CHAPTER FOUR

Shattered shame states and their repair

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Introduction: shame and the attachment bond

The primate relational systems for attachment, care-giving, mating, social ranking, inclusion, exclusion, and co-operation form a platform upon which complex human social life is built. Under ordinary conditions of peace, I would suggest that shame is one of the primary regulators of social relations. Fear is the primary regulator only in circumstances where social structures for maintaining peace have broken down and social relations are ruled by violence.

As the attachment system was initially conceptualized by Bowlby (1973), fear was considered the primary regulator. Bowlby described anxiety and anger as the infant's emotional responses to separation, and crying, following, and clinging as behavioural responses. As a good Darwinian, he saw the adaptive function of the attachment system in maintaining the infant's proximity to the care-taker, thus affording protection. This basic attachment system is common to human beings and other primates.

On the platform of this attachment bond are built the child's first internal working models of human intimacy. In primary attachment

relationships, the child learns to imagine other minds and to be in dialogue with beloved care-takers. Hennighausen and Lyons-Ruth (2005) propose that as humans have evolved "from biologic to dialogic" relational modes, the attachment system has been "partially displaced from its primate base". Emotional sharing and signalling become the primary mode for regulating security of attachment. The infant preferentially seeks out the care-giver who best knows her mind and is most attuned to her emotional signals. She also learns to imagine how others think of her, to become self-conscious.

While major disruptions in the attachment system produce fear, by the second year of life the child reacts to more subtle disruptions with shame. Trevarthen (2005) speaks of "the feeling of shame in failure that threatens loss of relationship and hopeless isolation". Schore (1998) conceptualizes shame as a toddler's response to a disappointed expectation of "sparkling-eyed pleasure" in the maternal gaze. Ordinarily, the child's abashed signals elicit a caring response. The child learns that shame states do not signify complete disruption of attachment bond and that they can be regulated. Through repeated experiences of this kind, the child and care-taker learn to negotiate emotional attunement and mutuality in their relationship.

Where no corrective relational process takes place, pathological variations in the attachment system can develop. In particular, we see disorganized attachment where the primary attachment figure is a source of fear. I would argue that we also see disorganized attachment where the primary attachment figure is a source of unremitting shame. In this case, the child is torn between need for emotional attunement and fear of rejection or ridicule. She forms an internal working model of relationship in which her basic needs are inherently shameful.

We are beginning to see the long-term effects of these "shattered states" in prospective longitudinal studies of high-risk children. Ogawa and associates (1997), in the Minnesota study, found that, as Liotti (1999) has explained, disorganized attachment in infancy was strongly correlated with adolescent dissociation. They also found that having a "psychologically unavailable" care-taker in infancy (as rated by observers in home visits) predicted pathological dissociation in adolescence. A second longitudinal study by Lyons-Ruth (2003) at Harvard Medical School independently reached the same conclusions. Both disorganized attachment behaviour on the part of the child and

"maternal disrupted communication" at eighteen months separately predicted dissociation in adolescence.

To unpack what was meant by "maternal disrupted communication", the raters distinguished three styles: hostile, withdrawn, and fearful. I would suggest that all three styles of maternal communication would be likely to produce chronic shame states: the hostile style through criticism and ridicule, the withdrawn and fearful styles through repeated rejection of the child's bids for emotional connection.

Our knowledge of the developmental trajectory of children with disorganized attachment is still rudimentary, but it appears that by age seven many of these children have essentially substituted care-giving or social ranking systems for the damaged attachment system as a way of controlling proximity to a care-giver who does not care (Lyons-Ruth & Jacobvitz, 1999). This can also be conceptualized as an attempt to avoid the constant shame of unrequited love. Both the Minnesota and the Harvard longitudinal studies have also shown us that children who developed disorganized attachment in infancy have later difficulties with peer relationships. They have not learnt to negotiate social co-operation or mutuality.

At the Victims of Violence Program at Cambridge Hospital, where I work, the majority of our adult patients report histories of abuse in childhood. Some were abused by their primary care-taker, but more commonly the abuse was at the hands of someone else. Perhaps the abuser was someone in the family whom the primary care-taker valued more than she valued the child, or perhaps the abuser was an acquaintance outside of the family who had access to the child because the primary care-taker was not paying close attention. In either case, the primary care-taker was not a source of fear, but she was "psychologically unavailable". It is this absence, this breach in the primary attachment relationship, which leaves our patients with the profound conviction that they are unlovable. In treatment, we find again and again that the core issue is shame. Our patients live in a state of chronic humiliation that profoundly distorts their view of self and others. I will speak later of how we try to address these shattered shame states in psychotherapy.

Liotti (2004) speaks of trauma, dissociation, and disorganized attachment as three strands of a single braid. I would like to add a fourth strand to the braid, by focusing on the role of shame in the development of traumatic disorders.

Characteristics of shame

Shame can be likened to fear in many respects. Like fear, it is a "fast-track" physiologic response that, in intense forms, can overwhelm higher cortical functions. Like fear, it is also a social signal, with characteristic facial and postural signs that can be recognized across cultures (Darwin, 1872; Izard, 1971). The gaze aversion, bowed head, and hiding behaviours of shame are similar to appeasement displays of social animals (Keltner & Harker, 1998), and might serve a similar social function among human beings. From an evolutionary point of view, shame might serve an adaptive function as a primary mechanism for regulating the individual's relations both to primary attachment figures and to the social group (Gilbert & McGuire, 1998; Izard, 1977).

Like fear, shame is a biologically stressful experience. In a meta-analysis of 208 laboratory studies, Dickerson and Kemeny (2004) demonstrated that socially embarrassing test conditions (for example, public speaking) reliably produced elevated cortisol and ACTH responses in human subjects. Perhaps because we have not found a reliable way to evoke shame in laboratory animals, however, understanding of the neurobiology of shame is rudimentary compared to the extensive literature on fear. Schore (2003) proposes that shame is mediated by the parasympathetic nervous system and serves as a sudden "brake" on excited arousal states.

More than a century ago, Darwin (1872) described blushing as the most characteristic sign of shame, and questioned "how it has arisen that the consciousness that others are attending to our personal appearance should have led to the capillaries, especially those of the face, instantly becoming filled with blood" (p. 327). This question remains unsolved. A more recent review article (Leary, Britt, Cutlip, & Templeton, 1992) notes that, while some of the available evidence implicates the parasympathetic nervous system, "knowledge of the physiological basis of blushing is meager and clearly ripe for future research" (p. ??).

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The subjective experience of shame is of an initial shock and flooding with painful emotion. Shame is a relatively wordless state, in which speech and thought are inhibited. It is also an acutely self-conscious state; the person feels small, ridiculous, and exposed. There is a wish to hide, characteristically expressed by covering the face with

the hands. The person wishes to "sink through the floor" or "crawl in a hole and die". Shame is always implicitly a relational experience. According to Lewis (1987b), one of the early pioneers in the study of shame,

> Shame is one's own vicarious experience of the other's scorn. The self-in-the eyes-of-the-other is the focus of awareness . . . The experience of shame often occurs in the form of imagery, of looking or being looked at. Shame may also be played out as an internal colloquy, in which the whole self is condemned. [pp. 15, 18]

Thus, shame represents a complex form of mental representation, in which the person is able to imagine the mind of another.

Developmental origins of shame

Developmentally, shame appears in the second year of life. Erikson (1950) formulates the central conflict of this developmental stage as "Autonomy vs. shame and doubt". Properly speaking no toddler is autonomous; rather, one might formulate the toddler's developmental task as learning to regulate body, affect, desire, and will in attunement with others. Positive resolution of the conflicts of this stage of life creates the foundation for healthy pride and mutuality in relationships, both self-respect and respect for others. Schore (2003) traces the origins of shame to the primary attachment relationship. Separations, which evoke fear and protest in normal toddlers, do not evoke shame; rather, shame can be seen in reunion interactions, when the toddler's excitement is met with indifference or disapproval. To a certain extent, such experiences are inevitable and normal, since no care-giver can be empathically attuned to her child at all times, and sometimes the care-taker must chastise the child. However, under normal circumstances, the child's shame reaction, like the appeasement displays of other primates, evokes a sympathetic response that in turn dispels the feeling of shame. The breach in attachment is thus repaired. Through repetition of this sequence, Schore postulates that the securely attached toddler learns the limits of the care-giver's tolerance and also learns to self-soothe and regulate shame states.

Though shame and guilt are often spoken of interchangeably, and though both can be considered social or moral emotions, the two

states are quite distinct. Whereas shame is focused on the global self in relation to others, guilt is focused on a specific action that the person has committed. Shame is an acutely self-conscious state in which the self is "split", imagining the self in the eyes of the other; by contrast, in guilt the self is unified. In shame, the self is passive; in guilt, the self is active. Shame is an acutely painful and disorganizing emotion; guilt might be experienced without intense affect. Shame engenders a desire to hide, escape, or to lash out at the person in whose eyes one feels ashamed. By contrast, guilt engenders a desire to undo the offence, to make amends. Finally, shame is discharged in restored eye contact and shared, good-humoured laughter, while guilt is discharged in an act of reparation (Lewis, 1987a, cf. table on p. 113).

The social functions of shame

Originating in the primary attachment relationship, shame generalizes to become an emotion that serves to regulate peer relationships, social hierarchy, and all the basic forms of social life. Scheff and Retzinger (2000), building on the work of Lynd (1958), Goffman (1967), and Lewis (1971), describe shame as the "master emotion of everyday life". In their conceptualization, shame is the "signal of trouble in a relationship". Shame, for example, serves to regulate social distance. People experience shame both if others are too distant, as in the extreme case of shunning or ostracism, and if others come too close, as in the extreme case where personal boundaries are violated.

Shame also mediates attunement to indices of social value or status. In its milder forms, shame is the result of social slights or ridicule. Mild experiences of shame are a part of ordinary social life. The everyday family of shame emotions includes shyness, self-consciousness, embarrassment, and feeling foolish or ridiculous. Through ordinary experiences of shame, individuals learn the boundaries of socially acceptable behaviour.

In more extreme forms, shame is the reaction to being treated in a degrading manner. The extreme family of shame emotions includes humiliation, self-loathing, and feelings of defilement, disgrace, or dishonour. In hierarchical societies, according to Miller (1997), disgust and contempt are "emotions of status demarcation" that consign to lower status those against whom they are directed. Relationships of

dominance and subordination are inherently shaming. The social signals of subordinate status (bowed head, lowered eyes) are ritualized expressions of shame. In slavery, the most extreme form of social subordination, the enslaved person exists in a permanently dishonoured status that Patterson (1982) describes as "social death".

Extreme social subordination is found in relationships of coercive control: in modern-day slavery, which takes the form of forced labor or prostitution (Bales, 2005), in political tyrannies, and in the private familial tyrannies of domestic violence and child abuse. Relationships of coercive control are established and perpetuated by an array of methods that are recognizable across cultures (Amnesty International, 1973). Among these methods, violence and threat of violence instil fear, while other commonly used methods, such as control of bodily functions, social isolation, and degradation, primarily evoke shame.

Extreme or catastrophic experiences of shame are a signal of profound relational disruptions or violations. When methods of coercive control are used within primary attachment relationships, as occurs in the case of child abuse, the developing child learns nothing of ordinary social shame. Rather, the child is overwhelmed with extreme shame states. Fonagy, Target, Gergely, Allen, and Bateman (2003) describe the shame of the abused child as "an intense and destructive sense of self-disgust, verging on self-hatred" (p. 445). They explain that "the shame concerns being treated as a physical object in the very context where special personal recognition is expected" (*ibid*.).

Schore (2003) describes catastrophic shame states as "self-disorganizing". Indeed, it is a characteristic of shame that it can feed upon itself. The shamed person feels ashamed of feeling ashamed, enraged, and ashamed of being enraged. Lewis (1990) describes these self-amplifying, disorganizing shame states as "feeling traps". She proposes that when shame states cannot be resolved, they are expressed as symptoms.

Shame as a predictor of post traumatic symptoms

Although the literature on this subject is sparse, three recent studies document an association between shame and post traumatic symptoms. Andrews, Brewin, Rose, and Kirk (2000) interviewed 157 victims of violent crime within one month of the incident and asked directly

about shame experiences. At six-month follow-up, shame was the only independent predictor of PTSD symptoms. Talbot, Talbot, and Tu (2004) examined the relationship between shame-proneness and dissociation in a population of ninety-nine hospitalized women with and without histories of childhood abuse. Shame-proneness was measured with a modification of the differential emotions scale (DES-IV; Izard, Libero, Putnam, & Haynes, 1993). Greater shame-proneness was associated with higher levels of dissociation, especially among women who had experienced sexual trauma early in their development. Interestingly, some women who had been abused in childhood were not particularly shame-prone and had dissociative scores within the normal range. The sources of resilience in these women are not well understood and warrant further study. Finally, Dutra, Callahan, Q2 Forman, Mendelsohn, and Herman (2008), in a study of 137 trauma survivors seeking out-patient treatment, measured self-reported shame schemas using a modified version of the Young schema questionnaire (YSQ-S; Young & Brown, 1999). Shame schemas were significantly correlated with measures of PTSD and dissociation. Shame schemas were also specifically correlated with self-reported suicidal risk variables, including recent suicide attempts, current suicidal ideation, and current suicidal plans. These data would support the inference that post traumatic shame states can be life-threatening.

Addressing shame in psychotherapy

Understanding that shame is a normal reaction to disrupted social bonds allows patients to emerge from the "feeling trap" in which they feel ashamed of being ashamed. According to Lewis (1981), addressing shame directly in the psychotherapy relationship facilitates therapeutic work, by normalizing shame reactions and by giving patients a relational framework for containing and understanding them. She writes,

> Adopting the viewpoint that shame is a normal state which accompanies the breaking of affectional bonds allows shame to take its place as a universal, normal human state of being. Analyzing shame reactions in an atmosphere in which their natural function is taken for granted makes analytic work considerably easier. . . . Perhaps the greatest

> therapeutic advantage of viewing shame and guilt as affectional bond controls is the emphasis placed on the patients' efforts to restore their lost attachments. [p. ??]

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The therapist calls attention to the patient's shame reactions as they happen, noticing the bowed head and averted gaze. The therapist then invites the patient to move out of the shamed position, to lift her head, to make eye contact, and to experience the restorative empathic connection of the treatment relationship. As shame is relieved, often patient and therapist will spontaneously begin to laugh together. Retzinger (1987) explains that shared laughter restores a sense of social connection:

> Shame is a major aspect of the human condition. It serves a fundamental purpose, enabling human beings to monitor their own behavior in relation to others . . . When shame is too great, one feels alienated, disconnected from others, and alone in the world. Laughter serves to reconnect these severed ties, breaking the spiral of shame–rage . . . Without both shame and laughter, complex social life would be impossible. [p. 177]

Numerous verbal, paralinguistic, and non-verbal cues should alert the therapist to shame states. The vocabulary of shame is extensive: words such as "ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed" can indicate feelings of shame. Paralinguistic cues include confusion of thought, hesitation, soft speech, mumbling, silences, stammering, long pauses, rapid speech, or tensely laughed words. Non-verbal cues include hiding behaviour, such as covering all or parts of the face, gaze aversion, with eyes downcast or averted, hanging head, hunching shoulders, squirming, fidgeting, blushing, biting or licking the lips, biting the tongue, or false smiling (Retzinger, 1995).

Courtois (1988), in her description of therapeutic work with incest survivors, observes that shame might be difficult to address directly because of the way it affects the transference. The patient might have difficulty trusting evidence of her therapist's positive regard, because she expects the therapist to feel the same contempt for her that she has for herself. It might be necessary for the therapist to challenge this

distorted perception, gently but directly. Shame also affects the countertransference; as Lewis (1987b) explains, shame is a contagious emotion, and the therapist might avoid addressing shame directly because of her own discomfort.

Cloitre, Cohen, and Koenen (2006), in their manual for treatment of survivors of childhood abuse, devote a chapter to the creation of narratives of shame. They write,

> In the same way that narratives of fear must be titrated so that the client experiences mastery over fear rather than a reinstatement of it, so too narratives of shame should be titrated so that the client experiences dignity rather than humiliation in the telling. [p. 290]

These authors identify numerous reasons for telling about shameful events. They point out that shame perpetuates the bond with the perpetrator; as long as the patient guards her shameful secrets, she might feel that the perpetrator is the only person who knows her intimately. Disclosure in the context of the therapy relationship is a mastery experience that leads to greater self-knowledge, greater self-compassion, and reduced feelings of alienation.

Patients with dissociative disorders have the additional burden of shame and secrecy about their illness itself. In their paper on treatment of dissociative disorders, Turkus and Kahler (2006) write that psychoeducation

> helps to undo the stigmatization and shame associated with being ill. We have heard the words *insane, crazy* and *freak* many times from patients who are traumatized. In fact, patients on our trauma unit have requested that we change the group name to *psycheducation* to eliminate any implication of *psycho*. [p. 246]

Because of the power imbalance between patient and therapist, and because the patient exposes her most intimate thoughts and feelings without reciprocity, the therapy relationship is, to some degree, inherently shaming. For this reason, among others, group psychotherapy might be a particularly valuable treatment modality for traumatized people (Herman, 1992; Herman & Schatzow, 1984; Mendelsohn, Zachary, & Harney, 2007; Talbot et al, 1999; van der Kolk, 1987). The group members are peers who approach one another on a social plane of equality. Moreover, group members are in a position to give

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compassionate support as well as to receive it. Thus, they can feel themselves to be of value to the group and deserving of the support they receive. The group becomes a little society within which members experience inclusion, co-operation, and mutuality.

Group treatment must be structured so that group members titrate their exposure and learn to stay present rather than dissociating, both while describing their own experiences and while listening to others. This requires the group leaders to take an active stance, intervening when they notice a group member is disconnected, and modelling the kind of empathic feedback that group members can expect both to give and to receive. The resultant feeling of group acceptance and belonging is a powerful antidote to long-held feelings of shame and stigma (Herman & Schatzow, 1984).

Conclusion

If the thesis of this paper is correct, the role of shame in traumatic disorders and disorders of attachment should be a potentially fruitful area for further study. In particular, future research is needed to develop a fuller understanding of the neurophysiology of shame, to elucidate the role of shame in disorganized attachment and in post traumatic symptom formation, and to explore the potentially therapeutic effects of addressing shame as a central issue in the treatment of trauma survivors.

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