Shame, Attachment, and Psychotherapy: Phenomenology, Neurophysiology, Relational Trauma, and Harbingers of Healing

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On sampling and shame

I recently attended a street festival in my adopted hometown of thirty years, Oakland, California (Art and Soul, 2016). Oakland is a wonderfully diverse community, with a large African-American population that migrated from the deep southern US, particularly Louisiana, in the 1940s. The southern African-American food tradition includes delicious barbeque of all varieties. At this festival, a contest for the best barbeque allowed people to sample several versions of barbeque and then vote for their favourite.

Some people enjoy trying many varieties, whereas others prefer to find one and return for more. I am of the latter type, particularly when long lines await me at other vendors. But I witnessed many who braved the longer lines, clearly enjoying the exploration of many "samples" before choosing their favourite.

Whether you like to spend time with one idea and mindfully savour all of what it has to offer, or prefer to sample several ideas, I am hoping this paper will interest you. Regardless of your preferred way of "sampling", I guarantee you will not have to wait in line.

In this paper, I will speak to many aspects of the relationship between attachment and shame, with a particular emphasis on disorganised or unresolved attachment and shame, different types of shame, the neurophysiology of shame, Porges' (2011) polyvagal theory, and dissociation. Clinical vignettes are sprinkled throughout this essay in order to bring these themes alive in ways that I hope will enhance the readers understanding and ways of working psychotherapeutically.

Introduction to shame, and its importance to psychotherapists

> "Man is the only animal that blushes. Or needs to."
>
> Twain, 1899, p. 238

To be human is to experience shame, although prototypical forms of shame are also observed in non-human mammals. While self-consciousness, that is, the

cognitive and certainly spoken components of shame, may be a uniquely human capacity given the development of the frontal lobe of the neocortex (see Sturm et al, 2006, 2008), from an evolutionary perspective prototypal aspects of shame exist in all mammals. For example, when a noisy baby elephant is "reprimanded" by an elder so as not to attract attention to the herd, "shaming", elephant-style, is at work. "Shame" or its prototypical, mammalian equivalent, serves as a powerful down-regulator of arousal (see Tomkins, 1963, who described shame as putting a brake on emotions, particularly interest-excitement), in order to preserve individual and species survival, and thus is *not* a uniquely human experience.

At the same time, self-consciousness may be uniquely human. In the Bible, when Adam and Eve ate of the apple and became aware of their nakedness, it was self-consciousness and shame that banished them from Eden. To become aware of one's self as an object of others' valuation or de-valuation, be it a deity or one's fellow mortal, is to become self-conscious that one has neither met one's own nor others' expectations, and shame (along with guilt) naturally follow. As Mark Twain wrote in his novel, *A Connecticut Yankee in King Arthur's Court*, "It shames the average man to be valued below his own estimate of his worth" (Twain, 2011, p. 351). Thus, shame is about self-valuation, others' valuation, and the interaction of those two lived realities. Shame is a peculiarly social emotion that at its most punishing leads to destructive forms of self- and other-banishment from one's loved ones, social group, and/or "tribe"—in effect, Eden.

Shame is ever-present in psychotherapy, whether the therapist and patient recognise it or not, as shame is always about "the self", and "the self-in-relationship", be that relationship with others (interpersonal) or aspects of self (intrapersonal), and psychotherapy is invariably about all that. Shame has been shown empirically to be central to many forms of psychopathology (Dearing & Tangney, 2011, p. 6). Likewise, contempt, a form of shaming the other, negatively impacts the emotional and physical health of couples. As John Gottman's (Gottman & Gottman, 2016) research demonstrated, increased contempt in couples is the best predictor of divorce as well as greater physical illness and decreased immune system effectiveness. In sum, developing new ways of understanding and working with shame is vital to being a well-prepared psychotherapist.

On the neurophysiology of shame, attachment, and its relationship with Porges' (2011) polyvagal theory (with a nod toward Wile E. Coyote)

The four-step model of shame

By observing with patients the experiential phenomena that result in pathogenic shame, I have deconstructed and then reconstructed shame formation. In tracking the genesis of shame, I identified a four-step arousal model of shame induction.

(For a fun cartoon rendition of this four-step model, see "Coyote Fall" (Anatkramer, 2008).)

Step 1: Shock

The person is either shamed as a result of his own behaviour (including thoughts, feelings, and/or actions); or as a consequence of the response or non-response by a significant other; or brings to consciousness and/or is traumatically triggered and taken over by a shame-inducing event/memory, thought/belief, feeling, physical sensation, etc.

The initial response of the shamed person is to try to socially engage with the shaming other, following Porges' (2011) description of the "social engagement system" (SES). (See Step 2: Drop, for a fuller discussion of polyvagal theory and its relationship to shame).

In the case of a developing disorganised attachment (and to be clear the four-step shame phenomenology occurs for all attachment styles), imagine a three-year-old boy who spills his milk and whose overwhelmed mother calls him an idiot. When the little boy cries, it is his SES that prompts him to try and re-engage his mother and elicit her empathy and soothing. When she responds by shouting, "I'll give you something to cry about!", particularly if this type of interaction has occurred many times, the little boy's SES would, following Porges' (2011) polyvagal theory, go offline and be replaced by an activated "sympathetic nervous system" (SNS) or "fight-flight response". SNS activation causes a spike in arousal that is experienced by the young boy as a *shock* or jolt to his nervous system.

For the young boy developing a disorganised attachment with his mother, neither social engagement (SES) nor fight or flight (SNS) will restore safe reconnection with his mother. Instead, the boy will experience, often fleetingly, an initial high "freeze" response (see Porges, 2011, "immobilisation with fear") marked by an hyper-focused, orienting response toward the "shaming stimuli", be these external (e.g., his mother's yelling or ignoring) or internal (e.g., his rapid heartbeat).

Step 2: Drop

After his initial "shock", the child experiences a perceived or implicitly "neuroceived" (Porges, 2011) threat to safe connection. Porges' (2011) polyvagal theory outlines a predictable sequence of neurophysiological responses designed to return the child to relational safety. The three "survival systems" are phylogenetically arranged from the most recent to the oldest system, and phenomenologically from the most complex and sophisticated to the most primitive survival strategies. Porges outlines this sequence as going from the social engagement system (SES), to the "fight or flight" response of the sympathetic nervous system (SNS), and finally to the "dorsal vagal complex (DVC) shutdown or rapid down regulation of arousal.

Using our example of a three-year-old's budding disorganised attachment, Porges' (2011) polyvagal theory predicts the scolded or ignored child will

1. first, try to socialise with his mother in order to safely reconnect (SES)
2. next, fight or flee his mother, followed by a freeze response if neither restores safety, all states of hyperarousal (SNS)
3 and lastly, experience a dorsal vagal "drop" (DVC) from hyper- to hypo-arousal. This rapid down-regulation of arousal is what comprises Step 2: Drop for both shame as emotional process and shame as triggered, traumatic state (each described at length, below). Tompkins (1963) described drop as the "braking" function of shame; it is when sympathetic hyperarousal is replaced by parasympathetic hypoarousal.

Step 3: Shame proper

What most think of as "shame" (as *emotion* or *traumatic state*) is Step 3. Neurophysiologically, this state of hypoarousal is characterised by a loss of energy, motivation, and interest, not unlike when depressed; a lifeless state akin to Porges' (2011) depiction of death feigning in mammals. The shamed person's neurophysiology ("lifeless") often matches their self-narrative, such that they not only "*feel* worthless" they "*are* worthless". Here, our little boy will come to believe he *is* a "bad boy", and his mother will likely agree.

Step 4: Dissociation

For some, the shaming experience is either repeated, unrelenting or mentally replayed (Scheff, 2007, p. 4). In our example, the mother regularly experiences her son as disappointing and perhaps "making her look bad" as a mother, and in turn shames her son repeatedly well beyond his immature nervous system's capacity for coping. Whether shame recurs for external (interpersonal) or internal (intrapersonal) reasons or both, as is common, the effect of Step 4 is the same: Nervous system overload for the boy, resulting in not only re-traumatisation but eventual dissociation. In disorganised attachment, recurrent traumatisation may develop beyond a dissociative response into, over time, structural dissociation (van der Hart et al., 2006).

Shame subtypes, and shame as emotional process *vs*. shame as traumatic state or "way of being"

(Note the term "way of being" is used interchangeably with "self-state" or "state" for short, and is taken from Chefetz, 2015, p. 66.)

"Shame" has been conceptualised from many perspectives. Nathanson (1992) described four typical responses to shame, that is withdrawal, avoidance, self-attack, or other-attack. Some authors differentiate "good" (adaptive) and "bad"

(maladaptive or toxic) shame, while others contend there is no such thing as "healthy" shame (Greenberg & Iwakabe (2011), and Tangney & Dearing (2011), respectively, both in Dearing & Tangney, (2011)). As discussed below under "good enough me shame", I contend that shame is sometimes very adaptive. Others categorise shame according to its content (e.g., thoughts, emotions, and/or behaviour, such as sexual, financial, work, etc.). In contrast, I do not find listing what patients feel shame about clinically useful, as people can experience shame about almost everything, including—and in fact, often—shame itself.

As a psychotherapist, I prefer keeping only a few phenomenological categories in mind, as too many interfere with my following what is going on within the patient, within myself, and between the two of us. With respect to shame, I find it most helpful to think of four shame subtypes (see Table 1). Given the "multiplicity of mind" such that within any individual reside several different mental states, it is not uncommon that patients, like many others, experience more than one shame subtype. Based upon my clinical experience, most patients experience at least one type of shame, although certain people who would be described as "sociopaths or psychopathic personalities" may not. Certainly people with these emotional difficulties do not *feel* shame.

Table 1: Shame subtypes

Emotional process
Good enough me
Bad me
Traumatic state
Not me
No me

"Shame as an emotional process", and within this category two subtypes:
"Adaptive shame", also known as "self-righting shame" or "good (enough) me shame".
"Maladaptive shame", also known as "pathogenic shame" or "bad me shame".
"Shame as a recurring and recursive traumatic state", and within this category two subtypes (see also Herman, 2006; 2007).
"Not me shame", best described by Bromberg (2011b) and seen in dissociated states of mind and enactments within the therapeutic relationship.
Shame that "seeks" to fill the void of non-existence, or "no me shame"

There are two important points I would like the reader to consider before I describe, in some detail and with clinical vignettes, each of the four subtypes of shame. These include:

1. levels of organisation and self-reflective capacity; and
2. differentiating "shame as emotional process" and "shame as traumatic state".

Levels of self-organisation and self-reflective capacity and the four shame subtypes

The four shame subtypes, that is good enough me shame, bad me shame, not me shame and no me shame, exist on a hierarchical continuum from most to least complex and integrated levels of self-organisation, as well as from the greatest to least capacity for self-reflection or non-judgmental, self-awareness. For example, while the person experiencing good enough me shame must have the capacity to hold feelings of shame alongside attitudes and beliefs about one's "better self", the person experiencing not me shame dissociates and unconsciously places outside of awareness those aspects of self that are deemed unacceptable. Likewise, while the person living with bad me shame feels more "*in* shame" than "*reflects upon* their shame experience", they still have more self-reflective capacity than the person living with no me shame, the latter showing little to no reflective capacity about their relationship with this form of shame. I hope these hierarchical distinctions will become even clearer as I specify the characteristics of each shame subtype.

Shame as emotional process *vs*. shame as traumatic state

Shame as an emotional process is related to, but not the same as, shame as a recurring and recursive, traumatic state (see also Herman, 2006, 2007) or "shame state" for short. Consider these two variants of shame as cousins; while they bear a family resemblance, they are not the same nor should they be treated clinically as if they were.

When describing the phenomenology of shame as emotional process, several features are important to appreciate. First and foremost, an emotional process is ever-flowing and changing. Emotions are never static, as the Latinate word origin *emovere* or "to move" suggests. Rather, emotions are responses to one's own thoughts, feelings, and bodily sensations (i.e., intra-personal), as well as to others' thoughts, feelings, behaviour, etc. (i.e., inter-personal). We know emotions are part of a dynamic interpersonal system when, for example, a securely attached infant interacts with her parent in an emotional tango. As Stern (1985) observed, "Like the dance for the adult, the social world experienced by the infant is primarily one of vitality affects before it is a world of formal acts" (Stern, 1985, p. 57).

More specifically, shame as part of an emotional process has many features familiar to most of us, and is common in people with dismissing attachment states of mind. For example, the shamed person's slumped posture might be slightly collapsed at the chest (concave, with diminished breath available), their eyes averted downward, and head turned slightly to one side, often to their right, and away from the shaming other. Note that the head turned to one side exposes the jugular to the shaming other, and is consistent with a "submit response" in the

animal kingdom. This looking down and away embodies what we observe psychologically, in that shame in humans typically involves a submission to another's will or beliefs about the relationship, as if the shamed person were to say, "I as inferior submit to your superior authority". As noted under the four-step model of shame, above, there is often an initial jolt of energy, perhaps the rush of blood to a flushed face, particularly cheeks, followed by a rapid down-regulation of arousal.

Emotionally, the initial shock is typically followed by a sinking feeling as though falling into a dark hole or wanting to crawl into a hole and hide. "Defeated", "deflated", "depressed", "collapsed", "sinking", "wanting to hide", "invisible", "nobody", etc. are all words or phrases that may capture the shamed person's physical or emotional reality (see Lakoff & Johnson, 1999 on the embodiment of language).

With respect to thoughts, the shame-laden person believes either explicitly (i.e., is consciously aware) or implicitly (i.e., outside their conscious awareness but influencing their sense of self and behaviour in relation to others) one or more of the following: "I am . . . 'inferior', 'bad', 'worthless', 'undeserving (of good things)', 'disgusting', 'damaged', 'defective', 'a failure' ", etc. Shame as an emotion is a relatively transient experience of "self-in-relation to self" (intra-relational shaming), or "self-in-relation to the shaming other" (inter-relational shaming). Shame as an emotional process is never "forever"; rather, it is now, and soon to be followed by "and now what?"

"Shame as traumatic states" (see also Herman, 2006, 2007) or "shame states" are best understood as subtypes of relational traumatic states more generally, wherein what dominates the interpersonally traumatised person's emotional landscape is, at that moment in time, shame. DeYoung's (2015) definition of shame points toward these forms of shame: "Shame is the experience of one's felt sense of self disintegrating in relation to a dysregulating other" (DeYoung, 2015, p. 18). As with other ego or self-states resulting from relational trauma, shame states are triggered responses that first develop in the context of overwhelming, emotional, and/or physical abuse or in the face of profound emotional and interpersonal neglect. The latter conditions, Bromberg (2011a,b), aptly characterises as "non-recognition". I describe two types of shame states more fully below, "not me shame" and "no me shame".

Shame states bear many similarities to traumatic states more generally, as depicted by Bessel van der Kolk (2013, 2014a,b) whose description of trauma bears directly on my understanding of shame states. For example, van der Kolk (2013) noted that when treating traumatic states, the amygdala's "alarm signal" must be calmed sufficiently to permit the thalamus to integrate the traumatic experience in a new way. In the therapy of shame states, the brain must be activated sufficiently (up-regulated) so that the patient can re-experience the shaming event, while remaining calm enough for the shaming event to be re-processed.

The initial inescapable shock to the nervous system is, by now, a well-known feature of trauma, and even found its way into the earliest descriptions of war trauma as "shell-shock". Similarly, the traumatised brain commonly undergoes what van der Kolk (2013) referred to as "cognitive flashbacks", or recurrent experiences of self on the level of meaning. That is, the traumatised person often returns to self-perceptions such as "I'm useless" or "weak". In traumatic shame states, the initial shock, marked by a surge of arousal, is evidenced when the person is faced with unavoidable rejection or humiliation, first by a shaming other and later, reflexively, in recursive self-shaming (Scheff, 2007, p. 4) and its associated self-state (e.g., "I'm damaged").

Likewise, van der Kolk (2013) observed that in trauma Broca's area of the brain often goes off-line, diminishing one's capacity to speak. The inability to speak during shame states is quite common, and often causes further self-shaming as the patient believes, erroneously, that they should be able to say what is wrong with them. Brain studies have also revealed that in traumatic states the left-brain is off-line or less activated than the right. The ventromedial prefrontal cortex is also off-line, resulting in diminished emotional regulation and meaning-making. Also observed in traumatic brain states is reduced activation in the anterior cingulate, correlated with diminished awareness of self or, more precisely, a complex, integrated self. Similarly, while I know of no comparable brain research into shame states, one readily observes the traumatically shamed person's decreased ability to analyse and reason congruent with left-brain dysfunction. In shame states, a complex sense of self, with positive and negative traits recognised in diverse social-emotional contexts, is replaced with a univocal self-state, as in "I'm worthless".

Van der Kolk (2013) summarised research that showed the orbitofrontal region of the cortex was off-line during traumatic states, resulting in disinhibited action. While disinhibition is not seen when a person is in the hypo-aroused or "shut-down" phase of shame states, it is readily observable in defensive rage or shame-rage cycles. Similarly, van der Kolk noted that in trauma the dorsolateral prefrontal cortex is often off-line, resulting in a reduced capacity for setting priorities and planning. Shame states similarly restrict the person to prototypical survival strategies, as in fight-rage or flight-withdrawal.

Van der Kolk (2013) wisely observed that in trauma and post-traumatic stress disorder (PTSD), the "brain gets stuck before liberation", in that *how* the trauma survivor survived is not registered and remembered. Similar "stuckness" is also seen in recurrent shame states, as the person gets psychologically stuck before self-confidence was restored. Thus, the person gripped by a shamed state automatically and often outside their awareness "gathers" memories congruent with a debased self-view, as if to say, "I was, I am, and I always will be damaged". Likewise, this reduces the shamed person's capacity to mentalize (Fonagy et al., 2002) and imagine the other, including the therapist, is not also thinking they are "damaged".

Van der Kolk (2014b) stated that trauma reorganises perception, resulting in diminished imagination and mental flexibility. As a result, trauma impairs the person's ability to learn from new experience and to feel alive in the present. Shame states reorganise perception by narrowing it, restricting imagination and cognitive flexibility. Shame states hyperfocus the person on a past, shaming event (or several shaming events), and its feared, inescapable recurrence.

Trauma results in the person developing a distorted relationship with their body, living with an impulse to run away or shut down. Likewise, trauma is associated with physical immobilisation and helplessness, leading to panic, fear, and/or collapse. Shame states also disrupt the person's relationship with their body, causing them to run, hide, feel self-disgust, and shutdown, neurophysiologically. Shame states are also associated with immobilisation and helplessness, with an initial jolt of fear followed by collapse.

Van der Kolk (2014b) reported that that neuroscientist Ruth Lanius discovered that in a traumatised state the areas of the brain associated with "feeling" and "knowing" "self", such as the insula, are impaired. Insula dysfunction in traumatised individuals results in problems with body regulation (e.g., sleeping, eating). Traumatised patients feel extremely uncomfortable in their own bodies, and thus seek different ways to "feel better physically", resulting in higher incidences of alcoholism, drug addiction, troubled eating, and becoming overweight. I do not know what the insula of patients with recurrent shame states looks like, but I would predict similar dysfunction as evidenced by shame bound patients often feeling very uncomfortable both in and about their bodies, and as with trauma survivors are more vulnerable to addiction, eating disorders, and the like (Dearing & Tangney, 2011, p. 7).

Van der Kolk (2014b) observed that rationality or reasoning tend to take place on the sides of the brain (left and right), whereas midline brain structures are associated with self-experience. Similarly, the medial prefrontal cortex, associated with "mindfulness", can have positive effects on the limbic (emotional brain) system, unlike brain regions associated with "rationality". Various therapies associated with mindfulness (e.g., *Internal Family Systems*—Schwartz, 1995; and *Sensorimotor Psychotherapy*—Ogden et al., 2006) have been found effective in working with those who have been traumatised. Likewise, the mindful deconstruction of shame states, that is, the non-judgmental and over time compassionate observation of the distinct beliefs, feelings, and physical manifestations of shame states, are essential to all forms of shame-state informed therapy, for example, compassion focused therapy. (Gilbert, 2010; Gilbert & Andrews, 1998).

The four shame subtypes

All of the following shame subtypes represent common exemplars of internal working models (Bowlby, 1969) of self, other, and self-in-relationship.

Good enough me shame

Within shame as an emotional process there are two subtypes, good enough me shame, that I also refer to as self-righting shame, and bad me shame, also known as pathogenic shame. Good enough me shame" intentionally echoes Winnicott's term, "good enough mother", in that the person experiencing good enough me shame does not think of themselves as "good" but, rather, "good enough". Good enough me shame also refers to Bowlby's (1969) concept of internal working model, where the child in a secure attachment internalises his or her relationship with a parent who reliably repairs the bond with their child when shame-inducing ruptures occur. From an evolutionary perspective, Greenberg and Iwakabe (2011, p. 72), called this "adaptive shame" as contrasted with "maladaptive shame"; the latter is equivalent to bad me shame, discussed below.

Good enough me or self-righting shame is shame that is consciously felt but emotionally and neurophysiologically better regulated than bad me shame. Following Ogden and colleagues' (2006) model of "optimal arousal", who borrowed from Siegel's (1999) "window of tolerance", states that "optimal arousal" occurs between two parallel lines. Thus above the upper line represents "hyperarousal" (such as rage or terror), and below the bottom line represents "hypoarousal" (such as despair and some dissociative states). Good enough me shame is well-enough regulated such that the person remains "between the two lines" and within their window of optimal arousal. Stated differently, the person with good enough me shame can feel, deal, and continue to relate effectively with themselves and others, while *also* dipping into feelings of shame.

Vignettes: The value of good enough me shame[1]

"Laura" and the value of shame

In good enough me shame, the person recognises from a non-reactive, self-accepting place that they have not been true to themselves and/or their values. This shame subtype is self-righting in that it helps the person return to living according to their deepest values. "Laura", a patient who was highly prone to experiencing bad me, not me, and even no me shame, described good enough me shame this way:

> "I didn't live up to what I know I am capable of, and how I want to be with others. I don't feel crushed or like I don't deserve to exist [as she typically felt when gripped by punishing bad me shame or annihilating no me shame], but I do feel shame nonetheless. I want to be better next time".

"Mark": moving from bad me to good enough me shame

"Mark" was highly prone to feeling bad me shame after losing a treasured job following his affair and almost losing his marriage. In one session, Mark moved from bad me shame toward self-righting shame. Mark started this session

describing how badly he felt about himself for losing his previous job, and how he felt too ashamed to share his feelings of loss with his wife. Together we worked to help Mark regulate his bad me shame sufficiently so that he could describe what he loved about his former work that still engendered feelings of genuine pride. As he began to feel some sadness around what he missed about his former work, Mark quickly slipped away from grief into bad me shame, again. Further work uncovered an implicit belief that demanded Mark shame himself to ensure he did not "mess up" again. ("Self-shaming" functioning as a primitive form of self-parenting or controlling of unwanted impulses is quite common). As Mark realised he could learn from his mistakes without plummeting into bad me shame, he got in touch with self-righting shame and adaptive guilt that motivated him, by the end of our session, to speak with his wife about what he lost as well as the ways he regretted hurting her. From an attachment perspective, good enough me shame enabled Mark to both re-connect with both his better self and his wife.

Self-righting shame would be more accurately labelled "self–other righting shame", as "the self" is always in relation to "an other", be that other a real person or an internalised other. One way of differentiating *shame* from *guilt* is that with *shame*, the emphasis is on the "self" side of the self–other equation, whereas in *guilt* the emphasis is on the "other" side of the equation. In Mark's clinical vignette, the session ended with his experiencing *both* self-righting shame and adaptive guilt.

Bad me shame

Bad me shame and its associated internal working model (Bowlby, 1969) develops both in response to what a caregiver *does* (active shaming) and *does not* do (passive shaming). An example of active shaming is when a young girl comes home from school, excited to share events of her day, and her father responds to her enthusiasm with, "Don't bother me! Can't you see I'm on the phone?". Passive shaming, in contrast, occurs when a parent fails to meet the developmental needs of their child, as when they ignore the child's need to share their day. Passive shaming is often more damaging than active shaming and is typically harder to identify and work with in therapy, as the patient retains no narrative or episodic memory of "what did not happen".

Clinical vignette: "How come I feel so bad about myself when I was never treated badly?"

"Ruth" and I met weekly in psychotherapy. She was a forty-year-old woman living with chronic and punishing self-criticism. Ruth often felt she was failing as a mother, a wife, and a professional. While of course not perfect, Ruth was a very thoughtful and devoted mother who always tried hard to be loving and firm with

her children. About six months into our work, Ruth and I discovered she lived with an implicit belief that dictated she "should never disappoint her children" and that when she did, this proved she was "a failure as a mother". This left Ruth wracked with terrible guilt (for hurting her children) and unremitting shame.

Ruth recalled no "active shaming" by her father or mother growing up. However, what we discovered almost by chance one session was that while she and her older sister, "Jane", often played very well together, there were times her mother tended to leave them to themselves. For example, Ruth recalled once she and Jane ran in an unfamiliar mall and Jane hit a pole and was knocked unconscious. While in the end Jane was fine, Ruth was left feeling she had "failed" as a sister and daughter, as she "had not looked after her sister" as the sisters had been instructed by their mother. The problem, of course, was not that Ruth failed to protect Jane, as Ruth was five and Jane seven, but rather that they were developmentally incapable of playing safely in the mall without parental supervision.

In this instance, Ruth and I discovered one crucial source of her punishing "not good enough" internal working model (Bowlby, 1969). Ruth's experience confirmed what is sadly all too common for many chronically shame-bound adults: The void left by the lack of adequate parenting is often replaced with a harsh inner-shamer, what I dub the "primitive parent". Children "parent" like children, and in the absence of adequate care and supervision, as adults they self-parent in harsh, binary ways, as in "good (proud) or bad (shamed)" and "success or failure". Said another way, Ruth often lived with her experience of bad me shame (or the threat that bad me shame would return if she did not behave "perfectly") because she lacked parenting that modelled more mature ways of modulating intense emotions. With respect to psychotherapy, understanding this makes it possible to help patients who lack more benevolent "inner parents" to develop, over time, more compassionate and flexible inner-parents both for themselves as adults, and for their internal experience of younger versions of themselves (look at Schmidt, 2009, for one approach to working this way). It must be noted that Ruth's bad me shame was so dysregulating that before she could hear the more compassionate voice of a "good enough" parent, I had to teach her how to calm her body down, as her self-hatred threw her into a state of hyperarousal well outside her window of tolerance (Siegel, 1999).

Not me shame

Not me shame refers to aspects of self that have become dissociated from consciousness, but can manifest behaviourally in clinical enactments (see Bromberg, 2011a,b for some of the best evocations of not me shame in clinical enactments), and/or unremitting symptoms (such as chronic anxiety, depression, pain conditions, troubled eating, addictions, etc.). As dissociated phenomena, the patient gripped by not me shame often projects unconsciously on to the other

those not me shamed or non-recognised qualities, that inevitably get played out in the patient–therapist relationship.

Mild and dramatic triggers alike can set off a traumatic shame state resulting in not me shame, depending upon the person's interpersonal and later intrapersonal history. For example, if a shame-prone person says hello to another person he knows, and the second person fails to respond, the first person could—given his history, for example, of being raised by a non-responsive, chronically depressed mother—plummet into a triggered not me shame response, even though his conscious mind might explain it away as "She just didn't see me".

Shame states are often recursive, in that the person living with traumatic shame states has internalised his experience of a shaming attachment figure and now engages in recursively, mentally replayed self-shaming (Scheff, 2007, p. 4). The person prone to recursive shaming repeatedly shames himself for big and small social infractions alike, sometimes consciously but more often habitually and outside awareness. This person, for example, might develop a perfectionistic style and berate himself for committing even the smallest social gaffe.

Whenever a person recursively shames himself, his mind/brain will at some point become overloaded and automatically respond by dissociating, something I think of as "leaving the scene of the crime". From the perspective of Porges' (2011, pp. 164–165) polyvagal theory, this is one psychological manifestation of a dorsal vagal shutdown. Shame that triggers dissociation is not "felt" and consciously known as in shame as emotion. The way we discover dissociated, not me shame is by its shadow effects, what Bromberg (2011b) referred to as "the shadow of the tsunami".

For example, imagine a man who remains unable to motivate himself to apply for a work position with greater responsibility despite being told by trusted others that he is extremely competent. "What's wrong with me?", he might berate himself, and even notice feeling some shame (bad me shame). However, on a deeper level, this man who is living with the effects of not me shame may be unaware he carries the cognitive-emotional-somatic legacy of being shamed by his father as a boy, so much so that his shame state is dissociated and not yet available to his awareness. Experientially, these not me shame states often have a recurrent, nightmare-like life of their own.

Vignette: Not me shame or "Whose shame is it?"

"Harold" had never experienced physical nor sexual abuse as a young child, but he had lived through marked emotional misattunement with his often very anxious and emotionally dependent mother and his more absent, insecure, and on occasion, verbally explosive father. When triggered by certain current, unmet relational needs, Harold would feel desperately dependent and fragmented, and flip between feeling hatred and rage toward the "depriving" significant other and

filled with overwhelming shame. Harold coped with these traumatic shame states in part by trying, unconsciously, to control and shame others, which inevitably left him feeling even worse about himself.

During a period of two months that followed one and a half years of intensive and helpful work, Harold became angry, controlling, blaming, and shaming of me whenever I made empathic errors. More specifically, whenever I was misattuned in ways that were particularly reminiscent of Harold's childhood, for example, when I spoke too much or too authoritatively, he was viscerally and painfully "reminded" of being unseen by his parents and to a lesser extent his older sibling when growing up.

At first, I responded to Harold's confrontations in ways that made things worse. I would anxiously "freeze up", feeling helpless, ineffective, and ashamed of myself, and try desperately to understand what was happening both within Harold and between us. I often found myself trying to appease Harold or intellectually explain and "interpret" his behaviour, responses that invariably left Harold experiencing me as emotionally distant and superior, and him as utterly alone and shamefully "judged".

With considerable consultation and self-reflection, I gradually was able to unfreeze out of my own shame state and countertransference entanglement in-session, a state of intense, immobilising fear, helplessness, and shame that had triggered visceral and emotional remnants of interpersonal trauma dating back to my own childhood, and began to discuss our shared enactment in ways that were neither shaming of Harold nor myself. Gradually, Harold was able to see how he had been engaged in "co-dependent" behaviour (his words) that left him feeling "weak", powerless, and ashamed, where he both expected me to know how to make him feel better or "fix him" while becoming enraged, blaming, and demeaning when I inevitably failed him. Increasingly, Harold and I found ways to avoid falling into our co-created, traumatic "rabbit hole" of shame and blame. For example, we agreed to make room for his rage by inviting him to direct it, verbally, toward my empty chair representing his internalised abandoning mother, while I sat more toward his side. This and related strategies, but even more importantly my becoming much more emotionally regulated (i.e., no longer immobilised by my shame, fear, nor reactive anger) and therefore present with Harold, gradually freed him to utilise his already well-developed self-soothing strategies. This further freed me to become more of a resource for and ally to Harold when faced with "disintegration" rather than the perceived, recurrent cause of his emotional abandonment and shame.

No me shame

This last and most primitive form of shame, no me shame is the most pernicious, destructive, and hardest to detect shame subtype. No me shame is impossible to

capture in words that are experience-near, as it first occurs developmentally between nine and eighteen months and sometimes even earlier, well before the very young child has many, if any, words to describe this profoundly disruptive and dysregulating experience. No me shame refers to the perceived or more often implicitly neuroceived threat (Porges, 2011) to one's existence or annihilation (De Young, 2015). The threat of annihilation can be physical, psychological, or both. Physical threat is the perception or neuroception that one is about to be killed or die. Psychological threat of annihilation occurs when the infant's or young child's basic psychological needs to be seen, felt, held, known, and delighted in go profoundly and repeatedly unmet. In these instances, the child and later adult can experience no me shame states whereby terror is supplanted by neurophysiological "shutdown", akin to "feigned death" in other mammals (Porges, 2011, pp. 164–165, 283). This shutdown state is seen in chronic depression, depersonalisation, emotional numbing, detachment, and more severe forms of dissociation. Note that in no me shame, the person may or may not be conscious of the terror of dissolution or annihilation, and thus often does not *feel* shame as in bad me shame. However, the extreme hypoarousal seen in this shame subtype is evidenced in deadened, dissociated, and/or depersonalised states apparent to both patient and therapist.

In order to survive physically and psychologically, an infant seeks proximity with attachment figures. As Main (2000) observed,

> It is understood . . . the infant . . . selects its primary attachment figures generally upon the basis of contingent social interactions. Attachment emerges as the product of interactions with a maltreating person as readily as they do with a sensitively responsive one, and biologically based proclivity to form attachments ensures that only in extremely anomalous circumstances will a child remain unattached. (Main, 2000, p. 1060)

Furthermore, in order to exist psychologically (which is not the same as merely surviving physically), the infant must come to know that they live in the heart and mind of the caregiving other. To dwell in another's heart and mind is to be seen, felt, and on the deepest level, "recognised".

The definition of the verb "to recognise" gets us closer to what recognition means psychologically to all humans, not only vulnerable and dependent infants and children or survivors of relational trauma. To "re-cognise" is literally "to know again", and further means to "acknowledge the existence, validity, or legality of . . ." (OED, 2017).

For a person to exist psychologically, particularly a vulnerable and highly dependent infant or young child, he must be re-cognised and re-membered (re-embodied) by his caregiver and in turn himself, over and again. The child discovers himself and thus comes into existence, psychologically, by interacting with his physical and social environment. It is through interactions with people,

particularly caregivers, where the infant or young child comes to discover who he truly is. When a mother, for example, sees and feels and delights in her infant son's exuberance, and responds in kind with matching exuberance and vitality affects, then her son comes to know, implicitly, "I am exuberant and exuberance is good with mummy". If the infant's exuberance is "good with mummy", and "exuberance" is essential to who the infant is in the world, then "mummy delighting in his exuberance" is the equivalent of "mummy delighting in him", that in turn is the psychological equivalent for the young boy of "I exist, and I am good (delightful)". (see also Fosha, 2005, on the caregiver as a true other.)

In contrast, if the mother repeatedly fails to delight in her infant or young son being himself and if, and this is worse, the mother fails to even notice her child, then the child is at risk of developing deep, indelible no me shame. This is not the same as bad me shame or not me shame, although those often co-exist in the person living with no me shame. No me shame is existentially more threatening, the equivalent of "I do not exist" or simply no me.

No me shame, then, develops in the presence of profound relational absence. Profoundly absent cargiving takes many forms, for example in parents with severe dissociative disorders and/or psychosis, or institutional cargivers who, as in certain orphanages, meet the basic physical needs of their charges, but otherwise fail to see these children as individuals with idiosyncratic psychosocial and emotional needs that are ever-changing day-to-day as well as developmentally over time.

Clinical vignette: No me shame

"Laura", the patient I quoted above (see good enough me shame) grew up with a mother who was likely psychotic and/or highly dissociative. Laura described her mother as always ". . . looking right through me, as if I weren't there", an experience Laura's husband, years later, attested to when he met Laura's mother. In addition to experiencing bad me shame, good enough me shame, and not me shame, Laura frequently wrestled with no me shame. For example, Laura loved to fly, especially as an amateur pilot, but would recurrently be overcome by a terrifying kinaesthetic sensation that the plane's floor dropped out beneath her, or picture herself walking off the wing and disappearing. With respect to the latter fantasy, Laura did not imagine falling to her death, but rather ceasing to exist, such that she tasted the terror of disintegration into non-being.

I now understand Laura's experience, that is her "falling off the plane into non-being" or more accurately, "no-being", as her way of articulating a dissociative experience that was something she not only feared but was viscerally and emotionally "remembering", based upon repeated non-interactions with her mother.

I hope it is clear from my discussion of no me shame that the person who experiences this form of shame need not "*feel* shame". If there were words to describe this terrifying, wordless state of mind/body, it might be something like the following:

> "I am nothing, a non-I. I look in the mirror, and there is no one there. I look at others, but I must be invisible because they never respond as though I exist. No matter what I do, I can never recover me. Since 'I' don't exist, 'I' certainly don't matter. I may be aware of terror, dread, depersonalisation or de-realisation, but that is the closest I can get to know that 'I', am. What is most troubling and alienating is that I see other people but don't feel them. They appear to exist to and for each other, but I do not; I have never been a member of that club. Worst of all, no one but me knows my terrible truth, leaving me feeling even more alienated from myself and others—a non-I and a non-we."

Shame, disorganised/unresolved attachment, and Porges' (2011) polyvagal theory

While shame occurs across all adult attachment styles, space here only allows for a discussion of traumatic shame states and their relationship to disorganised/unresolved attachment.

In disorganised attachment, the care-seeker's powerful, biological urge to go toward the caregiver is met with threat, leading to what Main and Hesse, cited in Liotti (2004), aptly characterised as "fright without solution" (p. 477):

> The attachment figure, in interactions leading to attachment disorganization, is "at once the source and the solution" (Main & Hesse, 1990, p. 163) of the infant's alarm, and this leads to fright without solution. That is, the infant has no way out of this paradox. There is no single, coherent behavioral or attentional strategy able to interrupt the loop of increasing fear and contradictory intentions (approach and avoidance) in the infant's experience." (Liotti, 2004, p. 477)

When this hardwired urge to seek closeness and care is met with "threat"—either actively, as when the intended caregiver angrily frightens or overtly shames the careseeker, or passively, when the caregiver's non-responsiveness or dismissiveness frightens or shames the careseeker—then humans, following Porges' (2011) polyvagal theory, are phyologenetically programmed to respond in a fairly predictable, hierarchical manner.

As noted earlier, Porges' (2011) polyvagal theory is based upon research into the neurophysiology of survival strategies as seen in humans, non-human mammals, and reptiles. Porges identified three response systems:

1. The social engagement system (SES), unique to humans.
2. The sympathetic nervous system (SNS) that leads to fight, flight (and I would add), "high freeze" responses, as seen in all mammals.
3. The dorsal vagal complex (DVC), first observed phylogenetically in reptiles, and linked to emotional shutdown or hypoarousal and dissociation in humans.

What is the relationship between a child's or careseeker's explicit perception or implicit neuroception of safety or threat and shame? Why does the neuroception

of threat to one's physical, psychological, and/or social-emotional survival often evoke powerful shame states that are more akin to traumatic states than to shame as an emotional process or merely feeling shame? More specifically, do the neurophysiological phenomena of so-called shame states and attendant beliefs about self-in-relation-to-others, bear any resemblance to what Porges' (2011) polyvagal theory would predict? When we observe what goes on between child and parent, and specifically patterns of action and interaction between careseeker and caregiver consistent with "disorganised attachment", might these behavioural patterns be more fully understood in terms of shame and Porges' polyvagal theory? It is not unusual for us psychotherapists to meet a patient who, as a child and perhaps older, presented a "true self" (Winnicott, 1965) aspect to a caregiver and was met repeatedly with active rejection (expressed as parental disgust, contempt, overt dismissiveness, etc.), and/or regularly experienced passive rejection (communicated by the parent's "not seeing", "not feeling", "not recognising", "not responding", "ignoring", or "neglecting" the child/careseeker). How do these common interactional patterns help us understand the neurophysiology and psychology of shame, and more importantly inform our responses as therapists?

I hope to begin to speak to these questions in the following sections devoted to disorganised attachment, Porges' (2011) polyvagal theory, and the neurophysiology of shame and, most importantly, traumatic shame states.

Disorganised (unresolved) attachment, dissociation, and shame states

Liotti (2004) characterised disorganised attachment thus:

> . . . essence of infant attachment disorganization [as] the simultaneity of approach and avoidance attitudes toward the caregiver that induces a serious lack of organization and orientation in the infant's overall attachment behavior. (Liotti, 2004, p. 475)

Said another way, disorganised child and later unresolved adult attachment patterns develop from what Stern (1985) called "repeated patterns of interaction generalized", such that neither going toward (Porges' SES), nor going against or away from, that is fighting and/or fleeing (Porges' SNS) is perceived and more often implicitly neuroceived as capable of reducing threat. Threat is defined here as threat to survival, be it physical, psychological, or both. The neuroception of this inescapable threat is what is presumably "baked into" the brain structures, creating well-worn neuronal pathways and associational networks, and from a psychological perspective internal working models (Bowlby, 1969) such that the person comes to believe implicitly that their very being—physically and psychologically—will not survive unless they do something dramatic and swiftly.

When no safe passageway is perceived nor neuroceived, and the child can neither escape nor expect to be comforted by the parent/caregiver, then the child

"freezes". This initial state is "high freeze" because it includes both "hyper-arousal" ("high arousal") and motoric "immobilisation" ("freeze"). Porges (2009, p. 53) called this state "immobilization—life threat" as contrasted with "immobilization without fear". I find "immobilisation with terror" a more apt term for many of our patients with complex/relational trauma as the threat, especially from the perspective of a very young child, is perceived/neuroceived as a threat both terrifying and often terrorising, depending upon the behaviour of the caregiver, the child's temperament and his developmental capacity to manage dysregulating arousal. A "high freeze" state is marked by immobilisation with hyper-arousal, and can be thought of as the person (child and later adult) automatically putting "their *gas* pedal" and "*brake*" to the metal *at the same time*. Thus, the sympathetic nervous system (SNS, fight/flight response) is activated at the same time as the parasympathetic nervous system (PNS), resulting in an initial "high freeze" state marked by simultaneous high activation and immobilisation or inhibition, or in many adult patients with unresolved attachment styles a fairly rapid alternation between states of hyperarousal (terror) and hypoarousal (emotional blunting).

At some point the survival of the organism requires an escape from this powerful clash of hyper-activation (gas) and hypo-activation (brake) of arousal functions. Following Porges' polyvagal theory, the dorsal vagal complex (DVC) eventually comes online and rapidly shuts down the whole system. This "shutdown" results in a rapid down-regulation of arousal away from fight, flight, or high freeze/immobilisation, but in so doing invariably "overcorrects" and precipitates overwhelming hypo-arousal. In non-human mammals this "shutdown" is referred to as "feigning death" (Porges, 2011, p. 16), and in humans may appear symptomatically as "depression" or "flatlining". For the purposes of this paper, this state often corresponds phenomenologically to what I call "shame proper" (see the four steps of shame, above), or if recurrent and traumatic, shame states. When the person attempts to get out of his shamed state and fails, repeatedly, or is at the mercy of repeated shaming interactions with an attachment figure, or engages in repeatedly recalling shaming events (Scheff, 2007, p. 4), the nervous system has one more "escape" function before madness or physical death set in, and that is dissociative behaviour and for some severely, early relationally traumatised individuals, structural dissociation (van der Hart et al., 2006).

While Liotti (2004) showed convincingly the connection between "disorganised/unresolved" attachment and dissociation, I do not believe he spoke directly to the relationship between these phenomena and shame states, although he mentioned attachment patterns associated with dominance and submission, and "submission" is congruent with shamed behaviour (Liotti, 2004, p. 481). I invite the reader to consider the following description of dissociation, and then to review the same passage inserting shame states wherever dissociation appears:

> *Dissociation* is usually defined as a deficit of the integrative functions of memory, consciousness, and identity and is often related to traumatic experiences and traumatic memories. During clinical interviews, dissociation is suggested either by such a degree of unwitting absorption in mental states that ordinary attention to the outside environment is seriously hampered or by a sudden lack of continuity in discourse, thought, or behavior of which the person is unaware (supposedly because of intrusion of dissociated mental contents in the flow of consciousness). (Liotti, 2004, p. 473).

Shame states (along with dissociation) result in the person having great difficulty remembering, knowing, and retaining a sense of self-in-relation to others that is *not* dominated by their relational trauma. The person in the grips of a traumatic shame state is taken over by that self state or "different way of being" (Chefetz, 2015, p. 66), so much so that they cannot think about, nor remember, nor imagine themselves as being anything *other* than shamed. For example, even if earlier in a session this shame prone patient described something they were proud of, such as being praised by their boss, once having fallen into a shame state, their genuine pride becomes "discontinuous" and no longer available to consciousness. As I sometimes say to my shame-bound patients, "A part of you believes you always have been (past), are (present), and always will be (future) a loser, and that part is actively marshalling highly selective memories and facts to support that belief." Unless this patient has been able to develop sufficient co-consciousness, that is to witness their shame state from a place of non-judgment and compassion, or at least do so by "borrowing from" my heart and mind, they may argue with me that what I call their "belief" is unquestionable "fact", even though (as I often point out) neither they nor I can know for certain "who they will be" in five minutes, much less in five months or years from now.

Should shame states be equated with dissociation? Yes, if one accepts Liotti's (2004) definition of dissociation, above. However, not every person who has experienced a shame state is *structurally* dissociated. At the same time, I have never heard of a person experiencing structural dissociation who is not also living with the effects of profound, destructive shame states, whether or not they are conscious of "feeling shame" (see shame as emotional process) at any moment in time.

Liotti (2004) went on to describe the mental state of adults who develop an unresolved attachment style:

> High levels of *incoherence* (e.g., lapses and discrepancies between feeling and thinking while reporting memories of past attachment relationships) and very poor metacognitive monitoring of discourse lead to an AAI classification called "unresolved". Unresolved interviews are characterized by episodic memories of attachment-related traumas or losses that are not well integrated in the semantic structures of self- knowledge. (Liotti, 2004, p. 473)

There are several crucial factors in the above quote that have bearing upon our discussion of the relationship between disorganised (child) and unresolved (adult) attachment styles and shame states:

1. The child (careseeker) seeks to attach and the parent's (caregiver's) response, including conflicted responding or non-responding on the part of the parent/caregiver, results in attachment trauma and/or significant loss for the child.
2. The child develops "poor metacognitive monitoring of discourse" and, as such, fails to adequately "think about" or reflect upon their own and the listener's mind. (This is congruent with problems in mentalizing; see Fonagy et al., 2002).
3. As a consequence of Nos. 1 and 2, the traumatised child cum adult's narrative is characterised "by episodic memories of attachment-related traumas or losses that are not well integrated in the semantic structures of self-knowledge" (Liotti, 2004, p. 473). As applied to shame states, the adult often does not realise (without therapeutic intervention) that the caregiver's traumatising abuse or neglect says far more about the caregiver than the child. The child's and later adult's sense of self as defective or "bad" is not integrated with other "knowings", for example all the ways the adult has been "good" to others, and on a deeper level, the reality that the parent was powerful and threatening and the child depended upon the parent for survival. Thus, by definition, if anyone were to be labelled "bad" it would be the parent, not the child.
4. These three features, that is, attachment trauma and/or loss, coupled with insufficient metacognition, and a "non-integrated" and thus distorted sense of self-in-relation to the traumatising caregiver, are all central features of shame states. In shame states, the patient does not realise that his feelings and implicit negative beliefs about self-in-relationship are to be expected responses to failures in parenting—past and/or present—rather than failures in and of "self". As a result, the traumatised child who would have experienced a disorganised attachment to his abusive or neglectful parent, and now as an adult lives with an unresolved attachment, confuses "I *feel* shame" with "I *am* bad, unworthy, despicable, etc." Said yet another way, the adult confuses shameful "feelings" and implicit "beliefs" that reference the self, with "facts" or "ultimate truths" about the self.

Clinical vignette: Unresolved attachment and shame states

I worked with "Paul" in weekly psychotherapy for about four years. Paul originally came to see me because he felt very stuck in most aspects of his life. At the start of therapy, he was living with moderate depression and social anxiety, had been unemployed for over two years, and had serious marital problems marked by considerable withdrawal from his wife for almost ten years.

Paul was a very bright, creative, articulate, honest, and well-intentioned man with a good sense of humour who, despite his likability, often felt he was "unworthy" or a "failure" in, following Freud, both love and work. Soon after Paul started therapy with me, he abruptly left his wife for another woman with whom he remained throughout our work together. Paul believed he was "messed up" not for leaving his wife, but rather for not communicating with her and his young adult children about what led to his decision, and in not working at a job commensurate with his previously demonstrated professional skills.

An outside observer might conclude Paul believed he was a "failure" and unworthy of success professionally and personally because of his diminished work status and lack of contact with his adult children. While Paul did feel ashamed that things were not better with work and his kids, his shame had much deeper origins and in fact led to his not pursuing better work nor reaching out to his adult children, both of which only intensified his feelings of bad me shame.

Paul's dominant attachment style, particularly in relation to his mother, was likely disorganised as a child and then an unresolved attachment as an adult. As a young boy, Paul was often frightened by his mother, who was mostly emotionally distant but who would also erupt unpredictably in explosive anger and then turn "cold like steel", becoming even more unapproachable. It became apparent, over the course of our work together, that Paul's mother's turning "cold like steel" was the emotional equivalent of his mother and her love, dying. The effect of this occurring repeatedly would be as though Paul experienced Tronick's "still face experiment" over and again (www.youtube.com/watch?v=apzXGEbZht0). No wonder he was "disorganised" by these events.

Furthermore, Paul likely learned pre-verbally and certainly when he entered grade school that he was mostly on his own when it came to meeting his emotional needs. Social anxiety, stuttering, probable mild ADHD (undiagnosed), inadequate study habits despite excellent intelligence, all contributed to Paul feeling very alone and different from his peers, something his parents consistently failed to recognise and ameliorate.

Fast forward to the present: when Paul thought about seeking better employment, or discussed reaching out to his adult children in order to reconnect, he inevitably anticipated "rejection". This resulted in his experiencing, following Porges' (2011) polyvagal theory, an immobilising "high freeze" (SNS) or dorsal vagal shutdown (DVC) response. Paul's immobilisation, a common feature of disorganised/unresolved attachment styles, not surprisingly intensified his bad me shame and, combined with the dissociation of not me shame, often made it impossible to think about his work and family problems, at least without my help and implicit co-regulation. Daily marijuana usage, used in part to quiet Paul's chronic anxiety, further served this dissociative process.

Paul anticipated blanket rejection despite knowing, "logically", that he was in fact employable at a better job and that his young adult children, while likely

angry with him for leaving their mother and, moreover, for not communicating afterwards, had not completely forgotten he had been very loving with them for most of their lives and, one might reasonably predict, wanted him back.

As Paul and I dug deeper, we discovered "rejection" did not refer to specific actions on his part, although Paul readily expressed feeling deep regret for not communicating with his children. Rather, "rejection", if it spoke (and it did not, as it was more a wordless "state of being") would say, "I am undeserving of anything good in life". How, then, does a bright, creative, funny, honest, and at heart kind man come to believe he is unworthy of love and work?

Clearly these self–other ways of being were the workings of shame, or more accurately a traumatic shame state. Paul's shame state was the outgrowth of parenting that was alternately "absent" (both parents were often emotionally non-attuned and non-responsive), "frightening" (mother), and then again "absent" (both parents) when comfort and soothing were called for following frightening parent to child self, child to child self, or later boss or co-worker to adult self interactions.

* * *

I concur with Liotti (2004) and others who have argued that often what is more damaging than abusive behaviour is the parents' failure to acknowledge the abuse and its effects, and to make appropriate relational repair. With respect to the development of shame states, what did not happen or "absence" is worse than what did happen or "presence", as the child and later adult come to believe implicitly, without any awareness of the origins of this belief, that their lack of self-worth is confirmed by the parent's failure to even notice their suffering.

As Liotti (2004) observed:

> Steele and Steele (2003), while reporting the preliminary findings of their study, called attention to an observation that can be confirmed by many clinicians dealing with the traumatic memories of adult survivors of child abuse: "while psychic pain certainly accompanies the recall of the abuse per se, this pales in comparison to the much greater pain that accompanies the recall of being betrayed by trusted care-givers and siblings" (Steele & Steele, 2003, pp. 116–117) That is, the memory of an attachment figure who fails to protect the child from the abuse perpetrated by another member of the family may be more painful than the memory of the abuse per se. The dissociative power of this subtle type of trauma, betrayal from a not otherwise maltreating attachment figure, is readily explained by attachment theory. Forced by the inborn propensity to preserve the attachment relationship and trust the caregiver, when a parent denies the very existence of the abuse perpetrated by another member of the family (or by a person outside the family), the abused child may collude with the parent's denial and dissociate the traumatic memory (Bowlby, 1988; Freyd, 1997). (Liotti, 2004, p. 475)

Paul had no memory of his father ever protecting him from his mother's eruptions nor comforting him after she lost her temper. If anything, Paul's father likely avoided his wife's ire as well. One can only wonder what the lack of a protective father-figure did to Paul's sense of himself as a man, both in the world of work, and as a husband, later father, and then boyfriend. What was clear was that in the face of disappointment, Paul was very prone to believing he was a loser, deserving of evisceration, and bereft of hope that his situation would ever improve.

Given the all-consuming quality of punishing shame states, it is easy to conclude that these states were mostly intrapsychic in origin. However, as Liotti (2004) observed, "Disorganization of early attachment . . . seems to reflect an intersubjective reality rather than a property of the individual child' s mind" (Liotti, 2004, p. 475). It is that same intersubjective reality, that takes shape both in the patient's intra-relational as well as inter-personal domains, that points the way toward transforming traumatic shame states arising out of a disorganised attachment.

While the scope of this essay does not allow me to detail Paul's movement away from immobilising shame states and toward greater agency and healthy relating, I will note that there were likely many factors that transformed Paul's view of himself over the course of our work together. These included intra-relational "parts work" that over and again made conscious, with empathy and compassion, the harsh internalised "bully" he was subject to, as well as my reliably genuine positive regard toward Paul. By year four of our work, Paul was better able to observe and interrupt the punishing messages of his internalised "bully", and over time learned to replace these "voices" with ones that were more forgiving of his lapses and even affirming and encouraging of his desires (Firestone, 2001). Whereas Paul was "raised in absence", he gradually became capable of both receiving his own benevolent self-parenting, and receiving and using my respect and explicit affirmation of his kind nature. Without being seen as "good and worthy" by me, that is, without his having earned secure attachment in therapy, it would have been impossible for Paul to begin to treat himself with the kindness he was clearly capable of affording others.

Working from his earned secure attachment base with me, Paul was in a place to begin to "update" implicit beliefs about self and other. Over time, for example, Paul and I came to understand his fear that his adult children would not believe he still loved them as akin to his repeated experience of his mother turning "cold like steel". Making his implicit fear explicit enabled Paul to hold in his mind and heart his actual experience of his adult children as contrasted with the anticipated "cold" rejection he endured with his mother. In therapy, I invited Paul to picture in his mind's eye, at the same time, a vivid image of his children's empathy and compassion juxtaposed with the traumatising image of his mother's coldness when hurt. This allowed Paul to shift from feeling immobilised with fear to sad but hopeful that he could be reunited with his children. This juxtaposition of Paul's original and more recent emotional reality—that is "hurt a loved one and

they turn cold like steel" *vs*. "hurt a loved one and they hear your regret and eventually show compassion"—is consistent with the model of therapeutic memory reconsolidation as delineated by Ecker and colleagues (2012). This all led, slowly but inexorably, toward Paul reaching out to his children, again, after a long hiatus. The latter freed him up to feel more worthy of better work, that he then pursued with greater vigour.

Final reflections

Shame, attachment, and psychotherapy that helps patients move out of pathogenic shame states are complex phenomena and processes offering no simple description, as they all speak to basic realities of being human: self and self–other valuation, relationship, bonding, safety, and threat in relating and its attendant neurophysiological, psychological, and behavioural correlates, and the development of internal working models. I hope the select "samplings" served here afforded you not only some new ways of thinking about and perhaps approaching these and related phenomena in-session, but more importantly engender a spirit of curiosity and play that, in themselves, represent some of the best ways out of the darkness and isolation of shame and toward the light and connection of authentic, non-hubristic pride, for patient and therapist alike.

Note

1. While the clinical vignettes in this article are based upon my work with actual psychotherapy patients, they are disguised to ensure patient confidentiality and privacy. I am grateful to all my patients, past and present, who have graciously given me permission to reference our work, and who have taught me so much about shame, pride, and psychotherapy.

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