

THE SEEDS OF SHAME;

THE DEVELOPMENTAL IMPACT OF PERSISTENT MIS-ATTUNEMENT IN INFANCY - IMPLICATIONS FOR PLAY THERAPY

Maggie Fearn
University of South Wales

Abstract

In the context of a humanistic, neurodevelopmental and trauma-informed approach to play therapy, this paper draws on theory and research that explores why some children appear to be more prone to shame than others, and how this may present in the play therapy room. A relational and neurobiological approach to understanding early child development supports the view that the infant actively co-creates the attachment relationship and, furthermore, that persistent mis-attunement in the first nine months may be correlated with proneness to core shame, with long-term impact on development in all domains. Expert interviews with a play therapist/bio-dynamic psychotherapist and a somatic movement therapist, and a play therapist's focus group discuss this perspective and applications to practice. Findings suggest identifiable play themes and play behaviours that may be indicative of core shame. Because of the implicit, hidden and visceral nature of core shame in the therapeutic dyad, the importance of therapeutic relationship is highlighted. An embodied approach to therapeutic presence is explored, with implications for therapeutic use of self in relationship with the child.

Key Words: Infancy, Attunement, Shame, Play therapy, Somatic movement therapy

Introduction

This paper draws on a humanistic (Axline, 1969, 1971; Landreth, 2002, 2012; Oaklander, 2018) neurodevelopmental, and trauma-informed approach to play therapy (Jennings, 2011; Gil, 2010; Prendiville & Howard, 2017). It is underpinned by the premise that play activity is a child's primary medium of communication (Landreth, 2012), that healing happens through play (Schaefer & Drevew, 2014), and that the

interpersonal neurobiology of therapeutic relationship is integral to healing, and compatible with play therapy processes (Kestly, 2014; Wheeler & Taylor, 2016).

As the author has previously stated: 'An integrative and humanistic play therapist approaches play therapy with deep curiosity about the child's experience of being in the world, as expressed through their play on a moment-by-moment basis. As well as the therapist drawing on

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the therapeutic powers of play (Schaefer & Drevew, 2014), considering the play environment and applying different theoretical approaches to therapeutic presence according to each child's needs, the therapist's curiosity is informed by study and observation of psychological and physiological development processes' (Fearn & Troccoli, in Prendiville & Howard 2017: 109).

Method Overview

This study used a qualitative mixed methods approach. The researcher seeks to answer the research questions by evaluating and synthesising current theory and a range of practical experience through the literature review, expert interviews from the fields of play therapy and somatic movement therapy, and play therapists' responses gathered during a focus group discussion.

The research questions were pre-formed as part of the study design and they provide a structure for the whole study. The literature review provides theoretical perspectives (Wisker, 2008) and establishes the foundations, parameters and contexts from which to explore the research questions. It also provides the theoretical underpinning that informs the analysis of the findings from the focus group and interview data. Interviews with experts in the field provide detailed investigations of the research questions from personal experience (Legard, Keegan & Ward, 2003). Majella Ryan IACP, a very experienced child, adolescent and adult biodynamic psychotherapist and play therapist, who utilises play therapy in her work with children who are dealing with the impact of relational trauma, and Kerstin Wellhöfer, an ISMETA registered somatic movement educator and therapist with a particular interest in early developmental movement in attachment relationships. Both interviews were planned as a semi-structured format, with scope for each of the interviewees to interpret the questions in their own

way. Both Ryan and Wellhöfer were sent the questions in advance of the interview date, so that they could familiarise themselves and consider their answers. Both interviews were conducted via Skype for one hour, and audio recorded. Both interviewees were asked the same questions in the same format, but not in the same order, as the researcher allowed them to lead the discussion in the way they wanted to. The researcher kept time and ensured that all of the planned questions were addressed.

The researcher also decided to use a focus group because she wanted to involve her contemporaries in a process of exploration. The five group participants were self-selecting. They needed to be willing to travel to attend the discussion, so they were geographically clustered within reach of the venue in Wales, UK. All participants either work or study in the field of play therapy or counselling children and young people and therefore have a shared background and relationship to the research topic. At the time of the focus group, four were educated to post graduate level, three had attained MSc Play Therapy in the last ten years and one was currently in her final year of study, three participants had more than twenty years experience working with children and young people, and the other two had ten years and five years respectively¹.

The focus group was planned as a semi-structured discussion and the researcher was open to unanticipated issues arising, following the guidelines from Finch and Lewis (2003), who describe focus group discussion as a mutually beneficial experience during which participants listen to each other and refine their ideas. Although everyone was informed about the research topic and the draft title, they were not sent the questions in advance. The researcher was keen to give the participants an opportunity to convey their own meanings and interpretations in a supportive context and she used the planned questions as prompts to guide the discussion when necessary, following the group's lead. She did not participate in the discussion apart

¹ Maggie Fearn is a child and adolescent psychotherapist and play therapist. She is Senior Lecturer MSc Play Therapy at University of South Wales and visiting lecturer at the Children's Therapy Centre, Ireland. She also works for The Windfall Centre as a play and filial therapist and clinical supervisor.

¹ Ethical approval was granted by the Children's Therapy Centre, Eire Ethics Committee. All seven participants gave signed consent to participate in the study and for their data to be used in publications about the study.

from prompting. She asked similar questions as in the expert interviews, but not in a planned order and she did not expect all of the questions to be covered, although in fact they were. The discussion was planned for one hour and extended by twenty minutes by mutual agreement, and was audio recorded. The different levels of experience and expertise in the group were seen as a distinct advantage, enriching the data from different perspectives.

The focus group data was shaped by group interaction, and provides a social context to the study, providing some evidence of how people talk to each other about the topic, and how they display and discuss difference (Finch & Lewis, 2003). The researcher regards the participants' own interpretations of the research questions as critically important and the findings are presented in a way that reflects this, in that the participants' own words were used as much as possible in the process of analysis. The audio recordings were transcribed by the researcher and checked back against the recordings for accuracy three times. The resulting transcripts and the literature review were systematically analysed and coded by the researcher. Thematic analysis of the entire data set was planned from the start as a deductive process, driven by the researcher's theoretical interest and preconceptions. She was interested in identifying relationships between the theoretical literature and personal accounts from the field of therapeutic practice with children. This fits with Braun and Clarke's (2006) description of a constructionist approach where broader assumptions and structures are theorised as underpinning what is actually in the data. The researcher acknowledges her bias, in that this study is driven by a desire for synthesis of theoretical argument and evidence from clinical practice, and the data was analysed with this agenda in mind.

Thematic Analysis - Results

The researcher initially coded for thematic analysis of the dataset according to the research questions (R.Q. A-F), and then, following Braun and Clarke's (2006) six-stage process, she arrived at a set of recurring themes summarised here:

R.Q. A. What is shame's function?

The main themes of Regulation and Embodiment were identified, with the subtheme of a functioning Attunement/Misattunement/Attunement cycle related to Feeling Safe, Socialisation and Core Affect (positive and negative).

R.Q. B. Is shame a core affect of the maturing primary attachment relationship?

This question is not answered directly or definitively. Its significance lies in the exploration of shame as a neuro-physiological event, and is related more generally in the data to affective development, the differentiation of emotion and pre-verbal development of a sense of self. Its relevance to the main theme of Embodiment with the subthemes of Core Affects (positive and negative) and the development of Core Beliefs (positive and negative) is explored.

R.Q. C. What turns healthy shame interactions into core shame?

The main themes of Regulation and Embodiment with the subtheme Persistent Misattunement related to Feeling Not Safe, Dysregulation and Core Affect (negative) and Core Beliefs (negative) defines the conditions for Core Shame.

R.Q. D. What does core shame look like? What does it feel like?

The main themes of Regulation and Embodiment with the subtheme Persistent Misattunement, resulting in Feeling Not Safe is linked via Dysregulation to Core Affect (negative) and Core Beliefs (negative) with distinctive association

towards Introverted and Extroverted modalities. Core Shame itself is strongly linked to the Introverted modality and the dynamics of Concealment and Contamination/Contagion.

(R.Q. E-F Section 2: Relevance and application in play therapy practice)

R.Q. E. How can a play therapist recognise core shame proneness?

In analysing the data set, themes relating to The Child's Presence and The Therapist's Use of Self were distinguished and then placed in relationship with each other. Thematic analysis applied to R.Q. D. (What does core shame look like? What does it feel like?) was also applied to The Child's Presence, Play Themes, and Behaviour. Therapist's Use of Self was analysed according to Embodiment and Attunement (qualities). Emphasis was placed on understanding the dynamics of shame interactions in relation to Transference and Countertransference.

R.Q. F. How can a play therapist work with children vulnerable to core shame?

Thematic analysis of The Therapeutic Relationship was analysed according to Therapist's Use of Self with key themes of Embodiment and Attunement (qualities) and emphasis on 'being with' the child and recognising Play Themes and Dysregulation (Introverted and Extroverted), and with the addition of recognising the child's Time Travel, and significant Turning Points in the therapy. Emphasis was placed on managing the dynamics of shame interactions in relation to Transference and Countertransference.

Findings and Discussion

These themes are now discussed in relation to the literature, expert interviews and the focus group:

Regulation and Embodiment

Does the way we respond teach shame?
(H. Focus Group).

Kohut (1977), Schore (1998) and De Young (2015) suggest that an infant's first experiences of

shame interactions may not necessarily be associated with guidance, discipline or punishment. Rather, these are brief moments of mis-attunement that cause distress, which is recognised by the parent, who moves quickly to soothe and regulate the infant, making possible the potential for the child's ability eventually to self-regulate.

Stern (1985) and Panksepp and Biven (2012) propose that curiosity and stimulus seeking appear to be motivational systems. Typically, a securely attached infant and carer in face-to-face interactions will generate increasingly pleasurable experiences during the first year. When necessary, the carer will do her best to soothe and calm the infant's overstimulation, by staying calm herself and attuning to the child's emotional and physiological needs. At its most synchronous, this exquisite dance between infant and carer has an energetic, resonant frequency that Stern (1985:132) calls 'interactivity'. Schore (1998) suggests that these early interactions support the emergence of a broad range of emotional states experienced by the child during infancy, and regulated by the mother via facial expression, voice modulation, rhythmic movement and sensitive touch and gesture. Positive and pleasurable processes promote and prolong contact, embedding patterns of interaction in the right brain limbic area that build up implicit memories of a warm and secure attachment relationship. Schore argues that there is a paradigm shift occurring in human development sciences, from a preoccupation with cognition, to acknowledgement of the fundamental importance of an attachment bond of emotional communication and the maturation of affect' (2005:205). He describes the phenomenal brain growth spurt, predominantly in the right hemisphere, which begins in the last trimester of pregnancy and continues until the end of the second year, shaped indelibly by the emotional communications within attachment transactions' (ibid.). The non-verbal, pre-conscious right brain specialises in processing affective states, providing information for the limbic system to adapt to rapidly changing environmental information and to organise and store patterns of learning. The primary attachment relationship is formed through right

¹ Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006: 80). In this study the analysis of the literature review findings and the expert interview transcripts provided a theoretical framework and epistemological context for analysis of the focus group transcripts: a triangulated analysis resulting in a thematic map that integrates theory and practice.

brain-to-right brain dyadic communication of emotional states, flowing back and forth between mother and infant via movement and touch, and face-to-face interactive play, facilitating the development of neural networks that will mature into the child's capacity for self-regulation. According to Schore (2005) this is the implicitly driven, primary goal for the infant during the first postnatal year. Stern (1985) describes how during this developmental phase, repeated, consistent patterns of interactions encode meaning into the infant's immature nervous system, forming implicit representations that are generalised into anticipation about relationships. Badenoch (2008:106) envisions the formation of an 'inner community that embodies these expectations', a prototype of the self-in-representation that will emerge as the child starts to move out into the world. Hofer (1984) proposes that internal representations of external human relationships serve an important intra-psychic role as biological regulators that control physiological processes.

Attunement and Misattunement

During interactions between securely attached mother/infant dyads, moments of asynchrony are inevitable and result in stress for the infant. In observations of mother/child interactions Chapple (1970), Feldman (2007) and Trevarthen (1979) identify a period of stress following misattunement, closely followed by attunement and synchrony that allows for a recovery period. The baby's facial expression, postural collapse and averted gaze are non-verbal signals of her distressed state and negative arousal. A sensitive caregiver will recognise the baby's state and engage in a 'mutual gaze visual affect regulating transaction' (Chapple, 1970: 631). As the mother and child are tuning into each other through gazing, prosody and touch, homeostasis³ can be re-established.

In this way the mother and baby develop characteristic strategies to deal with mis-attuned

states and the resulting distress, and 'these events are stored within an internal working model of a secure attachment' (Schore, 2005: 67). Of particular relevance to this study, Schore calls these continuously repeated events 'shame transactions' (ibid). In Schore (1998) he argues that the distress of disconnection that distinguishes the shame transaction and the return to homeostasis is directly related to visual information, particularly facial expression. Memory traces are detected in the right hemisphere orbitofrontal cortex: 'the core relational shame transaction becomes internalised in implicit, procedural memory as a visually stored image' (1998: 68). He proposes that this is crucial in the dyadic socialisation process: over time the experience of being watched over by another becomes 'the eye of the self, gazing inwards' (ibid) and, by late infancy the child does not always need an external person to regulate her actions in familiar contexts. Integrating the potential to modulate shame experiences is an important developmental step that supports the child's ability to adapt to rapidly changing environmental information without dysregulating. In late infancy and into the second year, as the child explores further into the world beyond the primary attachment figure, these transactions become crucial in the dynamic socialisation of the child.

However, when the infant's needs are not acknowledged and misattunement is persistent, the infant's experience of loss of intersubjectivity (Stern, 1985) activates intense panic and grief, which she is unable to modulate by herself, and there is no possibility of rescue. It is a matter of survival, and her experience tells her she is not worth saving. Proneness to core shame is the implicit acceptance that the dreadful feeling that arises out of misattunement is to be expected in relationships, because there is something inherently worthless about her. Once the process of socialisation of the infant has begun, which Stern suggests can be from as early as 7-9 months old (Stern, 1985), deliberate misattunement, which are inherent in healthy

shame transactions, only intensifies the child's suffering, because she has no experience, therefore no expectation, that relief will come swiftly through re-attunement, as occurs in healthy shame transactions.

Thus, a secure attachment relationship between child and primary carer acts as a buffer against core shame developing, because the child has an innate belief that she is worth saving. In agreement with interviewee Ryan, Dunn (1988) provides evidence that typically developing children in securely attached relationships show a robust tolerance of parental disapproval by playfully testing limits and boundaries. Therefore, this study suggests that the child who has integrated a felt sense of sustained and positive connection in the first year may be less vulnerable to core shame because she has an innate coherent and positive sense of self. This recalls De Young's hypothesis (2015: 20): 'What leads to chronic shame is unrepaired disconnection between parent and child, not a parent's intention to shame the child'.

When discussing misattunement, the metaphor of 'rupture and repair' of attachment (Siegel, 1999: 314) is used in the literature and in the transcript data. However, from a somatic perspective (Bainbridge Cohen, 2012), this concept does not fit easily with the continuous organic process of development within the nervous system. In order to understand the dynamic process of early shame interactions we need to have a felt sense of the young child's intersubjective experience (Stern, 1985). She is in an arousing positive affective state of excitement and expects her caregiver to join her and amplify her joy, but instead she encounters abrupt and unexpected misattunement. Her nervous system does not know how to survive the unexpected response, and this generates imbalance, which causes dysregulation and distress, which in turn causes affective acting out behaviours as the child's system tries to self-regulate. There is no rupture. Rather, the unexpected return interacts with the process of this child's lived experience of being in the world, and triggers the nervous system into a dysregulating arousal, simultaneously

embedding that script into implicit memory. There is no repair. Rather, if the carer then moves quickly to soothe the child's distress, the second return alleviates the imbalance caused by the misattunement, and it will re-pattern the system towards homeostasis (Bainbridge Cohen, 2012), simultaneously acquiring the entire experience as another neurological possibility implicitly learnt for the future. Thus, the child acquires the experience of more than one option arising from an interaction with the world; her core sense of self remains coherent and her 'Seeking System' (Panksepp & Biven, 2012) her life force, is encouraged, within the paradigm that it is safe to explore the world because she is seen, she is known and her needs for safety and attunement will be met.

Every interaction that occurs between an infant and her carer is a neurological experience that contributes to continuously shaping and patterning the body's physiology and responses. Positive interactions increase possible actions and responses, whereas negative interactions restrict and limit the possibilities. The quality of interaction informs the ongoing organic process of change that occurs in the nervous system and patterns implicit memories. We can therefore clarify further De Young's (2015) important statement in order to explain how a child who is prone to core shame may have integrated an implicit expectation of dysregulation in relationships, before shame consciousness is possible.

Recognising Core Shame

The literature establishes that implicit memory begins in utero, therefore at 0-2 months the infant is already actively co-creating experience with her mother. As interviewee Wellhöfer suggests, it is as if they share the same nervous system. The infant's brain is not fully developed at birth and grows exponentially fast in the first two years through affective and sensory interaction in relationship (Perry, 2008). As Ryan also observes: "the child is trying to make sense of their world through their mother's eyes" and internalising the gaze of the mother matures into self-regulation: 'the eye of the

³ Human physiology and neurophysiology are characterised by a continuous, dynamic process of modulation, regulation, compensation and activation designed to keep our body's systems in some state of equilibrium, or homeostasis' (Perry & Pollard, 1998: 33).

self gazing inwards' in Schore's beautiful phrase (1998: 68). The developing child is innately driven to seek care and connection and failing to reach out successfully makes the impulse 'toxic':

You bid for your parent's love past infancy ... you bid for their love and attention and acceptance ... ideally in a good enough situation 70% of the time you achieve that, 30% of the time something fails, but it's repaired, and that seems to be the key thing ... If it's rejected the need becomes toxic

(G, Focus Group)

In considering the relationship between shame and other emotions, Gilbert (1998) argues that any potential affect-behaviour is open to possible shame via the disapproval of others. As well as voice modulation, empathic resonance and qualities of movement and touch, affective interaction also includes gaze behaviour and facial expression (Chapple, 1970; Darwin, 1872; Lewis, 1992; Panksepp & Biven, 2012; Porges, 2007; Schore, 1998, 2005; Tomkins, 1963). Schore (1998) argues that the distress of disconnection that distinguishes the shame transaction is directly related to visual information, particularly facial expression. Misattunement that triggers a shame response may be communicated by the adult resonating negative affect on a spectrum of intensity, from communicating blank indifference to impatience, disgust, anger, blame, or criticism, through facial expression, voice modulation, and qualities of movement and touch. This paper suggests that although the impact can be mitigated by swift re-attunement, with repeated experience the infant's nervous system will accommodate the scars in implicit memory, and the infant develops a tendency to anticipate hurt. Thus, unconscious relational patterns are formed that persist over the life span.

Ryan proposes that shame interactions are linked to a child's innate need for approval. She

explores possible parent responses to a crawling one year-old infant's explorations. In healthy development the parent-child warning mechanism is designed to instantly stop crawling and walking children moving in order to keep them safe, literally to freeze them in their tracks (Cozolino, 2014). Ryan uses the example of an infant reaching out to touch a candle, the mother's intuitive response to grab the child, the child's startle, and the vital soothing response, supporting regulation. She speculates on the impact of no immediate move to soothe or regulate the child after a startle:

One of the things you're taught in biodynamic psychotherapy on that body level is that the child internalises the startle, and the startle actually gets held on a very physical level, so not just in a felt reality or an internalised sense of themselves, but really in a physical sense.

(Ryan, Interview 1)

Wellhöfer gives further insight into how being caught off balance triggers a primal startle/freeze response, and that an infant relies on her mother's attunement to complete the reflexive movement pattern:

Movements that might be part of the Moro reflex⁴ ... the initial fight flight reaction that the body naturally has to motor out, that is the startle, the opening yourself up, the asking for help, the receiving help, the really yielding into the help, the finding, the digesting, the resting and then that separating, differentiating yourself, saying OK, I'm OK again now ... (this can be) interrupted in any of its phases.

(Wellhöfer, Interview 2)

The findings suggest that repeated and persistent mis-attunement between primary carer and infant during the first year of life predisposes the child to core shame, whether the adult intends to shame the child or not. This raises the issue of

⁴ The Moro is a startle reflex and has two phases. A sudden noise or movement of the supporting surface will cause the infant to open and extend her arms, open her hands and cry. During the second phase the infant will flex her head, flex and draw in her arms across her body as though embracing and close her hands. The legs may extend or flex in both phases (Bainbridge Cohen, 2012).

unintentional misattunement, which could be attributed to energetic differences between mother and child, and may be a result of experiences that are passed on from one generation to the next. As this study argues, from a relational and neurobiological perspective, shame proneness is determined by the implicit patterns of interaction that are embedded in our nervous system. These "stories about ourselves" (Wellhöfer) are the implicit scripts that guide who we are in the world and how we interact throughout the lifespan. Implicit shame-based scripts distort and dysregulate everyday interactions (Bradshaw, 1988; De Young, 2015; Heller & LaPierre, 2012). In situations that trigger a parent's core shame, the parent may be unconsciously re-enacting their own shaming experiences with their child (Wellhöfer). The findings suggest that in cases of unintentional shaming, psychoeducation and therapeutic intervention with the parent may help the child. Encouraging a parent to develop a self-reflective attitude can change entrenched misattunement into self-awareness, understanding and attunement with her child, resulting in co-regulation and re-patterning of the attachment relationship.

Adults do also consciously use shame to punish children (Bradshaw, 1988; Kohut, 1977). This may be indicative of a chronic shame cycle, in which lack of attunement results in alienation, and the adult resents and negates the child (Van der Kolk, 2014). Conscious shaming can be characterised on a continuum of abuse, from deliberately withholding affection, to authoritarian discipline devoid of empathy, to the annihilation of the child's sense of self in physical and sexual abuse, to the denial of the child's right to exist through neglect. It is beyond the scope of this small study to explore the implications of working with parents who consciously shame their children.

According to the literature, and participant descriptions of what shame feels like, responses

indicate that shame itself is an introverted, visceral sensation that is intensely uncomfortable, implicit and often dissociated or projected, resulting in extrovert coping and defensive behaviours that are indicative of core shame but not an expression of shame itself. It is useful to consider the full range of behaviours possibly indicative of proneness to shame that may present in the playroom, because shame itself is so often hidden from view.

Dysregulation; Concealment; Contamination / Contagion; Feeling Safe/Not Safe

The next section summarises focus group and interview responses in relation to these four themes above.

The literature review describes a shame interaction as an interpersonal event that alters the body physiology, an implosion that leads to distress and dissociation. It is a profoundly personal visceral experience that is described graphically by the Focus Group participants and interviewees. Their responses have been divided into two different modalities:

- **Introverted.** Resonating with Schore's (2012) summary, they describe shame itself as a contraction, something that inhibits and restrains, induces nausea and a collapse inwards, causes emotional numbness and dissociation. It is something that takes you over, seeps into everything and comes to define who you are in the world. It feels annihilating.
- **Extroverted.** In agreement with the Compass of Shame (Nathanson, 1997) and Heller and LaPierre's (2012) Foreclosure of the Self, they describe reactive coping and defensive behaviours against the extreme discomfort of shame, such as defiance, denial, compliance, aggression and acting

⁵ Proprioception refers to the sensory information caused by the contraction and stretching of muscles and by the bending, straightening, pulling and compression of the joints between bones. Sheaths that cover the bones also contain proprioceptors ... Proprioception travels up the spinal cord to the brain stem and cerebellum, and some of it reaches the cerebral hemispheres' (Ayres, 2005: 41)

out as bad as you feel. Also, both interviewees describe how children seek proprioceptive feedback through pushing, pressing, constricting, constant chaotic movement, or extremely controlling behaviour, seeking security and control in a narrowed world.

Ryan describes a response to limit setting by a child prone to shame:

They dysregulate completely and become quite disruptive or fly round the room breaking stuff: what they hear is... or what gets triggered for them ... is that they're bad, and how they're bad.

(Ryan, Interview 1)

This fits with Wellhöfer's description of the child "Motoring out" physically, or verbally:

Getting away from ...sensations in the body ... or trying to establish a different felt sense of self ... speaking can be a way of motoring out as well, becoming very animated in a storytelling

(Interview 2)

'Communication from this level of hurt takes a long time to arrive and then announces itself as unspeakable' (Ulanov, 2001, cited in Schore, 2012: 98).

Shame doesn't come to me very quickly ... shame is something that you see fifteen sessions in, twenty sessions ... shame is something you dig out underneath everything else... it's the opposite of treasure isn't it ... it's like a coal that you find underneath, you know, before you get to the treasure of the child... it's all the dark black unlight-reflecting coal that sits on top of who the child is, and you don't get to that until you get through all the defences first and then you start to see stuff.

(G, Focus Group)

Shame is rarely mentioned by name:

Subconsciously the child has worked to really bury it. There's times when I've felt it and maybe we

would have discussed around it, I mean, I can't think of a time when a young person has said that word, and I can't actually think of a time when I've said it, because I would be really careful in using that word.

(S, Focus Group)

I think if there is any hint of the next layer of shame ... of somebody making a comment upon it or making you feel even worse that you're expressing about feeling ashamed, then you're not going to express it.

(Wellhöfer, Interview 2)

Shame is something you don't feel good about and you hide it.

(J, Focus Group)

Sometimes not caught as shame - sometimes caught much later.

(Ryan, Interview 1)

And often children blatantly lie:

I think as well, especially children, and probably adults as well, who are experiencing that kind of toxic and chronic shame tend to have a protective layer of lies around them, and so ... if somebody says to them, you've done such and such, they will deny that they've done it, even if you've just seen them do it ... they will lie that they've done it because that's their protection, that's their shell if you like, from more shame. They don't want to feel the shame from you and p'raps they just couldn't restrict themselves, they couldn't boundary themselves, but they don't want to feel the shame, so they lie.

(J, Focus Group)

There'd be a safety in it ... or perceived safety in it, there seems to be a distorted perception of what's safe.

(Ryan, Interview 1).

When shame is toxic, there is no part of the core sense of self that remains untouched by it (Nathanson, 1997).

It does actually start to seep into the sense of self to such an extent that it then begins to govern: very visceral, felt sense, absorbed, learnt, picked up in the misattunement, shame is already part of that story

(Wellhöfer, Interview 2)

Ryan describes how a young client expresses feelings of contamination/being contagious:

She said to me "I'm sorry for contaminating you". In the moment I didn't know how to respond to her, and sometimes we can only respond in a very immediate, in that very straight way ... and I said to her "I've worked in this area for more than twenty years, I've heard lots of stuff ... I don't feel contaminated when you tell me, I feel moved by your courage" and that was the truth. And I said to her "y'know it's a funny thing, contamination" I said, "cos it can feel very contagious sometimes" and I said, "you probably feel very contaminated but it doesn't belong to you... it belongs to the people who did this to you".

(Ryan, Interview 1)

Both the focus group participants and the interviewees explored characteristics of play behaviour that they identify as indicative of core shame. These provide further evidence of dysregulation, concealment, a sense of contamination and feeling unsafe:

- Has to tidy up all the time, needs order, leaves no trace
- Fear of getting something wrong
- Perfectionism
- Child makes a relationship with a play object that will not reject them
- Giving over responsibility for the play to the therapist
- Hiding/shutting therapist out
- Becoming controlling and manipulative in the play (eg either as behaviour during play, or these characteristics given to a play character)
- Animals or people shunned in play
- Themes of succeeding and failing
- Buried, things buried, and not wanting to look

at them

- Scrubbing the doll over and over again, just cannot get her clean!
- Killing animals in the play (often a desire to hurt something weaker/not human)
- Using imaginary voices, either hearing them or speaking for them

There is also evidence of an association between shame and post-traumatic play, which supports the links made in the literature review between persistent misattunement, shame proneness and relational trauma (Perry, 2008).

Because shame itself takes so long to be seen in the playroom, the findings also suggest that understanding the impact of persistent misattunement on the body physiology at the time it occurred, and how this affects a child's movements and non-verbal way of being in the world in the present moment, can be vital in identifying and working with proneness to core shame. Attuning to the child through movement can bypass resistance. Children constantly move as they play, so noticing qualities of movement can give the therapist volumes of information about the child's experience of being in the world. 'To an aware practitioner, our past is always detectable in the present' (Fearn & Troccoli, 2017:109). Because shame is hidden, unspoken and often dissociated, it is more likely to be first communicated through non-verbal, unconscious, idiosyncratic patterns of movement. "The 'not knowing' of being frozen out to yourself, not being in your power, not with your own truth" (Wellhöfer, Interview 2).

Misattunement between infant and parent in the very early infant stage will interrupt the full completion of the primary reflexes and the return to homeostasis will be obstructed, or the infant will have acquired adaptive coping strategies in the effort of trying to reach it. This incomplete movement will become an implicit pattern resulting in "incredible 'heldness' in the muscle body" (Wellhöfer, Interview 2). On the surface the child or young person may be able to give the impression that everything is all right:

But there is this almost subterranean deep freeze in the muscle body. It is sometimes really connected deep with the breath, so you notice that the person isn't engaging in a full flow of breath, that there is a limitation in the fluctuation of the diaphragm.

(Wellhöfer, Interview 2)

This resistance is also noticeable in how the child or young person responds to sensory information. Wellhöfer describes how the child can be defended against auditory and visual information, with noticeable tension in the jaw and neckline, which become "chronic places of shame". As a result

... there isn't in a hug or an embrace a sensation of sharing weight and yielding, there is like, a hold and then a letting go, and there isn't a clarity of taking enough time to differentiate and push back to reestablish that's you and that's me and we're OK here.

(Wellhöfer, Interview 2)

Ryan proposes that the most valuable resource we have in our work is ourselves. As therapists we must use ourselves daily in our work. In order to do this, we must ensure we are in a space that allows us to be fully present and aware of what is happening in the here and now, not just for our clients but for ourselves. The findings suggest that staying present in body and mind in order to give the child a sustained experience of attuned relationship demands self-awareness, honesty, courage, patience, tenacity and skill. The literature suggests that right brain to right brain communication in therapeutic relationship is facilitated by paying careful attention to voice modulation, affective resonance and qualities of movement and touch, and awareness that gaze behaviour and facial expression, particularly, impact on attunement with children prone to core shame (Schoré, 2012).

In therapeutic relationship the therapist becomes the regulating other (De Young, 2015) providing the conditions necessary for the child to take control of their own healing process. When settled into play therapy and feeling safe enough to

seek security, children have a tendency to find their way back to a safe time in their personal history, which is often embedded in implicit memory and from there they can imagine a different way forward, taking control and bringing it into consciousness through play. Ryan explains:

Even though it is terrifying they go back to the safe time, and of course for some there wasn't a safe time, so they go back to the womb. There wasn't a safe time in the world.

(Ryan, Interview 1)

She explores how a child with severe attachment difficulties travelled back in time in his play, and the challenges she faced in staying connected with him:

He used to set up the play where he'd want me to wrap him in the blanket and feed him a bottle, and he'd look for that mother-infant gaze, and I'd open my heart to him and meet him, and then I'd get head butted or spat on because he wanted it desperately, but the moment he got it he didn't want it, it terrified him. With him, I would get very wounded because my heart was open, but I was able to contain that and stay with him; I don't mean allow him to do that, but I was able to stay really present to him.

(Ryan, Interview 1)

Participant responses indicate that when being fully present in relationship with the child, the therapist can notice in her own body the child's experience in that moment. Findings suggest that a child experiences core shame as a visceral sensation before it is expressed as corresponding behaviour, or perhaps the visceral sensation may simultaneously be seen as behaviour. Tuning into how it feels to be in the presence of this child's implicit shame gives the therapist a located feeling in her own body and an opportunity for focused empathic response, attuning to the visceral sensation that shapes the child's behaviour.

It is therefore of paramount importance that the therapist is aware of how her own core shame issues manifest in therapeutic relationship with a child, in her feelings and in her thoughts and actions. Gil (in

Gil & Rubin, 2005) suggests that understanding counter-transference is a key skill in working therapeutically with children. If managed through supervision and personal therapy, it can bring our own life experience into the therapeutic play space: a conscious offering of the therapist's body-mind into the psychotherapeutic field as a valuable resource for insight.

Recommendations

This exploratory study has taken the researcher on a fascinating journey of discovery, and the findings suggest that there is much to be learned from a developmental approach to understanding why some children are more prone to core shame than others. Schoré (2012) notes that emotion researchers and clinicians have over-emphasised sympathetic dominant arousal at the expense of low-energy parasympathetic dysregulated states. The researcher offers this study as a small contribution towards re balancing this state of affairs. A relational and neurobiological approach to understanding child development supports the view that the newborn infant actively co-creates the attachment relationship and furthermore, that persistent misattunement in the first year may be correlated with proneness to core shame, with long-term impact on development in all domains. There is considerable scope for further exploration into the implications of this study particularly regarding the relationship between persistent misattunement and trauma, and issues of transference and counter-transference when working with children prone to core shame. Because of the implicit, hidden and visceral nature of core shame in the therapeutic dyad, there are also potential benefits in exploring further an embodied somatic approach to supervision and personal therapy when considering the therapeutic relationship.

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