Transcript for Module 4

How to Ease the Pain of Trauma-Induced Shame

Why Shame Is One of the More Challenging Emotions to Work With	1
The First Step to Treating Shame: Understanding How It Can Protect Clients	2
Two New Findings on the Neurobiology of Shame	5
How Shame Can Appear in a Client's Behaviors and Relationship Patterns	6
Four Defenses Clients Use to Manage Shame	7
How to Help Clients Process Shame in a Safe and Healthy Way	7
A "Parts" Approach to Working with Shame	9
A Somatic Approach to Working with Shame	12
Common Mistakes That Can Derail Therapy When Working with Shame	14
Why Trauma-Induced Shame Can Lead to Self-Harm	17
How to Help Clients Manage Their Urge to Self-Harm	19
How to Overcome the Challenges of Working with a Client Who Self-Harms	20
Why Moral Injury Can Lead to Debilitating Shame	21
How to Work with Moral Injury, and Why Resolution Is Essential for Healing	23

Why Some Clients Are Triggered by Positive Emotions 24

How to Help Clients Safely Experience Positive Emotions Again 25

by Ruth Buczynski, PhD

Bessel van der Kolk, MD; Ruth Lanius, MD, PhD; Peter Levine, PhD; Thema Bryant-Davis, PhD; Richard Schwartz, PhD; Pat Ogden, PhD; Janina Fisher, PhD; Kathy Steele, MN, CS; Stephen Porges, PhD; Martha Sweezy, PhD, LICSW; Deb Dana, LCSW; William Nash, MD

Table of Contents

Why Shame is One of the Most Challenging Emotions to Work With

Dr. Levine: I think that shame is one of the most corrosive, if not the most corrosive, of all emotions.

And it is, in a way, like a cancer. It starts off as a tumour, and then the tumor breaks apart and metastasizes, and it affects the whole body, the whole organism.

So, shame feels like death. It feels like death.

Dr. Buczynski: Shame. Nearly all of us know what it feels like. And you just heard Dr. Peter Levine, one of the world's leading experts in the treatment of trauma, explain why shame can be so devastating.
Shame can be one of the most challenging emotions to work with. You see, shame can mask itself as so many different behaviours, making it difficult for a patient and their practitioner to pinpoint the core issue.

And here's what can also be so insidious about shame. Even when a patient seems to be making progress, shame can sneak right back in and create road-blocks in a patient's recovery.

Dr. Fisher: I think most experts and specialists in the trauma field are very, very accustomed to the treatment moving along. And just as the client is beginning to resolve the trauma and be here now — more active in life, more confident — the shame becomes a boulder that will not let the client make further progress.

Ms. Steele: Shame is one of the most difficult things to work with in trauma survivors. Read the literature on shame; it all says, "Work with shame with trauma survivors; decrease their shame."

But the question is how? How can we do that?

Dr. Buczynski: That's the question we'll be examining in this session. In fact, we're dedicating this entire session to looking at how we can help patients overcome shame that stems from trauma.
Hi, I'm Dr. Ruth Buczynski, a licensed psychologist in the state of Connecticut, and the president of NICABM. And I want to welcome you to the fourth session of the Advanced Master Program on the Treatment of Trauma.

In this session, we're going to look at how to work with trauma-induced shame.

We'll start by looking at how shame develops in response to trauma and some of the more subtle ways it can present.

Next, we'll cover a variety of practical strategies to help you treat shame with greater skill and efficacy.

We'll also go over what can go wrong when working with shame and how to avoid making a few common mistakes with your patients.

Then, we'll address how trauma-induced shame can lead to self-harm, as well as how to help patients manage their urge to self-harm.

After that, we'll go over how certain traumatic experiences can cause moral injury – and how to work with the shame that often comes with it.

And finally, we'll walk you through how to help patients who may actually find positive emotion to be triggering.

By the end of this session, you'll have several concrete strategies and step-by-step approaches to help patients heal from trauma-induced shame.

The First Step to Treating Shame: Understanding How It Can Protect Clients

Dr. Buczynski: So, let's get started.
First, let's look at some essential characteristics of shame.

Dr. van der Kolk: Shame is about vision. Shame is about being seen, or about not wanting to be seen.

That's what people do who feel quality of shame is they go through the world hiding. "Don't look at me. Don't look at me."

Dr. Ogden: Shame is a sense of something being bad about the self, something being wrong, something being bad, as opposed to guilt, which is I think about the action, not the self. Shame is hidden. People rarely come to therapy and say, "Oh, I have so much shame. I want to work with shame."

Dr. Buczynski: By nature, shame can be so debilitating for two main reasons. One, it can lead a person to believe their entire self is bad. And two, shame can make someone fear being fully and truly seen by others.
But here's the thing – even though shame can be destructive, it can also serve a purpose.

Dr. Bryant-Davis: Shame is the way I protect my relationship with my family. Because if I'm still hanging out with them, then there is not space for me to be angry about what happened. So instead, if I hold the shame, then I can still go over for Thanksgiving and Christmas. If I hold the shame, I could hang out there and not have any feeling about it except my own shame, right?

Dr. van der Kolk: Rape survivors who blamed themselves had a better outcome than rape survivors who didn't blame themselves. This self-blame and this self-shame have a certain survival capacity. That means that if I behave myself differently, this won't happen to me. This really creates a new part. It creates a part, "I will never let anybody mess with me again," but deep down I feel deeply ashamed of myself.

Dr. Buczynski: So, shame can serve a protective purpose – it can sometimes give patients who have experienced trauma a sense of control. I want you to keep this in mind because later in this session, we're going to look at how this idea can help shift your patient's perspective on their shame.
But how does shame develop? Often, shame is conditioned in childhood by our caregivers in order to keep us safe.

Because here's the thing. . .

Dr. Fisher: Babies don't feel shame. Shame comes online at the age when children begin to walk. As soon as they have that ability to explore, they have that ability to endanger themselves.

Shame arises as a survival response, as a parasympathetic break that causes the child's body to pause. And we've all seen this — toddlers who approach the stove, and they're saying, "Hot! Hot!" as they reach out to touch the stove. What inhibits the child's reaching or touching or doing something dangerous is the experience of shame. Because parents say, "No, no, no, don't touch that," and the baby pauses and pulls the hand back and turns away in the universal gesture and posture of shame.

And then secure-attachment-promoting parents say, "Good for you. Thank you. Yeah. Yes. You didn't touch the stove." And they repair that shame state. So, the child does not grow up with shame as a habitual response.

Dr. Sweezy: Say the child was shamed in grade school for being too loud by the teachers who said, "You have to be quieter." So, the loud exuberant part of them, that was news to them, that, "Oh, this is not okay. It's not okay for me to be excited or loud or happy." And they take that in, in that setting. A protective part comes up who starts to shame them if that

loud part comes out again. If I'm too happy, there's a part who comes in and says, "Stop it. You're embarrassing yourself. You're bad."

And so that external interaction has been taken inside and become an internal interaction that goes on relentlessly and becomes an inhibiting force in that person's life. So that would be a proactive protective part who is trying to make sure that this child isn't embarrassed again or demeaned by somebody for that feature.

Dr. Buczynski: But people can pick up messages of shame from many other sources as well.

Dr. Bryant-Davis: So, even our language in the general public, where people will often say this one: "We teach people how to treat us and people only disrespect you if you let them".

The fact that I was selected or groomed or tricked into this, like, "What is it about me?" can create a lot of shame.

People are given messages in society, in the media, in family, in culture, in religion that teach you that you are responsible for what people do to you. And that's a very dangerous thing, to say that anyone who mistreats you, it's because of you.

Dr. Buczynski: So now that we've looked at some common sources of shame, I want you to take a moment to think of some of your patients who struggle with shame.
Throughout this session, consider how you might apply the specific strategies that we discuss today to their treatment – because all the training in the world won't make a difference if you don't apply it in your practice.

Two New Findings on the Neurobiology of Shame

Dr. Buczynski: Now, let's get into the neurobiology of shame.
What happens in the brain when someone experiences shame? According to Dr. Ruth Lanius, there are two areas of the brain that light up. . .

Dr. Lanius: One is in the area of the prefrontal cortex that is involved with moral reasoning. So, really helping you think about if what you did was right or wrong. And the other part that really shows increased activation is an area that's called the posterior insula. And the posterior insula is really interesting because it helps us to feel visceral sensations in our body. And I think when people feel a lot of shame, they feel really torn apart in their body. They feel this pit in their stomach. And they also feel a lot of disgust, self-disgust.

Dr. Buczynski: So, to recap, the prefrontal cortex is the part of the brain that decides whether something is right or wrong.
And the posterior insula is what makes us feel strong physical sensations. This is why patients can sometimes feel shame in the body.

Later in the session, we'll get more into how to work with the body to heal shame.

How Shame Can Appear in a Client's Behaviors and Relationship Patterns

Dr. Buczynski: But first, I want to highlight how shame might show up in a patient's relationship patterns. Think, for instance, about a patient who is often drawn to people who are emotionally unavailable. . .

Dr. Bryant-Davis: Often, what's underneath that pattern is shame because I don't really want to be known. I don't really want to be seen because if someone got really close to me, they would see something terrible. Something unworthy. So instead I'll keep picking people who aren't really going to be able to show up for me. Because if you carry a lot of shame, for somebody to really be into you, for somebody to really see you, that's overwhelming. That can be very frightening.

It's a lot when you're used to hiding. It's a lot for someone to really see you.

Dr. Buczynski: So, that's one way that shame can cause a person to hide behind certain actions and choices. But people can hide themselves – and their shame – in so many other ways as well.

Dr. Ogden: Shame is disguised. It can be disguised in a variety of ways, as workaholism, as in abusive relationships, as shutdown, as self-abuse and self-harm, or simply not taking good care of the self, overriding basic needs like sleep and hunger, perfectionism, being detached from the self, being over reactive, being angry and rageful.

Dr. Buczynski: At first glance, these behaviors might seem like self-sabotage. But if we take a closer look, we can see that these behaviors are actually acts of self-preservation. In other words, one part of the patient is working to protect another more vulnerable, fragile part.
Now, we just looked at several ways shame can show up in a person's behavior and in their relationships.
In the next module, we'll go more in-depth on how trauma and shame can impact relationships.

Four Defences Clients Use to Manage Shame

Dr. Buczynski: But for now, I want to get into the different ways a patient might cope with shame. According to Kathy Steele, there are four strategies people often use.

Ms. Steele: One is to attack the other. "You're stupid. You don't know what you're doing. You're a failure."

But the other one is to attack self. "I'm going to beat myself up because I have the hope somewhere in there," or the fantasy that, "If I beat myself up enough for being stupid, for being fat, for being unlovable, I will find a way not to be those things."

I avoid talking about things that are shameful, I avoid being around people where I might feel ashamed, I avoid dealing with parts that make me feel ashamed. Avoidance is a strategy.

And the final strategy against shame is this idea of, “I’m just going to avoid my whole inner experience. I don’t feel shame. I don’t feel anything.”

Dr. Buczynski: I want to make sure you got all four strategies patients might use to manage shame.
A patient might blame others, blame themselves, avoid things that trigger shame, or avoid their inner experience.

So far, we’ve gone over how shame develops in response to trauma and some of the more subtle ways it can present.

How to Help Clients Process Shame in a Safe and Healthy Way

Dr. Buczynski: Now, let’s get into how to help patients process shame in a healthy way.
A good first step is to normalize shame. One powerful way to do this is through skillful self-disclosure.

Ms. Dana: I will even share with my clients what my own response feels like, because it’s a common human response we all have. I think when we do that and get it on their map and talk about how it might come to life for them, then it’s not as terrifying of an experience.

Dr. Buczynski: It can also help to reframe a patient’s response to a traumatic experience. For instance, when a person experiences trauma, their body might respond to the threat by being passive. And because they didn’t resist, the person might blame themselves for what happened.
But approaches like Polyvagal Theory can help trauma survivors reframe their actions – or lack of action – in terms of survival. And this can help them let go of the shame they might feel because they didn’t fight back.

Dr. Porges: The prototypical example is the woman who’s raped, who doesn’t fight back. And the amount of shame and blame that gets incorporated into her personal narrative. And when many of them have read aspects of the polyvagal theory, their shame went away.

Dr. Buczynski: Now as we’ve said throughout this session, shame can be painful, but in many ways it can also be protective.
So how do you convey this idea to your patient?

Dr. Fisher: Sometimes I say, “What happens in your body?” And they say, “Oh, it’s this flush. It’s like a whoosh. And it’s so painful.

And then I can’t speak and I just want to hide my eyes and I want to creep away.” And I say, “Yes, exactly. And how did that help you survive?”
And they say, “Oh, oh. . . Well, it was always better not to say anything. And it was always better not to be seen. So, I guess it helped me to be better at being invisible.” And then they get it. Then they say, “Yeah. And being invisible was really a good idea.” And I say, “Yes. Yeah. And you were too little to think, ‘Oh, I better be invisible. I better shut up.’ So, the shame did it for you, right?” “Right.” “Hey, it was genius. And isn’t that amazing? Because you did survive, and here we are right here right now. You’re here.”

Dr. Buczynski: Notice how Dr. Janina Fisher skillfully walked her patient through the idea that her childhood shame was actually heroic. This is a straightforward exercise you can do with your patients to help them appreciate the protective power of shame.
Another effective strategy is to emphasize that a patient's shame stems from just one aspect of who they are. This can help them shed the idea that their entire being is fundamentally flawed.

Dr. Sweezy: It's very validating for people, and it's also very automatically de-shaming just to go back to that simple example of a child who had an exuberant part that was shamed in school. If that's just one part of you, it's not all of you, then you're not shameful.

It's saying, "No, there's one part of you who may have been too loud in class one day, but there was nothing wrong with that part. It just needed to be loud outside. And there's nothing wrong with you. You got hurt. Somebody was too tough with you, too rough with you, and not thoughtful and careful enough about you." That shifts the whole dynamic for people.

A "Parts" Approach to Working with Shame

Dr. Buczynski: That was Dr. Martha Sweezy. She co-authored the book Internal Family Systems Therapy with Dr. Richard Schwartz, who is the founder of the Internal Family Systems model. And Martha just got into that idea of "parts."
Earlier in this session, we touched on how certain parts can sometimes act in dysfunctional – and even unrecognizable – ways.

Now a couple weeks ago, we looked at "parts" when we talked about the Structural Dissociation Model.

In this session, we're going to look at parts in relation to the Internal Family Systems model.

In short, the theory says that the mind can be divided into subpersonalities, or "parts." These parts interact with each other to drive our beliefs and behaviour.

Dr. van der Kolk: We always need to deal with people in parts. When people come across as very tough, you know that they are very scared of being in touch with this shameful, compliant, weak part of themselves. You honour their tough parts, you go with it, and then you go, "How would that tough part take care of that little part, that shame part?" But the shame is, almost invariably, a part people develop in order to protect themselves from future harm. "If I don't do this anymore, it was my fault because I was too. . ." something or another. "So, I won't do that anymore. And then it won't happen to me again." It's an important defensive piece. But the post-traumatic piece of it, well, this is a very reasonable adaptation. You exile that shame piece of yourself. And that becomes what therapy's all about is to really meet the exiled — the parts of you that you feel too ashamed of.

Dr. Buczynski: That's a snapshot of how you can use parts work in your sessions with patients who are struggling with shame.
Now let's go more in-depth with a step-by-step approach.

First, we want to help a patient identify the part of them that's doing the shaming. Then, we want to help them pinpoint their feelings and attitudes toward this part.

Dr. Sweezy: If they say, "I feel shame." I'll say, "How do you know to tell me that? Where are you noticing that? Where does it show up physically? Is it in your body, outside your body? What's going on?" And the person would then probably identify an inner critic, although the critic might be in their ear or outside, out here, but it might be in their head. It tends to be up here somewhere. So, then we can get curious about that. Some people are very visual, and it's helpful to have a white board and just put that up on the white board. "Okay, so there's a part who's whispering in your ear, and what is it saying to you?" And then we would write down what it's saying.

And then, "How do you feel toward this part who's doing the shaming?" "Well, I hate it." That would be a very typical response. "I wish it would go away. It's terrible."

Dr. Buczynski: At this stage, it may be tempting to dive right in and work with this inner critic. But before we do that, we need to ask all the other parts for permission.

Dr. Sweezy: And so, then we have to ask the parts who are having such strong feelings about this critic to relax for a minute, because we need to get curious about this part. It's not going to be very responsive, as you and I wouldn't be very responsive if someone hated us and was in our face, right?

So, you have to get everyone who's reacting strongly to the critical parts to relax, because they're well hated within the system internally. So, you can put the critic in a room by itself and ask everyone else to chill. That often helps — some physical separation. And then you say, "How do you feel toward that part now?" "Well, I'm kind of curious. I wonder why it's doing that or why it's showing up like my critical father. Why is it doing this to me?" "Okay, would it be okay with all your other parts if you went in the room with the critic and had a chat about that?" "Okay, they're cool with that." So, the person then goes into the room.

Dr. Buczynski: I want you to notice the gentle languaging Martha uses to talk with these parts. This is so crucial for getting a patient's parts to cooperate during a session.
Now Martha did something else that was especially key – and that is, she created distance between her patient and their part. She did this by asking the part to "leave the room." Imagining a physical separation like this can help your patient be less judgmental toward the part.

The next step is to enter this room and speak with this inner critic.

Dr. Sweezy: They go into the room. Then they say to their part, "What's up? What compels you to do this behaviour?" And the part may start in. "Well, it's because you're so stupid." And then I interrupt. If I hear that going on, I'll say, "Okay, hold up," and I'll speak to the part directly and I'll say, "You can do your thing. We know you're really good at it. Nobody is better at this than you, but right now we're asking you to be direct with us about what you're worried would happen if you stop doing this. Why do you do this job?"

Dr. Buczynski: So, when you're talking to a patient's inner critic, it can help to ask what this part fears might happen if it stopped doing its job. And here's where you can introduce curiosity into the equation. . .

Dr. Sweezy: When it starts talking about its fears, it'll say, "Remember when X, Y, and Z happened? I'm trying to make sure that never happens to you again. I don't ever want you to be hurt like that. All those things are way too dangerous. We have to be careful here." That's a real eye-opener for people because all they've heard is these insults basically from these parts. And they believe it because the part often uses the voice of someone who was externally critical, too. So, there's never been any curiosity pumped into this dynamic. And the minute you get the curiosity in there and you find out about the underlying motives, the whole thing changes.

Dr. Buczynski: This can be such a pivotal moment for your patient. Once they understand that a desire for safety drives their inner critic, your patient can start to appreciate how this part works to protect them.
And that can open up your patient to the idea of working with their inner critic instead of against it.

Now you see, because an inner critic usually forms when a person is young, this part may not understand that self-shaming won't keep them safe from ever being shamed again.

But there is a way to help this inner critic. . .

Dr. Sweezy: And, so, at that point, you can say, "Well, how about if we could do something different and better? How about if there was a Sally who's not a part," which would be "the Self" in IFS, "who you could meet, who could help out with this, who could make sure that the part who is loud and exuberant is safe to be loud and exuberant in the right places and doesn't get into trouble in other places? What if we could fix this by having somebody who loves her take care of her?"

That's a revelatory idea for the critic.

Dr. Buczynski: So, you see, one of the keys to managing an inner critic is letting it do its job as a protective part, but teaching it how to do so in a healthy, functional way.
This is where a patient's core "self" comes in. When a patient has access to this resource, it gives them a wise, internal guide to turn to whenever they notice their parts are feeling unsafe.

A Somatic Approach to Working with Shame

Dr. Buczynski: Now so far, we've focused on several psychotherapeutic approaches that can help you treat shame. But for some patients, talking abstractly about shame can lead to rumination.
These patients may benefit from a somatic approach. So, here's Dr. Peter Levine again with an example of a body-based therapeutic exercise.

Dr. Levine: What I will do is have the person just very slowly – just the smallest amount – go towards the posture of shame, and very slowly coming out, resting there, settling there. Again, going very, very slowly into the shame, slowly into the posture of shame. Maybe just a little bit more. And then vertebra by vertebra coming back out of the shame, out of the

shame, and then feeling, sensing the body. When you do that, very frequently the client will then be able to begin in a productive way, to talk about the shame, where it came from.

Dr. Buczynski: So, when a patient struggles to verbalize shame, tuning into their bodily cues can open the door for communication.

Ms. Dana: You might notice a movement of the head. You might notice a hand movement. You might notice a foot movement. Those are usually the places I tend to look: feet, hands, head. Because a client in dorsal shame is usually looking away, eyes down. You might simply notice that very subtle looking up and down, just checking to see, "Are you there, is somebody there?"

It might be as simple as just a small sound. . . You might hear sort of a, "Hmm." That's all these subtle signs that energy is beginning to move in the system again. And as soon as you hear, see, feel one of those things happening, then you want to name it. So, I will name to my client, "Oh, I just noticed that small movement of your hand, and that's your nervous system letting us know that it's beginning to move out of this place that's so dark and despairing." Or, "Oh, I noticed that you peeked at my eyes, and I just wanted to let you know my eyes are here for you."

Dr. Buczynski: Finally, working with the body can help a patient let go of shame in a physical way. I want you to see how Dr. Pat Ogden did this with one of her patients.

Dr. Ogden: What I wanted to find was a part of her that could protect and defend herself. So, I asked her, "Is there any part of you that wants to make a different action?" And she said, "There's tension in my right arm." And so, I said, "Okay. How about we focus on that?" And as we focused on that, because tension's a precursor to action, she felt the impulse to push away her abuser. And for her, her whole body just ignited as it often does when you're restoring an instinctive response that had been abandoned because it wasn't effective. And so that was what mitigated the shame for her, was being able to make that action, feeling her power to defend herself.

Shame definitely lives in the body, so our body is a great resource. With all my clients, it's important to me that they have a new experience and then find the new meaning.

The new meaning that is the antidote for shame comes from a new experience, a new bodily experience.

Dr. Buczynski: So, you see, when we approach shame from a somatic angle, we can help patients uncover — and release — impulses that were buried by shame.

Common Mistakes That Can Derail Therapy When Working with Shame

Dr. Buczynski: At this point, we've covered a variety of practical strategies for working with shame – including psychoeducation, parts therapy, and somatic approaches.
But it's also critical to know what NOT to do when you're working with shame.

First, when it comes to trauma-induced shame, we don't want to get too caught up in the details of a patient's trauma story. In fact, focusing on these details can sometimes distract from treating the root causes of shame.

Dr. van der Kolk: I didn't take her trauma history. I dealt with the shame from the very first moment. And the trauma history came a year later. It's very important for therapists to put your voyeuristic tendencies on hold. The trauma story gets told for your benefit. Don't ask people to tell you stuff for your benefit. Whenever you ask people to tell you something, look at, "Who is benefiting from what I'm asking you right now?"

Dr. Buczynski: Not only that, certain therapeutic strategies can fall short when treating trauma-induced shame.

Ms. Steele: So, the first thing I learned was that I failed miserably at helping people with shame, because my nice little cognitive interventions weren't helpful. Like, to say, "You've got nothing to be ashamed of," actually leaves the client in their shame feeling ashamed for feeling ashamed. Or, "No, you're a good person. You're not a bad person." Again, it leaves the client feeling like, "Well, I know I'm not all that bad, but I feel bad." So, the felt sense is still there. And all of these cognitive things of, "No, you're not bad. Yes, you are lovable. You are smart." None of that goes in and sticks.

Dr. Fisher: And then they accuse us of empathic failure because they're not getting something and we're not getting something. We're not getting that that shame is associated with feeling safe.

Dr. Buczynski: This is crucial to keep in mind. You see, if a patient is stuck in shame, encouragement from others might feel too foreign to accept. What's more, reassurance can also invalidate a person's feelings and leave your patient feeling alienated and misunderstood.
Later in this session, we'll break down how to help a patient move out of a state of shame and into one where they're capable of experiencing positive emotion.

But first, I want to go over a few more points to keep in mind when working with shame.

And one is to remember that your goal as a practitioner isn't necessarily to get rid of a patient's shame. Instead, you want to help them process and regulate it.

Ms. Steele: As therapists, we tend to want to get rid of shame. Shame is a normal human emotion. We don't anymore want to get rid of it than we want to get rid of anger. We want to bring it down to size, just like we do with rage. But we can't get rid of shame, it's part of our makeup. It just needs to be more adaptive, just like every other emotion.

Dr. Buczynski: As we covered earlier in this session, shame is an adaptive protective response. And we know from parts theory that the more we try to control a part, the more it fights back.
Here, Dr. Richard Schwartz and Dr. Martha Sweezy explain why this is. Keep in mind that Richard uses language specific to Internal Family Systems – he uses the term "Exiles" to talk about a patient's traumatized parts, and he uses the term "Firefighter" to refer to a patient's impulsive, destructive parts.

Dr. Schwartz: If you go to an addicted part and say, "Just stop doing it," it won't say this overtly but it thinks you're an idiot because it knows, "If I don't do my job, the next Firefighter in the hierarchy is suicide. And he's going to kill himself if he stops drinking." And thinks that the therapist is just clueless.

And until you can get to the Exile and actually unload the shame, a lot of this isn't going to calm down, at least in the long term.

Dr. Sweezy: All this shaming is motivated. It's a motivated behaviour on the part of terrified young parts who are not bad. And we need to love them up, befriend them, honour their hard work instead of shaming them for doing it, be extremely kind to them and inviting.

The automatic response that most of us have, that I certainly have had for much of my life, is to fight with that, "I'm going to declare war on my critic. I'm going to shut it up. I'm going to ignore it."

You don't want to do any of that stuff. You want to give them a big hug and say, "I know you're really trying your best, and we can do this a better way. You really don't have to do this. It's a nasty job. Nobody likes you, and it's no fun. And you've done your best, and now we can free you from this if you're willing to let me help."

Dr. Buczynski: Richard and Martha just pointed out one essential fact about shame – it cannot be managed away. Instead, we want to help patients learn to be compassionate toward their parts.
But while self-forgiveness is often an essential part of healing, there's a particular nuance to forgiveness that we should be aware of . . .

Dr. Bryant-Davis: Some people, even some therapists, will talk about how clients need to forgive themselves. And I think you have to be very careful about that because sometimes you're facilitating a process for people to forgive themselves for things that they're not responsible for.

Often survivors are carrying other people's baggage. And so, releasing that baggage is not a matter of self-forgiveness. It is a matter of recognizing, "That wasn't me."

Dr. Buczynski: This is why we need to be careful about the language we use when we talk about trauma — because what we say and how we say it can lead a patient to internalize blame.
And paying attention to our languaging is also relevant when we talk about recovery. . .

Dr. Wilson: There is this kind of toxic recovery-ism, and I'm not a non-believer in recovery. I think that's a real thing, but the toxic version is that recovery restores you to this sort of "feel good" cultural ideal, which is an absurd notion. It's not real, it's not true. It is this kind of projection of what recovery looks like. Recovery is much richer than just sort of like, "And now everything's grand."

Recoveries are complex. If you push aside the kind of Instagram version of it and people are real about it, they're rich and complex.

Dr. Buczynski: Now what you just heard from Dr. Kelly Wilson is from a Focus on Application session. These sessions are all about helping you turn the expert ideas and concepts from each module into practical strategies you can use in your work.

Why Trauma-Induced Shame Can Lead to Self-Harm

Dr. Buczynski: Now, I want to pivot to a serious side-effect that can come from trauma-induced shame – and that is self-harm.
Just like shame, addressing self-harm requires delicacy and skill. And according to Dr. Ruth Lanius. . .

Dr. Lanius: The first thing that you really need to figure out is, "Is this suicidal behavior, or is this self-harm or parasuicidal behavior?" The way I elicit that is I ask someone, "So when you're cutting yourself, or when you're pulling out your hair, or when you're scraping your skin, are you trying to take your life? Or are you self-harming?" And people know, and so people will tell me, "Yes, by cutting myself, I'm trying to take my life." Or they say, "No, I do not do that to take my life."

And then the second step is really to figure out the underlying cause of self-harm. And I think that's so important not just for the client to understand, but also for the therapist to understand, because I think that's what fosters empathy.

Dr. Buczynski: So how do we pinpoint what drives a patient to self-harm? It may help to look at this through the lens of parts theory.

Dr. Ogden: Often, there's a part that wants to harm and another part that is harmed.

I'm thinking of a client who had a very angry, aggressive, protective, defiant part. And she hated the part of her that was weak and submissive.
The angry part of her wanted to kill off that other part. And when she was in a dissociative state, she would cut herself. And as she got insight into those two parts, she was able to help them communicate and eventually help each other, rather than one part of her trying to kill off another part.

Dr. Buczynski: But here's the thing about self-harm — while much of it can be pretty apparent, there are other ways it can present that may not be as obvious.

Dr. Lanius: When we think about self-harm, we often think about cutting behaviors, burning behaviors, skin picking, or pulling out hair. But I think we also sometimes need to think about when we see clients that are in session and they go into one flashback after another. This is not how PTSD presents, right? People with PTSD, they may have the odd flashback. But repetitive flashbacks, often, are used as a form of self-harm.

So, the way I deal with this now, when somebody has one flashback after another in session, I ask them, "Do you think self-harm or self-punishment may be at play here?" And it's amazing. People are very rarely aware. But when I bring it up, it's almost like they startle and they look at me and they say, "Oh wow. Yeah, there may be something to that." And then

bringing that into consciousness and really helping the individual to decrease that behavior, I think, can be very helpful and can also really facilitate the therapy.

Dr. Buczynski: Now, just like the other trauma-related responses we've discussed in this program, self-harm can also serve a survival function.

Dr. Fisher: The signal that is so striking to me about self-harm is that it works.

So, when we hurt ourselves, when we fall, when we break a bone or we cut ourselves, whether intentionally or unintentionally, the body responds to pain and to injury with an increase in adrenaline.

In response to self-injury, there's a one, two punch. First, the adrenaline, replacing numbness or emotional overwhelm with calm, cool, collected, and powerful, followed by an endorphin release that relaxes the body, takes away the pain, and gives us a feeling of wellbeing.

No wonder those two drugs which are made in our bodies — these are our own neurochemicals — no wonder they're so addictive.

How to Help Clients Manage Their Urge to Self-Harm

Dr. Buczynski: So how do we help patients break an addiction to self-harm? Sometimes it helps to have patients take a step back and reassess whether this behavior is actually serving them.

Dr. Fisher: So that simple question, "Oh, how long does the relief last now?" usually is the most effective strategy for helping people to become aware that there is a cost-benefit to their cutting.

I remember I was consulting to a 15-year-old in a locked unit in a psychiatric hospital. And she looked at me with this horrified look and she said, "Oh, I guess it lasts about 15 minutes." I didn't say a word because I could just feel the pennies were dropping.

Dr. Buczynski: We can also use somatic strategies to hone in on what's driving a patient's self-harm — and to help them channel their anger in a healthy way.

Dr. Ogden: I'm thinking of one client who whenever she experienced anger, she would self-harm and try to kill herself. It was not just cutting, but she would try to commit suicide.

I asked her if she could just touch the tip of the iceberg of that anger and notice what happened in her body, and she noticed that her right side tensed up. We stayed with that and kept going back and forth. We'd relax it, tense it back up. And what I was looking for was to find out if there was any impulse that would counter directing that anger towards herself.

Her arm was in her lap, but it was tight like. . . Her arm was tight like this and I said, "Well, if that arm had words, what would your arm be saying?" And she said, "Leave me alone," and her arm made this motion. And that was the turning point because from her body, we found emotion that went outward for that anger, which is where it belonged. It belonged

against her perpetrators, not against herself. And as she made that motion, it felt so good to her. And she laughed and she said she'd never felt that before.

And over time, we did all kinds of motions where that anger would go out instead of in.

How to Overcome the Challenges of Working with a Client Who Self-Harms

Dr. Buczynski: Now, working with self-harm can be especially challenging – not only because it's a sensitive subject, but also because it can be overwhelming for practitioners. Here, both Ruth Lanius and Deb Dana share some reminders for when treatment gets tough. . .

Dr. Lanius: When an individual has engaged in self-harm, often we feel guilt or we're blamed by others on the treatment team. And I think what's really important is that we see self-harm as a symptom of attachment trauma and other traumatic experiences. And there's a reason for that symptom. And we need to deal with the underlying cause to help the self-harm.

Ms. Dana: It's hard for therapists, all of us, to have clients who have these ongoing self-harming behaviors in a pattern that's really hard to interrupt.

I know it's really hard, because I've gone myself to that place of, "Oh for God's sake, can't we just stop? I can't keep doing this. This is too hard for me to be a witness to," which again, is my nervous system activating a survival response for me.

Again, it's about, how do we as therapists stay with someone who's suffering knowing that we can't stop their suffering for them? But what we can do is help them continue to befriend their nervous system and get to know what brings them to those self-harming behaviors.

Dr. Buczynski: Now, keep in mind that some ways of self-regulating can be counterproductive to a patient's treatment.
For instance, when it comes to suicide safety plans. . .

Ms. Dana: We want to be careful that we're creating a safety plan not for my nervous system, but with my client's nervous system. It's a different way of thinking about safety planning. If we simply come up with, "If this happens, I'm going to do this," that comes out of a book or comes out of a prescribed formula, and it's not going to be successful. Many of us have created safety plans for clients, and those safety plans don't work. A client will not follow that safety plan.

So, a safety plan is really an autonomic regulation plan. This might be what I would call it, which might be a better way to frame it both for myself and with my clients. Because it's really talking about the fact that, "Dysregulation is going to happen. And when this begins to happen, what are some of the things that we can do to either not have it happen, which is possible, or to have it happen less intensely, or to have a roadmap so that you know how to find your way back?"

Dr. Buczynski: So, these are just a few points to keep in mind when working with patients who self-harm.
By now, we've covered what can go wrong in working with shame and how to avoid making these mistakes with your patients.

We've also looked at how trauma-induced shame can lead to self-harm, as well as how to help patients manage their urge to self-harm in a healthy way.

Why Moral Injury Can Lead to Debilitating Shame

Dr. Buczynski: Now, I want to talk about a particular consequence of trauma that can lead to shame — and that is, moral injury.
In essence, moral injury is the distress a person feels when they cause, witness, or fail to prevent a situation that violates their core values.

Here's another way you might think about it. . .

Dr. Nash: Moral injury can be defined a thousand different ways. Most narrowly, it is a mental disorder, an injury to a whole person, from an experience that violates deeply held moral expectations, your own moral expectations.

It's always mediated by moral emotions. Something happens that evokes very intense moral emotions, negative moral emotions: anger, guilt, shame, sadness, hatred.

There's always a wound to a person's identity. Moral injuries are things you don't want to tell anybody because they're shameful. They detract from your self-esteem; they detract from your social worth.

Dr. Buczynski: And here's what makes moral injury especially debilitating. . .

Dr. Nash: Loss of the ability to trust people or oneself is always at the center of moral injury. Whoever betrayed your trust, you now know this person or thing cannot be trusted anymore. If that person who betrayed your trust is yourself, how much worse?

Dr. Buczynski: Now, when it comes to moral injury, we often think of people who have to make difficult decisions in high-stakes situations, like soldiers, healthcare workers, police officers, and firefighters.
Throughout this section, I want you to think about how these ideas and strategies about moral injury could support these people — whether it's a colleague who works in a hospital, a client deployed overseas, or possibly you, yourself, who might fall into one of these categories.

But these people aren't the only ones who can experience moral injury. In fact, according to Dr. Bill Nash, there are two factors that can put a person at risk of experiencing moral injury. . .

Dr. Nash: I think the common denominator for all at-risk groups is they're all people who care. They are willing to empathize with compassion, share the pain of people who come to them suffering. That's number one, they care. They're emotionally invested.

Number two, they take responsibility. That defines a service member. You don't join the military if you're not looking to serve a higher purpose, the Constitution, right and wrong, and you care about that personally as a service member, and you take responsibility for the outcomes personally.

Dr. Buczynski: So, while frontline workers and service members commonly experience moral injury, moral injury can affect anyone who is emotionally invested in a situation and takes responsibility for what happens.
And after being in a morally ambiguous situation, the question of whether they "did the right thing" might weigh on their conscience.

How to Work with Moral Injury, and Why Resolution Is Essential for Healing

Dr. Buczynski: So, how might we help a patient accept their past actions? According to Dr. Bessel van der Kolk, the first step is. . .

Dr. van der Kolk: . . . helping people to go back to that situation and to see who they were back then. Observe what it was like for that kid back there in Vietnam or back there in Afghanistan to see this happen, and how this kid got so enraged that he did these terrible things.
And then you need to have a dialogue with that person.

Dr. Buczynski: When a patient feels shame for how they handled a complicated moral dilemma, we want to help them extend compassion to their past self for what they did to survive a traumatic situation.
Here's how Dr. Pat Ogden helped one veteran. . .

Dr. Ogden: How I worked with him in regards to the moral injury was around our relationship. As he described the killing, he was shaking and really in despair and really dysregulated. I remember feeling, "How are we going to get through this together?" And how we got through it was through his body. His fingers just kept making a slight motion, a slight opening motion, and I brought his attention there.

And I didn't know what it meant, but I had a feeling it was around connection. And he said, "I just want to hold somebody's hand." Because I'm familiar with working with touch, I have a lot of training with touch, and I know how to use touch therapeutically, as an experiment, I was willing and glad to offer him my hand, and his hand just tightened around mine. And we kind of sat with that dilemma together of what he had been through. He said, "I felt like I was going to collapse into nothingness without any contact," he said.

With that contact, we were able to kind of hold it together, and I think that was the healing moment. It was in the relationship, because you can't make it okay. You can't minimize it. You can't put a Band-Aid on it, but you can hold it together.

Dr. Buczynski: This is a key point about moral injury. Often, what a patient needs isn't someone to help them reconcile their past. What they need is someone to help them hold it, and eventually move forward.

Dr. Nash: The most important recovery activities are to create new goodness to counter balance that badness. You can't remove the badness. It happened. You can't un-ring the bell. Whatever bad things happened, they really happened.

The only way to move your center of gravity toward the light, toward the positive end of the moral emotional spectrum is, you have to do good things. You have to create goodness. You have to love. That is the process, gradually, of accruing a more positive sense of yourself, a more positive competence.

In treating moral injury, one of the crucial things is to remind myself constantly that the mortal enemy of moral injury is love. Moral injury, it's also a failure of love, that moral injury always makes a person feel unloved and unlovable to a certain extent.

Dr. Buczynski: When it comes to moral injury, helping patients focus on creating new positive experiences can be one of the most productive steps in the right direction.

Why Some Clients Are Triggered by Positive Emotions

Dr. Buczynski: But for patients who have experienced trauma and are in a state of deep shame, positive messages might not get through. And for many, experiencing positive emotion may feel foreign or even frightening.

Dr. Fisher: Another really common impediment in trauma treatment is the degree to which positive feelings, positive experiences, are extremely triggering for traumatized clients. As much as they have a limited tolerance for distressing feelings, often there's even less tolerance for positive feelings.

Dr. Buczynski: Let's take a deeper look at why this is. . .

Ms. Dana: The nervous system has been shaped to be more in these patterns of protection than connection. As the client will begin to reach out and is met by your welcome, your autonomic welcome, your face, your gestures, just your presence can feel dysregulating to a client because it's not the expectation that their nervous system has been used to.

The nervous system is not used to this, it feels unfamiliar, there has not been predictable moments of being safe and feeling a positive emotion.

How to Help Clients Safely Experience Positive Emotions Again

Dr. Buczynski: Just like we said earlier in this session, a patient might associate pleasure with danger if someone once shamed them for being too loud or exuberant.
And so, the nervous system remembers that "feeling good isn't safe."

Now, in Module Two, we covered the Window of Tolerance, which is a tool that can help you and your patient track their arousal level.

The thing to know is, when a patient experiences positive emotion, it can sometimes bring them out of their window and into hyper- or hypo-arousal. This may cause them to panic, freeze, or even dissociate.

So how do we recognize when a patient might have trouble experiencing positive emotion?

Dr. Lanius: Often, when somebody has this incapacity to experience positive emotion, what they also feel is that they're non-deserving. And I think this is another very important question we need to ask when we do an assessment.

So, "Do you have difficulty experiencing positive emotion? Do you get flooded by negative emotions when you start to experience something positive? And do you feel non-deserving of experiencing anything positive?"

Dr. Buczynski: So how do we help patients begin to safely experience positive emotion? How do we help them break the association between feeling good and traumatic experience? According to Dr. Janina Fisher, the first step is to help the patient understand why positive feelings are linked with discomfort.

Dr. Fisher: One of the things I do is I ask people, "How did not being able to feel good things, how did that help you to survive?" And usually what I hear is, "Well, it wasn't safe. Because if I was smiling, my dad would say, 'I'll wipe that smile off your face.' If I was excited because I had been chosen for the school play, my father would call the school and say, 'No child of mine is going to be in some dumb school play.'"

And so, of course your body had to do what it had to do to help you survive.

Dr. Buczynski: Next, we want to help the patient titrate their positive emotions. We can do this by encouraging the patient to feel positive emotions that are within — but slightly stretching — their Window of Tolerance.

Dr. Ogden: I think with positive emotion. . . It's really helpful to go to the edges of the window with positive emotion. Because with positive emotions, both high-arousal emotion as well as low — emotions like calmness and satisfaction and contentment — traumatized clients have trouble at both ends because those extremes are coupled with fear and dysregulation.

The more you can go there and reregulate — go there again, reregulate, go to contentment and feel the anxiety, reregulate — the more you can do that at both ends of the Window of Tolerance, the more you'll build capacity for positive emotion.

Dr. Buczynski: And finally, to lock in the idea that these emotions are safe, you might want to have your patients stop, notice the feeling, and savor the pleasant experience.

Ms. Dana: So, I probably would also talk to a client about that experience of savoring, to stop there and notice it for five or ten seconds. It's a simple, quick practice. And again, to know that even with five seconds of stopping there and noticing it intentionally, that what should be an amplifying experience can quickly become a dampening experience. Because as you recognize it and put attention on it, it can feel like, "Oh, I shouldn't." There's that old sympathetic pathway that comes in and says, "Not safe. Shouldn't. Something bad will

happen if I feel something good." Those are the thoughts that get created, the stories that get created out of these dysregulated nervous system states.

Working with clients who really struggle to feel safe in feeling good, again, we want to just notice those micro-moments and let clients know that as the micro-moments begin to build up, it's going to be easier to feel good and feel safe in feeling good.

Dr. Buczynski: Deb just made an important point — and that is that during this savoring process, a patient's nervous system might revert to feeling unsafe when they start to feel good.
So, if this happens, how can we get a session back on track?

Dr. Fisher: As the therapist, I have to be very careful because we therapists want to relieve distress, but we also want heightened feelings of pleasure and wellbeing. And so, I have to often restrain myself from trying to increase the connection to positive effect too fast. I have to understate and I have to say, "Okay. Yeah. So, just feel this feeling of warmth, just feel this feeling of calm, and is it pleasurable or unpleasurable?"

And sometimes clients say it's very uncomfortable. And I say, "Yeah. Yeah. It's very uncomfortable. Because it's so new, and it was so dangerous when you were a kid. Right? So just notice it, notice the discomfort, notice the feeling, notice both together." Because over time, if my client notices both, "I like this feeling of warmth," and "I'm aware of the discomfort," over time, the discomfort, decreases.

I think the more we help people to understand, "Of course, right now your body feels like you're doing something really, really dangerous. And just notice right here, right now, it's safe to feel this warm feeling. And we're going to help your body get used to it."

Dr. Buczynski: So, when helping patients tolerate positive emotion, I want you to keep in mind two key points.
First, you want to use skillful, gradual pacing. And second, you want to make sure that you're checking in with your patient's nervous system, so you can readjust that pacing as needed.

The next module will be our fifth and final session, where we'll look at how to work with patients whose trauma triggers problems in their current relationships.

And I just want to end by saying —what you do is so important. When you help someone heal from trauma, you're not just influencing one person—you're impacting that person's partner, children, friends, and colleagues. And this can cause a chain reaction to better our communities, states, nations, and the world.

Remember, we are all connected – and so your work has the power to change the course of civilization.

Thanks for watching. Take care.