

The Neurobiology of Shame, Part 1:

How Shame Triggers the Body's Shut-Down Response

Dr. Buczynski: Shame is such a powerful emotion, it can trigger the body's shut-down response.

According to Dr. Stephen Porges, this is because the body interprets shame in the same way it interprets another strong emotion.

And when this happens, this is the direct way Stephen disrupts it.

Dr. Porges: Shame is a very interesting emotion or feeling – not everyone feels it, and yet, for a lot of people, it basically determines how they live their life.

Those who feel shame spend their lives trying to protect their body from the feelings associated with shame, literally building a whole set of protective mechanisms.

“Where are they feeling shame in their body?”

When people talk about shame, to make sure we're on the same page, I always ask them one simple question: Where are they feeling shame in their body?

I have had discussions with some of the people that you're talking to on this webinar series, and I was surprised that some of them used the word shame in a way that's not visceral – not a bodily feeling.

Yet when you talk to people who really experience shame, and it becomes debilitating, they're feeling it.

If you ask them where in the body they feel it, it's going to be below the diaphragm. Shame has physiological responses that are very similar to life threats.

That becomes the critical issue: our body gets challenged with words or feelings, and we try to disappear.

Shame has this whole effect on people – they want to disappear – they don't want to be there, and this very much may lead into dissociation and other sets of issues.

“Shame has physiological responses that are very similar to life threats.”

Dr. Buczynski: Do you find that people always know that they feel shame?

Dr. Porges: When we start using psychological constructs to describe bodily feelings, we're in an abyss.

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We're in an area where not everyone has the same labeling mechanisms or labels for the feelings that they have.

If you start thinking more in both an evolutionary and a neural-physiological model, you start thinking about adaptive responses and the association of some of those adaptive responses with situations.

If the issue of the initial shaming, or being shamed, is associated with a desire, a physiological reflex ability – not a voluntary desire, but a bodily response, then to get out, to disappear, to become invisible, to shut down, and to dissociate become the subsequent effects.

If shame is such a potent stimulus that the individual doesn't want to be in that setting, it triggers a physiological response of shutting down.

That's very primitive, so the question you're asking me is more about the issue of marginalization — becoming invisible, losing a sense of their body, losing the sense of others, and not wanting to be there — and sometimes this carries the word shame.

When someone feels shame, they lose their ability to have voluntary behaviors.

That's the other important aspect, and it hits sub-diaphragmatically – it hits the organs below the diaphragm, and when they get hit as a defense response, we're immobilized.

“When someone feels shame, they lose their ability to have voluntary behaviors.”

“A common theme among people who describe shame is a sub-diaphragmatic bodily feeling and the inability to move.”

So, a common theme among people who describe shame is a sub-diaphragmatic bodily feeling and the inability to move.

I actually think it's the initial association with an immobilization response.

The first response is like a baby or a child being yelled at by a larger person, and so fight or flight is not an option – the body often reflexively responds by shutting down, dissociating, and/or disappearing.

These are features that people of attachment theory often call disorganized attachment and features of dissociation when people are older.

Then, you start building associations, in a sense, higher brain associations with these very low core biological responses.

Now, you're into a sequence which is very difficult to break: if you try to get the person to, in a sense, experience the shame and shift the context of it, once they hit that physiological response associated with the shame, they're not in contact anymore.

I'd like to explain how we temper our feelings, and I'll use myself as a laboratory. Social anxiety, for example, is often a big issue for people, but I don't have a lot of social anxiety – public speaking is always fun.

But with other people when they get into that setting, their body falls apart – their whole notion of social anxiety is different for mine.

And the dimension of shame, which immobilizes many people, is the same. I may have done things that I'm not proud of – I may have memories of those things, but they are not immobilizing to me.

I have, in a sense, a tempered concept of shame within my own bodily feelings.

But I've talked to a lot of people, and shame is the critical, core vulnerability that they have, and everything is about protecting themselves from all the features related to shame – they don't even want to go near it.

So the answer to your question about shame is that there is great variation – there is great variation in the way people experience shame, and it may start earlier in life and may be associated with a profound bodily response.

The theme of my work, my ideas, my theories, and how I interpret a lot of critical syndromes is all about the physiological state as being an intervening variable.

If a person does something, it's not the event – what's critical is the response the person has.

So, you have a trigger — being yelled at or being criticized or being humiliated in public — that is the event, but it's not the critical point.

The critical point is having the bodily feelings below the diaphragm.

Do their legs get rubbery? Do they start to pass out? In a sense, did the body attempt to escape or disappear?

That is the core element of shame, and because it's a core element, the immobilization response is very difficult to deal with from a clinical perspective that focuses on explicit cognitive functions and voluntary behavior.

“If a person does something, it's not the event – what's critical is the response the person has.”

“The use of mobilization inhibits that sub-diaphragmatic response.”

Dr. Buczynski: Any thoughts on what works to help someone work through shame?

Dr. Porges: I would give you the basic principles of what the polyvagal theory tells us about these clinical states.

If you can elicit a voluntary behavior — a movement, a breath, a hand movement, a gesture — the use of mobilization inhibits that sub-diaphragmatic response.

Basically, by getting voluntary movement — it could be as simple as asking the client to stand up and sit down or asking the client to see if they can feel their hands, touch their body — voluntary movement requires a component of the autonomic nervous system, the sympathetic nervous system, that inhibits the sub-diaphragmatic, vagal, shutting-down response.

If we think of working with shame from neural-biological perspective, and we think of the psychiatric conditions as being derived from common core physiological states, then the therapeutic model should be focused on getting the person out of that state.

Dr. Buczynski: As Stephen pointed out, we all may have different ways of labeling the feeling of shame, but the physical response is very much the same.

In the next video, we'll look at how deep states of shame can be tied to depression.

I'll see you then.