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Shame and Attachment

THE NATURE OF SHAME

1. The feeling of shame can be described as a sense of smallness, worthlessness, and powerlessness in a given situation. This is compounded by a simultaneous sense of feeling quite exposed and extremely concerned about the other's evaluation of oneself. In fact, shame can be defined as the emotional experience of another's scorn, real or imagined. The "self-in-the-eyes-of-the-other" is the focal point of shame- "I am as I am seen". This tends to produce an implosion of the body: head lowered, eyes closed / hidden, and the upper body curved in on itself as if trying to be as small as possible. The aversion of eye contact in such moments is easily understandable and to push for eye contact in moments of shame can actually be hurtful.

2. Shame is much more visually based than verbally, as people report primarily internal images of being "looked at". Shame also induces hyper vigilant scanning in the service of self-protection.

3. Shame is more than a feeling. It is an entire organismic state that affects multiple systems in the body. Shame operates at primitive levels below the reach of rational thought processes. Embarrassment and humiliation are common variants of shame. Shame compounds itself like compound interest; we are frequently ashamed of feeling ashamed.

4. Shame is accompanied by intensified feedback from all perceptual modalities, particularly autonomic reactions such as blushing, sweating, and increased heart rate. These autonomic reactions induce a state of heightened bodily awareness which amplifies the extreme self-consciousness that is a part of feeling shame. That the autonomic nervous system is triggered by shame suggests that shame is interpreted by the brain as a crisis response, with the crisis most likely being a perceived threat to relational bonds and the highly valued resources they contain. Shame also brings with it a subjective sense of time slowing down which serves to magnify anything that occurs during a state of shame. All these elements come together to give shame the power to generate fight-flight tendencies (another indicator that shame is likely a crisis response). The flight option is the behavioral expression of the wish to disappear. The fight option is the verbal / behavioral expression of blame and rage directed towards another.

5. Shame is a self-absorbed, self-centered, and isolating experience. While acutely feeling shame, an individual is not considering the implications of his behavior for others, but is focused solely on the possible impact on himself. This has obvious troubling implications for developing attachments.

6. Shame is triggered by a "perceived" fundamental break in one's connectedness to others or to oneself. Behaving in a way that is significantly at odds with one's sense of identity can produce shame by leaving one feeling they have lost who they thought they were.

7. The more prone someone is to feeling shame, the more likely they are to have self-esteem deficits, blame others, hold onto resentments, and the less likely they are to feel empathy. Additionally, empirical research has consistently demonstrated a direct relationship between shame-proneness and depression, suicide, anxiety, addictions and family violence.
8. Shame-proneness in fifth grade accurately predicts all of the following in young-adulthood: drug and alcohol use, risky sexual behavior, legal involvement, suicide attempts, and degree of involvement / lack of involvement with the community.

9. Much of the power of what we term traumatic events lies in the shame bound up with these events. A useful distinction:

POWERLESSNESS: inability to influence the environment.

HELPLESSNESS: inability to manage, direct, or empower oneself.

Either of these perceptions creates shame as a by-product and either or both occur as part of the shame experience itself. Hence both of them are both cause and effect. The sense of powerlessness / helplessness includes not only the shaming situation itself but also its aftereffects. This spins an image of isolation out into the future, and this contributes to the intense anxiety that shame brings with it. The presence of shame increases the likelihood of future experiences of powerlessness / helplessness which can set up a progressively intensifying cycle.

10. Shame has a long history of being used for purposes of socialization {religion, education, family}. However, there is little empirical support for the widely held belief that shame has an inhibitory effect on behavior. The self-threatening nature of shame precludes the introspection necessary for longer-term behavioral change. There is empirical evidence that shame inhibits pro-social behavior, however.

11. PARENTING AND SHAME: Childhood shame bears a strong relationship to all of the following: parental hostility, lack of parental recognition of positive behavior, lack of discipline, neglect, over protectiveness, placing child in a parental role {parentification}, use of conditional approval, use of love withdrawal techniques, discipline that focuses on the child's self rather than behavior, and the use of public humiliation as a discipline tool. For children with attachment difficulties, ordinary discipline and being given directions is a reliable trigger for a shame reaction.

SHAME AVOIDANCE

1. DEFENSES AGAINST SHAME: The primary ones are denial, splitting, withdrawal, rageful acting out, perfectionism, entitlement, externalization, pre-emptive shaming of oneself, and inability to give or receive praise. Externalization deflects attention away from the self which reduces the chances of shame activation by minimizing any self-blaming. With practice, externalization can function as a pre-emptive strike in that it is employed so quickly, shame never even begins to be felt.

2. Protection from shame is also sought through disconnecting from one's overall feelings and seeking distance from shame-associated people, places, or events. Hyper vigilance is the method of choice here, for by placing attention intently on the environment, awareness of what is happening inside (FEELINGS !) is practically eliminated.

3. Shame elicits a "turning-of-the-tables", i.e., revenge. Shame-rage aims at triumphing over and humiliating the other, so the other is put in the position of experiencing shame.

In this way, escape from shame is sought by downloading it onto another. AD children wearing down their mothers typifies this. The mother's sense of being a terrible mother is the recreation, in her, of the child's shame. Eventually, the mother's shame-rage will erupt in hostility aimed at the child. This sets up a destructive cycle of reciprocal shame-rage, and to an AD child, this represents victory. However, this is self-deception in the service of self-protection. Directing hostility towards the other precludes recognizing that it is internalized shame-rage that is the real threat to oneself.

SHAME & THINKING

1. Shame is cognitively disorganizing, and this disorganization blocks thoughtful reflection in the moment of shame. This mental disorganization is also easily perceived as a threat to the self and therefore has much anxiety (which compounds the anxiety of helplessness) attached to it. This anxiety can impede subsequent reflection

about shame experiences after they have occurred which blocks learning from the experience.

2. Shame influences thinking in such a manner that explanations for events always rest on some perceived negative part of the self. The ideas that emerge out of shame tend to be stable over time because they are not modified by subsequent experience. These perceived flaws that carry attached shame can become a potent source of intrusive repetitive thoughts. This is sometimes mistaken for the intrusive thinking that is symptomatic of PTSD.

3. Shame is highly correlated with attitudes of entitlement, excessive self-importance, and exploitation. These attitudes increase the probability of shame experiences in the future as the unrealistic expectations they generate often go unmet, and the resulting sense of failure leads to shame.

4. Shame, by virtue of its intensity, cognitive disorganization, and heightened perceptual feedback, does not get encoded in memory discretely, but with a high potential for stimulus generalization. Shame spreads easily and defies higher level cognitive processes, such as logical thinking, to contain it. This increases the probability of future shame episodes.

5. Shame can manifest in fragmentation of thought and speech (pauses, repetitions, false starts, inaudible voice level, and unclear diction- all of which are common with AD children). Subjectively this often gets reported as "going blank".

6. Shame includes a sense of "I don't want to know" which becomes the basis for much denial as well as the self-protective "playing dumb" so typical of AD children.

SHAME & IDENTITY

1. Shame-based ideas involve negative views of the self that are all encompassing and block the recognition of anything good. In the moment of experiencing shame, no part of oneself lies outside the negative evaluation. Examples of shame-based core messages are: "I am not good enough", "I don't belong", "I am not lovable", and "I should not exist" (suicidal). This global self-criticism produces a sudden, but temporary, plunge in self esteem. The offering of positive feedback, in a shame-filled moment, is not only futile, but potentially damaging, for the person offering such feedback will be seen as completely out of touch with the one feeling shame.

2. Shame about the body always coexists with a deeper shame about oneself. If the deeper shame is not addressed no amount of more surface bodily changes will be satisfactory. Here is one blueprint for perfectionism: the endless pursuit of superficial changes that never is good enough because the deeper shame remains.

3. Shame defines a person as defective at their core, and this can extend to the point of believing one cannot even make adequate restitution so there is no point in trying. Any attempt to do so will only lead to more shame. This belief can be so pervasive for AD children that the idea of making amends never emerges.

4. Shame essentially splits the self into an "observer" and "the one being observed". The observer witnesses and criticizes the part being observed. The presence of another is not even required.

SHAME & ATTACHMENT

1. Losing the love of another is an experience that brings shame to the self. This occurs as a result of the loss itself, independent of the perceived reasons for the loss. Thus, a personal history of disrupted attachment(s) is intrinsically shame-filled. If the loss occurred at a very early age, an adopted child is still prone to arrive at shame via subsequent reasoning from the fact of having lost both birth parents. Healing is about addressing the loss experience itself and the child's explanation for it, not simply attempting to reassure the child that the loss of her birth parents was not her fault.

2. Shame follows experiences of personal betrayal, and young children experience abuse and neglect at the hands of caretakers as acts of betrayal, given the adult's supposed caretaking role. This sequence helps mold a blueprint that the self must experience shame in order to hold onto attachments. In this way, shame becomes a thread of the attachment process itself and forms the basis of an extremely destructive Internal Working Model. A child with such a model will work to set up shaming experiences in new relationships, believing such experiences to be components of relationship.

3. When shame from loss, from neglect, from abuse, from trauma is allowed to just settle in and fester without any attempt at interactive repair (as is so often the case), then when the child enters a new relationship, this shame will block attempts at repair that the new caretakers may make.

4. Shame can lead to the avoidance of attachment figures (and eye contact) for fear the adult will see the awful self the child believes himself to be and reject the child.

5. Positive attention reliably triggers internalized shame. The result is that receiving positive attention becomes a painful experience for an AD child, and the adult offering it may be seen as cruel rather than supportive.

6. When shame is activated, someone is always punished as the associated shame rage is either directed outwards towards others or inwards towards oneself.

7. Sometimes shame functions as a well-intended, but ultimately ineffective attempt to preserve an attachment. When the attachment is perceived as threatened due to a flaw in the child, the child tries to stay connected to the attachment figure by taking on the adult's perceived critical view of the child. Self-denigrating statements can be seen as an effort to mimic the critical voice of the adult in an attempt to repair the attachment and remain connected.

8. Defining oneself as having ”failed” in a relationship can be used to effectively deny the relationship’s end by creating an internal sense of having “failed the other”. Children who do this vis-à-vis lost birth parents can mire themselves in shame, block grieving, and block future attachments.

BELIEFS

1. Definition: A belief is a thought that we keep thinking. Many beliefs are not so much deliberate intentional thoughts as they are simply habitual ones. A core belief is simply a belief that we have utilized more often than most others. This has no direct relationship to truth or accuracy, though core beliefs are usually seen as somehow “truer in some deeper way” (which is just another belief). The bioelectrical mechanics of nerve cell connections.

2. Beliefs underlie and organize thinking into habitual patterns which hinder learning to think in new ways. This impairs problem solving skills and blocks learning from experience. If the belief is shame-driven, then the blocks to learning are further multiplied. Perception is very much shaped by beliefs and so how something impacts us is often more affected by one’s beliefs than by the event itself.

3. Once beliefs become firm through repeated use (core beliefs), perceptions tend to stabilize. What we believe progressively becomes what we see, thus bringing it full circle to reinforce the original belief. And so it goes.

4. Beliefs usually have significant emotion attached to them and are therefore closely guarded. In fact, beliefs can appear so necessary (another belief) that they cannot even be questioned (core beliefs). Challenging them can provoke significant anxiety and so it takes willpower to think in directions at odds with belief-driven patterns.

5. We vigilantly protect our beliefs with selective perception. In fact, beliefs can literally dull the workings of our physical senses such that some things don’t even register. People routinely discount information that threatens their beliefs, and the more strongly the belief is held onto, the more absolute the discounting. Beliefs are typically defended against the truth. It is for these reasons that attempting to challenge strong beliefs directly rarely succeeds.

6. Beliefs are often potent triggers for anger when experience does not align with belief-driven expectations. Those same beliefs are then used after the fact to justify the anger which produces another closed loop, impervious to direct challenge.

7. Belief systems bring with them a sense of familiarity, comfort, and control (their appeal for AD children). Familiarity is often confused with truth as in “it just seems / feels true” and thinking then goes no further. However, familiarity and truth intrinsically have nothing to do with each other. The result can be an internal map of the world that feels familiar but does not line up well with reality- the predicament of most AD children.

8. Belief systems often contain contradictory beliefs. Recognizing the contradiction could threaten “to break” the entire system which would stimulate massive anxiety. AD children generally manage this threat by keeping their belief systems fragmented. This allows any one belief to be expressed while ignoring other contradictory fragments. This also allows for confidently expressing different beliefs that contradict each other, at different points in time. Thus is the child’s sense of internal congruence maintained.

9. Helplessness (see Powerlessness / Helplessness above) can be triggered by the perception of being a prisoner of one's own belief system. This can create shame wholly in the absence of another person. Associated rage may lead to retaliation against oneself which usually leads to further shame, thereby creating a downward spiral. As AD children are often victims of their belief systems, they are quite vulnerable to this.

10. How anyone hears another has more to do with the beliefs of the listener than the words of the speaker (delineating roles of speaker and listener).

11. BELIEFS ALWAYS SHOW UP SOONER OR LATER IN BEHAVIOR.

12. Beliefs can never be taken away from anyone; they can't be changed against someone's will. They can only be given up. Healing almost always requires questioning beliefs that have gone unquestioned before.

13. ALL BELIEFS CAN BE CHANGED- THIS IS EVOLUTION / GROWTH.

VICARIOUS TRAUMATIZATION (VT)

1. Vicarious traumatization results from repeated exposure to another's trauma while attempting to respond empathically. With AD children, it is primarily parents and therapists, and to a lesser degree, teachers, that are vulnerable.

2. VT can alter others' view of themselves and their world in fundamental ways. The typical areas affected are: attitudes about safety, control / helplessness, and relationships. This alteration of attitudes is frequently accompanied by feelings of rage and loss and can produce intrusive symptomatology similar to Post Traumatic Stress Disorder itself.

3. In general, VT can be viewed as a signal that one has been too emotionally open for too long in relation to the AD child. Managing VT usually involves temporarily reducing one's empathic availability to the traumatized child while implementing some increased measure of self care.

INTERVENTIONS

THE OVERALL PURPOSE OF THESE INTERVENTIONS IS TO REDUCE OR REMOVE THE BLOCKS, CREATED BY SHAME AND THE BELIEFS IT SPAWNS, TO LEARNING FROM EXPERIENCE IN PRESENT TIME.

1. Healing shame requires an enormous sense of safety to know that humiliation won't be the response to expressing shame-based material. Thus, shame is usually revealed very carefully in layers to see if the person is safe enough to reveal deeper layers to. The adults involved must be very careful to not judge any of these layers or the revealing will stop there. And, REASSURANCE IS A FORM OF JUDGMENT, for it says that the way the child is looking at it is wrong.

2. Because shame creates an extreme sensitivity to others' reactions, adults must be very aware of their facial expressions and voice tone and keep both soft and accepting and free of disapproval when dealing with an AD child in a state of shame. Because the brain processes nonverbal information faster than verbal, if any disapproval is communicated with face or voice, it will sabotage any verbal message that is being attempted.

3. In general it is preferable to offer empathy for the child's subjective experience, rather than trying to persuade them out of it with additional "objective information".

4. Shame, like trauma, is timeless. It is always experienced as happening right now. Teaching the difference between "then" and "now" and communicating that the child has a choice about where in time he wants to live can be helpful. Do not underestimate AD children's lack of an internal sense of continuous sequential time.

5. As shame blocks seeing anything good in the self, adults will need to see the good in the child first and reflect it back, much as a mother does with an infant. Be prepared for this to be dismissed, many times, and grant the child her freedom to dismiss positive input. Do not attempt to convince the child of the good within him- this is a fundamental mistake. It will cost you your credibility in the child's eyes and increase negative self-feelings.

6. When offering positive attention, be observant for the nonverbal indicators of a shame reaction. If those appear, be prepared to follow the positive attention with some form of interactive repair.

7. All children need experiences of being seen as enjoyable in their parents' eyes. For the AD child carrying shame, "being seen as enjoyable" is often a fearful experience that may precipitate a barrage of behavior designed to make the child look unenjoyable (this is the child's version of "interactive repair"). Here, the need is for parental interactive repair in the form of showing understanding for how hard it is to be enjoyed by parents.

8. Because AD children commonly believe that saying negative things about themselves is the only way to have any connection with others, their self-critical statements can be redefined in a healthy way as carrying their wish to be connected to others. This approach ignores the self-critical content of the statement to focus on its much healthier purpose- to maintain connection. This turns self-critical speech into an attachment sequence- a good beginning.

9. Teaching emotional expression: Because AD children tend to express their feelings in relatively automatic ways, they need to learn to bring more choice to this process. The following three-way choice (that applies to almost all situations) can be laid out for them: 1) show the feeling with behavior and keep the feeling, 2) shut down / withdraw and keep the feeling, 3) put the feeling into words and let it go. This can be combined with pointing out to the child, his usual pattern. Grant the child her freedom to keep a tight hold on her bad feelings.

10. Most AD children have little or no understanding of the concept of restitution and this is a very important social skill for them. Having a child carry out an act of restitution after some transgression is far more useful than any prolonged conversation about the incident. Define the form of the restitution and have the child just carry it out without further conversation. This can be considered the consequence, but should not be framed for the child that way. Making restitution is an act of competence and can challenge the shame-driven belief that the child is so impaired they could never make up for any mistake.

11. Appreciation is a powerful antidote to shame, for it acknowledges having been the recipient of things of worth and being worthy of receiving them. Appreciation typically needs to be overtly taught to AD children for they generally have no grasp of it. The rationale is a practical one, not a moral one. Learning to appreciate will help them feel better. Making concrete lists of things to appreciate is a good way to begin.

12. The capacity to laugh at oneself is a powerful tool for dispersing shame. Role model this with yourself. Encourage your child not to take themselves so seriously (while granting their freedom to do so). Define this as a skill they simply haven't learned yet to preserve self-esteem.

13. Psychodramatic split self: here the child's sense of herself is going to be purposefully divided. Have the child be the shame-filled part and describe what that part believes, how it behaves, how it sees other people, and how it got started in the first place. The adult prompts this exploration with gentle questioning. Then have the child sit someplace else, making sure he does not replicate the body posture of the shame-filled part. Find out what the child thinks about what she heard, what keeps the shame-filled part going, and what could help it feel better. From this position, have the child define some beliefs that run counter to the shame-driven beliefs and see if a visual image can be generated to counter the potent images of shame. Block "I statements" while the child speaks about the shame to prevent identification with it. Shame is very compelling and part of the purpose of this intervention is to break the child's identification with his shame and to discover there are other parts that lie beyond the shame. Children typically have no idea how their shame got started. This can be useful in undermining the validity of the shame and its impact on the child's beliefs. Sometimes it is helpful to have the child can switch back and forth between the two roles.

14. Rather than ask a series of questions about why a behavior occurred or what it means, it can be more effective to offer an understanding interpretation in a "wondering out loud manner". Example: linking up shame–based behavior- "Don't look at me", with the shame-based idea "You won't like what you see". Don't press for a response- just let the observation hang in the air.

15. To minimize shame reactions to parental discipline, buffer the discipline on the front end with empathy for the turmoil that discipline will stir up in the child.

16. A basic part of the internal experience of emotion is the muscular sensations connected to that feeling. These muscular sensations include degree of tension / relaxation, posture, body language, facial expression, etc. One's emotional state can be changed by asking the person to shift one or more of the muscular sensations that accompanied the original feeling.

BELIEF INTERVENTIONS

1. Shame creates expectations that parents will view the child negatively. Describe for the child how he makes up his own mind that his parent dislikes him / is thinking badly of him, never questions this, and protectively withdraws or lashes out in response. It is generally not helpful to challenge the child's perception directly. An epistemological approach is a better choice. Ask the child how he got to his negative conclusion (How does she know what she thinks she knows). This is aimed at drawing out the child's thinking rather than opposing it with feedback.

2. Belief vs. truth: this is simple and powerful. Point out that belief and truth have nothing to do with each other. People believe things that aren't true and disbelieve things that are. If something is true, not believing it does not change its truth. If something is familiar, that does not make it true even though it "seems" true. AD children typically don't question their beliefs. This intervention can be a tool for beginning to drive a wedge between the child and her maladaptive beliefs.

3. Rather than challenging a belief directly (rarely effective), invite the child to flip the belief into its opposite and verbalize it. This is almost always met with enormous resistance which reflects the emotional investment in the belief. Here is the block to change and now it is out in the open. Exploring that resistance can yield much more than challenging the belief outright.

4. Rather than challenge a belief, take it as a hypothesis to be tested. Ask the child to predict what else will happen if her belief is really true and what will happen if it isn't. Things often unravel at this point. If there is an answer, note it, and let the future tell the story.

5. Provide evidence for what the kids don't believe, and then hold them accountable (empathically) for not taking it in while recognizing their right to choose to reject it and then question why would they want to continue to do that.

6. Because AD children live primarily in the present, with little appreciation of past or future, they need adults to be historians for them. This focus on "now" allows them to express opposite positions at different points in time. To help resolve this, adults can hold up both sides of a contradiction that the child keeps flip-flopping between and ask about the discrepancy. It can also be useful to ask where is the part of the child that believes the opposite of what is being expressed in the moment. Given the contradiction, it can also be helpful to ask what these two contradictory parts really want.

7. Burn out exercise: Fold a piece of lined paper in half lengthwise. At the top on the left, write a simple positive statement. Repeat that statement on each line down the left-hand side. When a negative thought emerges, write it on the right side and then go back to the left side. With repetition, over time, the negative thoughts become less frequent and may well disappear (the mechanics of the nervous system).

8. Separate out the roles of speaker and listener. The speaker is responsible for what she said and the listener for what he heard (remembering that what was heard typically has more to do with the beliefs of the listener than the words of the speaker). When the listener says "You said…", that is reframed as "What you heard…" and the speaker does not defend against what the listener says was said. This opens the door to wonder about how the listener heard what he did.

REFERENCES

Lewis, Helen: The Role of Shame in Symptom Formation. 1987.

Schore, Allan: Affect Dysregulation and Disorders of the Self. 2003.

Tangney & Dearing: Shame and Guilt. 2002.