

## **Sharing Space The Role of Shame in Infant Development**

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**Abstract:** Shame is a powerful emotion born of implicit mind and with lasting implications. This brief essay explores the source of this experience, including its possible role as an instrument of survival, its relationship to the processes of bonding and attachment, and its developmental aspects.

**Key Words:** Shame, Attachment, Dysregulation, Mother Infant Relations

### **Introduction**

Even for those of us whose childhood ended long ago, an experience of shame is easily conjured up in memory, complete with somatic responses as intense as the day it happened. It is a powerful emotion born of the implicit mind and with lasting implications for the life of its victim. It is hard to imagine that it could serve a biologically important purpose in the very survival of the human infant; certainly few would define it this way. With advances in our understanding of the brain through neurobiology, however, it appears that shame plays an important role indeed.

According to Schore (1998), “shame is the reaction to an important other’s unexpected refusal to co-create an attachment bond that allows for the dyadic regulation of emotion.” (p.65). At its core, it is a loss of attunement with one’s caregiver (Cozolino, 2006; Schore, 1994) and is the “visceral experience of being shunned and expelled from social connectedness.” (Cozolino, 2006, p.234). It has the physiological impact of a rapid transition from sympathetic to parasympathetic dominance of the autonomic nervous system, and from a positive to negative affective state in the person who experiences it (Cozolino, 2006, Schore, 1994, 1998). It is associated with such outward physical responses as facial expressions and behavior consistent with feelings of distress, accelerated respiration rates, sweating, and increased blood flow to the skin (Broucek, 1982). This experience of blushing

represents the physiological discharge of an experience of shame (Schore, 1998) and, according to Lewis (1981), is the outward signal to the watchful other that expresses a desire to be accepted back into society.

From the first moments of life the infant will seek out the closeness and security of his caregivers in an attempt to establish a communicative link between them (Badenoch, 2008; Cozolino, 2006; 2010; Siegel, 1999). It is a system built with survival in mind (Siegel, 1999). Through this system the infant will implicitly encode experiences regardless of being met in these moments with excitement and joy or disregard and anger (Badenoch, 2008). With time and repeated exposure these encounters come to form a mental model or generalized anticipation about whether the relationship is a trustworthy and reliable one or not (Badenoch, 2008; Siegel, 1999). How well or how poorly this early attachment relationship goes will affect the development of the essential components of the infant's brain from which the mind will develop: "...emotional regulation, social relatedness, access to autobiographical memory, and the development of self-reflection and narrative" (Siegel, 1999, p. 67). These models, although unconscious to the infant (and later, to the adult), effectively internalize the parent-child dynamic from these earliest interchanges and will have lasting influence on how the infant will perceive the world and the relationships in it (Badenoch, 2008; Schore, 1994, 1998; Siegel, 1999).

During this early development the infant, whose brain is not yet fully developed, will rely heavily on the adult caregiver to modulate its internal states (Badenoch, 2008; Schore, 1998). In fact, the infant's brain needs these brain to brain interactions in order to properly grow (Schore, 1998). This "borrowing" of the caregiver's brain, which Diamond, Balvin and Diamond (1963) refer to as the infant's "auxillary cortex," allows downloading of information from the adult brain to the infant brain and, in the process, creates neuronal patterns of connection that will foundationally influence the infant's developing behavior (Dawson, 1994). It is of critical importance that the caregiver is able to self-regulate affective states during this period. Failure to do so can have lasting impact on how the infant comes to view itself long term (Schore, 1998).

During the infant's first twelve months of learning to regulate feeling states, attention is on the functioning of the sympathetic branch of the autonomic nervous system and the generation of the pleasure states, such as enjoyment/joy and interest/excitement (Tomkins, 2008). This occurs primarily through synchronous gaze

interactions between infant and caregiver that motivate the infant to attach to the caregiver and where, ideally, the infant will receive further opportunities for positive affect experiences and fewer negative ones (Nathanson, 1987; Schore, 1998).

At around 13 months, as the infant becomes toddler and is more mobile and able to explore beyond the proximity of the caregiver, the toddler's brain becomes sufficiently developed to tolerate higher levels of arousal and an internal working model of the relationship with the caregiver is developed (Schore, 1998). Citing earlier work by other authors, Schore (1994) concludes that it is during this time that the infant "becomes aware of himself/herself as an object for observation and evaluation by another." (1994, p. 156). This emerging sense of self and other creates more ability to feel higher levels of joy and excitement as the infant's perceptions of the world expand. Along with these new abilities comes a change in the dyad.

Having worked hard these first 12 months to instill the pleasure states in the child, the caregiver must now focus on teaching the child to inhibit incessant and narcissistic pursuit of all things pleasurable, particularly those that are dangerous or forbidden (Cozolino, 2006), and learn how to regulate affect (Schore, 1998). This is an important and necessary step in brain development where the parasympathetic (dominate in shame states) and sympathetic (dominant in positive affect states) systems become fully developed and integrated (Badenoch, 2008; Cozolino, 2006). This development will allow "...the child to tolerate increasing levels of emotion while maintaining self regulation and keeping levels of stress hormones at optimal levels" (Cozolino, 2006, p.87). Cozolino (2006) states that the resulting affect regulation is necessary if we are to "...enjoy being inside ourselves and to successfully engage with others and manage life's day to day stressors." (p.85).

For the toddler, though, it is quite a change. Schore (1998) suggests that at 10 months an infant receives affection, play and caregiving from the caregiver 90% of the time. During the period between 13-17 months, this figure drops dramatically as the caregiver admonishes or restricts the toddler approximately every nine minutes (Schore, 1998).

The caregiver makes this change by the introduction of shame into their dyadic relationship. Through intentional misattunement the caregiver induces a stressful and negative state in the toddler in an effort to "terminate interest in whatever has come to attention" (Schore, 1994, p.155). Sometimes called "the primary social emotion" (Scheff, 1990, p.79), this very effective inhibitor essentially stops the toddler upon return to the caregiver with excited anticipation of a

shared affect. Being met instead with a break in participation or a facial communication that is not recognized and which leads to a rupture in the relationship. Still essentially preverbal, this new experience causes the child to feel a sudden, shocking drop and deflation in positive affective state, which the child is as yet unable to regulate (Schore, 1998). His arousal signals the activation of the parasympathetic system as it works to overpower the sympathetic system and reduce drive in the toddler (Schore, 1994). This is the shame experience.

In an optimal environment for learning affect regulation, the toddler will not be left to linger in this distressed place for long. The caregiver will seek to reattune and repair the rupture by interactively negotiating the stressful state, perhaps acknowledging the toddler's desire to pursue the restricted attraction and maybe even attempting to introduce a diversion. All of these actions will facilitate a return to homeostasis (Schore, 1998; 1994) and an "emotional refueling" (Mahler, Pine and Bergman, 2000, p.68). With the help of the caregiver, the toddler's arousal is regulated to a level that still encourages interaction but that no longer causes distress (Schore, 1994).

The response of the caregiver to these situations of broken attunement is critical to the toddler's ability to create internalized mechanisms for dealing with shame-induced stress states and to regulate the shame effect (Schore, 1994). In a "practice makes perfect" kind of way, these negotiations of the regulated/ dysregulated/ regulated states may be teaching the toddler that negative experiences can be endured and overcome and positive states can be restored (Schore, 1994). With repeated experience, neural networks of sensory, motor and emotional memory are reinforced and implicitly encoded as "...positive state transitions" in the toddler's brain and will create more opportunity for growth, connection and integration (Cozolino, 2006). Now and in later life, the child's expectation that re-attunement is possible following misattunement, that one can expect a positive outcome in relationships and life, will help the individual in the event of difficult social interactions (Cozolino, 2006, 2010).

Shame then, used carefully and with attention to the return to a more positive affective state, can serve a powerful function. However, when these periods of dysregulation are frequent, prolonged and without the benefit of repair there can be serious implications for the toddler (Badenoch, 2008; Cozolino, 2006; Schore, 1994), including a change in brain chemicals that can inhibit the plasticity of the brain and create "...a vulnerability to psychopathology." (Cozolino, 2006, p. 86). When shame is overused it can leave a lasting imprint on the child

that is reflected in self-identity and in the ability to regulate affect (Badenoch, 2008; Cozolino, 2006). Autonomic functioning can be permanently dysregulated and a child can be left feeling perpetually anxious and fearful (Cozolino, 2006; 2010). Children who have the great misfortune of growing up in such an environment will be hypersensitive to others and will probably "...find criticism, rejection, and abandonment in every interaction." (Cozolino, 2006, p.235). Tales of depression, despair, fatigue, chronic anxiety and failure to achieve perfection will be commonplace in their personal stories (Badenoch, 2008; Cozolino, 2006).

All individuals seeking therapy deserve an empathic and sensitive therapist, but with clients for whom shame is an issue, this is especially important. Although they have come to therapy seeking help, they will often have limited emotional means to establish relationships in a way that does not counteract their very attempts to heal their attachments (Badenoch, 2008). They may restrict conversation to superficial topics or may even try to draw the therapist into their shame story, making the therapist yet another perpetrator of their continued experience. As the therapist, listening closely and maintaining a watchful eye on one's own bodily states as well as those of the client is imperative as these clients can be very quick to experience overwhelm as they begin to uncover their painful past (Badenoch, 2008). When it can be determined where in early development the block in neural integration occurred, the therapist will have found the starting point from which to work in healing the effect of the shaming experience.

Essentially modelling a secure attachment relationship, the therapist gently guides the client through a titrated exploration of the feelings associated with early experiences of shame, moving in and out of "internal work and regulation in the present relationship" (Badenoch, 2008, p. 109) all the while paying close attention for signs of hyperarousal and/or somatic response in the client and in oneself. Gradually, and over time, as the therapeutic relationship deepens and the scars of the attachment experience become more fully exposed, the client begins to learn to self regulate in a way not previously possible (Badenoch, 2008). The brain, once dysregulated and incomplete, is now integrated and the sympathetic/parasympathetic system drawn into balance. Affect regulation has been learned. Calm at last.

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