoretical position helps in the understanding of shame within the therapeutic relationship. The self-psychologists add to this by suggesting how the sense of self develops in early relationships. An integration of self-psychology and developmental theories exposes the needs and wishes of pre-verbal experience and the resultant emotional pain that may be evoked in the therapeutic relationship; an example of such pain would be shame. A further integration of Reich's work leads to the importance of the body in the shame response and underlines the significance of the pre-verbal world and somatic experience.

Phenomenology and the lived-body experience

Two hundred years ago, Hegel stated that 'the self is only a self by virtue of being defined as such by the other' (Lansky, 1994b). This observation seems to bear a striking resemblance to the thinking of latter-day self-psychologists and developmental theorists. It is interesting to note that the notion of lived-body arose from the work of Erwin Strauss (1966) and Maurice Merleau-Ponty (1962); both of these workers were influenced by the theories of Gestalt psychology. Thus, phenomenology would appear to have a strong linkage to some psychological theories pertinent to this discussion on integration.

The lived-body paradigm is of significance here as it introduces the phenomenological perspective of how our body becomes our means of belonging to our world (Merleau-Ponty, 1962). The body is considered to be active in this process and thus becomes 'the very basis of human subjectivity' (Crossley, 1995). This is an important argument; for, and as I have suggested elsewhere (Shaw, 1997), we see that the body is not only symbolic of itself, but also becomes symbolic for other meanings. In fact, bodies are another example of a common factor, since we all have bodies, and come to know of them in both a self-reflexive manner as lived-body experience, and also in relation to other bodies and their reaction to us (Shaw, 1997). The lived-body paradigm, therefore, has links with pre-verbal communication as we learn to be in the world via our bodies. The medium for communicating needs and receiving those needs is via the body.

Other authors have made the link between phenomenology and pre-verbal experience. Simms (1993) suggests that the world is experienced as meaningful by means of the lived-body and that our sense of self then develops 'through (not inside) the body'. Ablamowicz (1992) views shame as 'the awareness in consciousness of one's lived experience' and thereby introduces the notion that shame is related to the lived-body. Chessick (1992) links phenomenology to the work of Winnicott, Kohut and Stern by addressing the very early development of the self. The idea of using phenomenology is, therefore, not new for psychotherapy, but the current trend would seem to be towards an inquiry into the pre-verbal world. In order to do this it would seem apposite to integrate the lived-body paradigm into the work of the self-psychologists and developmental theorists. One means of trying to achieve this is via the pre-verbal body, hence the importance of Reich's work. The essence of this project would be an understanding of self-development; 'the self is formed or constituted where inner and outer meet, at the interface between persons' (Wright, 1991). My contention is that the body acts as an important boundary at which the pre-verbal self emerges and moves towards an understanding of the world. At this boundary important messages are picked up and hard lessons learnt, one of which may be the experience of shame. Such painful experiences may be evoked within the therapeutic relationship.

The movement towards these pre-verbal phenomena becoming verbal will depend on adequate and consistent attunement, combined with a belief on behalf of the therapist of the client's phenomenological lived-experience. In this process, the experiences of the lived-body may be felt and described as feelings within the body. This act of raising bodily feelings to consciousness may well enable words to be used which may help describe pre-verbal phenomena. In a sense, a translation needs to occur: the pre-verbal becomes verbal, the mediator for this process being the lived-body.

Lynn

Lynn is a 40-year-old married woman with two daughters aged eight and 12. Currently she works part-time as a cleaner in a hotel. Her referral to me was originally via an osteopathic colleague for treatment of physical symptoms.

Lynn has been seeing me now for just over three years. This time can be divided into three phases. The first phase involved osteopathic treatment and was predominantly pre-verbal in nature. The second phase was exceptional in that it combined osteopathic treatment with elements of counselling and was the beginning of the pre-verbal becoming verbal. The third phase was psychotherapy, which necessitated a change in the contract; this uncovered the shame-based nature of the client, and demonstrated the continuing struggle of the pre-verbal to be related to the verbal.

First phase: osteopathic treatment

Lynn originally presented with severe pain in her left neck and arm, combined with generalised low back pain. She also had severe pins-and-needles sensations in the left arm, which would wake her up at night. The onset of these symptoms was a road traffic accident two years previously, where a lorry shed its load of turf on to her car as she was driving it. Her husband and two daughters were also in the car. As a result, the car was buried in turf. Lynn was the only one to suffer physical injury, and was treated for whiplash injuries in the local hospital. However, her symptoms persisted and she came to see me for pain relief. At the first session only she brought her husband, which is an uncommon occurrence within osteopathic practice (the majority of patients arriving on their own). It was clear that over the previous two years Lynn had undergone a plethora of medical investigations which had revealed no abnormal pathological process. The medical fraternity had, therefore, given up on treating her symptoms other than via a continual supply of painkillers. She had not received any manual therapy up to this stage. There was a prolonged medico-legal battle over compensation for which I was asked to contribute a formal report of my osteopathic assessment.

The treatment in this phase involved gentle soft tissue massage to the neck, shoulders and low back. This was done with Lynn undressed to her underwear, as is typical of osteopathic treatment. The contract between us was clearly to deal with the physical pain by physical means. In this case the treatment was to involve physical 'hands-on' work. This first phase lasted for about a year, with Lynn initially coming on a weekly basis which moved to a two-and then three-weekly basis after six months. As is also typical is such settings, the patient talked. Over this first 12 months, it became clear that Lynn had had a very violent childhood. Initially she would say that her father used to beat her, and her mother

would give her 'just-in-case wallops'; i.e., she was hit just in case she did something that would not be approved of by her parents. Lynn also had difficulties at school, and has since realised that she is dyslexic.

During this first phase, I was providing her with pre-verbal contact at a profound level. I was in a position to feel the tension in her body, and to recognise that she was in pain. This period of pre-verbal support was a grounding for the next stages and was reminiscent of Reichian vegetotherapy. As I have described elsewhere (Shaw, 1996a;b), this form of support is rare in our society and may be an important element in allowing pre-verbal material to be acknowledged initially. It also ties in with lived-body experience as, by working on the body, the perception of pain within the soma can be felt and reflected back in a pre-verbal manner by the touch of the manual therapist.

At this time, Lynn's lived-body experience was of her body being in pain, being restrictive and denying her access to any pleasure. She felt caged and locked in by her body. The manual therapy enabled her at times to realise that her body did not always have to hurt, but could also feel pleasurable sensations. She found the bodywork relaxing as at times it felt that she could 'turn off'. It was as if there was a battle being fought within her body, and that the osteopathic work helped to assuage the fight, albeit temporarily. Over the first year, her physical symptoms decreased, but there was still a general pain over her shoulders and low back.

Second phase: osteopathy with an element of counselling

This was a much shorter phase of only three to four months. It was during this period that some of the horrific nature of Lynn's childhood was revealed. Initially, she told me of being sexually abused by her father; this was carried out in a ritualistic and brutal manner. At this time, I was in supervision with a therapist well versed in psychoanalytic and Reichian psychotherapies. I was advised to treat Lynn fully clothed, and gradually to move away from the bodywork-orientated methods to a verbal therapy.

Third phase: psychotherapy

The full impact of Lynn's childhood was allowed to emerge. She had to endure the abuse not only from her father, but from three other men, her uncle and two 'friends' of her father. The sheer horror of this still shocks me, and I am aware of my difficulty in putting it down in words. It was during the beginning of this phase that Lynn and I drew up a clear contract that we were not going to work osteopathically, and that the work from now on was going to focus on psychotherapy. The alteration in the contract was unusual, but the nature of the work had now changed. This phase of our work was an in-depth exploration of

the therapeutic relationship which also coincided with a change in my supervision. In this context the work leading up to this point was a form of pre-therapy. The osteopathic treatment had enabled a movement towards a psychotherapeutic contract, therefore; osteopathic treatment was no longer appropriate.

This phase was also marked by a process whereby Lynn became angry, and then went into denial, stating that her past had no bearing on her present, although she had recently revealed that when she had flashbacks of the abuse she would hit a wall to stop the pain. Clearly, there was a link here with her pain and her body. The deliberate self-harm seemed to act as a way of forgetting; it became a means of exchanging one, psychic, pain for another, physical pain. Indeed, she had a history of deliberate self-harm: at one stage, when 12 years old, she put her hand in an electric mangle in order to escape to hospital and avoid her father's abuse.

Lynn, therefore, has developed a profound ambivalence towards her body. In fact, up until the road traffic accident, she had coped with her past largely by using deliberate self-harm, mainly by hitting walls. The violence of the accident and sudden loss of control and the pain inflicted by someone else was too much to bear. It fractured her defences and revealed the vulnerability of her body to external forces. The consequent legal battle added to her pain; it was as though the culprit was avoiding blame. Such powerful feelings evoked memories of the earlier abuse, and were enhanced by visits to a series of medical specialists who tried to discredit her story to decrease the financial liability of the insurance company. Not being heard and not being believed were powerful messages and painful misattunements from Lynn's childhood.

There are several significant moments from this phase of the work, but for the purposes of this paper I shall pick just two moments. The first arose when I became aware of how touch could be employed in a different way within therapy, especially by means of physically holding and supporting, and also by hugging. After a session with Lynn that was very demanding, I asked her if she would like a hug and she said she would. At the next session, she commented on how she'd felt reassured by my hug, and that she had felt unclean and ashamed of her body when, all those months ago, I had stopped the bodywork. This demonstrated how, for Lynn, shame was inextricably linked to her body; it was her body that had been used as a child, and her body that she had punished as an adult as a way of taking in and trying to control the environment. Her self-object needs when a child had been consistently and savagely missed, and as a consequence the internalisation of this misattunement had resulted in a negative self-image and a shame-laden body. In therapy she had held on to my misattunement of her need to be reassured that her body was OK, and had been able to confront me with this later. This seemed a significant moment in the work, especially as Lynn was able

to assert a very basic need, i.e. to be held in a safe and supportive manner without feeling ashamed of her body.

The second moment arose over an incident between Lynn and her eldest daughter, who had just turned 12. Lynn was finding it difficult to be physically close to her daughter. It was at 12 that Lynn suffered almost daily assaults from both parents, either physical beatings from her mother or sexual abuse from her father. Lynn was starting to deny her elder daughter love and affection. I tried to point this out in a respectful way. Lynn took this as a message that she was not a good mother, and that she was to blame for everything.

I received a letter from Lynn a few days later informing me that she wanted to finish the therapy, and saying that it had not achieved anything; she just wanted to go back to how she had been before. My reply was to suggest a final meeting in order to end the therapy. She agreed to come in and was very depressed. She was aware of grieving for her mother who had not really been there for her. Her mother certainly had not protected her, and had left Lynn at the mercy of her father. Lynn stated that she wanted to continue the therapy, and we arranged a further meeting after her holiday. At this next session she realised she had missed coming in to see me. Over the next few sessions her dependence on me had obviously had an effect on her, and she was able to use the therapy as a safety net following a confrontation with her mother.

This highlights how the therapist can become an important self-object, and within this process is likely to be the recipient of some powerful negative transference, in this case epitomised by the letter disparaging the therapy and wishing to end it abruptly. However, she was able eventually to recognise that I was important to her, and I was invited to her 40th birthday party as someone of significance to her. (I declined the invitation on the grounds that it would interfere with boundary issues and transference processes.)

Over the course of this work, Lynn has begun to see herself differently. There has been a shift in her intrapsychic structure; instead of seeing herself as the bad part of the mother-daughter relationship, she has started to see that it was not all her fault. In this process, she has started to grieve for the mother who wasn't there. The powerful messages she received from a young age were of not being good enough and of being worthless. Her body was cruelly treated and became associated with feelings of disgust and shame. In a very real sense, she carried the shame of the family. The concomitant negative body image is, therefore, easy to understand. The careful, slow and methodical pre-verbal work of the first year could be seen as a form of pre-therapy. The trust that was engendered probably allowed Lynn to take the risk of disclosing the abuse she was subjected to, and that led on to the psychotherapy phase.

Recently Lynn has successfully completed a counselling skills course for

which she wrote an assignment on child sexual abuse. I shall end this section with a quote from her work (which remains uncited owing to confidentiality), as a mark of where she is now and as my tribute to her courage and continuing struggle: 'Survivors do not need or deserve to be punished for a crime that was committed *against* them, and the blame, guilt and shame must be directed to where it really belongs - the abuser.'

Reaching towards deeper meaning

In presenting a case study such as Lynn's, there is a danger of trivialising her experience by using notions such as transference, self-psychology, phenomenology, etc. It is not my intention, either, to objectify her experience, which is another potential trap, by the use of specialised terminology. I hope to have provided a glimpse of how shame may be felt and experienced and then verbalised. My intention has been to locate this within bodily experience by drawing on Reich's work and contextualising this within the phenomenological lived-body paradigm. I have also introduced the theories of self-psychology and the developmental theorists to provide a psychotherapeutic grounding for my discussion. However, in the end it is people like Lynn who work with us in the therapeutic endeavour, and not theoretical constructs.

Perhaps the aims of this paper - to integrate various theories within a phenomenological philosophy - highlight the problems of integrating theory and practice, yet the importance of attempting this project are significant in trying to reach towards the deep meanings and subjective experience of our clients.

Feel the shame: Lynn's story

My first recognition of the feeling of shame was in my early childhood at approximately 7 years old. It was to come in two totally different forms but not totally unconnected.

It started at school and not being able to read, and the humiliation that teachers, pupils and my parents subjected me to resulted in pain, fear and shame. Mental pain, when constantly told you were thick, stupid, an imbecile, retarded, slow, a 'no-hoper', over many years was bad enough, but add to that the humiliation in front of 40 other classmates, of being told to stand on a table and read the first chapter of Shakespeare out loud and to remain there all day until you had, when you could not read even the first word of Janet and John. The sheer fear, the lack of trust, the no-hope situation, paralyses the whole body so not even a tear is

shed. As for my parents, every evening I would have to read and I would sit at a table with the book in front of me with my father hovering behind me. I knew it would start by the shouting of abusive words and it always ended with a clout around the head. The only thing I did not know was which side the clout would come from, left or right!! *No trust, no help, no hope, no happiness = shame.*

As an adult I have found out I am dyslexic and have since learnt to read and taken many courses to prove to myself that I was not as thick and stupid as they all told me. But I still will not own a simple thing like a cheque book and the shame obviously is still with me on this issue.

My second encounter with the feeling of shame was different in many forms but, as I said at the beginning, not totally unconnected. First, it was a very secret shame and had been kept that way as it was the only way I could cope with the pain. To bring it out into the open would have needed me to trust someone enough to ask for their help, and experience told me to keep my mouth shut as it was far safer to pretend that I was happy. That attitude prevailed for nearly 30 years until I lost my brother through cancer, and had a car accident a few months later. I was trying to cope with the past, brought back by my brother's death, as well as the physical pain resulting from the accident. I clearly remember trying to cope with all the pain when my daughter came out of the bath and dropped the towel that was around her, which brought it all flooding back. The past was suddenly confronting me, for I was her age when my father started to sexually abuse me. I looked at her and thought it was not physically possible. How could someone enter and take away a childhood? I was physically sick, mentally sick and in so much pain that words would never be able to express my feelings.

Still no tears, though, as I had vowed never to let my father have the pleasure of seeing me cry during sexual or physical abuse. The result was that I could no longer cry when hurt, and the only time tears flowed was when I was happy.

The physical pain from the injuries sustained from the accident led me eventually to seek help from an osteopath, as I had been to doctors, hospital consultants and specialists and they seemed not to believe the pain I was in; they just did not believe me. It was bad enough having to be poked and prodded by so many so-called specialists, without my clothes on, but then for them to disbelieve what I was saying made the pain I was in unbearable. I finally plucked up courage to make my first appointment with the osteopath (Robert Shaw) but I insisted my husband came with me. After all, how could I trust a man I did not know, when I could not trust the ones I did know? Namely, my father, my uncle and my father's so-called friends, all of whom had sexually abused me over many years. Even with my husband there, when the osteopath told me to take my top off the feeling of shame was overwhelming and when he went behind me while I sat up and started to touch my back I went straight into my own self defence routine

that was, and still can be, repeating in my head, 'It won't hurt for long'. This is something I had taught myself from the early days of sexual abuse. It blocks out all physical pain and fear while it is taking place. All I have to do is concentrate on something in the room and repeat 'It won't hurt for long.'

The osteopath agreed to start treatment on my back and neck, and I returned first with my husband waiting outside and then on my own, but I was still very much on my guard. After seeing the osteopath for a year or so and building up both trust and hope by talking and getting to feel safe, the physical pain seemed to be improving.

Then one week he made the suggestion that my pain might be not just physical but emotional as well, and he offered me the opportunity of counselling. I was not amused at first and told him so. Finally I agreed to give it a try and he counselled me at the same time as working on my back and neck. This was doubly painful as I now had to trust him with my mind as well as my body. I felt fear, shame and physical pain once more, but gradually I felt some hope. This became a feeling of security, but only after a long period; and a very special rapport built up between us through his caring empathy and his knowledge of both counselling and osteopathy and my willingness to start to open up a little.

Progress was suddenly shattered, however, when one day he suggested that we concentrate on psychotherapy and no longer use physical treatment. I felt I was suddenly untouchable again. Why did he no longer wish to touch me? Was it because I was now considered dirty, as he knew I was abused? Did he think I was contagious? The shame he brought on me was unbearable and I did not go back for a month. I eventually went back and confronted him about my feelings. After much consideration and long discussions I agreed to continue with the psychotherapy, although with much apprehension.

I am still in therapy and have learnt many things over a long period, which has been difficult and painful not just for me but at times for him too. Coping with someone who has so much pain, anger and fear takes a very special combination in a person and a huge amount of perseverance over a long period of time, and if that person is not totally dedicated to giving that time, then the consequences can be devastating and can have the opposite effect to that intended.

Many issues have been dealt with over the years, but I can say with hand on my heart that the most wonderful of them all is that I have NO SHAME left with me from the sexual abuse I suffered.

Yes, I have still to work on many other issues, but I could not think of anyone more trusting and helpful and who gives me so much hope, which in turn must lead to greater happiness. I must add that we end each session, if I ask for it, with a comforting, reassuring hug, which no matter how bad the session might have been makes me feel it is all safe and OK to return. If I could give one

important message to future or ongoing psychotherapists or counsellors, it would be the vital point of incorporating positive touch - the gentle hand that reaches out and just touches, or a reassuring arm or shoulder that must be secure, safe and trusting to both client and therapist.

I would compare this with an image I have had for many years, and I would like you to contemplate this picture for a moment. Someone special had hand-blown the most beautiful glass vase. It has been made with loving care then placed in a box with a huge amount of protection, cushioned from all sides, then the lid firmly taped on. It then starts on a journey and its arrival pleases anyone who has the opportunity of viewing such a masterpiece. Then one day, after a few years of wonderful pleasure, it is shattered into hundreds of pieces. All seems lost, it will never ever be perfect again; so do you just throw it away or hide it, or do you send the pieces to a specialist for repair? Well this particular glass vase went to a specialist and has been very tenderly and patiently put together once more. Some cracks are much more obvious than others, some have disappeared all together and some still need attention, but this vase does not have to be hidden away. This vase can be admired even with all its imperfections, and the only way that this has been achieved is that it found the right person to help rebuild it by using their eyes, ears, touch and devoting time and patience for what is a very slow process. 'Handle with care' should be written on every patient that comes through your doors.

I have written this with great respect for Robert Shaw (Bob) and my husband, because they so rightly deserve the compliments for all their perseverance, understanding and empathy. I do believe God delivered me to both so I could feel what true love, trust, happiness and empathy really means.

References

Ablamowicz, H.(1992) Shame as an interpersonal dimension of communication among doctoral students: an empirical phenomenological study. *Journal of Phenomenological Psychology,* 23(1): 30–49.

Amati, S. (1992) Ambiguity as the route to shame. *International Journal of Psychoanalysis,*73(2): 329–41.

Bowlby, J. (1988) *A secure base.* London: Routledge.

Chessick, R. D. (1992) Phenomenology of the emerging sense of self. *Psychoanalysis and Contemporary Thought,*15(1): 57–88.

Cornell, W. F. (1994) Shame: binding affect, ego state contamination and relational repair. *Transactional Analysis Journal,* 24(2): 139–46.

Crossley, N. (1995) Merleau-Ponty, the elusive body and carnal society. *Body and Society,*1(1): 43–63.

Davis, M. and Wallbridge, D. (1981) *Boundary and space: an introduction to the work of D. W. Winnicott.* London: Karnak House.

English, F. (1994) Shame and social control revisited. *Transactional Analysis Journal,* 24(2):109–20.
Erskine, R. G. (1994) Shame and self-righteousness: transactional analysis perspectives and clinical interventions. *Transactional Analysis Journal,* 24(2): 86–102.
Erskine, R. G., Clark, B., Evans, K.R., Goldberg, C., Hyams, H., James, S.and O'Reilly Knapp, M. (1994) The dynamics of shame: a roundtable discussion. *Transactional Analysis Journal,* 24(2): 80–5.
Evans, K. R.(1994) Healing shame: a Gestalt perspective. *Transactional Analysis Journal,* 24(2): 103–8.
Fosshage, J. L. (1994) Commentary on Andrew Morrison's 'The breadth and boundaries of a self-psychological immersion in shame'. *Psychoanalytic Dialogues,* 4(1): 37–44.
Frankl, G. (1990) *The Unknown Self.* London: Open Gate Press.
Frankl, G. (1994) *Exploring the Unconscious.* London: Open Gate Press.
Gilbert, P., Allan, S. and Goss, K. (1996) Parental representations, shame, interpersonal problems, and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy,* 3(1): 23–34.
Hyams, H. (1994) Shame: the enemy within. *Transactional Analysis Journal,* 24(4): 255–64.
Kaufman, G. (1993) *The psychology of shame.* London: Routledge.
Lansky, M. R. (1994a) Commentary on Andrew Morrison's 'The breadth and boundaries of a self-psychological immersion in shame'. *Psychoanalytic Dialogues,* 4(1): 45–50.
Lansky, M. R. (1994b) Shame: contemporary psychoanalytic perspectives. *Journal of the American Academy of Psychoanalysis,* 22(3): 433–41.
McClendon, R. and Kadis, L. B. (1994) Shame and early decisions: theory and clinical implications. *Transactional Analysis Journal,* 24(2): 130–8.
Merleau-Ponty, M. (1962) *The phenomenology of perception. London:* Routledge & Kegan Paul.
Morrison, A. P. (1994) The breadth and boundaries of a self-psychological immersion in shame. *Psychoanalytic Dialogues,* 4(1): 19–35.
Nathanson, D. L. (1994) Shame transactions. *Transactional Analysis Journal,* 24(2): 121–9.
Randell, P. (1989) A contribution towards a psychodynamic theory in osteopathy. *European Journal Of Osteopathy,*1: 3.
Randell, P. (1992) The crisis of clinical theory supporting osteopathic practice: a critique and new proposal. *British Osteopathic Journal, 9:* 5–7.
Reich, W. (1983). *The Function of the Orgasm.* London: Souvenir Press.
Reich, W. (1990) *Character Analysis,* 3rd edn. New York: Noonday.
Sechirest, L. and Smith, B. (1994) Psychotherapy is the practice of psychology. *Journal of Psychotherapy Integration,* 4(1): 1–29.
Shaw, R. (1994) An exploration into the relationship between visualisation, somatised pain and the unconscious. *Changes,* 12(1): 18–23.
Shaw, R. (1996a) Towards an understanding of the psychodynamic processes of the body, *Psychodynamic Counselling,* 2(2): 230–46.
Shaw, R. (1996b) Towards integrating the body into psychotherapy. *Changes,* 14(2): 108–14.
Shaw, R. (1997) Towards a sociology of lived-body experience. *Journal of Contemporary Health,* in press.
Simms, E. M. (1993) The infant's experience of the world: Stern, Merleau-Ponty and the phenomenology of the pre-verbal self. *Humanistic Psychologist,* 2 1(1): 26–40.
Stern, D. N. (1985) *The Interpersonal World of the Infant.* New York: Basic Books
Strauss, E. W. (1966) *Phenomenological Psychology.* New York: Tavistock.
Weinberger, J. (1993) Common Factors in Psychotherapy. In G Stricker, and J. R Gold (eds.), *Comprehensive Handbook of Psychotherapy Integration.* New York: Plenum Press.
Wright, K. (1991) *Vision and Separation.* London: Free Association Books.