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SHAME & ATTACHMENT

SHAME AND ITS RECOGNITION

DESCRIPTION: The feeling of shame can be described as a sense of smallness, worthlessness, and powerlessness in a given situation. This reflects shame's benign developmental origins as the toddler's natural response to limits and discipline. It is triggered by a "perceived" break in one's connectedness to others or to oneself. This is compounded by feeling exposed and extremely concerned about another's evaluation of oneself. Shame can be defined as the emotional experience of another's devaluation or disgust, real or imagined. It 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 self. Shame essentially splits a person into both an "observer" and "the one being observed". The observer part witnesses and criticizes the part being observed. Sometimes, the presence of another is not even required to generate shame. (Attachment implications).

VISUAL DIMENSION: The "self-in-the-eyes-of-the-other" is at the center of shame- "I am as I am seen". Shame is much more visually-based than verbally, as people report internal images of being "looked at" and a wish to disappear. Shame produces an implosion of the body: head lowered, eyes closed or hidden, and the upper body curved in on itself as if trying to be as small as possible (the bodily acting out of the wish to disappear). The avoidance of eye contact in such moments is easily understandable and to push for eye contact in moments of shame can actually be harmful.

SHAME & BEHAVIOR: Shame is self-perpetuating. Internalized shame tends to induce behavior in the future that will lead to an outcome of further shame. This is not recognized at the time. The original motive for the behavior appears to have nothing to do with shame. Yet, shame invariably results, and this final outcome indicates the true, underlying motive for the behavior as being the generation of shame, rather than the prior illusory motive. Behavioral attempts to escape shame always work this way. This can easily lead to an upwards spiral as increasing amounts of shame accumulate within which then fuels further shame-creating behavior. A percentage of addictive behavior fits this model.

SHAME-RAGE: Shame, in being an intensely painful emotion, simultaneously generates self-protective anger or rage along with it. This shame-rage may or may not be expressed at the time, but it does find expression in some form sooner or later and often turns into a desire for revenge. Shame-rage aims at triumphing over, and humiliating another, 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 with repeated rejection and criticism typifies this. The mother's sense of being a terrible mother is the recreation, in her, of the child's shame about being a terrible person. No matter the outward appearances however, it is the internalized shame-rage in the AD child that poses the real emotional threat to the child. (Attachment implications).

SYSTEMIC IMPACT: 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 thinking. Shame brings with it a subjective sense of time slowing down which serves to magnify anything that occurs during a state of shame. It also 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 combines with the slowed sense of time to produce the extreme self-consciousness that is a part of feeling shame.

CRISIS RESPONSE: The activation of the autonomic nervous system is part of the brain's overall crisis response. The fact that the autonomic nervous system is activated by shame suggests that the brain interprets shame as a crisis of some sort. The most likely crisis signaled by shame is a threat to relational bonds and all the highly valued resources they contain. Activating the brain's crisis response system gives shame the power to generate flight-fight tendencies. The flight option is the behavioral expression of the wish to disappear. The fight option is the verbal and behavioral expression of blame and rage directed towards another. Is there a point at which shame = trauma ?

SHAME AND TRAUMA: Shame both mirrors trauma and is bound up with it. Much of the power of what we term traumatic events lies in the shame bound up with these events. Through traumatic events, perpetrators can download their own shame onto the victim who ends up being pervaded by it. For the victim, this becomes an experience of powerlessness or helplessness. Perceptions of being powerless create shame, for the self is seen as being weak / ineffective. This often leads children to vow to "do it right" the next time in an attempt to overcome the trauma and prevent further trauma. This can easily evolve into a perfectionistic stance which, in the end, only fuels the shame as perfectionism generally guarantees failure.

SHAME SIGNALS: In addition to aversion to all eye contact, shame can manifest as fragmented thought and speech including: pauses, repetitions, false starts, inaudible voice level, and unclear diction. All of these are common with AD children. Subjectively this often gets reported as "going blank", somewhat like dissociation.

COPING DEFENSES: The primary defenses for handling shame are denial, dissociation from all feeling states, splitting, withdrawal, perfectionism, entitlement, externalization, rage-driven behavior, pre-emptive shaming of oneself, and inability to give or receive praise. With repeated use, these defenses, like all defenses, can function so quickly that the child never even consciously experiences any shame.

SHAME PRONENESS: 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. There is a direct relationship between shame-proneness and depression, suicide, anxiety, addictions and family violence. 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 or lack of involvement with the community.

PARENTING & SHAME: Childhood shame bears a strong relationship to all of the following: parental discipline that focuses on the child's self rather than behavior, following discipline with rejection / devaluation rather than interactive repair, lack of discipline, hostility, overprotectiveness, lack of parental recognition of positive behavior, neglect, placing child in a parental role (parentification), use of love withdrawal techniques, and the use of public

humiliation as a discipline tool. For children with attachment difficulties, even ordinary discipline and being given directions can be triggers of shame reactions.

SHAME & SOCIALIZATION: Shame has a long history of being used for purposes of socialization (religion, education, family, workplace). However, there is little empirical support for the widely held belief that shame has any long-term inhibiting effect on the related behavior. The self-threatening nature of shame blocks the self-reflection that is necessary for longer-term behavioral change. There is, however, empirical evidence that shame inhibits prosocial behavior. In addition, moral judgment, which contains cognized anger, is quite inhibiting to the development of empathy.

SHAME & ATTACHMENT

LOSS AND SHAME: 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. In an effort to manage loss, and its accompanying pain, children may well define themselves as having "failed" the relationship. This strategy effectively denies the relationship's end by creating an internal sense of having failed the other, and this "connection through failure" gets carried forward in time. Doing this vis-à-vis lost early attachments mires children in shame, blocks grieving, and blocks future attachments. Healing then becomes about 1) addressing the loss experience itself, 2) the child's explanation for it and, 3) any *internal* "connection through failure" that may have developed. This is a far more complex task than simply attempting to reassure the child that the loss of his early attachment figure(s) was not his fault.

SHAME AS AN ATTACHMENT TOOL: When shame is an integral part of early relationships, as is the case when abuse and neglect occur, a child develops an IWM in which the shame becomes a thread of the attachment process itself. This happens with a goodly percentage of AD children. Shame comes to be seen as necessary in order to hold onto attachments, and AD children with such an IWM are likely to set up shaming experiences in new relationships. Such shame-based behavior then functions as attempts to preserve attachment. If the attachment is perceived as threatened by a flaw in the child, the child may try to stay connected by reflecting what she imagines the adult's critical view of her to be. Self-critical statements or self-injurious behavior are offered as "gifts" to the adult, and the attachment is repaired in the distorted view of an AD child.

SHAME, EMOTIONS & EQUIVALENCE: When children are shamed for the expression of another emotion, that emotion itself, acquires a loading of shame. This amounts to "hurting a child's feelings about their feelings" and is often worse than any pain associated with the original feeling. The mere existence within, of the shamed feeling, becomes a condemnation of the child's whole self. This is also true of shame itself- it is shameful to feel ashamed (therefore asking an AD child if they feel ashamed is a delicate process). Thus shame not only perpetuates itself, but it can also become an emotional equivalent to other feelings: sadness = shame. There is no longer any "reason" for sadness being shameful- it just is. This operates beneath the level of "because". Typically, this blocks subsequent expression, or even acknowledgement, of the shamed feeling. The blocking, in turn, generates its own ripple effects, including impairment of the attachment process.

POSITIVE ATTENTION: 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 ends up being seen as cruel rather than supportive. This fuels distrust and can trigger distancing behaviors. This can be very confusing for parents and teachers.

SHAME, THINKING & IDENTITY

COGNITIVE DISORGANIZATION: Shame is cognitively disorganizing, and this disorganization blocks self-reflection in the moment. This disorganization / dysregulation is easily perceived as a threat by the AD child and so has much anxiety attached to it (annihilation anxiety). This anxiety can impede thinking about shame experiences long after they have occurred. In addition, because of its intensity and disorganizing impact, shame does not get encoded in memory precisely, but with a high potential for stimulus generalization, much like trauma. Thus, shame spreads easily and gets connected to many things in memory. Higher level logical thinking does not effectively contain shame's spread because higher level circuits are too slow. These manifold neural connections can increase the probability of future shame episodes.

SHAME & IDENTITY: Shame-based ideas about the self are all encompassing and block the recognition of anything good. In a moment of experiencing shame, no part of an AD child lies outside this negative evaluation. As a result, shame-based views of the self become statements of identity. Some examples of shame-based identifications are: "I am not good enough", "I'm nobody", "I am not lovable", "I should not exist" (suicidal). The ideas that emerge out of shame tend to be stable over time because they are not modified by subsequent experience (defective IWM). This saddles self-image with a chronic negative bias. This influences thinking in such a manner that explanations for future events often come to rest on some perceived negative part of the self. These shame-based perceived defects can become a potent source of repetitively intrusive thoughts over time, and this is a mirror image of the intrusive thinking that is symptomatic of Post Traumatic Stress Disorder. Attempting to counter all this with positive reassurance is potentially damaging, for it can accentuate the shame by being so at odds with the self-image, and it can make the person offering such feedback seem completely out of touch to the AD child. (Attachment implications).

AFTER EFFECTS: Shame typically includes a sense of "I don't want to know". This can become the basis for much of the self-protective "playing dumb" that is so, so typical of AD children. Shame is also highly correlated with attitudes of entitlement, excessive self-importance, and a willingness to exploit others, which can be both compensatory attempts to cope with the shame, or acts of revenge. Ironically, these very attitudes increase the probability of future shame experiences as the world is unlikely to meet the unrealistic expectations these attitudes generate. The resulting sense of failure circles right back into another shame experience in what can be a very damaging cycle.

INTERNAL WORKING MODELS & BELIEFS

INTERNAL WORKING MODELS: Out of everyday experience, we all build up what has been termed an Internal Working Model (IWM). The IWM is the sum total of all that an individual has learned and believes about how he, other people, and the world work. The construction of an IWM begins very early in life and is gradually added to over time. The word "working" in the name signifies 1) that one's internal model works as a map for navigating reality, and 2) is always a work in progress, meaning it is modifiable across time as new experience comes in and is never

"done". The net result is that one's IWM becomes progressively more accurate as it is modified. This is not the case with a child with attachment disorder. In the case of AD children, their IWM's are usually heavily colored by shame. The IWM's of AD children tend to be inflexible and therefore, immune to new experience. They operate in an all-or-none fashion because of the sense of control this brings. Driven by hypervigilance, conclusions within an AD child's IWM are arrived at rapidly, as anxiety does not allow time for pondering.

BELIEFS: The building blocks of IWM's are essentially, beliefs; and many of the beliefs of AD children are grounded in shame. Most simply defined, a belief is a thought that has been repeatedly referenced over time. Many beliefs are simply habitual thoughts rather than intentional or purposeful ones. A core belief is simply a belief that we have utilized more often than most others. How often a belief has been used bears 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. Beliefs tend to have significant emotion attached to them and are therefore closely guarded. If there is identification with a belief such that the belief has become part of the definition of self, then the belief will be more closely guarded still, to protect the sense of self. Such a belief can appear so necessary that it cannot even be questioned. Challenging a belief that has been woven into the sense of self can provoke significant anxiety and anger. Beliefs carrying identification will typically be defended against the truth and are done so primarily with selective perception. This can dull the workings of the physical senses such that things which challenge the beliefs don't even register.

BELIEF SYSTEMS: Belief systems organize thinking into habitual patterns which hinder learning to think in new ways. This impairs problem solving skills and blocks learning from experience. Belief systems trade truth and accuracy for a sense of familiarity and control (their appeal for AD children). Things are seen as true because they "feel" true and thinking goes no further. The result can be an internal map of the world that feels familiar but does not line up well with reality. This is precisely the predicament of most AD children.

CLINICAL INTERVENTIONS

THE HEALING ENVIRONMENT: Healing shame requires an enormous sense of safety to know that humiliation won't be the result of expressing shame-based feelings or ideas. Thus, shame is usually revealed very carefully in layers to see if the situation is safe enough to reveal a deeper layer. Because shame creates an extreme sensitivity to others' reactions, the adults need to be aware of their facial expressions and voice tone and keep both soft, accepting and free of disapproval when dealing with an AD child in a state of shame. Since the brain processes nonverbal information faster than verbal, if any disapproval is communicated with face or voice, it will sabotage any verbal message before even a word is heard. In addition, the adults involved must be very careful not to judge any of the revealed layers or the revealing will stop there. This includes well intended reassurance, for reassurance is a form of judgment as it says that the way the child is looking at things is wrong. It is more helpful to draw out the child's feelings and thinking further while listening attentively. This acknowledges the child's experience rather than challenging it or contouring it in some fashion.

SLOW MOTION THERAPY: Due to the systemic impacts of shame, if it is accessed in therapy, the session should be instantaneously put in a metaphorical "slow motion" format. An AD child in an acute state of shame is extremely vulnerable to being overwhelmed due to the heightened sensory input and bodily awareness, slowing down of time, and intense self-consciousness. This is why being vigilant for the nonverbal indicators of shame, is so important.

If these are missed and a session proceeds at a normal rate, the result for the child is likely to be harmful. This slow motion format involves the therapist, slowing down the rate of speech, softening the voice tone, limiting verbal input to small chunks, asking yes / no questions vs. open-ended ones, allowing more time for processing, looking at the child for only brief intervals, and integrating a prop into the interaction so visual focus is on that instead of the child. The goal here is to keep the shame within a therapeutically workable range.

NOURISHING POSITIVE SELF FEELINGS: Since 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. However, being seen as enjoyable in adults' eyes is often a fearful and shame-filled experience for AD children because it is so at odds with their experience of themselves. Therefore, adults should be prepared for positive input to be dismissed, many times, and grant the AD child his freedom to do so. Countering the dismissal only defines it as one more thing the child has done wrong and this will not help self-esteem. Attempting to convince the child of the good within her is an even more fundamental mistake. It will damage the adult's credibility in the child's eyes, feed the AD child's sense of power, and increase the child's negative self-feelings. Beyond allowing for dismissal when offering positive attention, adults should also be observant for the nonverbal indicators of a shame reaction. If shame indicators appear, shift immediately from a focus on positive input to interactive repair in the form of an empathic observation of how emotionally difficult it is for the child to hear something positive about himself.

PHYSIOLOGY: A basic part of the internal experience of emotion is the muscular sensations connected to each feeling state. These muscular sensations include degree of tension, posture, gestures, and facial expression. Emotional states can sometimes be shifted by asking the child to relax one or more body parts, change facial expression, or adopt a different body posture and then ask if the child notices any difference or comment upon any observed difference. "Before and after" pictures can further enhance the impact. It the AD child resists, this resistance can also be a useful item with which to work.

SHAME & TIME: Shame, like trauma, is timeless. It is always experienced as happening right now. Teaching the child that he is mixing "then" and "now" and helping him learn to separate them is a very important skill, without which, shame cannot be properly placed in time. Pointing out, repeatedly, concrete differences between "then" and "now" can be useful. Additionally, visual aids such as then vs. now collages or visual time lines can be of much assistance Finally, telling the child he has a choice about where in time he wants to live is valuable, for it is almost always a concept completely unimagined by AD children.

TEACHING EMOTIONAL CHOICE: Because AD children tend to express their feelings automatically, if at all, they need to learn to bring more choice to this process. The following three-way choice (that applies to most situations) can be laid out for them: 1) show your feeling with behavior and keep the feeling, 2) shut down / withdraw and keep the feeling, or 3) show your feeling on your face and put your feeling into words and let it go. This can be combined with pointing out to the child, her usual pattern while acknowledging she has the freedom to choose to keep her bad feelings . Once an AD child begins openly sharing her feelings / pain, responding with sensitivity while also pointing out the competence demonstrated in the emotional expression, is a potent combination. The child's affect may well shift in the literal blink of an eye from having her competence affirmed.

APPRECIATION: Appreciation can be a powerful antidote to shame, for it acknowledges having received something of worth from another. Appreciation typically needs to be overtly taught to AD children for they generally have no grasp of it. The rationale here is a practical one, not a moral one. Learning to appreciate will help them feel better. AD children will initially need to be given concrete examples of things to appreciate. They will also likely need to be given the specific words to say and then to practice that in the moment. Appreciation should be extended back to them for having engaged in the practice.

RESTITUTION: Most AD children have little or no understanding of the concept of restitution and this is an important social skill for them since it is part of relational repair. Having a child carry out an act of restitution after some transgression can be more useful than a prolonged conversation about the incident. Define what is to be the act of restitution and assign it to the child to carry out without further conversation. The act of restitution can be considered the "consequence", without framing it 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 that she could never make up for any mistake.

DISCIPLINE, SHAME, & EMPATHY: When imposing a consequence as part of discipline, offer emotional support (empathy) for the hardship that the consequence will cause the AD child. Communicate the understanding that being disciplined probably feels like humiliation and this will lead the AD child to want to misbehave. Express a vote of good faith that the child has the resources to handle the discipline and the expectation that she will make a good choice even though she does not want to. This both preserves attachment while maintaining discipline (interactive repair). The parent should let go of any anger that remains after imposing the discipline, as quickly as possible, to avoid sabotaging the interactive repair as well as the intended effect of the consequence. The clinician may have to teach this skill initially as it falls beyond the typical range of parenting skills.

SHAME AS ATTACHMENT: Because shame has often been an aspect of early relationships for AD children, they can carry an IWM in which shaming interactions are seen as a way to connect with other people. As a result, AD children are apt to say negative things about themselves in an attempt to make some kind of connection. These self-critical statements can be interpreted as carrying their wish to be connected. This approach ignores the self-critical content of the statement in order to focus on its much healthier purpose- to make a connection. Thus the goal is separated from the means used to try to achieve it and held up as valuable.

CHILD'S NEGATIVE EXPECTATIONS: Shame creates expectations that adults will view the child negatively. Describe for the child how she makes up her own mind that adults dislike her, never questions this, and protectively withdraws or lashes out in response. Challenging the child's perception directly is not a helpful response: 1) it frames the child as "wrong" which only erodes self-esteem, 2) it feeds AD children's sense of power as they can't be made to accept the adult's challenge, and 3) AD children are quite vulnerable to seeing the challenge as an adult attempt to fool them. An epistemological approach is a better choice. Ask the child how she got to her negative conclusion (How does she know what she thinks she knows is true?). This is aimed at drawing out the child's thinking rather than opposing it with feedback.

SHAME & INCOMPETENCE: Shame commonly generates a view of the self as existentially incompetent. This often manifests as frequent statements of "I can't", which the child genuinely believes. This should not be directly confronted, but instead, inquired into from an epistemological stance: how does the child "know" he can't. In the absence of a response, "I can't" can also be reframed as "You haven't yet", which opens the door to future change. However, the clinician needs be cautious here as AD children

commonly use "I can't" as a tool for avoiding anxiety or responsibility. When "I can't" is a tool of avoidance, the useful reframe is "I won't". The key discrimination is whether the child seems to truly believe his "I can't".

SPLIT SELF: Here the AD child's sense of self is going to be purposefully divided. Have the child speak for the shame-filled part and describe what that part believes, when it started, and how it got started in the first place. AD children typically have no idea how their shame got started and, identifying this fact can begin to soften the shame a bit. See if a visual image or physical object can be chosen to represent the shame-filled part. The adult prompts this exploration with gentle questioning. All responses should be written down. Then ask the child if there is any part of him that is different from the shame part. Again, aim for a visual image or symbolic object. If the child says there is no other part, frame this as reflecting the child not having yet discovered the other parts that are there because the shame-filled part fools the child into believing that's all there is. This begins to reframe the problem as one of belief rather than fact. Any identified symbols can be saved for future use. The goal here is twofold: 1) this intervention can access shame in the moment, providing an opportunity to work with it directly, and 2) this intervention can begin the process of breaking the child's identification with shame which makes it more available for healing.

BELIEF VS. TRUTH: This can be a simple, yet powerful intervention. Point out that belief and truth are not the same thing. People believe things that aren't true and disbelieve things that are all the time. If something is true, not believing it does not change its truth. If something is not true, believing it does not magically make it true. If something is familiar, that does not make it true even though its familiarity makes it "seem" true. The child can be invited to examine the source of the belief. In the absence of any clear grounding in reality, skepticism should prevail. The therapist can always apologize for being wrong later. The therapist should clearly establish herself on the side of truth and point out this may lead to disagreement with the child's position. This intervention requires repeated use over time to keep the boundary between belief and truth distinct. This intervention can be a tool for beginning to modify their IWM so it more accurately reflects reality rather than being primarily a tool of defensive protection.

CHALLENGING BELIEFS (tiered): Rather than challenging a belief directly, which is rarely effective, invite the child to flip the belief into its opposite and then verbalize it. This is almost always met with enormous resistance which reflects the emotional investment in the belief. That resistance can be pointed out along with the suggestion that the opposite idea is an uncomfortable one- this can open the door of emotional access. Ask the child to describe how things would be if "the opposite of what you believe now is true ?". This usually meets with more resistance which can again be pointed out, thus upping the "emotional temperature". The clinician and parent can go on to offer possibilities of how things would be if the opposite were true and look at what that experience might be like for the child, which may encounter more resistance still. Now there is a clear basis to suggest that the child needs to keep the belief for some reason, true or not, which shifts the focus from what's true about the outer world to what's true about how the child's inner world is working. This increases the chances of accessing emotion. If things remain deadlocked by resistance, the final step can be to develop an experiment to test the belief out. Ask the child to predict what else will happen if the current belief really is true. It then becomes incumbent on the adults to keep track of relevant events going forward and allow the future to "tell the story". The therapist should state that if the future proves her wrong, she will acknowledge that and congratulate the child on being right all along. The implication here, though it should go unstated, is that the same is expected of the child if the future story goes the opposite way. The therapist and/or parent then need to bring this back up after some future

data has been gathered. The parent can also make reference to the experiment, in the moment a relevant event occurs. This intervention is a good example of a tiered intervention wherein there are several linked steps which evolve successively. Each step shifts the angle of approach of the interaction and incrementally turns up the emotional intensity, which is so important in working with AD children.

THE BURN OUT EXERCISE: This exercise is most applicable for older adolescents / young adults. 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. Often, surprising negative thoughts emerge, and these represent deeply buried beliefs that can be worked with subsequently. With repetition of this exercise, over time, the negative thoughts become less frequent, less compelling, and can disappear altogether.

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