SHAME, ATTACHMENT, AND ADDICTIONS: IMPLICATIONS FOR FAMILY THERAPISTS

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ABSTRACT: Research based on attachment theory is reviewed for its relevance to the development of later addictions. The problem of internalized shame as an attachment related issue is discussed. Some original research into internalized shame using the Internalized Shame Scale is summarized. The relevance of this research and theory for family of origin based treatment of addictions is explored.

The seedbed of later addictions, as well as other forms of psychopathology, is clearly in the family of origin from earliest childhood. There is considerable prospective research which confirms this (Bretherton & Waters, 1985; Sameroff & Emde, 1989; Zucker & Gomberg, 1986). Having said that, it is equally clear that the pathway to the development of addictive behaviors is a complex one and the etiology of many addictive problems can include genetic factors as well as psychosocial factors (Zucker, 1986).

Individuals carry forward from infancy and childhood "representations" of self, others, and relationships that tend to persist across developmental time and mediate behavior and emotions (Sroufe, 1989; Stern, 1989). In the context of attachment theory Bowlby (1988) refers to these representations as "working models" of the self and of caregivers or significant others. Epstein (1980) describes the process clearly:

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> People with high self-esteem, in effect, carry within them a loving parent who is proud of their successes and tolerant of their failures. . . . In contrast, people with low self-esteem carry within them a disapproving parent who is harshly critical of their failures, and registers only short-lived pleasure when they succeed. Such people are apt to be unduly sensitive to failure and to rejection, to have low tolerance for frustration, to take a long time to recover following disappointments, and to have a pessimistic view of life. The picture is not unlike that of children who are insecure in their parents love (p. 106).

In the language of affect theory, the people Epstein describes with "low self-esteem" are "shame-bound" or have high levels of "Internalized shame" (Kaufman, 1989). In the language of attachment theory these people are "anxiously or insecurely attached" (Bowlby, 1988). This article will review some of the literature that provides a basis for understanding the relevance of early childhood experiences of caregiving to addictions. I will argue that one of the primary psychosocial roots of addiction can be found in the internalization of shame and how shame becomes related to attachment issues. The implications of these connections for family therapists will be explored.

SHAME AFFECT

Shame is a primary innate affect rooted in subcortical mechanisms that involve a complex interaction of biochemical events which ultimately present themselves for display on the face (Nathanson, in press; Tomkins, 1963). Shame affect is only triggered in the presence of one of the positive affects of interest or enjoyment. Anything that acts as an impediment to the normal flow of these positive affects, when compelling reasons for the continuation of those affects remain, will trigger shame affect. Shame affect is thus an urgent, painful amplification of any trigger that causes interest or enjoyment to cease (Tomkins, 1987).

Shame *affect* differs from shame *feelings* or *emotions*. Shame feelings or the shame "family of emotions" (e.g. embarrassment, shyness, humiliation, etc.) require the development of language and other higher cortical functions that make learning possible. If shame affect is biology, shame emotion is biography.

An example of the appearance of shame affect in infancy comes from the "still face" experiment of Tronick (1989). A 2-3 month old baby gazing with interest at a caregiver's face but receiving no affectively tuned response from that face (e.g. a blank stare instead of a smile, as directed by the experimenter) will terminate interest, turning the head away and losing body tonus. This results from the triggering of shame affect (Nathanson, 1987). This affect, in turn, is experienced as a negative, painful state because the positive emotion of interest is reduced. This state can be repaired by a positive response from the caregiver and the shame affect will be short-lived. However, repeated experiences in which positive affect is terminated, triggering shame, with infrequent or very inconsistent reparations will gradually lead to an internalization of the shame such as was described in the quote above from Epstein (1980).

Through the learning process following infancy innate shame affect becomes the consciously experienced emotion of shame. Repeated experiences of shame affect triggered by neglect or rejection lead the child to develop a sense of self as unworthy, unwanted, and inferior. This self structure (representational self, self schema or working model of the self) is a deep cognitive structure (Guidano & Liotti, 1983) based on the internalization of repeated shame experiences. It is painful and toxic because it consists of a constellation of feelings associated with inferiority, defectiveness, unworthiness, incompetency, threats of exposure, emptiness, alienation, and self-contempt. Because of its earliest associations with the failure of the caregiver to respond or to respond with rejection or abuse, one of the major triggers for internalized shame feelings is abandonment or the threat of abandonment.

Liotti (1987) describes the process by which this self structure develops and becomes difficult to change. This structure is tacitly held and consists of unquestionable assumptions about some important aspect of self and reality.

> The situations that elicit regularly recurring emotions, for every child, are mainly those created by family interactions. . . . The child's emotional schemata that have been formed during any emotionally intense family interaction are likely to be repeatedly reinforced and confirmed by subsequent interactions-thus leading to strongly held beliefs about the character of oneself and of other people (Liotti, 1987, p. 96).

This leads directly to developmental issues that are the focus of attachment theory.

ATTACHMENT THEORY

Bowlby's (1988) attachment theory provides an empirically based model for understanding the relationship between early childhood experiences with caregivers and later addictions. Bowlby (1988) defined attachment behavior as

> any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. . . . For a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship (pp. 26-27).

Bowlby viewed this behavior as innate to human beings (in varying patterns) and shared with other species. The biological function attributed to attachment was that of protection, or as Bowlby refers to it, "a good insurance policy".

Attachment theory research is based on the development of a laboratory method (the "Strange Situation") for categorizing the quality of attachment of infants at 12 to 18 months (Ainsworth, Blehar, Waters, & Wall, 1978). The three standard attachment categories that have been established are secure, insecure-avoidant, and insecure-ambivalent. The latter two represent different behavioral manifestations of the insecurity. Avoidant infants tend to be emotionally detached and will avoid contact with the caregiver. Ambivalent infants will make contact but display resistant, angry behaviors toward the caregiver.

Erickson, Sroufe, and Egeland (1985) reviewed a number of prospective studies that followed infants across several years comparing the behavior and personalities of children whose attachment category at 12 or 18 months was assessed. These studies have found that securely attached infants were more cooperative at 22 months with mother and were more enthusiastic, persistent, affectively positive, and compliant in problem solving at age two, more socially competent with peers at age 3 1/2, and more "ego resillient" at age five. These findings on middle class children were confirmed with lower SES sub-

jects in the research reported on by Erickson, Sroufe, and Egeland (1985).

Erickson and colleagues (1985) also reported on differences between the avoidant and the ambivalent children. Avoidant children were more likely to be described by teachers as hostile, socially isolated, and/or disconnected (psychotic-like) in the preschool setting. Ambivalent children were described by preschool teachers as impulsive, tense, helpless, and fearful.

Main, Kaplan, and Cassidy (1985) examined children at age six who had been classified on quality of attachment at 12 and 18 months. They found that the insecurely attached children tended at age six to have the lowest ratings on emotional openness. Unlike the secure children, they could not easily balance "self-exposure" and "self-containment". In another study of six-year-olds Cassidy (1988) found that the secure children had the highest levels of self-esteem while the avoidant and ambivalent children had the lowest levels of self-esteem. These results were interpreted as evidence for the connection between the later "working model of the self" and the quality of mother attachment in infancy.

As part of the study reported by Main, Kaplan, and Cassidy (1985), a structured interview (Adult Attachment Interview) about the family of origin was administered to the parents of the six-year-old children in the study. Based on an analysis of the content of these interviews the researchers were able to classify the adults as securely or insecurely attached. For the latter group, two classifications that paralleled the infant classifications were identified. One group tended to dismiss the importance of attachment figures and the early childhood environment, often despite anecdotal data suggesting rejecting parenting. This group, labeled "Dismissers", was similar to the avoidant category. The other group tended to remain preoccupied with their relationship to caregivers, still seeking for approval and acceptance in adulthood. This group, labeled "Preoccupied", paralleled the ambivalent category in infancy. The attachment category of the children of these parents tended to follow that of the parents, with the secure parents most often having securely attached children, and the Dismissers and Preoccupied tending to have more avoidantly and ambivalently attached children, respectively.

In a study of college students that also used the Adult Attachment Interview Kobak and Sceery (1988) found that both insecure groups demonstrated less "ego-resiliency" than the secure group. The Dismissing group was rated by peers as more hostile than either of

the other groups, and the Preoccupied group was rated as more anxious than the other two groups.

Attachment research has demonstrated a robust relationship between the quality of early caregiving and the later personality and behavior of children, adolescents and adults. When caregiving was not consistent, responsive, and nurturing children later tended to manifest constricted emotional development, hostile or helpless behavior and lower self-esteem. These patterns have been noted in research on older adolescents and adults as well.

SHAME AND ATTACHMENT

If affects are taken as the primary motivators of human behavior, as Tomkins (1963) has argued, then shame plays a key role in the development of attachment relationships. The interplay of affect between infant and caregiver is largely made possible by the display of affect on the face. The primary affect of interest motivates the infant to attain behavioral proximity to the caregiver, but the affect of shame will be triggered when interest has been terminated by, for example, the rejection or ignoring of the infant by the caregiver. Thus, shame is invariably associated with social relationships and is most frequently triggered with regard to social situations where there is a breaking off of the connection between individuals where one is seeking to establish or maintain that connection. Kaufman (1989) has referred to this as the breaking of the "interpersonal bridge".

The way attachment theory conceives of the development of the self further suggests the critical role played by shame affect. As Sroufe (1989) states, the ". . . self should be conceived as an inner organization of attitudes, feelings, expectations, and meanings, which arises from an organized caregiving matrix. That is, the dyadic infant-caregiver organization precedes and gives rise to the organization that is self" (p. 71). When shame has been frequently triggered without repair the "inner organization of attitudes, feelings, etc." (i.e. the self structure) becomes what Kaufman (1989) has referred to as "shame-based". This, of course, is the same process described above by Epstein (1980) and Liotti (1987) in relationship to the development of cognitive structures of the self.

SHAME, ATTACHMENT, AND LATER ADDICTION

What might be the etiological connections between shame, attachment, and the later development of an addictive behavioral pat-

tern? For any particular individual we must postulate that there are multiple pathways to addiction and that along the way there are both developmental continuities and discontinuities that enter into the process. Peele (1985) defines an addiction as an extreme attachment to an experience that is acutely harmful to the individual but which the addict feels compelled to repeat again and again because it feels essential to her or his life. The most powerful and reinforcing experiences to which a person could become addicted are those which either increase positive emotional states, decrease negative emotional states, or both. Alcohol and drugs of abuse tend to do this. Eating can do it, as can excitement (e.g. gambling, sex) and an intense emotional relationship with another person. Anything powerful enough to distract from negative emotional states, such as television, could become an addicting experience.

Though shame is necessary to our emotional ecology to protect the boundaries of the self (Schneider, 1987), when magnified through repeated experiences in infancy and childhood it can lead to the development of a self structure dominated by shame emotions. Thus, intense negative emotional states are frequently triggered for such persons and some means must be developed for defending against this painful state. Becoming addicted to experiences which ameliorate or minimize the negative emotion of shame becomes one possible defense against shame. Since shame is rooted in the earliest of relationships between infant and caregiver, the connection to attachment is clear. Behind the development of most addictive patterns we would expect to find magnified shame emotions and the kind of child-caregiver environment that is known to readily trigger shame. Some empirical evidence for this will now be reviewed.

ALCOHOLISM AND EARLY CHILDHOOD EXPERIENCES

The most extensively studied addiction is alcoholism. Although a number of prospective studies (see Zucker & Gomberg, 1986; Zucker, 1986, for reviews of these studies) have established that there is a consistent thread of continuity from early adolescence that can predict alcohol problems, there are no prospective studies of alcoholism that began with preschool subjects, though one such study is now underway (Zucker, 1986).

Zucker (1986) summarizes findings from a dozen major long term prospective studies on alcoholism. He identifies a set of six findings

that emerge from these studies: 1) Childhood antisocial behavior is consistently related to later alcoholic outcome. 2) More childhood difficulty in achievement-related activity is consistently found in those who later become alcoholics. 3) Males who later become alcoholics are more loosely tied to others interpersonally (e.g., more indifferent to their mothers, cool and indifferent to siblings). 4) Heightened marital conflict is reported with consistently greater frequency in the prealcoholic homes. 5) Parent-child interaction in prealcoholic families is characterized by inadequate parenting and lack of contact with the parents. 6) Parents of prealcoholics are more often inadequate role models for later normality as they are more likely to be alcoholic, antisocial, or sexually deviant.

The patterns that are summarized by Zucker bear a striking resemblance to the patterns of behavior associated with avoidantly insecure children in the attachment studies. The parenting that is described would also be likely to result in insecurely attached children. These data certainly suggest that the kind of caregiving that results in insecure attachment and high levels of internalized shame is a predisposing factor for the later development of alcoholism.

Two more recent studies shed further light on the shame-attachment-addiction connection. Werner (1986) studied a sample of children of alcoholics from birth to age 18. She was particularly interested in what factors served to protect this high risk sample from the development of serious coping problems by age 18. The factors she found in the caretaking environment of the "resilient" children were the following:

> 1) Plenty of attention received from the primary caretaker during infancy and the absence of any prolonged separation from the caretaker; 2) no additional births into the family during the first 2 years of life (that might have averted such attention); and 3) the absence of conflict between the parents during the first 2 years of life (p. 39).

These are obviously factors that we know from the attachment literature will contribute to a secure attachment and a positive sense of self-esteem. The fact that there was an alcoholic parent in those families did not preclude an adequate caretaking environment. These findings also reinforce the need to look carefully at the developmental history of adult children of alcoholics rather than to assume that alcoholism in the family of origin automatically means dysfunction.

Shedler and Block (1990) studied 18 year-olds who had been part of a longitudinal study beginning when the subjects were three years old. A measure of drug use at age 18 enabled the researchers to create three categories of users: abstainers, experimenters, and frequent users. In general, their findings were that the background and personal characteristics of the abstainers and frequent users were remarkably similar and tended to be significantly different from the same factors for the experimenters who were the "healthiest" of the three groups. The description of the quality of the parenting in early childhood of the abstainers and frequent users was practically identical. Compared with mothers of the experimenters, the mothers of the frequent users and abstainers were described as "hostile, not spontaneous with their children, not responsive or sensitive to their children's needs, critical of their children and rejecting of their ideas and suggestions, not supportive and encouraging of their children, . . . (and) appearing to lack pride in and be ashamed of their children" (p. 621). To summarize, the authors described the mothers of two extreme groups of drug users/abstainers as relatively cold and unresponsive.

Few items discriminated between fathers of the experimenters and frequent users. However, there were differences between the fathers of the abstainers and experimenters that suggested the fathers of abstainers were more authoritarian and domineering, squelched spontaneity and creativity, and demanded that things be done their way.

Familiarity with attachment theory makes it understandable how this kind of parenting in early childhood can lead to the later development of problems. Of particular interest in the Shedler and Block study, however, is that abstainers from drugs and frequent drug users were parented in a similar manner. This illustrates the principle of multiple pathways to drug and alcohol addiction, but clearly does not preclude the development of non-substance addictions among the abstaining group. Boys and girls in this group, for example, might be particularly prone to serious relationship problems, and girls might be prone to eating disorders.

With regard to the latter, Strober and Humphrey (1987) studied the family environments of bulimics. They found bulimia to be strongly associated with a lack of parental affection and overly negative, hostile, and disengaged patterns of family interaction. This family environment was thought to hamper the development of a stable identity, of autonomy, and self-efficacy. Clearly these family environ-

ment patterns are related to the descriptions of family environments that result in insecure attachment and high levels of shame. They are also similar to the patterns found for the abstainers and frequent drug users in the Shedler and Block study.

RESEARCH ON INTERNALIZED SHAME

I have focused my own research on shame using the Internalized Shame Scale (ISS) (Cook, 1987, 1990). This scale consists of 24 negatively worded items that reflect intense shame feelings to which subjects respond on a scale of frequency from never to almost always. Six positively worded items (not scored as part of the shame scale) are included to minimize response set. Examples of some of the shame items are the following: "I feel intensely inadequate and full of self doubt. I have an overpowering dread that my faults will be revealed in front of others. At times I feel so exposed I wish the earth would open up and swallow me". With two large reliability samples representing non-clinical subjects (N = 645 college students) and clinical subjects (N = 370) the scale had alpha reliabilities of .95 and .96 respectively.

Validity studies have focused on concurrent correlations with related variables and differences between clinical and non-clinical samples. As predicted, the ISS correlates substantially with measures of self-esteem such as the Tennessee Self Concept Test (−.66) for 118 college subjects. Other shorter self-esteem measures produced correlations with the ISS ranging from .52 to .79. The ISS also correlates substantially with measures of depression. A non-clinical sample (N = 193) produced a correlation of .75 with the Multiscore Depression Inventory. On studies with the Beck Depression Inventory, the ISS correlated .72 for 300 college subjects and .75 for a clinical sample of 185 psychiatric patients.

When clinical subjects were compared with non-clinical subjects on the ISS, the clinical subjects scored significantly higher. ISS means for the different groups were as follows: non-clinical (N = 514), 33.98; alcohol/drug patients (N = 247), 49.34; affective disorders (N = 84), 48.51; other psychiatric disorders (N = 36), 48.75; post-traumatic stress patients (N = 47), 58.59; eating disordered women (N = 25), 68.92. On the oneway ANOVA, $F = 54.31$, $p = .0000$. On the post-hoc test all clinical groups were significantly different from the non-clinical group. In addition, the PTSD group was significantly

higher than all the group means below, and the eating disordered women (mostly bulimics) had a mean ISS score significantly higher than all the other groups. These data substantiate that the ISS is measuring a clinically significant variable related to these shame-based self feelings.

One other study provides support for the shame and family of origin connection among alcoholic women. Ninety-two women undergoing a four-week inpatient treatment for alcoholism completed the ISS and a brief survey that asked about childhood sexual abuse before age 14 and some treatment related questions. On the basis of their answers to the sexual abuse questions the women were classified as either not-abused, moderately abused, or severely abused. Severity of abuse was based on whether the women had experienced intercourse as part of the abuse (severe), or had been touched sexually and/or forced to touch someone else only (moderate).

On the treatment variables examined, there were no differences on the ISS based on the number of times in treatment (once, twice, three or more) and on early versus late onset of alcoholism. There were differences based on the week in treatment with the women in the first two weeks of treatment having significantly higher mean scores (57.8 and 53.0) compared to the women in the last two weeks of treatment (46.2 and 42.4).

When the effect of abuse was examined, the mean of the combined groups of abused women ($N = 40$), 57.6, was significantly different from the mean of the not-abused women ($N = 52$), 45.1 ($F = 11.6$, $p = <.001$). When the severely abused women were compared with the moderately abused and not-abused, the mean ISS score for the severely abused women ($N = 19$), 66.0, was significantly higher than both the moderately abused women ($N = 21$), 50.0, and the not-abused group (45.1). The moderately abused and not-abused groups did not differ from each other.

Even within a group of alcoholic women where levels of shame would be expected to be high, these data indicate that severe sexual abuse in childhood leads to significantly higher levels of internalized shame. Of course, such abuse, particularly at the hands of a parent, would indicate the kind of parenting that would be expected to produce very insecure attachment and trigger intense shame. The ISS appears to be sensitive to these differences.

The ISS was also found to correlate significantly (though modestly) with a retrospective measure of parental caregiving, the Parental Bonding Instrument (PBI) (Parker, 1983). The PBI yields scores

on the dimensions of care and protection for mother and father. High care and low protection represent optimal parenting, promoting secure attachment. Low care and high protection represents parenting that would be expected to produce insecure attachment. The ISS was expected to correlate negatively with care and positively with protection. Subjects who had taken both instruments included a non-clinical group (N = 155) and a clinical group (N = 200). All correlations except where noted were significant at <.01. The correlations respectively for each group were: for mother care −.30 and −.26; for mother protection, .25 and .20; for father care, −.16 (p = <.05) and −.24; and for father protection, .29 and .28. The direction and significance levels of these correlations indicated that the lower the level of care and nurturance from mother or father, the higher was the reported level of internalized shame. Also the higher the level of parental control and overprotectiveness, the higher was the level of internalized shame.

IMPLICATIONS FOR TREATMENT OF ADDICTIONS

The theory and research reviewed here has a number of implications for the family therapist involved in treating clients who present with addictive problems. Space permits only a brief highlighting of these implications.

1. The quality of early caregiving is given continuity across developmental time by the cognitions that are established on the basis of that caregiving. These are primarily cognitions about the self and cognitions about significant others and relationships. When the early caregiving environment involves neglect, unresponsiveness, abusiveness, or rejection the cognitions about the self tend to be dominated by a sense of internalized shame. Individuals will vary in the way they learn to defend against this shame, but these defenses are often manifested in their problems and symptoms, including addictive behaviors. Helping the client to change these cognitions means, to some extent, examining their roots in early childhood experience. Clients need help to examine the validity of current self-image and expectations of others that were based on childhood experiences outside their control, namely the behavior of their parents.

2. The therapist should help the client to consider the relationship between these shame-based cognitive patterns and her or his addiction. The addiction is usually serving the purpose of "protecting" the client from the pain of her or his shame. Clients will need to learn

to identify their shame feelings and how they originated in childhood experiences. By exploring the source of the shame feelings and what triggers them, the client can learn to pay more attention to them and learn ways to counteract them, especially in situations that place the client at risk for returning to the addictive behavior.

3. In doing family therapy, the intergenerational transmission of shame and attachment insecurity means that it is likely the parents of the client were themselves inadequately parented. This "no blame" stance must be coupled with the expectation that the client must now take responsibility for herself or himself in changing the addictive behaviors and learning a healthier lifestyle. Since it is never too late for parents to make changes in their relationships with their children (and vice-versa), family therapy can assist all generations present to identify the losses and rejections that have handicapped them, but do not prevent them from doing better now.

4. Addictive behaviors must always be addressed directly in therapy and change fostered in these behaviors and then maintained (i.e., relapse prevention) once a change has been made. Exploring shame and childhood experiences by itself is not likely to free the person from his/her addiction. But stopping the addiction is only the beginning of a process. The vulnerability that predisposed the person to becoming addicted in the first place may remain unchanged if not explored.

This review attempted to stress the importance of shame emotions and their genesis in early childhood experiences as crucial elements in understanding and treating addictions. I do not argue that these factors are always present in all addicted individuals, but the research evidence certainly suggests that shame and attachment insecurity is widespread among addicted individuals. Familiarity with this research and theory can help focus the clinician where the important work of therapy and relapse prevention must be done.

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