The aggressor within:

Attachment trauma, segregated systems, and the double face of shame

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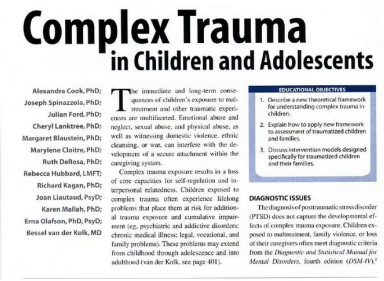
Outline of this lecture

I. Introduction to attachment trauma
II. Effects of attachment trauma on individual's development
III. Bowlby's concepts of defensive exclusion and segregated systems
IV. The relationship between defensive exclusion and shame
V. The concept of Core Shame Feeling
VI. Discussion and Conclusions

Attachment trauma

- "***Attachment trauma***" is one of the many names given to a condition of psychological suffering deriving from childhood experiences of loss, abuse and neglect in the attachment relationships. Other common names include "traumatic attachment", "childhood/early relational trauma", "complex PTSD", and "developmental trauma".
- Attachment trauma is considered as a **key variable for understanding both mental and physical disorders.**
- Meta-analytic findings show that people who were exposed to attachment trauma are at **increased risk for psychotic disorders** (Varese et al., 2012), **bipolar disorders** (Agnew-Blais & Danese, 2017), **depressive disorders** (Infurna et al., 2016), **eating disorders** (Caslini et al., 2016), **borderline personality disorder** (Winsper et al., 2016), **substance use disorder** (Konkolÿ Thege et al., 2017), **PTSD** (Brewin et al., 2000), and **dissociative disorders** (Dalenberg et al., 2012) , among other disorders.
- Another recent meta-analysis by Hughes and colleagues (2017) based on 37 studies and providing risk estimates for 23 psychical outcomes, with a total of 253,719 participants, showed that people who were exposed to severe attachment trauma (more than three ACEs) were at increased risk of all health outcomes compared with individuals with no ACEs. Associations were modest for **physical inactivity, overweight or obesity, and diabetes** (Odds-Ratio [O-R] < 2); moderate for **smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease** (ORs between 2 and 3); strong for **sexual risk taking, mental ill health, and problematic alcohol use** (ORs between 3 and 6), and even stronger for **problematic drug use and interpersonal and self-directed violence** (ORs > 7).

The impact of attachment trauma on biobehavioral functioning



Complex Trauma
in Children and Adolescents

Alexandra Cook, PhD;
Joseph Spinazzola, PhD;
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Margaret Blaustein, PhD;
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Ruth DeRosa, PhD;
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The immediate and long-term consequences of children's exposure to maltreatment and other traumatic experiences are multifaceted. Emotional abuse and neglect, sexual abuse, and physical abuse, as well as witnessing domestic violence, ethnic cleansing, or war, can interfere with the development of a secure attachment within the caregiving system.

Complex trauma exposure results in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment (eg, psychiatric and addictive disorders; chronic medical illness; legal, vocational, and family problems). These problems may extend from childhood through adolescence and into adulthood (van der Kolk, see page 401).

EDUCATIONAL OBJECTIVES

1. Describe a new theoretical framework for understanding complex trauma in children.
2. Explain how to apply new framework to assessment of traumatized children and families.
3. Discuss intervention models designed specifically for traumatized children and their families.

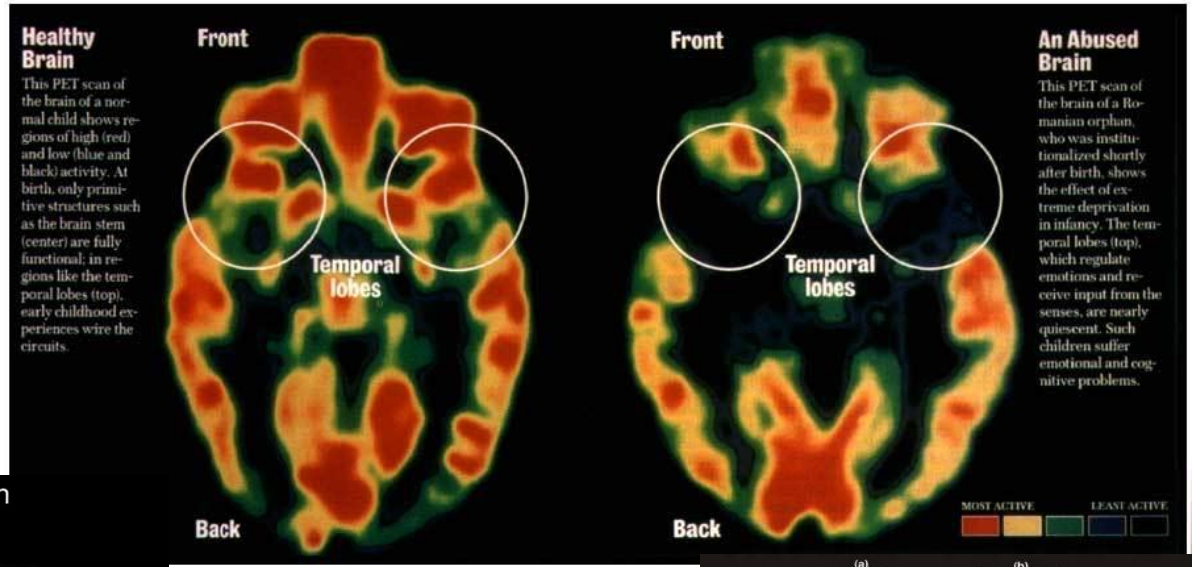
DIAGNOSTIC ISSUES

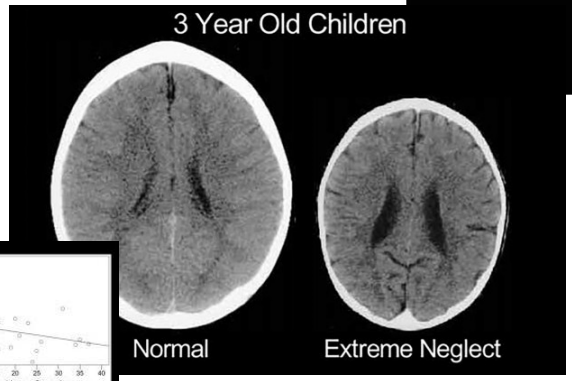
The diagnosis of posttraumatic stress disorder (PTSD) does not capture the developmental effects of complex trauma exposure. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria from the *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition (*DSM-IV*).[1]

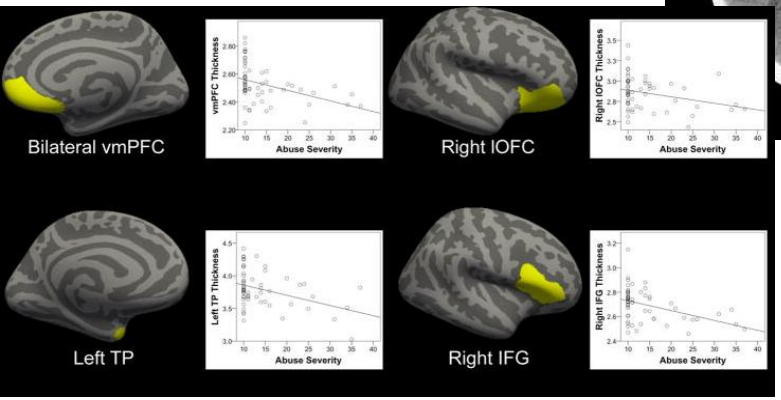
- Cook et al. (2005) highlighted seven primary domains of impairment observed in children exposed to attachment trauma. Just to summarise:
  - (a) the **attachment** domain is affected by uncertainties about the reliability and predictability of the world, that generate difficulty attuning to other people's emotional states, social isolation, and interpersonal difficulties;
  - (b) the **biological impairments** involve sensorimotor developmental problems, somatisation, increased medical problems across a wide span;
  - (c) **affect regulation problems** involve difficulty with emotional self-regulation, difficulty knowing and describing internal states, difficulty communicating wishes and desires;
  - (d) the **dissociation** domain concerns significant alterations in states of consciousness, with amnesia, depersonalisation and derealisation;
  - (e) **behavioural control is reduced**, with poor modulation of impulses, self-destructive behaviour, aggression against others, pathological self-soothing behaviours (including substance abuse and eating disorders);
  - (f) the **cognition** domain is affected by difficulties in attention regulation and executive functioning, problems with processing novel information, problems with object constancy, difficulty planning and anticipating, with all their developmental consequencies;
  - (g) the **self-concept** is dramatically damaged, with a poor sense of separateness, disturbances of body image, low self-esteem, shame and guilt, together with a lack of a continuous, predictable sense of self.

Impact of attachment trauma on the developing brain

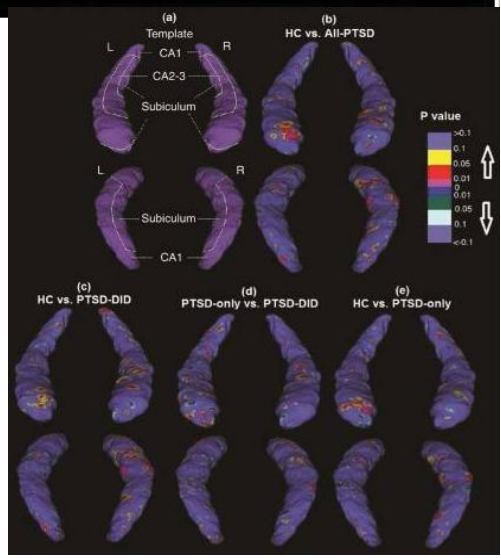
- Attachment trauma generates significant alterations in the right brain, the prefrontal and orbitofrontal cortex, the hippocampal region, the amygdala,the hypothalamic-pituitary axis, the concentrations of corticotrophin release hormone, the noradrenergic system and so on (Chalavi et al., 2015 De Bellis, 2005; Gold et al., 2016; Ford, 2005; Perry, 2009; Schore, 2003, 2009, Thomaes et al., 2013).







- Accordingly, the network of cortical and subcortical interactions that produces the emergence of self-awareness and the ability to organise mental and behavioural states is damaged in children who have been maltreated and/or have experienced significant failures of care (Schimmenti, 2012).



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The trauma factor: Examining the relationships among different types of trauma, dissociation, and psychopathology

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The trauma factor

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Trauma-Related Dissociation Is Linked With Maladaptive Personality Functioning

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- In recent articles, I have postulated that **attachment trauma is linked with other trauma** occurring in an individual's life.
- Just to make an example here: a child who loses a parent (**trauma n. 1**) will have an increased probability of being neglected (**trauma n. 2**) by the other parent (for example, because the living parent struggles to cope with his or her own depressive feelings, and/or because the death of his or her spouse generated financial problems in the family); being neglected at home, in turn, increases the probability that the child will be exposed to abuses (**trauma n. 3**) outside the family (e.g., being bullied at school), because he or she lacks a loving and protective figure who can help him or her to adequately cope with difficulties and problems. It is clear that this sequence of consecutive exposure to multiple traumatic experiences can continue. However, what is critical here is that **the psychological and behavioral functioning of this child will be intensely affected by such negative experiences, to the point that his or her development will be deviated toward atypical trajectories.**

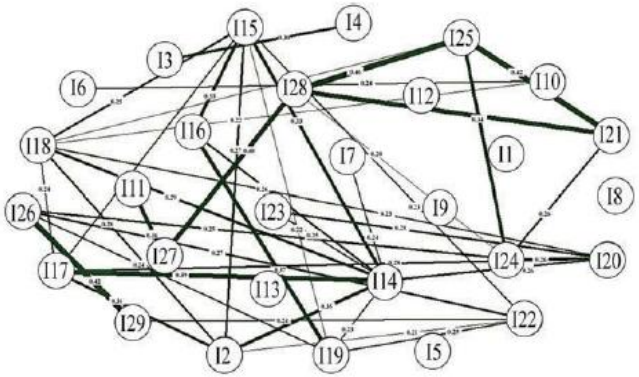
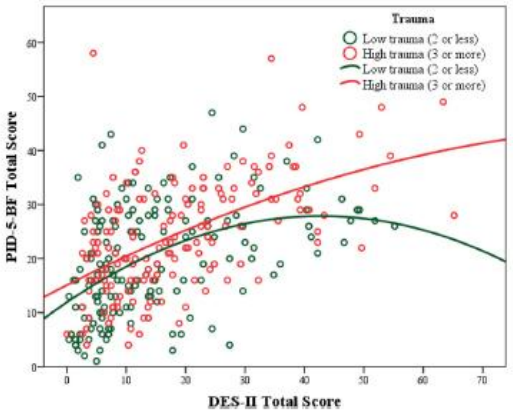


Figure 1. Correlation network of potentially traumatic experiences (N = 359).



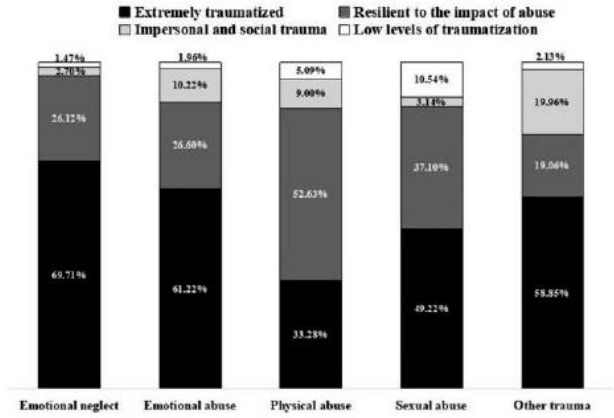


Figure 2. Predicted probabilities of class memberships for different types of trauma.

Attachment trauma, defensive exclusion, and segregated systems

- According to this model, attachment trauma may foster feelings of inadequacy and unworthiness and also feelings of anger and resentment in the child. The child may need to **dissociate** such feelings from awareness to preserve a positive internal image of the caregiver (Schimmenti, 2017). However, such dissociated feelings may surface in the form of dysregulated and impulsive behaviors, together with other internalizing and externalizing symptoms.
- These considerations are consistent with **Bowlby's** (1962, 1980) original insights on defensive exclusion and segregated systems. In his unpublished "**Defences that Follow Loss: Causation and Function**," Bowlby observed that "... selective exclusion is an integral and ubiquitous part of the action of the central nervous system." However, Bowlby also argued: "What characterises a pathological condition is that **exclusion acts in such a way that it creates not only the usual temporary barrier but a permanent one**. Thereby psychic systems are segregated from one another as though by an iron curtain" (Bowlby, c. 1962). The mind can retain some conditional integration in deploying defensive exclusion in response to an experience that would otherwise be overwhelming, though at the price of segregating certain kinds of environmental information, paralleled by the segregation of mental systems and their neurological architecture (Reisz et al., 2018).
- In fact, Bowlby proposed in the same paper that **prolonged and intense avoidance of mental contents can result in the defensive exclusion of internal or external cues to relational needs.** In this way, defensive exclusion can ultimately undermine integration and shift the mind into a segregated state, because **defensive exclusion can inhibit the ability to update representational models of self and other, and thus discrepant experience and information remain segregated and unavailable.**

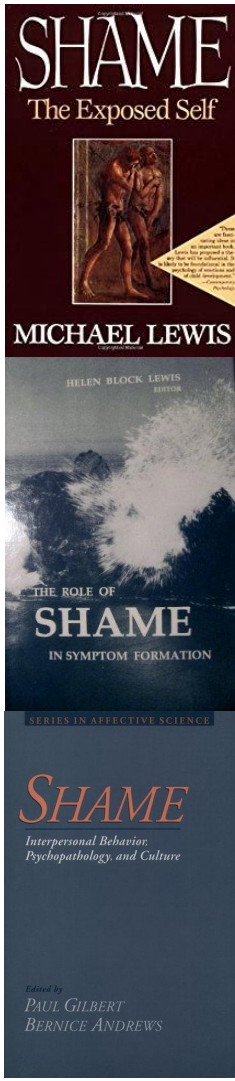
The relationship between defensive exclusion and segregated system

- In his 1979 paper "**On knowing what you are not supposed to know and feeling what you are not supposed to feel**", Bowlby wrote that "Children not infrequently observe scenes their parents would prefer they did not observe; they form impressions their parents would prefer they did not form; and they have experiences their parents would like to believe they have not had." Bowlby provided examples of parents who seek to disconfirm their child's observations of events, their natural emotional responses to distressing situations, and even their perception of parents' personalities and behaviour. Especially, three situations are believed to render children particularly prone to engaging in defensive exclusion:
  - (a) situations in which children have done or thought about doing something of which they are deeply ashamed;
  - (b) situations that parents do not wish their children to know about, even though the children have witnessed them;
  - (c) situations in which the children find the parents' behavior too unbearable to think about.

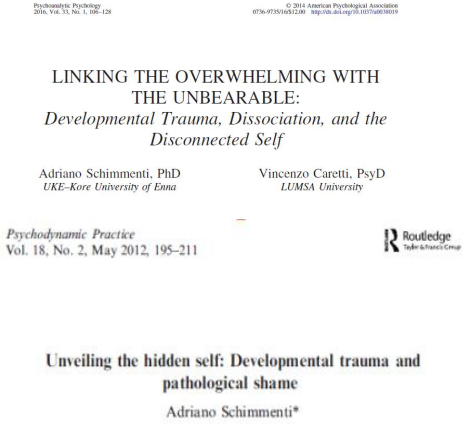
Defensive exclusion leads to a split in the IWM. One set of working models is accessible to awareness and discussion, and is based on what a child has been told. This set represents the parent as good and the parent's neglecting, rejecting, and abusing behavior as caused by the "badness" of the child. The other model, based on what the child has experienced but has defensively excluded from awareness, represents the hated or disappointing side of the parents (Bretherton, 1992).

Shame prevents the access to the segregated system(s)

- Shame is an aversive state, a **self-conscious emotion** accompanied by a feeling of being exposed, ridiculous and devalued.
- The experience of shame can arise from many sources, such as a violation of some role or standard, a failure to meet expectations, or a defect of the self that cannot easily be repaired (Michael Lewis, 1992).
- **Shame is always a relational experience**. According to Helen Block Lewis (1987, p. 15), "shame is one's own vicarious experience of the other's scorn. **The self-in-the eyes-of-the-other is the focus of awareness**."
- As with most affect, the root of shame can be traced back to childhood experiences. Shame already occurs in the first stages of life in response to perceived rejection or separation from caregivers. Shame alerts the child to the threat of separation, and then action can be taken to protect the attachment bond (Schore, 1998).
- If caretakers are not affectively attuned or if they "disconfirm their child's observations of events [and their child's] natural emotional responses to distressing situations"(Bowlby, 1979), the child may feel that his or her own internal experience is unworthy and shameful. As the trust in an attachment figure is betrayed, **early trauma creates a template for traumatic shame** (Hahn, 2000; Schimmenti, 2012).
- **Such shame is double-faced:** on one side, it threatens the individual's self-esteem, also fostering a sense of defectiveness, inadequacy and unworthiness; on the other, it has the critical function of **protecting the access to the individual's "psychic pits"** (Schimmenti & Caretti, 2010, 2016), i.e. to the **segregated system(s) containing an identification with the aggressor** (Ferenczi, 1932, 1933)**, the "real" perception of the attachment relationships, and the awareness that the deepest attachment needs have not been fulfilled**.
- In this context, **shame feelings can be organized in layers that protect the individual from the awareness of the representations included in the segregated systems**, with all their flood of emotion dysregulation.



Identification with the aggressor and the Core Shame Feeling


LINKING THE OVERWHELMING WITH THE UNBEARABLE:
Developmental Trauma, Dissociation, and the Disconnected Self

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Unveiling the hidden self: Developmental trauma and pathological shame

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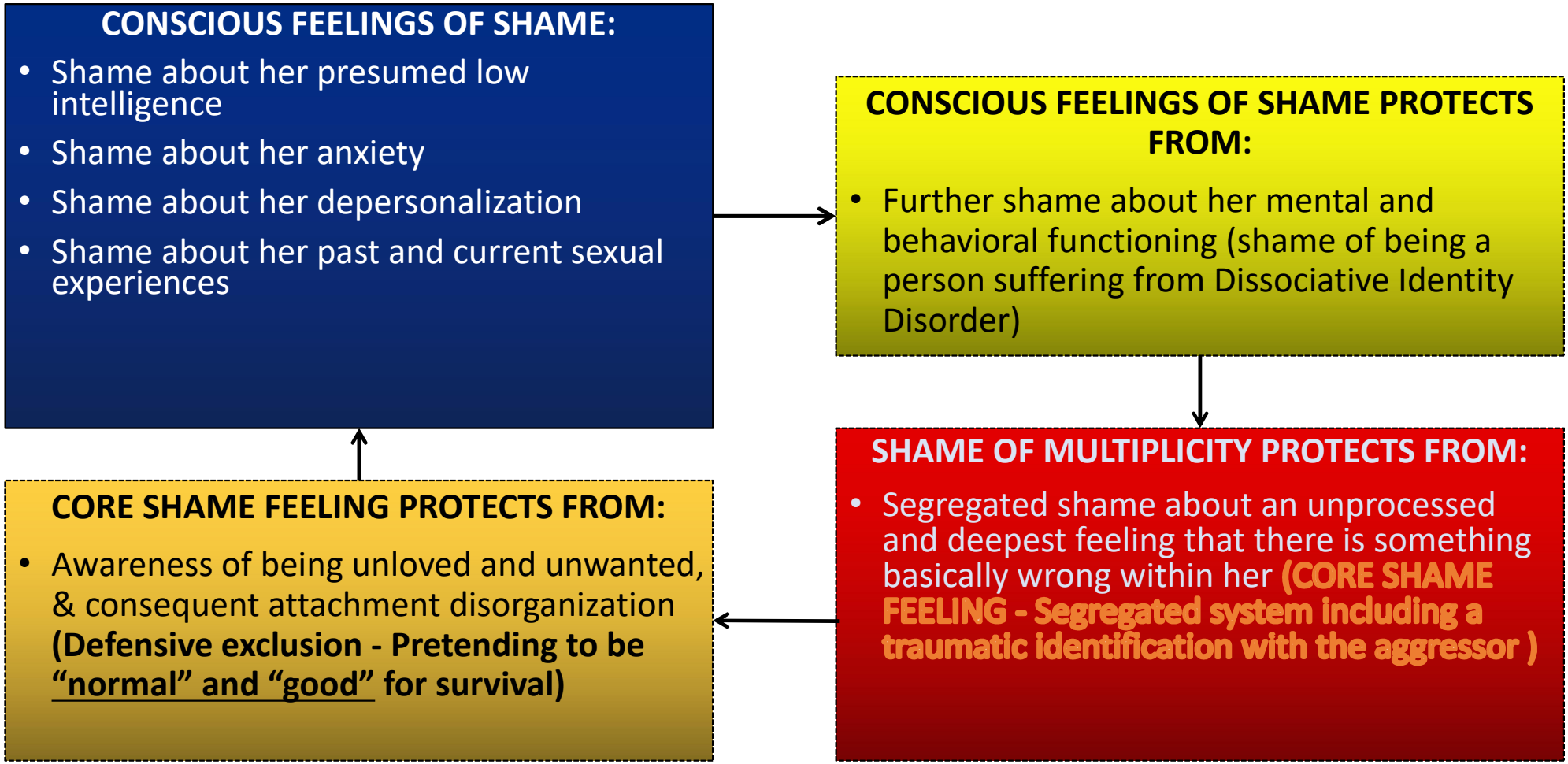
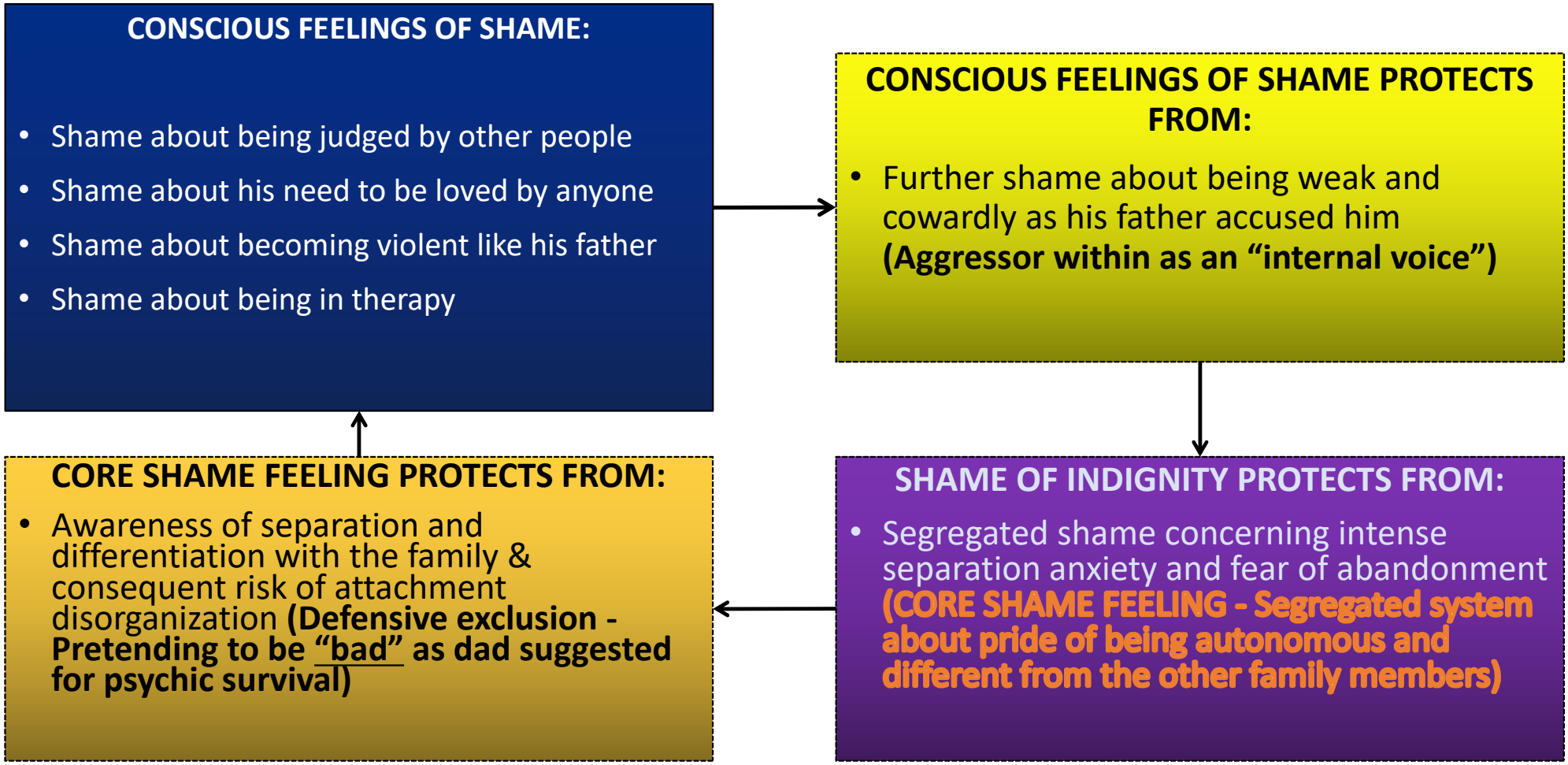
- Thus, self-conscious shame, especially in attachment trauma, may constitute the ***facade*** (in terms of observable shame behaviours, such as blushing, avoiding eye contact, lowering the head, the desire to hide or escape) of a deepest and unbearable shame feeling, which I would call here the **Core Shame Feeling**.
- The Core Shame Feeling is the result of a traumatic identification (Schimmenti, 2017) with a neglecting and abusing attachment figure, which his not easily accessible as it is segregated and paradoxically protected by self-conscious shame.
- In this traumatic idenfication, the segregated system includes an “alien transplant” (Ferenczi, 1933) in which **the individual's representation of self corresponds to that projected onto the child by the abusing and neglecting caregiver** (Schimmenti, 2017).
- In fact, as Ferenczi (1932/1949, p. 228) has sensed many years ago, “the weak and undeveloped personality [of the child] reacts to sudden unpleasure [...] by anxiety-ridden identification and by introjection of the menacing person or aggressor.”
- This poses a serious question to the treatment of people who have suffered from attachment trauma and who display traumatic shame. As I said elsewhere (Schimmenti, 2012), “an individual must have developed a sense of security in order to tolerate the painful experience of facing his or her own “monsters”, and that sense of security must be stronger than the fear of succumbing to the monsters.”

EXAMPLES

Case A (30-years-old female with DID)

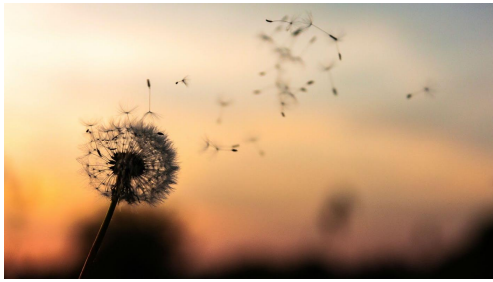


CASE B (30-years-old male with anxiety symptoms)



Discussion and Conclusions

- In this talk, I have discussed the role of attachment trauma in the development of conscious and unconscious feelings of shame.
- I have illustrated with clinical vignettes that feelings of shame among people who were exposed to severe attachment trauma can be structured in layers that protect the individual from a deeper shame and thus from a risk of attachment disorganization.



- I have specifically highlighted that the unbearable nature of such core shame feeling is defensively excluded, and that a traumatic identification with the abusing and neglecting attachment figure is the bulwark to preserve the mind from the flood of dysregulation deriving from the emotional awareness of the attachment trauma, and thus from the fear of disorganization.

- Finally, I have suggested that shame can be repaired in therapy if there is a recognition of the clients' attachment needs that are expressed also by means of shame and other symptoms, and if their dignity is preserved by fostering their safety, security, and emotional regulation , but also their curiosity, their mentalizing abilities, and their capacity to “play” with reality, including the reality of the therapy.

Grazie per l'attenzione / Thank you for your attention

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