SHAME, CHILDREN AND THE DSM

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INTRODUCTION

Four-year-old Gavin is as adorable as most children his age, aided by a sweet charm and a pair of stylish blue glasses. Yet his parents report a contrasting side to Gavin's personality.

At age three, Gavin began to be disruptive and defy rules at preschool. This escalated to 45-minute tantrums where he threw objects, dumped bins of toys, and "trashed the classroom." He is easily frustrated learning new tasks, struggles to follow directions, and "has difficulty with transitions." When he began to hit and kick adults and children, he was expelled.

Gavin was expelled from his second preschool — on his first day — for these same behaviors. He is scheduled to enter kindergarten and may not meet behavioral requirements. His parents saw a pediatrician and a psychologist who gave diagnoses of attention deficit-hyperactivity disorder, oppositional defiant disorder, and generalized anxiety disorder. Gavin was immediately put on medication without any attempt at therapy or parenting changes.

This shocking example of over-diagnosis and over-prescribing with a young child is just one negative outcome of the medical model as presented in the Diagnostic and Statistical Manual (DSM-5). Psychiatrists merely identify behaviors that match a DSM checklist and prescribe medications, without any consideration of reasons for a child's behaviors. One of the most important of these causes — the emotion of shame — is completely ignored by the DSM.

This chapter will identify shame as a trans-diagnostic emotion, describe its impact on behavior, explore the neurological basis of shame, and identify the five factors that exacerbate poor shame tolerance and lead to three shame management strategies. Gavin's case will be considered from the paradigm of a shame-informed case formulation model and specific examples of how to identify shame in clinical cases will be presented.

SHAME AS A TRANS-DIAGNOSTIC EMOTION

One of the most powerful of human emotions — shame — is often ignored by clinicians, yet strongly influences intrapersonal emotional wellbeing and interpersonal behavior. Research indicates that shame is a major trans-diagnostic component in mood disorders, personality disorders, proneness to aggression, and behavioral problems. (Gilbert & Irons, 2005; Gilbert, 1997; Gilbert, 2003; Gilligan, 2003; Tangney & Dearing, 2003)

This should not be surprising, given that humans, as a social species, have evolved to prioritize acceptance, love, and belonging. We could categorize shame as the opposite of love, because disconnection and exclusion are contrary to the primal need for connection and inclusion. Shame is the foundational emotion that fosters so much dysfunctional human behavior because it creates the feeling of being unworthy of love and leads to a survival-related dread of social exclusion.

What is often missed is this important fact: Poorly tolerated shame also drives us away from loving ourselves, provoking levels of distress that become labeled as mental illness. Feeling unloved by others is devastating; feeling unloved by oneself is an existential crisis. It is no wonder a person would respond with escalated emotions, illogical thoughts, and unstable behaviors.

The self-conscious, prosocial emotions (shame, guilt, remorse, and embarrassment) are designed by evolution as helpful experiences in that they should trigger feelings of immorality that drive us to correct antisocial behaviors (selfishness, cheating, lying, abusing, etc). This encourages reputation management behaviors such as accountability, contrition, reciprocity, generosity, altruism, compassion, and caregiving, which bring us back in connection in relationships and in society.

These social affiliative motives are survival related and help shape human social and moral behavior by encouraging compliance, social cooperation, and mutual protection.

However, many children in today's hyper-individualistic Western cultures do not learn how to subsume personal needs and cooperate in relationships. Parents and schools, perhaps through efforts to boost "self-esteem," may coddle children with permissive parenting. This fails to teach children how to handle imperfection or failure with resilience. Or children may be harshly judged by parents, creating children who are hypersensitive to real or perceived experiences of criticism, discipline, or correction. Parents fail to realize the irony that the more they shame their child, the less likely the child will learn to feel healthy levels of shame and guilt, which are needed for normal, prosocial functioning. A child or adult cannot learn from guilt if they have developed a "thick skin". Instead, a person who has learned to feel no remorse may develop antisocial tendencies.

"[E]arly shaming experiences are likely to trigger a threat to the 'social self' (Dickerson, Gruenewald, & Kemeny, 2004; Gilbert, 2009; Perry et al., 1995), leading to defence-based behaviours in the form of experiential avoidance to avoid such emotions (i.e., shame)." (Farr et al, 2021)

Thus begins a cycle. Parents may not model or teach emotional regulation in moments of shame, so a young child does not build skills to manage this difficult experience. As the child grows and experiences normal struggles, such as learning new behavioral, academic or athletic skills, they take these "failures" personally. If their reactions are extreme, such as tantrums, arguing, withdrawing, or low persistence with tasks, parents, teachers, and most clinicians will focus on correcting the behavioral issues. The child will feel chastised and embarrassed, as well as having their feelings ignored. The child may also be diagnosed, medicated, and taken to therapy, when all they needed was help managing a normal emotion.

Although the DSM overlooks self-conscious emotions, their power should not be discounted. Most DSM diagnoses could be more concisely rendered under a case formulation model that categorizes most mental health diagnoses as "shame disorders" or shame intolerance.

THE NEUROLOGICAL BASIS OF SHAME

The reason for overreaction to shame is actually rooted in human neurobiology, a fact also ignored by the medical model. Shame can generate a fear of being discovered as flawed and unworthy, and possibly rejected, which triggers the sympathetic threat response. Fear of social ostracism signals the adrenal gland to release cortisol, the primary stress hormone, leading to increased heart rate and the flooding of major muscles with glucose (Lewis & Ramsay, 2002).

It is interesting that the range of typical emotional and behavioral affects of shame map onto the various vagal system responses. The vagus nerve extends from brainstem into chest and abdomen and influences the lungs, heart, and digestion. It tells our brain how our body is feeling, notably if we feel safe or threatened, but does not distinguish whether the threat is physical, social, or emotional.

This means that an embarrassing experience may prompt the sympathetic system responses of mobilization in response to threat: a desire to slink away and hide ("flight") or anger and stubbornness ("fight"). The dorsal vagal response, part of the parasympathetic nervous system, may also be triggered, especially if there is no escape from danger. This leads to immobilization or "freeze," with cognitive or physical paralysis, hopelessness, apathy, and emotional dissociation, as well as downcast eyes, blushing, and submissive behaviors ("fold" or "fawn"). (Rosenberg, 2017)

Self-criticism is also experienced by the brain and body as fear-provoking. A child thinking "I'm not good enough" creates a stressor that will affect behaviors. A child who is sensitive to shame needs no further external stressors, merely her own brain to trigger the body's threat response system.

If we view child behaviors through the lens of shame and the vagal system, we can rethink the etiology of behaviors of emotional dysregulation, impulsivity, hyperactivity, poor focus, poor executive functioning, shyness, perfectionism, and even social withdrawal or autism. If feelings of unworthiness and fears of social exclusion are so powerful that they affect the vagus nerve, it seems important to consider these as influencing child emotional and behavioral issues, rather than blaming as-yet-unidentified biochemical causes.

FOUR SHAME MANAGEMENT STRATEGIES

Shame presents a conundrum for humans. It is designed by evolution to strengthen social relationships. However, when poorly tolerated it can block human connection because it leads to fear-based reactions that create conflict, self-destructive thinking, or avoidance. These unhealthy shame management strategies may serve as adaptive for individual emotional needs, but are maladaptive for relationships.

In addition to healthy shame tolerance, children and adults have three unhealthy choices in responding to overwhelming and untenable shame:
1) Blame others and externalize shame and anger
2) Blame self and internalize shame and anger
3) Avoid blame and shame

Shame is a primary emotion, with avoidance and anger toward self or others as secondary reactions. An adult client once observed, “Shame makes me small and quiet or loud and aggressive.”

Other-blaming is fairly easy to identify because of its overt behaviors: oppositional arguing, bullying, excuses, rationalizations, inability to apologize, lack of self-discipline, and struggles with being accountable. A person may seek to divert from a demoralizing experience by blame shifting and gaining a feeling of empowerment via anger toward others.

Self-blame often goes unrecognized in children yet is very harmful. Consider that the typical social behaviors associated with shame are abject slinking away, downcast eyes, and submissive postures. When embarrassed we tend to remove ourselves from contact with others. However, when the source of shame is the self it is impossible to escape. The self is attacker and attacked and there is no safe haven. Feeling “never good enough” creates chronic fear and defeat. What the DSM labels as depression, anxiety, and other mood disorders are directly related to the experience of self-shaming.

Avoidance strategies may serve to help a person regulate emotions in the absence of comforting caregivers or self-compassion skills. “[I]ndividuals may engage in experiential avoidance in response to overwhelming emotions (i.e., shame), due to limited emotional regulatory resources available to regulate such distress (Mikulincer & Shaver, 2017; Kashdan, Barrios, Forsyth, & Steger, 2006).” (Farr et al, p. 955)

I worked with one family where the child would react oddly when disciplined — by making faces, making loud sounds, engaging in distracting behaviors, laughing or joking. The parents would send him to his room, not recognizing this was his coping mechanism for the heavy-handed shame-based discipline he was receiving. They were provoking him with overwhelming shame and he had learned to divert from this emotion, rather than experience it in healthy ways.

Most parents and clinicians observe only the child’s secondary emotion or behavior, such as hyperactivity, defiance, avoidance, or depression. They try behavioral interventions and medications, both of which create additional shaming messages to the child: “I am defective and ‘crazy’. I need drugs to fix my broken brain. I am unable to control myself without these drugs.”

Most adults adopt one shame management strategy. (Although those diagnosed with borderline personality disorder seem to alternate between strategies of angry blaming, needy clinging, and self-loathing.) Children often have not developed a preferred strategy, but may alternate, sometimes instantly, from one strategy to another. They may be screaming in anger one minute, then hide in their closet, and then sob and apologize the next. Clinicians must not be distracted by the secondary behaviors, but must preference an awareness of the trans-diagnostic emotion of shame. What started this behavioral cascade? Most likely it was an experience of being criticized, of failing, or feeling unworthy or rejected.

RETHINKING GAVIN AND OTHERS

Looking at Gavin's behaviors from a perspective other than the medical model offers insight into his struggles. Further history taking with parents and teachers might reveal shame-based discipline, excessive criticism, or modeling of poor shame tolerance.

Gavin had become very sensitive to failure so that even something as simple as a teacher telling him to line up for recess mades him feel unworthy. When he over-reacted with tantrums he got punished for these outbursts, bringing additional layers of guilt that his undeveloped mind was not able to manage. His numerous behavioral incidents were engraining a pattern of failing to control his temper, being punished, then feeling ashamed and getting angry again.

Next began a cycle of self-blaming: "I'm stupid because I had to be told three times to line up for recess. The other kids are smarter than I am. When will I get it right?" Parents reported that Gavin often judged himself as a problem ("I'm bad at school") and mades predictions ("I'm going to have a bad day at school today") — overt signs of self-blaming. Shame is such a painful emotion that one method of managing it is to preemptively avoid it through self-criticism and self-correction.

Evidence of this is that on the first day at his new daycare he froze at the door and screamed, "I don't want to go to this school." He had connected schools with shame and rightfully dreaded this new opportunity for failure. Sure enough, that day he kicked and hit teachers and was removed from this school, too.

Gavin's behaviors were much worse at school than at home, which confused his parents until I had them consider this: Perhaps his behaviors were worse when peers and teachers were present because he feels socially judged, which triggers more shame and anger, escalating and prolonging the tantrum.

Gavin also called his mother "stupid", possibly a projection of his self-beliefs. Clinicians should watch for excessive name calling and bullying that serves to socially up-rank the self and down-rank others.

His hostility to any authority may be due to fears that parents and teachers can tell him what to do. For shame sensitive children, even small, normal directions trigger reactivity. I had one child say her tantrums over being told to brush her teeth were because she was mad at herself for forgetting this task and when her parents reminded her it "felt terrible." She was already self-shaming to such an extent that a small reminder created an overwhelming experience of failure.

"SYMPTOMS" OR SIGNALS OF SHAME SENSITIVITY?

Let's consider a range of child behaviors that get labeled as "symptoms" of "mental disorders," but are very likely signs of shame sensitivity.

1) Hyperactivity, impulsivity, and attentional problems: At one level, ADHD symptoms are indicators of an elevated threat response. ADHD symptoms can be seen as hyper-vigilance to danger (sensory sensitivity, lack of focus) and hyper-reactivity (fidgeting, emotional dysregulation). But consider: What is making the child worried and fearful? In the absence of specific traumas, clients with attentional problems report shameful thoughts intervening while reading or doing homework ("I am a slow learner," "I don't want to make a mistake," "Everyone else is going to finish before me," etc). Internal self-shaming messages trigger the fear response, leading to distractibility, impulsivity, poor memory, and poor cognitive performance.
2) Hyperactivity only in social settings: Parents may report children who are overly active and easily distracted in school. However, the child can sit quietly and read or play a video game at home. This confusing presentation may be due to fear of disapproval, leading to hyper vigilance and scanning the environment for social cues. Many children report worry about what others are saying or thinking about them. Their attention is divided between focusing on schoolwork and what peers are doing in the classroom. I had one adult patient who was distracted with intrusive thoughts when co-workers walked by his office: "Do they need me? Are they mad at me? Are they ignoring me?"
3) Excessive socializing: For the same reasons as above, many children talk out of turn, act the clown, or get out of their seat to socialize. They need approval from others because of their lack of self-approval. We could normalize this as an attempt to build social relationships, yet this gets labeled as hyperactivity.

4) Limited socialization: Children with low self-worth may self-isolate from peers. Children with poor shame tolerance may be sensitive to rejection by peers, so that normal, age-appropriate conflicts cause the child to become angry at peers and/or reject peers. This may show up as beliefs that peers dislike them or if a friend makes a new friend or plays with a new peer, the child may become distraught or refuse to talk to the friend.
5) Opposition and excessive arguing: Shame sensitivity makes it difficult for a person to admit they are wrong, so they may argue persistently over minor issues rather than change their opinion. Lying to avoid being held accountable and cheating to avoid losing are due to the same issue.
6) Defiance and refusal to listen: Children may defy rules because to submit to authority feels like an admission of fault and a loss of social standing. Often this behavior is worse in public, because the child is even more embarrassed at being disciplined and shamed in front of peers or siblings. It should also be noted that children have good instincts for when they are being treated harshly and will eventually push back with indignation, which may be justified in the face of abusive parenting.
7) Sullenness and uncooperativeness: When forced to submit to parents or teachers, children may cooperate grudgingly to signal their resentment at being shamed or blamed. However, they may repeat messages of other-blaming to themselves ("This was not my fault") that may lead to lack of accountability that is more overtly expressed as anger and blame shifting later in life.
8) Avoidance, shyness, and isolation: A 10-year-old child dreaded school and yet did well academically and socially. She revealed a difficult experience of failing a test in second grade and feeling deeply embarrassed. On the surface she was compliant and nice, but internalized feelings of dread, resentment, and anger. School or social avoidance can be signs of a child who has already adopted a pattern of self-blaming and may avoid situations that might provoke judgment or social rejection. Often these children are not brought to therapy because they are compliant, pleasing, and passive. However, their inner dialogue may be loaded with self-doubt. Many times, children who have fears of social judgment have been judged excessively or harshly at home, at school, or by athletic coaches.
9) Emotional fragility and excessive crying: Highly sensitive children may respond to discipline, criticism, or direction with over-reactions such as running off or unexplained sobbing. Highly empathic or sensitive children are attuned to the emotional needs of others, so that when parents or friends get upset the child's default response is to self-blame.
10) Sensory issues: A common presentation with young children is being overly sensitive to sensory inputs. An elevated threat response system uses heightened senses as part of the survival arsenal. However, the elevated stress may be due largely to the child's harsh inner critic, not any physical or emotional danger in the environment.
11) Perfectionism: One child wanted to do things perfectly and often spent so long spelling his name that he could not complete a school worksheet on time. If he made a mistake while coloring, he threw the entire project away and started over, also delaying his finish. He would refuse to move to the next task and had a tantrum. Clinicians should watch for perfectionism or slow task completion as signals a child is working hard to avoid failure and shame. This child may have learned to be hard on himself and over-achieve to avoid feelings of inadequacy. One child became irritated when his father called and simply asked, "How was your day?" He revealed that when his father asked questions it "makes me afraid I'll give the wrong answer," a subtle sign of fear of failure.
12) Poor persistence and frustration tolerance, low motivation, and lack of resilience: While some homework refusal and school resistance are normal, an elevated defeatist mentality may be indicative of shame avoidance and the "fold" response. A child may have concluded they are incompetent and may engage in high levels of social comparison: "Everyone else is better at spelling, so why should I try?" To avoid feelings of shame it seems emotionally safer to quit, rather than persist to acquire a skill or knowledge. Those who lack self-acceptance struggle to provide themselves with compassion in the moment of failure.
13) High anxiety: Just as in adults, worry is nearly always a sign of low self-worth. If a child feels inadequate, she will be hyper-vigilant for social exclusion or feelings of unworthiness.
14) Bullying: Children who dominate others almost certainly are modeling parents who engage in harsh judgment or even abuse. Parental rejection provokes a child to feel weak, shameful, and powerless. He may attempt to compensate by up-ranking himself with others. Children quickly learn that dominance and angry, externalizing behaviors (other-blaming) feel protective of shame. Their brain quickly is habituated to anger as a safe experience because it relieves feelings of unworthiness.
15) Grandiosity, boasting, and gloating: Narcissistic behaviors begin in childhood with self up-ranking, bragging, and excessive need to win and be better than others.

16) Eating disorders: Anorexia and bulimia are widely recognized as shame-based, with sufferers often expressing dislike of their body and a high need for approval.
17) Autism: While causes of autism spectrum disorder may be complex, it seems important to recognize that if a person feels self-disgust, they might engage in a freeze response when in social settings or might withdraw to avoid disapproval. Some research shows that those with autistic behaviors have less proneness to guilt, perhaps indicative of a learned avoidance of this emotion. (Davidson et al, 2018)
18) Dissociation and lack of reciprocity: Children who have experienced relational/complex trauma have learned that relationships are threatening, or at least not a likely place to experience warmth. A vagal system chronically activated by all relationships may lead to emotional shutdown or dissociation as a default coping response. This may present as children who are lacking in ability to read or respond to social cues in reciprocal ways; flat or constricted affect; and low expressed positive emotions of joy, relaxation, or playfulness.
19) Lack of accountability: This behavior can start very young. One child, age 6, was being uncooperative in play therapy for 30 minutes, hiding behind chairs and playing with a lamp in dangerous ways despite being reprimanded. When he stopped misbehaving, he stated without prompting: "It wasn't my fault I wasted all my time in the session and don't have enough time to play." He knew what he was doing was wrong yet reassured himself that he was not responsible — a tactic to manage his guilt. While all children normally struggle to handle accountability for behaviors, high levels of blame-shifting are an important sign of shame intolerance. Watch for laziness, poor self-discipline, irresponsibility, rationalizing, and excuses. Learning to face mistakes with equanimity and accountability is a key skill for fully functioning adulthood and happy relationships.
20) Suicidal thoughts and self harm: Even children as young as four have expressed self-loathing and acted out self-harm, such as hitting themself on the head or banging their head on walls. Older children have verbally expressed statements such as, "Why don't you just kill me" and "I want to put a pencil through my neck and bleed to death." Clearly indicative of self-blaming behaviors, these behaviors are obvious commentary about shame, self-judgment, and low self-worth. Unfortunately, many clinicians and parents will become distressed at this behavior, not acknowledging the real causes. They will quickly hospitalize and medicate, leading a child down a path of being a "mental patient," perhaps for years.

FIVE FACTORS CAUSING SHAME INTOLERANCE

While shame is a naturally occurring emotion and essential to social and moral functioning, five factors can exacerbate shame intolerance and therefore lead to emotional and behavioral dysfunction. The first three of these factors affect everyone, while factors 4 and 5 are affected by a person's life experiences. When considered together, these five factors provide a useful paradigm to understand the causes of emotional and behavioral struggle and directly provide guidance regarding a shame-informed case formulation model.

<u>Five Causative Factors of Shame Intolerance</u>

1. Threat Response: As previously discussed, the nervous system is designed to detect threat and ensure safety with activating or inhibitory responses. Most DSM diagnoses can be viewed as various iterations and severities of threat responses. Anxiety, mania, and ADHD are elevations of the activation or sympathetic system, with hyper-vigilance and hyper-reactivity to perceived danger. The inhibitory (dorsal vagal) threat response is labeled as depression or avoidance behaviors.
2. Fear of Social Exclusion: The urge for social affiliation is so elemental that feeling victimized, rejected, or shamed by our social group can trigger survival fears and responses. Neuroscientists now know that the same parts of the brain that evaluate physical pain are used to judge the emotional pain of social rejection (Ochsner et al, 2008). Studies show that feeling alone and excluded triggers feelings of fear, hostility, and shame that may result in physical symptoms, such as high blood pressure and heart disease (Hawkley & Cacioppo, 2010). Considerable research has been done on the power of social affiliation or rejection sensitivity and its links to social anxiety, depression, anger, and blame of self or other. (Baumeister & Tice, 1990; Baumeister & Leary, 1995; Gilbert & Miles, 2000)
3. Shame as an Attempt to Prevent Social Exclusion: As discussed previously, shame is a normal emotion with healthy implications, but if poorly tolerated can create emotional distress.
4. Acute Trauma: Trauma is one of the most widely recognized external causes of psychological suffering, especially following the Adverse Childhood Experiences Study (ACES) (Felitti et al, 1998). This landmark study found that childhood abuse, neglect, witnessing violence, or experiencing parental substance abuse or mental illness, predicted emotional, behavioral, and physical health consequences throughout life. Frightening

experiences in childhood are especially impactful because they couple terror with helplessness and unworthiness. Childhood trauma sensitizes the threat system and causes physical changes in the body and brain that affect emotional regulation, cognitive comprehension, and social behaviors. Children who have experienced significant trauma show significantly reduced grey matter in the cortex, an area related to decision-making and self-regulatory skills, and in the amygdala, or fear-processing center (Sheridan et al, 2012). Shame, trauma, and childhood sexual abuse have even been considered the cause of "hearing voices" or auditory hallucinations (Woods, 2017).

5. Attachment Status or Chronic/Developmental Trauma: A secure attachment experience with caregivers teaches a child a positive relational model. This permits healthy, loving relationships with others and with himself. Secure attachment is the origin of emotional wellbeing and directly affects cognitive, emotional, social, and physical development. Relational trauma is devastating because the child concludes that caregivers are not willing or able to protect and that the world and relationships are frightening. Those who have been harmed, neglected, or rejected by others will be especially attuned for that rejection in the future. They may develop shame management strategies, such as self-rejection with excessive guilt and blame, in an attempt to "fix" the self. Researchers believe that rejection sensitivity stems from early attachment relationships and parental rejection (Gilbert, 2005).

Factors 1, 2, and 3 are naturally occurring tendencies. A childhood filled with love, safety, and acceptance predisposes the child to have emotional resources and resilient responses to life's difficulties. However, trauma (factor 4) and insecure attachment (factor 5) are variables that can increase maladaptive behaviors, including hyper-vigilance to social threat and rejection, elevated shame sensitivity, lack of emotional resilience and coping skills, and blame-shifting behaviors to manage shame. An ability to respond with self-soothing and the contentment system may be underdeveloped. "Tend-and-befriend" urges may even be experienced as a danger, simultaneously making it difficult to regulate emotions and blocking attempts at self-comfort through self-compassion.

Most DSM diagnoses are actually descriptions of hyper-vigilance to being shamed, victimized, betrayed, or rejected by others, combined with an inability to self-soothe, which results in maladaptive shame management strategies.

When assessing children for emotional and behavioral problems, these five factors should be considered to develop a complete understanding of causes of the child's shame intolerance issues. Discarding the disease model and using a shame-informed case formulation model would allow clinicians to easily identify indicators of client negative self-image and beliefs of unworthiness.

CONCLUSION

It is common sense that a person experiencing self-criticism is constantly triggering their social threat system, which can lead to anxiety and rejection sensitivity. By shifting the mental health paradigm to awareness of the power of shame, much of the DSM could be replaced with one idea: Shame causes mental distress and self-acceptance improves shame tolerance. Case conceptualization and treatment planning for clinicians would be significantly simpler, yet more effective under a shame-informed case formulation model.

Compassion-focused and attachment-focused therapy models provide evidence-based interventions that directly address cognitions of self-criticism and the neurobiology of shame/fear states (Gilbert, 2010; Hughes, 2007). Compassion strengthens the ability to self-soothe via the social engagement system (ventral vagal). Helping children gain self-acceptance improves their ability to tolerate shame with equanimity and without emotional distress by decoupling experiences of fear and shame, leading to improved outcomes compared to the drug and behavioral interventions of the medical model.

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