Shame, Guilt, and the Body

An IoPT Perspective on Shame and Guilt as Survival Strategies and Self-Harm

Lilit Abrahamyan

Traumawork Institute, Oslo, Norway iopt.no

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Introduction

This thesis explores shame and guilt as survival strategies enacted through the body, examined through the lens of Identity-Oriented Psychotrauma Theory (IoPT), known as the Intention Method developed by Professor Franz Ruppert over the last 30 years. The study is motivated by a deep curiosity and commitment to understanding how these emotional dynamics operate not only as personal feelings but as embodied survival strategies.

This thesis is based on my work with over 35 individuals, during which I conducted more than 200 sessions in both one-on-one and group settings over the past 2.5 years. My focus on the body and self-harming behaviors is shaped by my own healing journey with bulimia, and the patterns I observed across client work where food, the body, and self-harm were consistently the site where shame and guilt expressed themselves most visibly. Shame and guilt as embodied survival strategies that manifest through the body are drawn from patterns observed across seven client documented cases out of which two carried clinically recognised eating disorder diadnosis.

Across these cases, a consistent pattern emerged: shame and guilt were present in all the processes, sometimes named directly, more often revealed through the body, through food, through self-harm, or through the relationship with physical existence itself. These patterns prompted deeper inquiries:

- What role do shame and guilt play in forming and maintaining self-harming behaviors enacted through the body?
- How do these emotions affect our relationship with our bodies, food, control, identity, and self-worth?
- What does IoPT offer in working with shame, guilt, and the body that other therapeutic approaches cannot reach?

This thesis aims to explore these questions by analyzing the inner structures, split identities, and trauma dynamics observed in my work with clients. My goal is not only to contribute to the field of trauma-informed therapy but also to provide a personal reflection on how these themes have shaped my development, both as a therapist and as a human being.

Personal motivation: My Bulimia Healing Journey and Beyond

After hearing about Professor Franz Ruppert's theory of the fragmented psyche, I searched for help with my bulimia and found the Traumawork Institute in Norway. My entry into IoPT was from the Module on Trauma of Sexuality. It was powerful and unexpected. This felt like the right place to start, especially after reflecting on the

connection between eating disorders and the trauma of sexuality discussed in the training. I kept silent about my bulimia, carrying immense shame, guilt, and a fear of being misunderstood or judged.

The first self-encounter process was intense. I cried through most of it. My first intention was "I am a woman." To my surprise, it touched on the Trauma of Identity — my sense of being. The resonator for my part "woman" appeared as a three-year-old child, crying out: "I don't care what or who I am — even if I am a chicken, I just want to be accepted and loved as I am." I felt confused and overwhelmed afterward, yet certain that IoPT was the path I needed. For the first time, I felt safe enough to face the truth, however raw or painful.

The bulimia attacks continued. Before committing fully to IoPT, I consulted a nutritionist who recommended psychiatry. I was resistant to medication. I felt I had to confront the pain through therapy or risk losing everything, including my life. I chose to continue my studies online while also participating in live training in Munich with Professor Ruppert.

Making the decision to go to Munich was agonizing. My younger son was turning one, my elder son was turning thirteen. They celebrated their birthdays in Yerevan while I was in live IoPT training, desperately trying to hold myself together. Did I leave my children out of selfishness? Did I feel shame and guilt for prioritizing my own survival? Was I attempting to escape, or was this an act of truly choosing myself for the first time? I still don't fully know.

What I do know is that healing was not a single moment or a single decision. It is a committed process. For me it began five months before Munich in online modules, and the parallel live work in Munich that deepened what was already underway. I followed my intuition. It proved to be life-changing. After seven months of committed effort to face my truth, the bulimia attacks were gone.

Looking back, I now see what happened more clearly. When my son was three months old, I decided I had to "get my perfect body back." Though I was at a healthy weight, I felt enormous and unworthy. I began dieting, effectively stripping away my only existing coping mechanism. With nothing left to hold the pain, bulimia came in as a more aggressive, self-harming response to the loneliness and terror I had no language for.

Bulimia was never a standalone disorder. It was the visible part of a larger network of survival strategies: self-harm, perfectionism, control, and deep-rooted shame and guilt. Throughout my healing journey, I learned that within the cycle of bingeing and purging, I was generating feelings of shame and guilt as a form of self-punishment — reinforcing the belief: *I am wrong. I am guilty. I must hide.*

Through IoPT, I discovered not a quick fix, but a space where my inner reality was welcomed without judgment. Although the journey was not linear, it gave me the tools to confront my true self. While the bulimia stopped, the healing process revealed other hidden layers of survival strategies. Gradually, I felt more present, connected, and safe within my body and myself.

Since beginning my training at the Traumawork Institutt, I have prioritized both personal healing and professional growth in parallel. My training includes twelve modules at the Traumawork Institutt, two years of live training with Professor Franz Ruppert in Munich, additional training with Vivian Broughton, and ongoing supervision with Professor Ruppert and a supervisor from Norway. This learning journey has not been separate from my healing — it has been part of it.

This is not a fairy tale of recovery. It is an ongoing practice of self-contact, self-compassion, and truth-telling. I continue my own therapy, meeting my traumatized parts and learning how to live without the layers of survival that once protected me. Healing, I have learned, is not an arrival but a continuous relationship with the self. And it is this understanding that I now carry into my work with others.

Understanding Shame and Guilt: Survival Strategies

Shame and guilt are emotions that shape our morals, relationships, and sense of self. *“Shame is part of a healthy psyche because it reminds us that we have made a mistake or done something that is not appropriate for the community in which we live. What is more important is whether the community is also living from a healthy psyche.”* Franz Ruppert (Love, Lust and Trauma, page 91).

Unlike primary emotions such as love, fear, and anger, I view shame and guilt as adaptive responses shaped by social expectations and early relational experience. They are not strictly good or bad — they can be expressed in healthy or unhealthy ways depending on how they are processed and what they are protecting.

Shame focuses on the self — *I am bad.* Guilt focuses on behavior — *I did something bad.* This distinction, while seemingly simple, carries profound clinical consequences. Healthy guilt arises when we recognize that our actions have harmed others — it motivates repair, nurtures empathy, and strengthens relationships.

When distorted by trauma, both emotions shift from signals into survival strategies. Unhealthy shame moves from regret over a specific action to a global belief of unworthiness, the shame of existence, where the person comes to believe: ***“I am the***

problem simply because I exist." (Ruppert, F., Love, Lust and Trauma, p. 91). Unhealthy guilt arises when individuals feel responsible for things beyond their control, stay loyal to irrational family rules, take on the emotional burden of caregivers, or feel guilty simply for having needs. This distorted form serves survival and keeps the person small, loyal, and hidden from a truth that once felt unbearable to face.

Franz Ruppert describes a profound emotional injury known as the shame of existence. This shame arises not from actions, but from one's very being, often rooted in early relationships where a child feels unwanted or inherently wrong. It stems from caregivers or society communicating a fundamental "no" — the idea that one should not exist. This ontological shame leads to the belief that existence itself is the problem. For individuals with self-harming behaviors, this belief can manifest in cycles of self-punishment and control, reflecting the deeper emotional wound of feeling unwanted or unaccepted.

Psychologist Paul Ekman differentiates shame from guilt in how they manifest physically. Shame is often shown through withdrawal — lowered eyes, a downward head tilt, and slumped shoulders — indicating a desire to disappear and not be seen. In contrast, guilt promotes engagement and action, often leading to confession or reconciliation. Ekman notes that guilt can enhance social connection, whereas prolonged internalized shame can result in isolation and self-rejection (Ekman, P., Emotions Revealed, 2003).

Professor Ruppert proposes that shame can function in a healthy way — as a signal that reminds us when we have acted against our moral values or community norms. While I understand this position, my clinical observation and engagement with the broader research literature lead me to question whether what functions as healthy in this context is more precisely described as guilt — what Brown calls "I made a mistake" — rather than shame, which she defines as "I am a mistake" (Brown, B., Listening to Shame, TED, 2012). This resonates directly with Ruppert's own observation that shame of existence leads to the belief that one's very existence is the problem. It is not a healthy signal but an identity wound. This remains an open theoretical question that I explored further in a research interview with Professor Ruppert on April 2, 2026, which I intend to develop in my future work.

3.1 Types of Shame and Guilt: An IoPT Perspective

Shame and guilt each manifest in four primary forms that are particularly relevant to trauma and self-harm. These categories presented below were developed through IoPT theory (Ruppert, F., Love, Lust and Trauma, 2018; Broughton, V., Trauma and Identity, 2014), practical observation, and a research interview with Professor Franz Ruppert (April 2, 2026), who confirmed this framework as consistent with IoPT thinking.

Shame:

- **Primary shame:** *I am wrong for existing as I am.* Preverbal, identity-level, somatic. Encoded before language and lived in the body — in posture, breath, and muscle tone.
- **Transferred shame:** the parent's unprocessed shame, carried by the child as if it were their own. Absorbed without awareness; feels mine entirely.
- **Social and adaptive shame:** a surface-level belonging regulator. Triggered by specific exposure, motivates hiding or social withdrawal.
- **Shame in the perpetrator dynamic:** split off, unconscious, avoidance-driven. Expressed through rage, grandiosity, or control to stay unconscious of the harm caused.

Guilt:

- **Survival guilt**: *I feel guilty for existing, thriving, or having needs at all.* Chronic, disproportionate, and rooted in early identity trauma.
- **Loyalty guilt:** *I betray my parent or system by healing or leaving.* Getting well feels like abandoning the traumatized parent.
- **Perpetrator guilt**: guilt from having caused harm, often split off and not consciously felt. Acted out through self-sabotage or compulsive self-punishment.
- **Introjected guilt**: guilt that belongs to the parent but was handed to the child. The child carries the parent's failures, losses, or actions as if their own.

3.2 Shame and Guilt as Survival Strategies

Shame and guilt become survival strategies when they are generated not as authentic emotional responses but as protective mechanisms in response to early trauma. In toxic or neglectful environments, the child cannot afford to recognize the caregiver as the source of harm — this would threaten the attachment bond that is essential for survival. Instead, the child turns the pain inward: *I am wrong, I must have done something wrong, if I change, I will be loved and safe.* By internalizing blame, the child maintains the attachment and avoids the unbearable truth of betrayal.

In this way, shame and guilt serve a paradoxical function — they are both the wound and the protection. They keep the person loyal to those who harmed them, small enough not to threaten the system, and busy enough with self-punishment to avoid looking at the deeper pain. As survival strategies, they are not signs of weakness. They are signs of intelligence — a psyche doing everything it can to survive an environment it could not escape.

IoPT in Practice: My Work as a Therapist

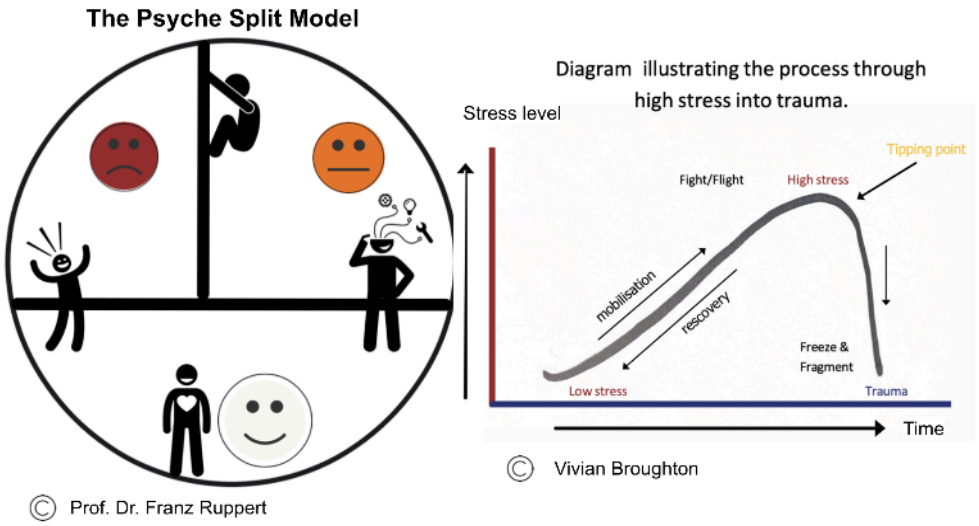
This section documents my work with over 35 individuals in more than 200 sessions over 2.5 years, in both one-on-one and group settings. Each therapeutic journey begins with a discovery meeting where I introduce core IoPT principles.

4.1 Ethical Considerations

To maintain confidentiality, names of intention givers in this thesis are not mentioned or have been changed in accordance with our therapeutic agreement. All clients were informed about the nature of the therapeutic work and consented to their anonymized cases being included in this research. No identifying information is present in the documented cases. In all cases, the therapeutic relationship was maintained with clear boundaries, transparency about the IoPT method, and ongoing attention to the client's safety and readiness to engage with the material.

4.2 Therapeutic Approach and Working Principles

Each therapeutic journey begins with a discovery meeting that establishes orientation and safety for the client.



Firstly, I explain Vivian Broughton's stress-to-trauma diagram (Trauma and Identity, p. 72). Clients learn about basic emotional responses such as fight, flight, fawn, freeze, and fragment. Secondly, I use Professor Franz Ruppert's Split Psyche Model to illustrate this the psyche splits in order to survive. I show three parts: the traumatised parts that carry unbearable pain and remain frozen at the moment of trauma; the survival parts that work to suppress and manage that pain; and the healthy parts that

remain connected to reality and hold the capacity for healing (Ruppert, F., My Body, My Trauma, My I, p. 25-26). This simple visual helps clients understand that their behaviors, including self-harm, food obsession, or emotional withdrawal, are not character flaws but intelligent survival strategies developed in response to overwhelming experiences.

4.4 Transition to Technical Work: Introducing Resonance

Resonance is essential in IoPT — it allows the intention giver to connect with internal dynamics through their own felt sense, or through the support of resonators in a group setting. To help clients experience resonance before a full self-encounter process, I use a simple introductory exercise in which each participant writes their own name and the name of a significant person on separate sheets of paper. These are shuffled and selected blindly. Participants then share their emotional and physical sensations as they hold the roles. As the session progresses, connections become evident — especially when deeper feelings such as guilt, fear, or sadness arise. This exercise consistently helps clients understand how the resonance field works before entering their own process.

In individual sessions, the intention giver formulates their intention. Each selected part for resonance is a floor marker with a name, placed on the floor. The client initiates the resonance process by standing on each marker, holding each, or using chairs to physically embody the parts by sitting on them. In online sessions, the same process is used, with objects or written materials visible on screen. This practical and flexible approach has been consistently applied across all sessions documented in this thesis.

Case Studies

Case 1 — Femininity, Visibility, and the Fear of Existence

The intention giver came to therapy sharing struggles from childhood, teenage anorexia, and a current obsession with alcohol in the evenings when feeling lonely. She believed that improving her sense of identity and relationships could help address both the loneliness and the alcohol use. We worked together in three individual sessions. All sessions were conducted onsite in a one-on-one setting.

In her first process — *"I want to find my femininity"* — the intention giver resonated with her "I" and "femininity." She initially struggled to connect with her "I". A recurring theme was feeling invisible and a deep desire to be seen, intensified by her complex relationship with her mother, experienced as dominant and overwhelming. She connected her teenage anorexia to her mother's harsh messages. A pivotal realization emerged: *"I am afraid to exist because if I exist, my mother will break me down."* By the end of the session, after expressing sadness and some anger, she could finally see her "I" and left with the insight that love must first come from within.

In her second process — *"I want to shine"* — she resonated only with "shine." This highlighted her deep desire for visibility, contrasting with her survival belief that she must remain small and hidden. An identification with her mother emerged — the same woman who had modeled invisibility. The competitive dynamic between them became visible and was mirrored in her friendships.

In her third process — *"I want to find myself"* — the parts "I," "find," and "myself" resonated. Although I do not recall all the details, the session was similar to the previous ones. What stood out was her tendency to compare herself to others, especially her close friend, making her feel inferior and invisible. She grappled with the desire to connect with her true self versus the belief that she would never be valued. By confronting her pain, she could integrate some parts of herself, but ultimately concluded, *"It is too much,"* which helped release some of the energy.

Therapist Reflection

Working with this client, I observed Trauma of Identity clearly, as well as deepened my understanding of primary shame, the belief that existence itself is dangerous. The teenage anorexia was not about food. It was about making herself small enough to survive her mother's presence. This became viscerally clear in one session when the intention giver made a cracking gesture with her hands—physically demonstrating what her mother had communicated with words: *"I will break you."* She was caught in a profound existential dilemma: *I exist when I do not exist.* This dynamic became even more visible when she shared her joy at finding her father's diary, in which he had written, with delight, that his daughter was an Aries — *"He did not do it for my brother,"* she said. In that small detail lived the hunger for being seen and valued simply for existing.

As a therapist, I learned to respect the psyche's pacing and hold space for what is not yet ready to surface. A client cannot reconnect with her authentic self until she first feels safe to exist. Sometimes, the most healing thing a therapist can offer is simply to stay present when the client meets her own limit.

Case 2 — Appearance, Illusion of Happiness, and the Fear of Separation

The intention-giver attended a single online session with the goal of losing weight. She presented with a long-standing struggle with body image and Binge Eating Disorder. Although only one session was conducted, the depth of material that emerged in this single process illustrates how quickly IoPT can reach core trauma dynamics when the intention giver is ready to meet her truth.

Her intention was *"I want to lose weight."* Starting with the word "I" she recalled her experience at eighteen when she had lost significant weight and begun a romantic relationship. Her boyfriend had frequently criticized her appearance, making her feel unseen and unappreciated. Despite her efforts, she regained the weight, internalizing the emotional pain and rejection.

She connected to the word "want" from her past at age fourteen, and deeper emotions emerged as she reflected on her parents' divorce and the pain of being separated from her father. She admitted feeling jealous of her father's new family, longing for what they had. For the first time, she voiced what had remained unsaid: *"I want my father to take care of me, to see me, and to love me."*

This led to a regression to age four or five, coinciding with her parents' divorce. In tears, she processed the grief of that early loss and felt calm afterward. I encouraged her to reflect on her prenatal period and birth story as she repeatedly used words like "always" and "as long as I remember myself." She remembered her parents' relationship deteriorating during her mother's pregnancy and described her own traumatic birth — delivered via emergency C-section. Her mother had been ill and emotionally unstable during that time.

In resonance, the part of her psyche emerged — deeply identified with her mother's pain and struggle. This brought her to a profound realization: *"I want to live."* Immediately, an intense inner conflict followed: *"I want to live my life, but I cannot leave my mother. What about her?"* The identification — the loyalty to her mother's pain — was a significant barrier to embracing her own autonomy. Simply recognizing this brought her relief.

Therapist Reflection

What began as a simple goal, *"I want to lose weight,"* unveiled a profound journey into identity, abandonment, and survival. Each layer of the intention revealed deeper needs: the desire for connection, the grief from her father's absence, and the weight of her mother's pain. Trauma of Identity was at the core. As a therapist, I learned that what presents as a body or weight concern is rarely about the body at all. It had become the carrier of an impossible choice.

Shame and guilt were present as two sides of the same wound. The shame was unconscious and preverbal — carried in the body, in the belief that she was not enough to be loved. The turning point — *"I want to live my life, but what about my mother?"* — showed the trauma of symbiosis in one sentence. This case illustrated **survival guilt** — guilt for thriving and living fully — and **loyalty guilt** — the inability to heal without feeling it means abandoning the traumatized parent — in their clearest form.

Case 3 — Orthorexia, Control, and the Cold Mother

The intention-giver initially came for coaching sessions with the primary goal of bringing order to her life. Over time, it became evident that her desire for control extended beyond herself. She applied strict rules to her food, her body, her daily routine, and her entire family. This pattern revealed an underlying obsession with control, which manifested as orthorexia — an unhealthy fixation on clean and healthy eating. We transitioned from coaching into IoPT work to uncover the deeper layers behind these behaviors. We worked together in three individual sessions.

In her first process — *"I want to stop controlling"* — the intention giver resonated with her "I" and "control." In resonance with "I" she shared that her mother was a cold and emotionally unavailable person. At age twelve, when her close friends and teacher moved abroad, she found herself emotionally alone at a moment when she desperately needed connection and warmth. Her healing sentence emerged clearly: *"I need a warm mother. I need a mother who is interested in me."* In resonance with "control," an identification with her mother emerged. Her orthorexia was revealed here as a survival strategy rooted in both guilt and shame — guilt for potentially becoming a burden, shame for having needs at all. The healing moment came after she recognized: *"I am as cold as my mother was. I have become her."*

In her second process — *"I want to share my perceptions only when asked and without insisting on the truth"* — the parts "I," "insisting," and "truth" resonated. In resonance with "I" it emerged that she had been given two different names by her parents following a conflict, and at school, she was known by yet another name. This split of identity since birth was heavy to hold. The energy shifted when she said, *"I want to be whole. I want to be one."* In resonance with "insisting," she regressed to the age of three or four, when she encountered her parents' conflicts. As a small child, she had tried to rationalize what was happening around her — searching for truth to feel safe. *"I want to be a child that is looking for warmth and comfort"* became her healing sentence. The breakthrough came when she said: *"I want my mother to be emotionally present"* — acknowledging that vulnerability, which she had always perceived as dangerous, was in fact her deepest unmet need.

In her third process, the intention giver continued working with the identification with her mother. She recognized that with obsessive control over food intake, she believed she would be healthy and wouldn’t become a burden for her children because her mother was a burden for her as she was ill and did not follow any nutrition or “healthy” rules the IG asked her to do. Moreover, she had to take care of her mother's treatment. But in the end, she repeated the exact pattern she feared in another form, becoming cold to her own children as her mother had been to her. In naming this, she took the first honest

step toward breaking the cycle. The recognition of her own perpetrator position was not met with collapse but with a quality of honest self-seeing that opened space for change.

Therapist Reflection

This case illustrated how orthorexia — on the surface a story about healthy eating — was in fact a story about loyalty guilt and survival guilt operating simultaneously. The intention giver felt guilty for having needs, guilty for potentially becoming a burden, and guilty for her mother's illness — none of which were hers to carry. The rigid control over food was her answer to it all. I observed how the identification with the perpetrator — becoming the cold mother she had resented — was itself a survival strategy rooted in transferred shame. She had internalized the only model of strength she had known and was unconsciously passing it to the next generation.

As a therapist, I learned that control and orthorexia are not about food or order. They are about the terror of needing someone who is not there. When the intention giver finally said, *"I want my mother to be emotionally present,"* the control began to soften. Not because the behavior changed immediately, but because the truth beneath it was finally named.

Case 4 — Bulimia, Self-Harm and the Body as Survival

The intention giver came to therapy, diagnosed with bulimia nervosa, taking a significant number of laxatives daily, and engaging in self-cutting. She had lost a large amount of weight in a short period by eating every two to three days, after which bulimia nervosa developed with severe physical symptoms, including hair loss.

We have worked together for almost 1.5 years across over 20 individual and several group sessions. This is the longest and most intensive therapeutic relationship documented in this thesis. It is also the only case where the new approach developed by Professor Franz Ruppert after September 2025 was applied, specifically in the final process described below.

The work began in a place of complete dissociation. In the first meetings, she shared that she felt nothing at all, which both frightened her and felt somehow acceptable. The early sessions focused entirely on helping her reconnect with her emotions. Over time, she began to feel—and then to fear what she felt. Shame around her very existence became the dominant theme. She had been born premature, kept in an incubator, and fed with a syringe. She had no emotional connection to this information when it first surfaced. She shared it as if it were a fact about someone else. Over time, the body began to connect what the mind had kept at a distance.

After approximately nine months of therapy, she agreed to see a nutritionist to support her nutrition. In one session, after a moment of good contact with herself, I suggested she might hold herself — like a safe haven. She said she could not. If she touched her arms, she believed they were obese, despite being thin. She also shared that when walking through a narrow space, she would turn sideways, certain she could not fit through, as if she still inhabited a body that no longer existed. The disconnection between the body she lived in and the body she experienced internally was profound.

Below are three session works from her entire IoPT journey.

In one of her first processes, the intention giver worked around *"I want to get out of the vicious cycle,"* referring to the obsessive control over food intake, laxatives, water intake, her appearance, and daily weighing. Only "I" was resonated. She connected to her teenage years, school, friends, and the hypercontrol that had entered her life when she turned twelve, imposed by her parents. Friends were everything to her, and without them she felt profoundly lonely. What emerged was that she had been parenting her friends — giving enormous amounts of love — while receiving very little in return. In resonance, she connected to the love she was giving and expressed a wish to be loved the same way. When I asked, *"Do you love yourself?"* emotions came. She ended the process with her healing sentence: *"I want to be true to myself."*

After this process, she set the intention *"I want to feel my emotions"* several times across multiple sessions. This became the foundational work, rebuilding the capacity to feel at all before anything deeper could be reached.

In a significant process, several months into the work, the intention-giver set the intention: *"I want to accept being healthy as normal."* Only "I" resonated. Early years surfaced immediately with an overwhelming sense of shame attached to her very existence. Body reactions followed, headache and dizziness. She shared that she had no memory of her mother's presence in her childhood — only her grandmother and her father's family. When asked about her birth, she named for the first time the story of being born premature, placed in an incubator, and fed by syringe. The information was present but not yet felt. She shared it the way one shares a fact about someone else. The loneliness and the prematurity were named but not yet integrated. What this process opened was a door, the beginning of a connection that would deepen in later sessions and find its fullest expression.

In her most recent process, the intention-giver set the intention: *"I want to stop hyperfocus."* This is the only process in this thesis conducted with the new approach developed by Professor Franz Ruppert, as it took place after September, 2025. After the preliminary talk, the trauma part named and resonated by the IG was “Alisa that feels

empty”. The intention-giver placed two markers for resonance using chairs, herself today, and for “Alisa that feels empty”.

In resonance, the part felt stiff and shut down, existing only from the neck up, creative and aware but without a body. However, it was aware of the body and experienced it as huge, disconnected from physical reality. It was identified with the mother as she shared that she recognizes her mother in this way. She decided to bring in the mother. She placed her behind the trauma part. Then she resonated with the empty part again and said: *"I feel safe because the mom is behind my back."* Then, after a pause, she said: *"That is not true. She was never there."* She placed the marker for the mother the way she wanted it. That was a shifting point. After a while, she removed the mother's marker herself from the field.

The resonance moved to the trauma part from survival, to the two-day-old infant in the incubator trauma part. What had been named but not felt in earlier sessions now arrived with full emotional weight. The loneliness and sadness that had been kept at a clinical distance finally became real and felt. To my question, *"What do you need?"* she said: *"I want to be aware that I am."* I proposed her stay with “*I am. I exist”.* An energy shift happened. She relaxed. Then she moved to resonate with herself today — and felt genuine contact between her present self and the part that had been waiting alone since the very first days of her life.

Therapist Reflection

This case has been the most demanding and the most humbling of my practical work so far. Over one and a half years, I observed a psyche that had developed extraordinary survival strategies: dissociation, control, perfectionism, and self-harm, all protecting the same wound: a two-day-old infant alone in an incubator who had not been held. What became clear at the beginning of work was that the control she exercised over food, her body, and her environment was to entrench the behavior towards herself, as she had from her parents. She had absorbed their control and turned it inward, becoming her own perpetrator. This is the vicious cycle in its clearest form — and the healing sentence *"I want to be true to myself"* carried the entire weight of that recognition.

The intention *"I want to accept being healthy as normal"* remains one of the most profound clinical moments I have encountered, naming what so many clients carry but cannot articulate: that health itself feels foreign, unsafe, and undeserved. This process triggered something deep in me as a therapist. I brought it to supervision and set a similar intention to encounter myself. This is an important reminder — the more intensively we work as therapists, the more we must do our own work. When a client triggers us, it is not a problem to be managed but information to be explored. Supervision is not optional. It is essential.

The final process demonstrated what became possible after 1.5 years of committed work. When she said *"She was never there"* and removed the mother's marker herself, that was not a collapse but a liberation. When she arrived at *"I am. I exist."* what had been named but not felt in earlier sessions finally became real. The part that had been waiting alone since the first days of life was finally met. This is what IoPT makes possible, not a cure, but a self encounter.

Case 5 — Weight, Existence, and the Need to Be Seen

The intention giver came to therapy as a professional in the helping field himself. We worked together in four individual online sessions.

In his first process — *"I want to be my true self"* — set twice across the work, the intention giver connected to his mother's stress during pregnancy. She had been studying while pregnant, and his early arrival two weeks before the due date was experienced as disrupting her plans. The shame of existing, of being an inconvenience from the very beginning, was present from womb time. A second and equally significant source of shame emerged: he shared having strong feminine energy, which had been criticized by his family, particularly his mother. He had loved dolls as a small boy, and that was when his mother was most available to shame him. His healing truth arrived clearly: *"I am loved by my mother when I am shamed."* Shame had become the condition for love, a fundamental survival strategy.

In his second process — *"I want to attract 20 clients per week"* — the work again returned to early childhood. At one to one and a half years old, he had felt invisible, and his mother stressed and unavailable. Food emerged as directly connected to love and existence. His mother and grandmother had expressed love primarily through feeding him. A confusion developed: *I am loved when I am fed.* His healing sentence was: *"I want my mother to love me in a healthy way."*

In his third process — *"I want to weigh 68kg"* — the parts "I," "weight," and "68kg" were resonated using objects. The "I" was represented by a hat he placed on his head, and he resonated with being aware of his "I" but not really seeing it. In resonance with "weight," a profound inner conflict emerged: *"If I am heavy, at least I can know I exist. My I is not strong, so the weight makes me feel my existence. If I am smaller, I am less worthy."* He then moved to resonate with "68kg". His hands began to shake. Strong body reactions emerged — nausea, self-hatred, shame, and dissociation. His resonated truth: *"It is dangerous to be attractive. It is dangerous to be seen."* The inner conflict became visible, weight kept him existing, but also kept him invisible and therefore safe. Being attractive meant being seen, and being seen meant danger.

Therapist Reflection

In this case, I observed both Trauma of Identity and Trauma of Love operating from the very beginning of life. The intention giver had not been wanted as he was; his existence had disrupted his mother's plans from womb time, and his feminine energy had been criticized throughout childhood. Love was available only under conditions, only when he performed shame, only when he made himself smaller or different than he was. Shame had become the condition for love, and therefore for identity itself: *I am loved when I am shamed.*

This case illustrated **primary shame** in its earliest form — rooted in womb time, before birth, before language. The weight process revealed one of the most striking inner conflicts. The body was simultaneously the proof of existence and the shield against visibility. This is the body as a survival strategy in its clearest form, not about appearance but about the fundamental question of whether it is safe to exist as oneself.

Case 6 — Shame as Identity: When Feeling Becomes Healing

The intention giver is a colleague with whom I have worked in a reciprocal therapeutic relationship for over a year, meeting monthly. This case is included because it demonstrates how shame as a survival strategy operates through the body and is covered and protected by other survival layers — including illusions about parents. Interestingly, she shared that as a newborn she had been fed on a scheduled hourly basis rather than on demand, and in her twenties had experienced difficulties with food.

Her intention was *"I don't want to feel my shame anymore."* I resonated "shame" in this process. In resonance, I, as her part, “shame” felt very small and sexually violated — an image of a man approaching kept appearing. I felt lonely, like an object people could do whatever they wanted with. When I shared this, the intention giver was confused and felt sensations in her genitals. She then shared that she had been sexually abused as a child.

She resonated her "I" and "feel." In resonance with "I" she was identified with her perpetrator uncle — once we brought in the resonance marker for the uncle, anger and rage emerged. Once she felt these emotions, shame began to lift. Her healing sentences arrived one after another: *"I feel that I am all shame. I am all covered by shame. Who am I if I am not shame?"* As “shame” in resonance rejection was felt. I switched to the facilitator role afterward. A shift happened on IG after she proposed welcoming all her emotions, meaning to welcome herself and her truth as they were. It resonated well in the IG, so she repeated: *"I welcome all my feelings”.* She relaxed and shared that she feels free.

When the energy calmed and the part “shame” felt welcome, pain and sadness of loneliness emerged from beneath, the original wound that shame had been protecting all along. There was genuine contact between shame and the other parts. The intention giver wrapped up the process at this point.

Therapist Reflection

This process confirmed that shame is not the wound itself — it is the cover over the wound. Shame had become identity: *Who am I if I am not shame?* The identification with the perpetrator uncle was a survival strategy — by becoming him internally, she avoided the full helplessness of her victimhood. Once the identification entered the field and anger emerged, shame lost its grip.

The dynamics between the victim and the perpetrator were clear throughout. I observed Trauma of Sexuality present in this case, and underneath it Trauma of Identity — the two layers that most commonly appear together in this work. The intention giver had a sufficiently strong, healthy "I" to face and begin integrating the Trauma of Sexuality — something I do not take for granted. Working with the trauma of sexuality requires particular care. As I describe in the therapeutic approach section of this thesis, I always address Trauma of Identity first — the client needs a stable enough sense of self before the deeper layer can be safely approached. Even when working with a colleague, this principle holds. This process confirmed for me that feeling is healing — not as a concept but as a lived clinical reality. The more we reject an emotion the more we reject ourselves. When we choose to feel, we choose to feel all of ourselves, all our parts, our whole identity.

Case 7 — Guilt as Control: The Vicious Cycle in Practice

The intention-giver came to therapy with a clear presenting concern: she felt guilty about everything. Small everyday moments, like parking her car imperfectly, would trigger worry that people around her were judging her. Food emerged as a secondary theme — she was attentive to her weight, felt guilty when she ate sweets, and alternated between healthy and unhealthy eating cycles. We worked together in three individual sessions with the same intention set each time. This case is included because it demonstrates how guilt as a survival strategy operates through the body.

Her intention across all three processes was *"I don't want to feel guilty."* Only "I" resonated in each session. She was mainly identified as a victim, with a strong rescuer part present.

In the work, it became clear that the trauma of physical abuse was present. There had been domestic abuse toward both her mother and herself. As a child, she had kept scissors and knives in her bed to protect her mother from violence. She never called her father "dad"— she referred to him only as "one of my parents." She held a strong illusion that her mother was perfect and could not yet acknowledge her mother's perpetrator position — her failure to protect. There was a clear identification with her mother's victim attitudes.

The guilt emerged as a control mechanism — *as long as I am guilty, as long as I do something wrong, I have control over the situation and can change it.* This kept her in the vicious cycle. She had been shamed in childhood and expected to be a perfect child; perfectionism and self-loathing became her primary survival strategies. The rescuer part appeared consistently — promising change, promising to do better — while the vicious cycle continued underneath.

A significant memory emerged in one of the sessions — the family had been short of money, and her mother had asked her to step back so nobody would notice her worn-out shoes. That single image carried everything: the mother's own shame transferred onto the child, and the child learning to make herself invisible to protect others from seeing the truth. The eating pattern she described — attentiveness to weight, guilt around sweets, cycles of restriction and indulgence — followed the same logic.

Across three sessions with the same intention, the layers deepened each time. The guilt was not random — it was organized, purposeful, and loyal. It protected the image of her mother, kept her identified with victimhood, and gave her the illusion of agency in a situation where she had had none as a child.

Therapist Reflection

This case illustrated **loyalty guilt** and **survival guilt** operating simultaneously in their most organized form. The guilt was not a feeling — it was a structure. It held the entire psyche in place, protecting the attachment to the mother, maintaining the illusion of control, and preventing the deeper pain of acknowledging what had actually happened. The worn-out shoes memory was a perfect illustration of transferred shame — the mother's shame passed directly onto the child's body, teaching her to make herself invisible.

I observed Trauma of Identity — she had never been allowed to exist as herself in an abusive environment without the burden of perfection and guilt. The eating pattern — attentiveness, guilt around sweets, cycles of restriction and indulgence — was the body expressing the same survival logic.

As a therapist, I learned that guilt organized around protecting a parent's image is among the most persistent survival strategies — because touching it means facing the unbearable truth that the person who was supposed to protect you did not.

Summary of Findings

Across the seven cases presented in this thesis, several consistent patterns emerged that deepen the understanding of shame, guilt, and the body as survival strategies within IoPT.

- Self-disclosure serves the client only when it is clearly beneficial — this was discussed directly with Professor Ruppert and confirmed in the supervision group.
- IoPT theory should not be over-shared in sessions. The client's own process is the guide.
- When the trauma of sexuality is recognized by the therapist before the client is ready, it must be approached with great care, without naming sexual abuse until the client arrives there themselves.
- Reflecting back on what the client has shared is among the most powerful therapeutic interventions. It allows the client to hear their own truth and begin making connections.
- Clients are the best mirrors for the therapist. When triggered, through overthinking, headaches, or dizziness during or after sessions, this must be taken to supervision and addressed in the therapist's own process. The more intensively we work, the more our own work matters.
- Space must be given to emotions before moving to floor markers or resonance. If resonance begins naturally without markers, it should be allowed to unfold without interruption.
- Shame presented as unconscious and preverbal across all seven cases carried in the body before it could be named. Guilt presented first, and the person consciously knew they were doing something wrong and hid it.
- Control was a shared survival strategy across every case: over food, body, environment, and relationships. What presented as control was always the internalization of an early experience of chaos, emotional unavailability, or danger.
- Problems with food, whether or not clinically diagnosed as an eating disorder, were consistently the surface of multilayered survival strategies. The body was the site where shame and guilt were most visibly expressed. As observed across cases, an intelligent mind and a creative psyche can develop many layers of survival, and food is one of the most common and socially tolerated vehicles.

- Trauma of Identity was present underneath every case, often preceding and shaping Trauma of Love and Trauma of Sexuality. Addressing the Trauma of Identity first was essential before deeper layers could be safely approached.
- The victim–perpetrator dynamic was observable across all seven cases. The rescuer part, often overlooked in trauma frameworks, was consistently present as the part that promised change while keeping the person trapped in the cycle.

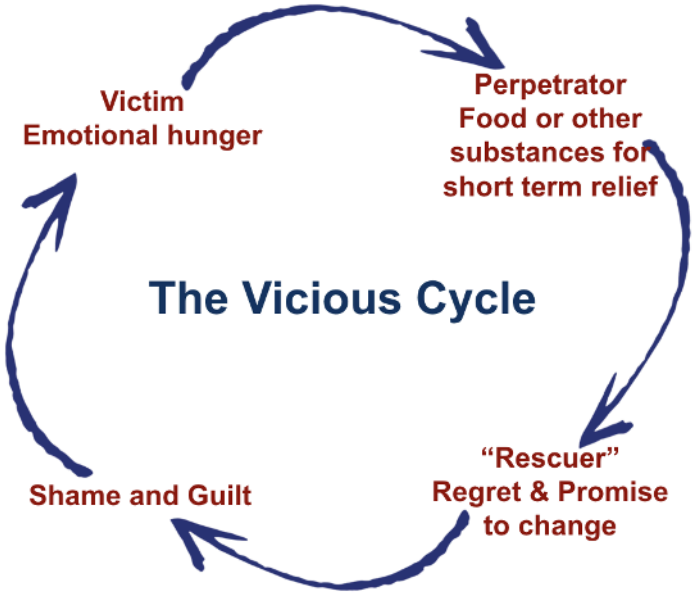


Figure 1: The Vicious Cycle (Lilit Abrahamyan)

The vicious cycle illustrates the internal dynamic observed across all seven cases — the victim experiencing emotional hunger, the perpetrator using food or other substances for short-term relief, and the rescuer emerging through regret and promises to change. All three positions are unhealthy survival roles. None of them leads to healing. Shame and guilt drive the cycle back to the beginning, keeping the person trapped in a fragmented relationship with themselves.

- Each session is a new beginning. Information from previous processes should not be brought in — the work is always with and through the intention that is present here and now.
- Reflections and hypotheses must be shared with humility — *"this is my suggestion, my hypothesis, my feeling — see how it lands for you."* This protects both the client and the therapist and keeps the process honest.

Conclusion

"An individual cannot take a cognitive approach to escaping from trauma because trauma does not exist in the thoughts but in the unbearable feelings and physical sensations and reactions connected with these feelings."

— Franz Ruppert, Symbiosis and Autonomy, p. 235

The seven cases presented in this thesis tell one story in seven different voices: the story of a psyche doing everything it can to survive an environment it could not escape. Shame and guilt, the body, food, control, perfectionism, and self-harm, none of these are problems to be fixed. They are answers to questions that were never safe to ask out loud. They are signs of intelligence and protection, not weakness.

What IoPT offers is a space where the body's truth is welcomed before the mind is ready to name it. Where the two-day-old in the incubator, the child who learned that love comes with shame, the teenager who controlled food to feel safe, can finally be met. Not analyzed. Not corrected. Met.

Food is not the problem. It is the symbol, the carrier of suppressed pain. The body is not the enemy. It is the keeper of everything that had no other place to live. Healing begins not when the behavior changes, but when the person beneath the behavior is finally seen and eventually felt by themselves. Feeling is healing.

This thesis is not a conclusion. It is the beginning of research that deserves to continue, of questions that deserve to stay open, and of a clinical practice that will keep learning from every person who is brave enough to set an intention and meet what is there.

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