Addressing Shame
in Child and Family Psychotherapy

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Thanks for your interest in this book. I am publishing and distributing it for free to spread awareness of important topics on the emotion of shame and on new ways of considering mental health diagnosis.

Please share any feedback with me at harperwest@me.com so this book can be improved for future readers.

I will be making regular updates, so to ensure that others have the newest version, do not distribute this copy. Have others contact me via email to get the latest version. Thank you.

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Introduction

Four-year-old Gavin* is adorable, aided by his sweet charm and a pair of stylish blue eyeglasses. However, 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, has very high energy much of the time, and "has difficulty with transitions." When he began to hit and kick both adults and children he was expelled from preschool.

Gavin was then expelled from his second preschool for these same behaviors — on his first day. He is scheduled to enter kindergarten and may not meet behavioral requirements.

By this point in the story, most clinicians reading this have probably already thought of some diagnoses to give Gavin. Before coming to see me Gavin's parents had been to 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 psychotherapy or parenting changes — at age four!

* All cases in this book are based on fictionalized or composite patients and families.

Considering Shame and Reconsidering Child Behaviors

Let's look at Gavin's situation from a shame-focused perspective to give a brief introduction to this powerful new paradigm clinicians can use to understand a child's emotional and behavioral struggles.

First, Gavin's case is a shocking example of over-diagnosis and over-prescribing with a very young child — just one negative outcome of the medical model as presented in the Diagnostic and Statistical Manual (DSM). All too often psychiatrists and general practitioners merely identify behaviors that match a DSM checklist and immediately prescribe medications, without any consideration of the emotional or environmental reasons for a child's behaviors. Therapy and parenting education are either not recommended or recommended as a future alternative if medication does not work.

As I'll discuss in Chapter 1, the biomedical model of mental disorders and the DSM have fatal flaws that render them useless in accurate case formulation, treatment planning, and interventions.

Rethinking Gavin's behaviors and considering shame as a cause brings an understanding of his emotions, his thinking, and his behavioral choices. This model points the way to a clear "golden thread" flowing from diagnosis to case conceptualization to treatment planning to interventions.

But first: Can a four-year-old really feel shame and to such a point that it impacts his behavior? Yes, as I'll explain in Chapter 3 on Shame: The Terrorist of Emotions. The prosocial and attachment emotion of shame makes its appearance in development from 14 to 16 months old and can be triggered by misattunements and attachment failures from parents that the child interprets as disgust and rejection.[1] The "symptoms" of shame intolerance are many, as outlined in Chapter 6: Case Assessment and Formulation. Some are obvious, many are subtle and misunderstood by parents and clinicians. I have worked with three- and four-year old children who say things like: "I'm no good," and "I'm a bad kid." These children can even engage in self-harm, such as biting, scratching, head banging, or hitting themselves. Often these incidents occur after they have been corrected or disciplined. How sad that even young children show that they have already developed a self-image that includes a very low opinion of themself, with lots of self-blaming and self-criticism.

Let's unpack Gavin's case to see how shame very likely led to his behavioral issues.

In Gavin's case, further history taking with parents and teachers revealed they used shame-based discipline and excessive criticism. They also modeled poor shame tolerance themselves — so Gavin had no healthy adult examples on how to handle this painful emotion.

Schore, A.N. (2003) Affect Dysregulation and Disorders of the Self. New York: W. W. Norton, p. 17 & 18

Gavin had become very sensitive to failure so that even something as simple as a teacher telling him to line up for lunch made him feel inadequate. His shame led to secondary anger reactions and lashing out at others physically. When he over-reacted with tantrums he got punished for these outbursts, bringing additional layers of guilt that he was not developmentally able to manage. His numerous behavioral incidents then engulfed him a cycle of feeling ashamed, failing to control his temper, being punished, then feeling ashamed and getting reactively angry — which started the cycle of punishment and shame again.

Even though he was just learning to speak well, he was engaging in feeling states of self-blame and shame: "I had to be told three times to line up for lunch so I must be stupid. The other kids are smarter and better behaved 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 made predictions ("I'm going to have a bad day at school today") — overt signs of self-blaming and fear. 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 occurred on the first day at his new preschool when he froze at the door and screamed, "I don't want to go to this school." He had connected schools with shame and so — 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 felt socially judged, which triggered more shame and anger, escalating and prolonging the tantrum. I'm sure that as he was "melting down" he could sense the judgmental eyes of others on him and this escalated his shameful sobs and rage.

Gavin was known to call his mother "stupid," likely a projection of his self-beliefs. Clinicians should watch for excessive name calling and bullying that serves to socially up-rank the child and down-rank others, a sign of shame intolerance and insecurity.

His hostility to any authority may be due to dread of the fact that parents and teachers could tell him what to do — which felt shameful to him. He had connected the experience of shame with adults who correct him. For shame-sensitive children even small, normal directions trigger reactivity. I had one child who had tantrums when told to brush her teeth. She reported these happened because she was mad at herself for forgetting this task, so that 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. I often use this metaphor with children and parents: If you are filling your own shame bucket to the brim, it will only take one drop of shame from someone else to cause it to overflow.

Unfortunately, as Gavin's case exemplifies, one of the most powerful of human emotions — shame — is often ignored by clinicians, especially in child mental health. The research that does identify shame in children tends to focus on those who have experienced physical or sexual abuse and other traumas. Yet millions of children who have not experienced acute trauma have difficulties regulating the primary emotion of shame and their secondary reactions to it. They present for general outpatient psychotherapy with parents noting concerns about the child's "hyperactivity" or "anger issues and tantrums" or "big emotions they can't control."

In many family systems, these behavioral issues create a negative cycle. It often starts with parents who have not modeled shame tolerance in their own behaviors. They may also have failed to teach a child emotional regulation skills in moments of shame. Parents may be harshly critical or shaming in their punishments, or even inadvertently shaming, as I'll discuss in Chapter 6. As the child grows and experiences normal struggles, such as when learning new social, academic or athletic skills, they then begin to take these "failures" personally. If the child's secondary reactions to shame are extreme, such as tantrums, arguing, withdrawing, anxiety, depression, or low persistence with tasks, then parents, teachers, and most clinicians will focus on correcting the behavioral issues.

Even worse, the child may be diagnosed with a stigmatizing label, identified as the problem, and medicated, when all they needed was help managing a normal emotion.

If the child is taken to therapy, many clinicians will attempt to treat the superficial behaviors, often in individual child therapy. The prosocial emotions of shame, guilt, and embarrassment are never addressed. I find that most clinicians rarely if ever include parents in sessions or use parenting education interventions. I have yet to find an-

other clinician who educated parents on the impacts of their shame-based parenting styles or how their personal modeling of shame intolerance is viewed by children.

And yet shame is a powerful, trans-diagnostic emotion arising out of feeling judged as inadequate and feeling rejected — one of our deepest human fears.

When the source of judging and shaming is a child's parent, the impact of emotional abandonment and loss of attachment on the child's emotional wellbeing is enormous. It is no surprise that a child's resulting behaviors might involve emotional dysregulation resulting in feelings of fear, guilt, sadness, anger, and even self-loathing. The child is attempting to solve an emotionally difficult situation without the cognitive skills to recognize they are not the problem — the parents are the problem. The resulting self-blaming patterns can become entrenched, causing lifelong psychological problems in adulthood, such as mood disorders, personality disorders, and limited or dysfunctional interpersonal relationships.

Although the DSM overlooks self-conscious emotions, their power should not be discounted. Fortunately, outside the DSM shame is increasing being considered a trans-diagnostic emotion that strongly influences intrapersonal emotional wellbeing and interpersonal behavior in adults. 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. I believe that this pattern is also true for young people and this concept must be considered in child psychology.

The powerful impact of shame 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. Early shaming experiences are likely to instill a view of self as unworthy of love, leading to adaptive behaviors that help a child cope with shame by blaming others with defensive anger, being hyper vigilant to signs of social rejection, or self-blame and guilt.

A case formulation model that privileges shame is powerful because it explains how the hyper-vigilance and hyper-reactivity of ADHD, the anger of oppositional defiant disorder, and the anxiety and depression of mood disorders have roots in shame sensitivity.

I find this work with families deeply satisfying because if we can address issues of shame early enough, it can prevent the development of engrained habits of self-loathing, which can result in emotional and relationship problems in adolescence and adulthood.

I have seen hundreds of children like Gavin in my therapy practice and I am extremely frustrated with the very limited — and unscientific — perspective offered by the supposed diagnostic manuals and textbooks currently in use in the mental health profession.

I wrote this book (and I'm giving it away for free!) because I feel very strongly that today's children are being significantly harmed by the current medical model of "mental disorders" and the false "neurochemical imbalance" or "neurodevelopmental" constructs. Instead, what the DSM labels as disease is merely a child's expected and adaptive response to their environment.

I hope to help clinicians learn the powerful impact of shame on children and families so that they can use it in their clinical case formulation and interventions. I believe that once clinicians see the deep and broad impact of shame, it will explain so much about human behavior that they won't be able to unsee it. My hope is they will give up the pathologizing framework of the DSM and cease the over-prescribing that accompanies that false and unscientific model.

Chapter 1: The Failures of the Disease Model of Mental Illness

To gain full understanding of a new shame-focused model of emotional distress, readers will need to set aside belief in a disease model of mental illness. It is obvious that humans engage in emotions, thoughts, and behaviors for many reasons that have nothing to do with a disease of the brain, generally as ways of coping with situations perceived as physically, emotionally, or socially threatening. It seems obvious that the mental health profession should reconsider the traditional ways of defining mental disorders based on scientific evidence and common sense about what is known of the emotion of shame.

Most cogently: Why are normal human reactions — such as fear, shame, self-criticism, and the need for love and belonging — labeled as "mental disorders?"

Numerous authors have very capably presented the many faults of the DSM, including its lack of scientific rigor, poor reliability and validity, disregard for psychosocial and environmental factors, arbitrary diagnostic criteria, and overly cozy relationship with pharmaceutical companies.[2][3][4][5][6][7][8] There is no need to repeat those arguments in depth here. I have blogged about this topic extensively on my website (www.harperwest.co), notably on this blog which includes a list of resources and websites for further reading.

Some mental health consumers have become anti-psychiatry activists, asserting that the DSM stigmatizes sufferers, over-emphasizes medication as a treatment option, and harms far more than it helps. (See www.MadInAmerica.com and other country-specific versions of that website.)

The DSM is based on two unproved assumptions: that "mental disorders" are caused by imbalances in brain chemistry or are passed along genetically; these concepts have never been proven by research. Notably, a meta-analysis of 107,000 studies failed to find a biological marker for any mental illness.[9]

When the false disease model is stripped away, there is nothing left of the DSM, leaving its labels arbitrary and meaningless. Vanheule states the DSM is essentially a "belief system."[10]

Phillip Hickey, Ph.D., a leading anti-psychiatry advocate, writes: "(T)hose of us on the anti-psychiatry side of the issue have been saying for years that the various items listed in the DSM are nothing more than loose collections of vaguely defined problems with no explanatory or ontological significance." He has also called the disease model the "Great Psychiatric Hoax" and "a lie".[11]

A look back in history reveals that numerous diagnostic labels have fallen by the wayside with changing cultural norms — an indication of the arbitrary nature of these "scientific" labels. The profession no longer diagnoses monomania, masturbatory insanity, hysteria, homosexuality, and drapetomania. (In the 19th century drapetomania was considered the mental illness that would cause enslaved people to flee their enslavers.) Why should we be wedded to today's DSM, which is likely to be filled with similarly ill-considered labels?

In no less than the well-respected publication *JAMA Psychiatry*, Kendler wrote that despite years of research there is little scientific evidence for DSM diagnostic labels because the pathophysiologies of major mental health disor-

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[2]Vanheule, S. (2014). *Diagnosis and the DSM: A critical review.* London and New York: Palgrave Macmillan.

[3] Whitaker, R. (2010). *Anatomy of an epidemic*. New York, NY: Broadway Paperbacks.

[4] Whitaker, R. (2019). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. New York, NY: Basic Books.

[5] Whitaker, R., & Cosgrove, L. (2015). *Psychiatry under the influence; institutional corruption, social injury, and prescriptions for reform.* New York: Palgrave Macmillan.

[6] Deacon, B. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, 33: 846-861.

[7] Kirk, S.A.; Gomory, T. Cohen, D. (2013) *Mad science: Psychiatric coersion, diagnosis, and drugs*, Transaction Publishers

[8] Szasz, T.. (2008) *Psychiatry: The science of lies*, Syracuse, NY: Syracuse University Press

[9] Kapur, S, et al (2012) Why Has it Taken So Long for Biological Psychiatry to Develop Clinical Tests. *Molecular Psych* 17, 1174-9

[10] Vanheule, S. (2014). *Diagnosis and the DSM: A critical review.* London and New York: Palgrave Macmillan.

[11] Hickey, P. (2016). The overdiagnosis of ADHD. Retrieved from http://behaviorismandmentalhealth.com/2016/06/28/the-overdiagnosis-of-adhd/

ders cannot be directly observed. As a result, current psychiatric diagnoses are merely working hypotheses, subject to change, and do not correspond to reality.[12]

Fortunately, more individuals and organizations are recognizing that "mental disorders" are correctly conceptualized as understandable reactions to adverse events. The British Psychological Society's Power Threat Meaning Model focuses on the impact of external or environmental factors, notably social or cultural factors.[13]

In 2019, the United Nations Special Rapporteur issued a report stating that effective mental health interventions have been hindered by narrow conceptions of causes of emotional distress and an over-reliance on biomedical explanations of mental health conditions.[14] The report advocates for a human rights approach and recommends considering social conditions, such as poverty, discrimination, and violence, as the root causes of mental distress.

Then, in 2021, after years of promoting the biomedical model, the World Health Organization changed course and released a report that concurred about the failure of biomedical mental health systems. In a 300-page document, WHO echoed the UN report and stated that mental health systems over-diagnose human distress, over-rely on psychotropic drugs, and under-estimate the impact of environmental factors. The report criticized "an entrenched over-reliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach" [15]

The report concluded that what is needed is "a fundamental paradigm shift within the mental health field, which includes rethinking policies, laws, systems, services and practices across the different sectors which negatively impact people with mental health conditions and psychosocial disabilities."

It is becoming clear that millions of dollars in research funding have been thrown at trying to prove a biological cause of emotional problems, with an almost frantic avoidance by psychiatrists and pharmaceutical companies to even consider other explanations.

The disease model and the DSM are promoted by these two industries that make billions of dollars selling and prescribing psychoactive drugs, despite well-documented harmful side effects and lack of efficacy. Big Pharma, colluding with their paid researchers in academia, has spent millions of dollars convincing physicians and the America public that popping a pill will "fix" the neurotransmitters in one's brain and "treat" depression, anxiety, ADHD, or schizophrenia.

This theory has never been proven to be true. Neurotransmitters cannot even be measured in the brain to determine if there is some presumed shortfall or excess. Peter Breggin, MD, a longtime advocate for appropriate prescribing of psychiatric medicine, writes that the idea of biochemical imbalances is sheer speculation aimed at promoting psychiatric drugs.[16]

In fact, psychoactive drugs often make mental health and functioning worse, as noted by many authors, including Robert Whitaker in "Anatomy of an Epidemic."[17] There is more and more evidence that all classes of psychiatric drugs produce chronic brain impairment, frequently prevent recovery, and can cause chronic or permanent disability.[18]

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[12] Kendler, K. S. (2021). Potential lessons for DSM from contemporary philosophy of science. *JAMA Psychiatry.* Published online December 8, 2021. doi:10.1001/jamapsychiatry.2021.3559

[13] Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society. https://www.bps.org.uk/member-networks/division-clinical-psychology/power-threat-meaning-framework

[14] Pūras, D. (2019). Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. United Nation Human Rights Council, Forty-first session (24 June–12 July 2019). A/HRC/41/34. Retrieved from: https://www.ohchr.org/en/statements/2019/07/statement-mr-dainius-puras-special-rapporteur-right-everyone-enjoyment-highest

[15] World Health Organization. (2021). *Guidance on community mental health services: Promoting person-centred and rights-base approaches.* p. xvii Retrieved from: https://www.madinamerica.com/wp-content/uploads/2021/06/9789240025707-eng.pdf

[16] Breggin, P.R. (2001) *The Anti-Depressant Fact Book*. Cambridge, MA: Da Capo Press, p. 21

[17] Whitaker, R. (2010). *Anatomy of an epidemic*. New York, NY: Broadway Paperbacks.

[18] Breggin, P.R. (2014) *Guilt, Shame and Anxiety: Understanding and Overcoming Negative Emotions*. Amherst, NY: Prometheus Books, p. 262

This smokescreen of the disease model has distracted the profession and researchers from some obvious truths that actually do explain emotional wellbeing in a fact-based, common-sense, research-proven manner. The fundamental truth about human behavior is that emotions and thoughts drive human behaviors, especially two of the most powerful emotions: shame and fear. The DSM completely ignores the entire construct of moral emotions, notably the self-conscious emotions of shame, regret, and disgust, and the resulting spectrum of antisocial and prosocial behaviors. These very simple, understandable facts, however, explain far more about human behavior and do so more completely, accurately, and parsimoniously than does the disease model.

The DSM confuses more than it clarifies and it harms more than it helps. The current mental health diagnostic system has for decades hindered therapeutic treatment and caused harm by:

- stigmatizing clients as "disordered", leading to social distancing[19] [20] [21] [22]
- increasing symptomology and worsened outcomes
- leading clinicians to view clients as "diseased" and "disordered," which shuts down avenues for acceptance, hope, and empathy
- driving clients away from seeking treatment due to stigma[23]
- promoting helplessness, avoidant behaviors toward treatment, and lack of accountability for personal change[24]
- promoting ineffective and harmful drugs over effective and harmless therapy or self-help
- merely diagnosing symptoms, not causes
- focusing on red herring biomedical causes of emotional distress and ignoring the real cause of suffering, such as trauma, relationship or attachment distress, parental neglect, unhealthy relationships, social/cultural impacts, or lack of self-acceptance
- offering no logical connection between assessment, diagnosis, case formulation, and treatment.

Even Thomas Insel in 2013, then the director of the National Institutes of Mental Health, issued a statement prior to the release of DSM-5 that distanced the agency from the DSM, citing its lack of validity.

In a further complicating factor, the internet is a vast, unregulated forum of information on mental health issues — much of it inaccurate and overblown by influencers attempting to gain followers and make money. Numerous websites inaccurately list "chemical disorders" as causing emotional and behavior problems. Social media self-help sites glamorize disorders and encourage self-diagnosis by young people. Tse and Haslam found that self-diagnosis in the narrow sense can foster help-seeking but can also prompt over-diagnosis, over-utilization of services, maladaptive coping and loss of perceived control over one's condition.[25]

The DSM makes all this possible, so that adolescents and young adults now find identity and belonging by claiming a mental health disorder and discussing it with their friends. Too many teens come to therapy stating they "have ADHD" and admit that they talk or text about their supposed symptoms with friends *every day*. The result is people misidentifying normal behaviors as disordered leading to a belief in lack of agency over their thoughts and emotions, lowered resilience, lack of coping skills, loss of autonomy. It can even result in unnecessary and harmful treatment.

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[19]Schomerus, G., Schwahn, C., Holzinger, , A., Corrigan, P.W., Grabe, H.J., Carta, M.G., and Angermeyer, M.D. Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*. 125: 6, 440-452, June 2012.

[20] Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica, 114*, 303-318

[21] Angermeyer, M.C., Holzinger, A., Carta, M.G., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: systematic review of population studies. *British Journal of Psychiatry, 199*, 367-372.

[22] Elliott, M., Ragsdale, J. M., and LaMotte, M. E. (2024). Causal Explanations, Treatability, and Mental Illness Stigma: Experimental Study. *Psychiatric Services* 75: 131-138. DOI: 10.1176/appi.ps.20230169

[23] Oliffe, J.L., Ogrodniczuk, J.S., Gordon, S.J., Creighton, G., Kelly, M.T., Black, N., Mackenzie, C. (2016) Stigma in Male Depression and Suicide: A Canadian Sex Comparison Study. *Community Ment Health J*. Jan 5, 2016.

[24] Ahuvia, I.L., Eberle, J.W., Schneider, J.L, & Teachman, B.A. (2024) Anxiety Identity Centrality is Associated with Avoidant Coping in Anxious Adults. In preprint. Doi: https://doi.org/10.31234/osf.io/5wgnc

[25] Tse, J. S. Y., & Haslam, N. (2024). Broad concepts of mental disorder predict self-diagnosis. SSM – Mental Health, 6, 100326. (Link)

It breaks my heart to hear story after story of how the DSM and the myths of Big Pharma have destroyed young psyches. I sometimes use an assessment tool that can indicate a child or teen's inner narrative and self-image. I have the child tell me the story of their life starting with "Once upon a time…" Usually these are rambling snippets of important events strung together without much significance. However, when I asked Madeline, age 10, to tell the story of her life it focused only on her "fits" (tantrums) starting at 18 months and worsening over the years. She listed the many psychiatric medications she had been given, the many disciplinary problems at school, and the many attempts at therapy. She couldn't, of course, remember what happened when she was 18 months old, but her parents, teachers, prior therapists, and doctors had told her this story so many times it was now the main narrative of her life. She completely omitted normal childhood memories of friends, pets, vacations, birthday parties, or holidays. Her narrative was only of her behavioral problems. This may be an extreme case, but why should any child have to endure this type of experience?

I've worked with teens and young adults who were diagnosed with a "mental disorder" and told that this would be a permanent disability for the rest of their life and they would need psychiatric medications forever. They believed this falsehood from the authority figure of the doctor or psychologist and, unsurprisingly, the result was low self-worth, hopelessness, helplessness, dependency, and very low expectations for themselves.

One family noted that many of their adolescent's problems worsened in eighth grade when she was allowed to attend a school Individualized Educational Program (IEP) meeting. As is normal in these meetings, numerous school staff members talked at length about how she was in the lowest 5th percentile for performance, "has ADHD and dyslexia", and will need special supports for the rest of her school career. This shamed the young girl so much that she broke down crying and could not be consoled. She later said she felt stupid and hopeless because of these labels and the way she was talked about. She internalized feelings of low self-worth and began to give up on studying. She started avoiding school and underperforming because school was where she felt judged as stupid — actually a very understandable response to intolerable levels of shame.

Another young man, Daniel, recalled being diagnosed with bipolar disorder with psychotic features at about age 14 and put on a cocktail of drugs, which must have included an antipsychotic because he quickly gained 90 pounds on a very small frame. The psychiatrist kept pushing to admit Daniel to an inpatient hospital for no specific reason. Daniel resisted this, but when he was forced to go in he became distraught and lonely — normal reactions for a child — but these reactions earned him days in an isolation cell and additional diagnostic labels, which worsened the trauma of this hospitalization experience. He was then further ostracized by peers, because their parents learned he was diagnosed with bi-polar and refused to let him play with their children. The real reason he was given these drugs and diagnoses? His narcissistic mother was verbally abusing him constantly and Daniel was standing up for himself against the abuse. She then blamed him for his behaviors and pushed the drugs and therapy as a way to sedate and control him. It allowed her to blame him for the situation and escape accountability as a parent. Daniel then would go on to spend years of his young adulthood trapped in shame about the labels, afraid his friends would find out he had been in a mental hospital, engaging in self-judgments about being "crazy," and unable to think clearly because of all the meds harming his brain. He became addicted to Xanax and struggled to wean himself off.

If we want to decrease shame as an inherent part of mental health interventions, ending the use of stigmatizing, inaccurate, unscientific, and harmful "diagnoses" would be an excellent place to start.

The DSM Ignores the Impact of Shame

One of the most egregious failures of the disease model is that it completely ignores the evolutionary genesis of emotions. As a social species, humans relied on moral emotions to ensure acceptance. Shame and compassion are both strategies that arose through evolution because they helped support survival and reproduction through prosocial mental states and behaviors. Immoral acts, such as greed or violence, could have led to expulsion from social groups, possible harm or death, and reduced reproduction opportunities.

In another failure, the DSM ignores the role of the parents and family environment as causes of developmental trauma, relational trauma, or attachment distress. And yet most DSM diagnoses are descriptions of those who, because of adverse life experiences, are hyper-vigilant to being interpersonally harmed — abused, shamed, victimized, or rejected. Many have learned to cope by adopting unhealthy shame management strategies and behav-

iors. Nearly all DSM diagnoses could be more concisely rendered under a case formulation model that categorizes most mental health diagnoses as “shame disorders” or poor shame tolerance.

Shame is so powerful because it triggers a survival-related dread of social exclusion. In essence, shame is the opposite of love, because disconnection is the opposite of the primal need for belonging. It is no surprise that shame is the foundational emotion that fosters so much dysfunctional human behavior—it drives us away from love. What is often missed is this important fact: Poorly tolerated shame also drives us away from loving ourselves, which is why it provokes levels of distress that become labeled as mental illness.

It is common sense that a person experiencing self-criticism is constantly triggering their social threat system, which can lead to fear and rejection sensitivity. Shame leads to the fear of being discovered as flawed and unworthy and then rejected by others or by oneself.

Understanding the power of shame allows us to uncover the real motivation for most human behavior — finding love.

The DSM’s core construct is that normal human emotional responses are a sign we are broken and need fixing. In contrast, compassion-focused therapy provides a counter narrative: It normalizes our human need for love, connection, and worthiness and provides the tools to build inner resources toward self-acceptance.

The good news is that self-compassion is a skill we can learn to develop. We are not born to live chronically with fear, anxiety, and insecurity. By uncovering inherent self-attachment, one can have improved relationships with others and with the self.

A New Paradigm of Case Formulation

In stark contrast to many harms of the DSM and ICD, a shame-focused model is based on several well-accepted and well-researched psychological concepts, which, when considered together, provide a powerful new paradigm to understand and promote long-term change in behavior. It provides a multi-component, ecosocial approach to emotional and behavioral struggles rather than merely a disease-based approach.

The field of psychology has shifted over the last 100 years from a focus on psychoanalytic to behavioral to cognitive understandings of human actions. Most researchers and clinicians have now begun to privilege an emotional framework for understanding human behavior. The shame-focused model is in line with this movement and bases its case formulation, theoretical constructs, assessments, and interventions on current understanding of the power of emotions to drive human thinking and action.

Mental health professionals owe it to their clients to be open-minded about ways to reconsider the DSM and disease model that provide benefits and reduce harms.

Chapter 2: Benefits of a Shame-focused Model

A shame-focused model brings numerous benefits to clients and to behavioral health clinicians. It provides one simple, coherent, integrated conceptual framework to describe, understand, and manage emotional and behavioral states of all types. 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.

Shame-focused concepts are easier to remember for clinicians, simplifying assessment, case formulation, and interventions. In contrast, the DSM is complex and confusing; it provides no meaningful way to conceptualize human emotions and behaviors other than as lists of symptoms. Why should we have hundreds of labels for behaviors when we can identify them much more concisely and parsimoniously?

One of the many problems with the DSM is that the symptom-based criteria for "disorders" leads to an over-focus on minutiae, rather than identifying underlying causative social experiences, contexts, beliefs, and emotions.

For example, a teenaged client may mention that she worries a lot about what others think or sometimes wonders if she will ever be popular. But because these statements are not on the DSM list of symptoms, a clinician may completely ignore these very telling signs of low self-worth, social comparison, and attachment distress. The clinician may ask questions about symptoms only or spend time conducting assessment tests to determine the level of anxiety or depression. Yet the client gave very clear indicators of shame and self-blame, which are the major underlying cause of the DSM symptoms of anxiety or depression.

Unlike the DSM, which merely lists symptoms, a shame-focused model describes causes of behavior based on scientific findings from a wide range of fields, such as social psychology, evolutionary psychology, neuroscience, child development, mindfulness, compassion-based therapies, and even primatology.

The shame-focused model leads logically and coherently from assessment and case conceptualization through treatment planning and intervention. Because compassion is the antidote to shame, compassion-focused therapy provides evidence-based interventions based on actual causes of emotional distress, not false assumptions about biochemical imbalances. Interventions are not temporary solutions or harmful, as are psychoactive medications, but can lead to permanent changes in emotional health.

A long-standing complaint about the DSM is that it fails to describe a healthy, emotionally functional person. A shame-focused model inherently describes this state as a person with self-acceptance who can tolerate shame with equanimity, accountability, and emotional non-reactivity.

Shame-focused concepts explain human behaviors as normal, natural responses to perceived threats and fears. This more optimistic and accepting framework strips away harmful, judgmental labels and de-stigmatizes mental illness in a profound and fundamental way. This alone can be curative, as I have witnessed repeatedly when clients are educated on these facts. Their relief at having hope in changing their emotional and cognitive reactions is remarkable. One young woman had been diagnosed with bi-polar disorder in her middle school years and had been on medications for over a decade. When told she was not permanently disabled and disordered and that medications were not curing her bi-polar, she cried in relief and within a week had started weaning off her medications. Unsurprisingly, her "bi-polar" symptoms never returned.

The DSM completely fails to acknowledge the importance of human bonding, social affiliation needs, and the value of emotional attunement and empathy in relationships, giving it an insurmountable deficit that limits its usefulness at explaining human behavior. By ignoring the effect of relationships, both in childhood and adulthood, the DSM continues to do a major disservice to the public's mental health. In contrast, a shame-focused model addresses interpersonal factors, not just intra-psychic factors.

For clinicians, a framework that removes the labels of "disordered" and "diseased" would encourage an attitude of acceptance, empathy, and hope. Clients can often intuitively sense when a clinician is judging them as disordered, which reduces the alliance between client and clinician. Numerous studies show that a safe, trusting bond between client and clinician is key to success in psychotherapy.

By clearly stating that clients have control of their emotions and behaviors, the shame-focused model promotes accountability. It removes the crutch of blaming a purported biological cause, leaving clients fully responsible for changing their unhealthy behavior patterns.

Shame-focused intervention protocols of self-acceptance and mindfulness have extremely minimal risk of harm and are cost-effective. Change through self-acceptance can bring permanent, lifelong change in character, personality, and emotional and social functioning.

For children and families, a shame-focused model for child behavioral problems offers additional benefits:

1. It places the family system and parenting at the center of the solution, rather than stigmatizing the child as the identified patient and problem.
2. It emphasizes parenting education to decrease shame-based parenting tactics and improve attachment-based behaviors.
3. It de-stigmatizes, eliminating the "lifetime disease" label of current DSM/ICD diagnoses and offers hope for change.
4. It does not prioritize use of medications that harm a child's brain functioning and health.
5. It builds secure family attachment patterns by working with the parents and child in an integrated fashion.
6. It helps parents learn new skills at healthy shame management that help them individually and improve their parenting.

The following is a comment I received on my website that offers not only an evocative personal story of the impact of shame on a child, but also thoughts on the stigmatizing impact of DSM disorders.

Reading through this website has been very enlightening and helped me understand myself much more clearly.

I wish this school of thought was more widespread, as I think it's an approach to "disorders" that is closer to the truth than popular approaches of labeling people and medicating them.

Years ago I read a blog from a psychiatrist who labeled those suffering from deep internal conflict as "disturbed." I took offense to this because it lacked compassion and was stigmatizing to those suffering from mental illness when they are stigmatized enough as it is. I suffered from severe depression at the time and would never want to be labeled as "disturbed." It felt like adding insult to injury.

As a child I was very angry, oppositional, and full of rage, beginning as a toddler. This would lead to a vicious cycle of my oppositional behavior being met with more discipline and labeling, which only made me more oppositional.

I was labeled as disobedient by my elders, and I internalized this label by concluding it meant I was a bad child, the proof being my misbehavior, and worsened my already non-existent self-esteem.

What I couldn't communicate or verbalize at the time to the adults around me was that any perceived criticism I received made me feel deeply ashamed instead of guilty. Guilt encourages a change in behavior, but shame encourages withdrawal and defensiveness. If I did something bad, I can fix that, but if I am bad, how can I fix that? Instead I would become angry and defensive.

Deep inside, I believed I was a bad child, so I could not change my behavior, because to change it meant I had to acknowledge my badness.

At school, I was abused, bullied, and ostracized by the entire class, which is why I initially developed low self-esteem. That coincided with me becoming oppositional. Any time I was directed to do something by an adult, I felt like I was being "controlled" and didn't like that, so I wouldn't listen. This led to me being criticized and verbally disciplined by the adult, which would make me deeply ashamed to my core. At school I was already hated by everyone, and now on top of that I was a "rude, disobedient, disrespectful" child. This made me feel I was worthless.

After experiencing a rush of such deep shame and worthlessness, I would react and lash out with rage.

After I calmed down, I would look back on how I behaved (screaming, crying, destroying things) with intense shame. My behavior proved to me I was a bad child as previously said, and I would feel even worse about myself. My self-esteem would diminish and plummet more and more.

The more awful I felt, the more I tried to escape my pain through other things: fictional books, fairytales, TV, anything that would make me forget how much I felt hated by my peers and inferior as a person. Of course I didn't realize at the time I was doing this; and if you had questioned me as a child why I read so much, I would've simply said "it makes me feel happier." On the surface this may seem innocuous, but it was a a great display of unhealthy behavior that went undetected, because the adults around me thought I simply liked to read. In reality I was running away from myself and that was why I was constantly reading, so I could get absorbed into the world and lives of the characters and forget myself and my negative feelings towards myself. I hated myself and didn't even know it.

This habit of escapism developed more sinisterly as I became older, translating into addiction during my teenage years. Ironically, my addiction which I turned to in order to relieve my emotional distress only lowered my opinion of myself further, and I would turn to it more to escape those feelings.

Reading this website has brought me a lot of clarity. I used to joke that I "came out of the womb angry"; I have always been angry as far as I could remember. Until I found this website a part of me carried a bit of shame thinking I was just "born broken" but now it's obvious this is not true.

I appreciate your contribution to the field of mental health.

Chapter 3: Shame: The Terrorist of Emotions

I say that shame is the terrorist of emotions: We fear it so much that we over-react to the actual level of threat.

In terms of real-world terrorism, consider that we had one unsuccessful shoe bomber on a plane, yet 20 years later millions of us every year still have to take off our shoes at airport screenings. In the same way, one humiliating experience in second grade and an adult may still be thinking about that event or be unconsciously influenced by it decades later. That is a powerful emotion! We fear the judgment of others so much that a minor experience of embarrassment or inadequacy may haunt us for years.

This should not be surprising given that humans, as a social species, have evolved to prioritize acceptance, love, and mutual support. We could categorize shame as the opposite of love, because it provokes feelings of inferiority, disconnection and abandonment that are contrary to the primal need for connection and inclusion.

Shame is the foundational emotion that fosters unhealthy human behavior because it creates the feeling of being unworthy of love, leading to a survival-related dread of social exclusion.

"[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)."[26]

Over time and without help in regulating shame, some children can develop unhealthy habits when they experience this family of emotions. As we'll learn later some move very quickly away from the primary emotion of shame into externalized blame of others. Many others engage in excessive internalized guilt and self-blame. These habits become engrained into a belief system about the self as unworthy or others as "less than."

In this deep-dive chapter on shame and other prosocial emotions, we'll look at the neurobiology of shame, differences between guilt and shame, common behaviors that arise from shame intolerance, and why shame is a transdiagnostic emotion.

The Neurobiology of Shame

The reason that many people overreact to shame is actually rooted in human neurobiology, a fact ignored by the medical model. It is interesting that the range of typical emotional and behavioral effects of shame map onto the various vagal system responses. The vagus nerve extends from the brainstem into the 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. It is important to recognize that this system does not distinguish whether the threat is physical, social, or emotional.

The three systems of the vagus nerve are:

1) Dorsal Vagal complex: The parasympathetic nervous system includes our most primitive brain structures and immobilizes the body into a "freeze" response when threat is sensed and there is no escape. In this state, humans experience feelings of hopelessness, withdrawal, shutdown, and apathy which may be labeled as "depression."

3) Sympathetic nervous system: The next to evolve, the sympathetic nervous system mobilizes the body to take action, often shorthanded as "fight-or-flight."

3) Ventral Vagal complex: Our social engagement system was the last to develop in the evolutionary process and is affiliated with mammalian behaviors. It promotes social engagement when we feel emotionally and physically safe and allows us to access openness in relationships, positive expectations, and trust. If we don't feel safe, we move "down" the ladder of the nervous system toward sympathetic or dorsal vagal responses.

The key concept is that shame can generate a primal fear of being discovered as flawed and unworthy, and possibly rejected by peers or family, which may trigger the sympathetic threat response of the vagal system. Fear of

26 Farr, J., Ononaiye, M, Irons, C. (2021). Early shaming experiences and psychological distress The role of experiential avoidance and self-compassion. Psychology and Psychotherapy Theory, Research and Practice, 94:4, 952-972. https://doi.org/10.1111/papt.12353

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.[27]

The perception of threat occurs when we experience misattunement from others or when we have violated social rules. We fear the loss of social and emotional connection and co-regulation opportunities of relationships.

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 defensive anger and stubbornness ("fight"). The dorsal vagal response leads to immobilization or "freeze," with cognitive or physical paralysis, hopelessness, and emotional dissociation. Other shame-related responses can include downcast eyes, blushing, and submissive behaviors ("fold" or "fawn").[28]

The left hemisphere of the brain concludes: "I'm not good enough to be loved" or "What is wrong with me?" The prefrontal cortex goes off line, the amygdala (a primitive threat assessment area of the brain) goes into overdrive leading to cognitive distortions, especially of shame. What we could call rejection sensitivity or insecure attachment behaviors can be provoked by cognitions, making the self a source of threat to the self.

It is important for clinicians and patients to understand that this means that self-shaming thoughts are experienced by the brain and body as threats. A child thinking "I'm not good enough" is triggering their body's fight-or-flight response system, resulting in standard fear-based reactions such as hyper vigilance, hyper reactivity, distractibility, sensory sensitivity, emotional dysregulation, impulsivity, reduced executive functioning, reduced rationality, and excessive anger.

It is important to educate adult and adolescent clients on this topic so they understand the physiological power of shame, fear of social rejection, and self-criticism. For older teens I say: "Your nervous system reacts the same way, whether it is a loud clunk in the middle of the night or when your boyfriend doesn't text you back fast enough or when your mom is mad at you for not cleaning your room. Your brain also gets very upset when *you* say negative things about *you*. The feeling of rejection and unworthiness triggers the fight-or-flight response no different than a physical danger. This means it isn't just a good idea to stop bullying yourself — it's biology!"

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, inattention, 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 supposed shortfalls in serotonin or other brain chemicals.

The good news is that research has found that self-compassion decouples shame and fear. By training clients how to activate the ventral vagal complex it provides the way out of both fear and shame responses of immobilization and mobilization.

Differences Between Shame and Guilt

Many authors have drawn distinctions between guilt and shame. These contrasts may be helpful to clinicians, but are largely irrelevant to children and parents. In fact, with children, I often start off using terms they usually employ that focus on the somatic experience of shame: "Did you have an *icky* feeling after you cheated on your spelling test?" Or "I'll bet you just wanted to crawl into a corner after you flubbed your baseball tryout."

But let's explore the differences between shame, guilt, and embarrassment because it can offer insight into important aspects of human neurobiology and emotional responding.

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27 Lewis M, & Ramsay D. (2002). Cortisol response to embarrassment and shame. Child Development, 73(4), 1034-45. doi: 10.1111/1467-8624.00455. PMID: 12146731

28 Rosenberg, S. (2017). Accessing the Healing Power of the Vagus Nerve. Berkeley, CA: North Atlantic Books.

Shame is a pervasive feeling of innate humiliation, inadequacy, or defectiveness, according to Kaufman.[29] Harder & Lewis write that shame is a debilitating emotion in which the self is viewed as incompetent and as an object of ridicule, contempt, and/or disgust.[30]

Feelings of shame are thought to develop in response to self-denigrating thoughts and beliefs that undermine one's sense of efficacy and self-acceptance.

Shame triggers physical experiences of a sinking feeling, tightness in the gut, nausea, hollowness in the head, feeling "punched in the gut," dissociating, a desire to hide, sweating, fidgeting, and blushing. Affiliated emotions include disappointment, sadness, fear, and anger. Mental states include confusion, inadequacy, unworthiness, inferiority, self-criticism, and powerlessness.

In contrast, guilt is often considered to occur after a specific behavior that is contrary to one's morality, as opposed to the global sense of inadequacy of shame.[31]

Guilt is outwardly focused and is about not wanting to hurt others and then, ideally, being prepared to make amends. In shame we label ourselves as bad, unattractive, or unwanted and are concerned about what others think about us. In guilt we reach out with our hearts and feel sorrow; in shame we withdraw and feel fear, disgust, or anger.

GUILT	SHAME
Focus is on behavior as harming others	Focus is on self as bad, unattractive, unwanted
The need is focused on protecting the welfare of others	The need is to protect the self
Evolved from care-giving system and avoiding doing harm to others; is related to competencies for altruism (Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. Sociology Research, 70, 1205-1230.)	Triggers social threat system (Gilbert, P. 1989. Human Nature and Suffering, Hove: Lawrence Erlbaum Associates.) Related to social threat to self (Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. Sociology Research, 70, 1205-1230.)
Non-competitive behavior	Related to competitive behavior and the need to prove oneself acceptable or desirable to others
Behaviors of reaching out, apology, reparation (Tangney, J.P. & Dearing. R.L. (2003). Shame and guilt. New York: Guilford.)	Behaviors of withdrawal and concealment due to fear, disgust, or anger.
Can make amends and feel regret. Improves chances of accountability and behavior change.	Decreases accountability and behavior change. Cannot make amends or feel regret due to overwhelming emotional dysregulation.
No anger toward others (Harder, D. W., & Lewis, S. J. (1986).	Can trigger anger at other or self
Not associated with submissive behavior, negative social comparisons, social anxiety, depression	Associated with submissive behavior or fear of social down-ranking, which can lead to dominant behaviors and social up-ranking
Is not associated with feeling inferior to others therefore a person can focus on others without threat-based responses.	Feelings of inferiority and overwhelming shame make a person self-focused and fear driven, decreasing social affiliative behaviors.
Goal: Avoid harming others. Accepting blame with accountability. (Healthy guilt and shame.)	Goal: Attack self or other as source of shame. Deflecting shame to others. Excessively shaming self in an attempt to fix inadequacies. Avoidance of shame. (Shame management strategies)

[29] Kaufman, G. (2004) The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes, 2nd Ed., Springer

[30] Harder, D. W., & Lewis, S. J. (1986). The assessment of shame and guilt. In J. N. Butcher & C.D. Spielberger (Eds.), Advances in personality assessment (pp. 89-114). Hillsdale, NJ: Lawrence Erlbaum.

[31] Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*(6), 1256–1269. https://doi.org/10.1037/0022-3514.70.6.1256

The chart briefly outlines some differences between guilt and shame. Notice the various concepts that relate to the ventral vagal system, social threat theory, social rank theory, and evolutionary psychology.

With this chart, it is clear that guilt could be considered shame decoupled from an experience of fear — or what I call healthy shame tolerance. I prefer to reserve the term guilt for healthy levels of shame and healthy responses to shaming experiences. With guilt, feelings of inadequacy can be processed and then managed with appropriate social behaviors.

"Unlike guilt, an emotion that sometimes motivates productive behavior… shame is generally viewed as a non-productive and often incapacitating emotion."[32] This is because high levels of unregulated shame seem to make healthy guilt and accountability less likely. Feelings of guilt and embarrassment are experiences that allow us to adjust our behavior and repair relationships through accountability, contrition, and reconciliation.

Kagan's work uses this model and he noted that within the context of the emotional development of the child, guilt appears developmentally later than shame and is related to the recognition that the violation of a personal standard could have been inhibited and its cause should be attributed to self rather than to others.[33]

Shame triggers the social threat system and provokes efforts at self-protection in the social rank system. With shame, we engage in unhealthy shame management strategies of blame shifting, avoidance, denial, deflecting or Self-blame. In healthy guilt reactions, we can face our mistakes with equanimity. The conundrum of guilt and shame is that these prosocial emotions are designed to improve social relationships, but instead, when used in extremes or poorly tolerated, can block human connection.

Embarrassment is often framed as a temporary feeling after being seen doing something inappropriate or foolish. It doesn't seem to carry the moral weight of guilt or the global experience of unworthiness of shame. What often happens, however, is that a simple embarrassing act is then made worse by an inner dialogue of Self-blaming, catastrophizing, and global judgments that often follows: "You tripped going up the auditorium steps in front of the whole school! What a complete moron you are. How will you ever make friends now? Who would want to be your friend when you are such a clumsy goof? Everyone will remember forever and you will never be popular for the rest of your life!"

As I'll discuss in Chapter 8, compassion-focused interventions directly engage the vagal system by improving the ability to be mindful of emotional states, to down-regulate the threat state and to up-regulate the soothing or ventral vagal responses. The goal of therapy is to move people from the right column to the left column, building their ability to engage their caregiving system, to decrease self-criticism and self-generated feelings of threat, and to feel healthy guilt and accountability.

Shame as a Trans-diagnostic Emotion

Despite being one of the most powerful of human emotions, shame is often ignored by clinicians. As we'll learn in the next section, shame strongly influences both intrapersonal emotional wellbeing and interpersonal or relational behavior.

Research indicates that shame is a major trans-diagnostic component in mood disorders, personality disorders, proneness to aggression, and behavioral problems. [34] [35] [36] [37] [38] When poorly tolerated, shame creates dysfunctional human responses and behaviors that are mistakenly labeled as "mental illnesses."

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[32] Deblinger, E., & Runyon, M.K. Understanding and Treating Feelings of Shame in Children who have Experienced Maltreatment. Child Maltreatment. 10:4, NOV. 2005., 364-376 doi: 10.1177/1077559505279306

33 Kagan J. (2001) Emotional development and psychiatry. *Biol Psychiatry.* 49:973–979.

34 Gilbert, P. (1997) The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. British Journal of Medical Psychology, 70:113-147.

35 Gilbert, P. & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In Gilbert, P., ed. Compassion: Conceptualisations, research and use in psychotherapy. London, UK: Routledge.

36 Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. Sociology Research, 70, 1205-1230.

37 Gilligan, J. (2003). Shame, guilt and violence. Sociology Research; 70, 1149-1180.

38 Tangney, J.P. & Dearing. R.L. (2003). Shame and guilt. New York: Guilford.

Throughout the history of psychology, it has been noted that low self-worth is a driver of emotional and behavioral problems. Alfred Adler called it "the inferiority feeling," and Carl Rogers believed that low self-esteem was a major contributor to emotional issues.

Psychiatrist R.D. Laing in his 1959 book *The Divided Self* described those with serious "mental illness" as suffering from a loss of connection to the social world and to parts of their identities.[39] This speaks directly to the experience of shame as socially isolating.

Peter Breggin notes about depression: "It is a mistake to view depressed feelings as a 'disease.' Instead, it is merely a kind of unhappiness that involves helpless self-blame and guilt, a belief of being undeserving of happiness, and a diminished interest in life."[40]

Shame has even been considered the cause of "hearing voices," or auditory hallucinations, often linked with a history of trauma and childhood sexual abuse.[41] Given that shame involves fear of social exclusion, it makes sense that an "other" would be expressing messages of judgment in the minds of those with high levels of Self-blaming.

The topic of shame is essential to understand as it relates to self-acceptance. Consider that the normal social behaviors associated with shame are abject slinking away, lowering the eyes, and submissive postures. When embarrassed a person tends to remove themself from contact with others. Many of the diagnoses in the DSM are actually descriptions of a person who is hyper-vigilant to being shamed, victimized, or rejected by others.

Even worse, when one's thoughts are the source of shame, it is impossible to escape. This creates an untenable situation and a chronic sense of self-shaming and fear that are labeled as depression, anxiety, and other mood disorders.

It is clear that shameful feelings and cognitions of low self-worth are major drivers of human behavior. Why is this fact completely ignored in the DSM? Why should the emotion of shame be considered a "mental disorder?"If shame and the threat response are so clearly linked in physiology, why does the DSM not address the emotion of shame as a cause of diagnoses such as generalized anxiety disorder and depression?

Shame's Impact on Behaviors: Shame Management Strategies

An adult client once observed,
"Shame makes me small and quiet or loud and aggressive.
Neither of these help me or my relationships."

The family of self-conscious, prosocial emotions (shame, guilt, remorse, and embarrassment) present a psychological conundrum. They are designed by evolution to strengthen social relationships by triggering feelings of moral failure that drive us to correct antisocial behaviors such as selfishness, cheating, and lying. In a psychologically mature person this encourages reputation management behaviors, such as healthy guilt, regret, accountability, and contrition. When a person is able to experience healthy guilt, they can stay regulated, make wise and moral choices, and then bring themself back in right relationship with others. These social affiliative motives are survival related and help shape human social and moral behavior by encouraging compliance, generosity, social cooperation, and mutual protection.

However, when shame is poorly tolerated it can block human connection and lead to fear-based emotional overreactions that create conflict, self-destructive behaviors or thoughts, and harm to relationships. Overwhelming shame leads to predictable behavioral responses. In people of all ages, shame can lead to hiding/avoidance ("flight"), paralysis ("freeze"), shutdown/submissiveness/Self-blaming ("fold"), or anger/stubbornness (fight").

These unhealthy shame management strategies are adaptive for individual emotional needs, but are maladaptive for relationships, families, and society. A person with shame sensitivity will work hard to protect their self-identity with avoidance or withdrawal strategies, or by blaming others and deflecting shame. Even self-blaming tactics

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[39] Laing, R.D. (1959) *The Divided Self*. Tavistock Publications

[40] Breggin, P. R. (2001) *The Anti-Depressant Fact Book*. Cambridge, MA; Da Capo Press, p.14

[41] Woods, A. On shame and voice-hearing. *Medical Humanities*. Published Online First: 07 April 2017. doi: 10.1136/medhum-2016-011167 Retrieved from http://mh.bmj.com/content/early/2017/04/07/medhum-2016-011167

aim to castigate the self in an attempt to avoid failure, seek perfection and meet external and internal expectations.

Unfortunately, very few people in today's society have learned healthy shame tolerance. The epidemic of selfish, narcissistic behaviors at all levels of American society at present is proof.

As a result, many children and adults develop one or more unhealthy choices in responding to overwhelming and untenable shame. The vast majority of people who have been adversely affected by the Five Causative Factors respond to feelings of shame with three predictable and easily identified behavioral responses:

1) **Blame others to externalize shame and anger (Other-blaming)**

2) **Blame self to internalize shame and anger (Self-blaming)**

3) **Avoid blame and shame (Blame Avoiding)**

The key to assessing for these shame management strategies is the answer to this question: How does the person handle criticism, failure, or inadequacy? When held accountable for a behavior, what does the person do? Do they blame others, blame themself, or preemptively try to avoid blame.

All three behaviors have low self-worth as a root cause. The behaviors occur on a continuum from minimal to high levels.

In contrast, healthy guilt or shame tolerance helps a person manage feelings of inadequacy in appropriate ways. Those who achieve self-acceptance have an ability to hear and tolerate messages of shame from others and from themselves. They have low levels of self-shaming, accurate perceptions of the critical messages from others, and appropriate emotional and behavioral reactions to feelings of failure or inadequacy. This improves the relationship with others and with oneself, and reduces anxiety and other symptoms commonly labeled as "mental disorders."

Shame as a Primary Emotion

Shame is often well-hidden, especially in children, causing confusion for parents and clinicians. One helpful construct is to recognize that emotions can be divided into two groups:

1. Primary emotions are deeper emotions that are often unexpressed, unconscious, or ignored. Shame, as you might guess, is the big one here. Others are grief, sadness, rejection, and loneliness.
2. Secondary emotions are surface emotions that are expressed more readily or apparently. In interpersonal conflict these often include anger and withdrawing/avoidance, as well as self-directed anger and recrimination.

Other-blaming is fairly easy to identify in children and adults because of its overt behaviors of oppositional arguing and defiance, non-compliance, lying, bullying, excuses and rationalizations, inability to apologize, lack of self-discipline, and irresponsibility. Watch for verbal blame shifting that deflects accountability and helps the person gain a feeling of empowerment via anger toward others.

Self-blame and avoidance traits often go unrecognized in younger children, but are more noticeable in pre-teens and teens when depressive symptoms can present.

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)."[42]

Most parents and clinicians observe only the child's secondary emotion or behavior, such as hyperactivity, defiance, avoidance, or self-harm. They may try behavioral interventions and medications, both of which give 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."

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[42] Farr, J., Ononaiye, M, Irons, C. (2021). Early shaming experiences and psychological distress The role of experiential avoidance and self-compassion. *Psychology and Psychotherapy Theory, Research and Practice*, 94:4, 952-972. https://doi.org/10.1111/papt.12353. p. 955

Children often have not yet settled on a preferred strategy, but may alternate, sometimes quickly, from one strategy to another. They may be screaming in anger one minute, then hide in the closet, and then sob out an apology. Clinicians must not be distracted by the secondary behaviors, but should hold an awareness of the trans-diagnostic emotion of shame. Investigate with the family what started the child's behavioral cascade. Most likely it was an experience of being criticized, of failing or losing, or feeling rejected.

If children don't develop healthy shame tolerance skills, when they reach adulthood they generally settle on one of the shame management strategies of Self-blaming, Other-blaming or Blame Avoidance. Temperament, personality, parent/child relationships, attachment and trauma history, and environment all combine to make a person favor one style or the other.

Using evolutionary psychology concepts, we can conceptualize the shame management strategies in several ways. All humans engage in traits and various behaviors that fall on the antisocial to prosocial spectrum. We may be selfish and self-absorbed one minute, then generous and empathic another. Other-blaming traits are more antisocial in nature and can be viewed as an evolutionary adaptation. This theory considers antisocial behaviors as a social strategy that benefits the individual instead of the group. In contrast, Self-blamers tend to favor caring, self-sacrifice, and community-focused behaviors as an adaptive strategy. Relied on to an extreme, however, these traits can become harmful patterns of enabling, dependency, passivity, and tolerance of abuse. Ideally, healthy individuals balance and moderate these traits.

The shame management strategies also correspond with the social ranking theory which states that humans attempt to find their place in a group hierarchy by up-ranking or down-ranking themselves to achieve social goals or acquire resources. (See Chapter 4, Factor 3.) Gilbert (1999) found that those who see themselves as relatively lower in rank tend to blame themselves for criticism, while those who feel relatively superior tend to blame others.[43]

Admittedly, there are other motivators and predictors of human behavior. But shame management strategies identify many of the the dysfunctional behaviors that cause difficulties in human relationships with self and other. These behaviors also lead directly to symptoms that the DSM then labels as disorders.

Rather than consider the shame management strategies as pejorative labels for personality or traits, they should be considered from a compassionate framework: These behaviors are learned, self-protective, adaptive traits that arose out of a person's exposure to the Five Causative Factors (Chapter 4), especially trauma and insecure attachment patterns. These strategies may also have worked well in childhood by allowing a child to titrate exposure to levels of shame they could tolerate at the time. However, these strategies cause difficulty in adult functioning and relationships by leading an individual to be too selfish and self-focused (Other-blaming), withdrawn and emotionally unavailable (Blame Avoidance), or too tolerant of boundary violations or abuse in relationships (Self-blaming).

Although research is needed, it seems likely that higher exposure to the five factors would increase both the likelihood and intensity of these unhealthy coping skills. In clinical practice, I have found that patients with the most negative life experiences are usually the ones with the highest use of the tactics and the least self-acceptance.

These strategies are not based on any biomedical genesis, but are merely learned behaviors caused by the Five Causative Factors. As such, unlike the disease model, they should not be considered intransigent "disorders" that cannot be unlearned or that need medication to "treat."

Shame and the Relationship with the Self

It is important to reiterate that poor shame tolerance not only impacts interpersonal relationships, but also the intrapersonal experience of self. Clinically, the relationship with the self is an essential consideration.

A major developmental task of childhood is creation of a self-identity that is realistic and resilient, so that a person can have confidence, self-worth and feelings of adequacy and competence. Healthy self-identity promotes healthy social and and emotional development because the person feels worthy, acceptable and lovable in the eyes of others. Repeated shaming experiences prime a child to internalize shame and to fear social rejection. Ex-

[43] Gilbert, P., and Miles, J.N.V. (1999) Sensitivity to Social Put-Down: it's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. Personality and Individual Differences 29 (2000) 767-774

cessive internalized shame damages intrinsic self-identity and self-worth and can lead to a person with extremes of either shamelessness or shamefulness.

Recall that when embarrassed we tend to remove ourselves from contact with others. The typical social behaviors associated with shame are abject slinking away, downcast eyes, and submissive postures. However, when the source of shame is the self it is impossible to escape. The self is attacker and attacked; there is no safe haven. Feeling "never good enough" creates chronic fear and defeat. Because perfection can never be attained (according to the belief schema), a person can experience a pervasive sense of self-rejection and self-betrayal.

Inadequacy can cause an ongoing inner dialogue of self-criticism and even global self-loathing. If you loathe yourself, it leads to an experience of fear or threat, making it feel unsafe merely to be in a relationship with yourself. Many people beat themselves up mentally so often that incoming criticism from others is a very uncomfortable experience. However, many clients say they don't fear the criticism of others so much as they fear their own self-denigration. That is more painful because it is experienced perhaps thousands of times a day in negative self-talk. If one is not self-accepting, the world looks frightening, relationships look frightening, and even one's intrinsic self looks unknowable, unworthy, and perhaps even frightening.

Lack of relationship with yourself is the ultimate loneliness — an especially difficult experience for a child who looks out at the world as big, unknowable, and frightening.

In overwhelming shame, one is in an ongoing state of threat and anxiety, yet unable to access the soothing system to help down-regulate thoughts and emotions. This is why the intervention of self-compassion is so important. It allows a repair of the relationship with the self through repeated practices of kindness and acceptance of imperfection.

In low levels that can be tolerated, guilt and Self-blaming could be considered self-protective and adaptive in that they aim to improve social relationships and gain acceptance. Many people express hope that if they correct some aspect of themselves or their behavior, they will be more lovable. I believe that at a deeper level, Self-blaming is a way to figure out how to love yourself.

What the DSM labels as depression, anxiety, and other mood disorders are directly related to the experience of self-shaming. The core experience of self-hatred that underlies the shame management strategies is what must be addressed clinically, then the behaviors will decrease.

The following chart summarizes the differences between unhealthy shame management strategies and healthy guilt responses. Note that shame leads to a fearful response, triggering emotional reactivity and unhealthy shame management strategies of Other-blaming, Self-blaming and Blame Avoiding. Healthy guilt, in contrast, does not trigger fears of social exclusion, permitting healthy responses of remorse and accountability.

Pro-social emotions = guilt, shame, embarrassment, regret, remorse

Evolutionary Goal = Maintain relationships by correcting immoral behavior

UNHEALTHY SHAME PROCESS

Triggering Incident or Thought
- criticism from self or other
- embarrassing incident
- real or perceived failure or mistake
- real or perceived exclusion, rejection, or slight

Feelings
- Shame >>> Fear (of further rejection, exclusion, or feelings of unworthiness)

Thoughts are irrational
- I made a terrible mistake. (catastrophizing)
- I'm unlovable, unworthy, toxic, bad.
- They were completely right and I'm completely at fault.
- I'll never be able to fix it. (hopelessness)
- No one else makes mistakes. (feeling different or excluded)
- I'm a burden and deserve to be alone.
- I'll work extra hard to avoid criticism.
- That person [who criticized me] is a stupid jerk.
- Fine… I'll never darken your doorway again.
- Fine… see if I work hard again.
- I give up.
- Everyone is a harsh critic… including me!

Behaviors (Goal: Mostly Ego Protection)
1. Blame others: blame-shift, deny, deflect, defend, contempt, anger, violence, retribution
2. Blame self: inner critic, perfectionism, unworthiness, rejection sensitivity
    1. Fawning: Submission, avoid conflict, lack of assertiveness (Goal: keep connection no matter what,)
3. Avoid: avoid responsibility, disconnect from relationships/life, addictions, numb emotions, denial/minimization, avoid situation/person
4. Withdraw (two types)
    1. Retreat to manipulate (Other-blame): passive-aggressive sullenness, pouting, resentment, withdrawal of affection
    2. Retreat in shame (Self-blame): isolation, mistrust, misreading of intentions, hopelessness, emotional shutdown, freeze/fold response, depression
5. Mix of above responses

HEALTHY GUILT PROCESS

Triggering Incident or Thought
- criticism from self or other
- *real* failure or mistake
- embarrassing incident
- *real* exclusion, rejection or slight
- Healthy guilt allows less likelihood of *perceived* failure or rejection.

Feelings
- Guilt
- NO FEAR or MINIMAL FEAR, which allows more rational assessment of the situation

Thoughts are reality-based and rational
- I made an actual mistake.
- Someone unintentionally ignored me/excluded me/made a mistake.
- We all have accidents and embarrassments.
- It's just feedback, I'll learn from it and do better next time.
- I am still worthy because all humans make mistakes. (Common humanity/feeling the same as others)
- Others will be understanding and still love me.

Behaviors
Goals: 1) Change behavior 2) Compassion 3) Repair of relationships with self and others
Hold SELF Accountable > Apology > Behavior Change > Re-engagement
- Discernment, wisdom, accurate assessment of blame, pause to reflect and assess
- Self-awareness, learn from mistakes
- Vulnerability, honesty
- Compassion for self and others
- Humility and healthy pride
- May withdraw in self-protection from Other-blamers and set boundaries if relationship cannot be repaired = healthy blaming of person who did the harm and appropriate accountability

The Shame Management Strategies In Depth

In the following in-depth explanation of each of the three shame management strategies, consider that an individual may use all three broad strategies at different times in their life. As noted previously, children generally have not consolidated into one preferred strategy, while adults often have one predominating behavior pattern. The specific behaviors listed below do not occur in all individuals with these tendencies. For example, not all Other-blamers are aggressive or violent or not all Self-blamers are perfectionistic or depressed.

The behaviors occur on a continuum from minimal to extreme levels of frequency and intensity. Some individuals, such as Donald J. Trump, are extreme Other-blamers who show nearly all the character traits listed in extremes. Some Self-blamers are severely depressed and suicidal; other Self-blamers function very well and seem quite confident. Children will, of course, have more extreme behaviors in some areas due to their normative lack of ability to regulate emotions, behaviors and cognitions. Young children may not exhibit some traits, such as lawlessness and criminality, while adolescents may engage in these behaviors. Clinicians should not get over-focused on identifying the specific behaviors, but should bear in mind the underlying concept of shame intolerance. Look for broad patterns of behavior within each of these categories.

Be aware, too, that many people have different blaming behaviors with family or primary partners than in their school or social relationships. For example, they may be highly Other-blaming toward a family member, but quite tolerant of criticism from teachers or friends. Some children exhibit compliant behaviors at school, but are very defiant at home.

1. Other-blaming

As with all shame management strategies, Other-blaming responses arise in childhood as an attempt to manage the experience of shame in ways that are self-protective and adaptive. The key behavioral signs are hyper-vigilance to and over-reactivity to criticism and an inability to admit fault, apologize or be accountable. Other-blamers tend to argue or attack to keep any taint of blame from landing close. While these strategies provide comfort to the individual, they are counterproductive in relationships. Other-blaming is often at the root of relationship problems because of the reluctance to admit fault. Ironically, Other-blamers are so busy managing shame in counterproductive ways that they act in shameful ways, such as insisting they are right at all costs. Their fear of shame makes it difficult for them to recognize that they are behaving in very unlovable ways.

Other-blaming is at its core a lie on several fronts. It is a self-deception with the goal of avoiding feelings of shame. To inappropriately blame others for problems is a lie told directly to others and indirectly to oneself. How can a relationship withstand a constant barrage of lies, excuses, denials, and attacks?

In relationships, Other-blamers try to control, manipulate, or intimidate. They prefer relationships with people who will be submissive and will not challenge them, correct them, or blame them.

Corresponding with the saying “narcissists are made not born,” we know that Other-blamers are created by:

- shame-based parenting
- permissive parenting that did not hold the child accountable
- a combination of permissive and shame-based parenting styles in one or more caregivers
- parents who modeled Other-blaming behaviors
- lack of secure attachment
- or other developmental trauma that fostered feelings of unworthiness and a craving for approval.

Other-blamers may at times lack compassion or empathy. They may easily express direct criticism of others and impatience with inferiority, yet cannot tolerate feedback. They lack compassion for others because they lack tolerance for their own failures and inferiority. They judge others just as they judge themselves.

Other-blamers have a consistent pattern in arguments that is easy to assess clinically. Both adults and children may engage in an attacking and blame-shifting style of arguing that I label “zig-zag” arguing. The argument starts with problem A, but because the Other-blamer cannot simply admit fault for problem A, he distracts by changing the topic to B and often accusing someone else of a fault. The partner follows this bait, explains and de-

fends her behavior. When the Other-blamer realizes he has been proven wrong, he changes the subject again and they are off to topic C and on and on. All this is done in service of the Other-blamer's lack of accountability for his behaviors. The argument could have ceased after the first accusation if he had merely accepted blame graciously.

Adult Other-blamers have many tendencies that would be labeled "Narcissistic Personality Disorder." I dislike the use of this terminology not just because of the DSM's disease model and its arbitrary and inaccurate grouping of these behaviors. The word "narcissist" also incorrectly focuses on vanity as a defining characteristic. Not all Other-blamers are overly focused on their looks or other measures of social approval, per the Greek myth of Narcissus. Use of this name distracts from the core concept that poor shame tolerance is the real cause of Other-blaming and that a lack of moral character and accountability are the key behavioral problems.

Some researchers and writers have drawn distinctions between covert and overt narcissists, however I believe that these distinctions are confusing to the general public. The core behavior, an intolerance of shame, is the same cause in all of these variations of behavior. Blame-shifting behaviors and lack of accountability should be the main focus of assessment, especially as this provides guidance on how to proceed with interventions.

Many studies note that narcissists often report high levels of self-esteem. However, these studies are based on self-reported levels, which may indicate an inaccurate self-assessment, not true self-acceptance. Other-blamers are very unlikely to admit in a study questionnaire that they might have self-doubt or low self-worth. It would go against their desire to protect themselves from shaming experiences. In actuality, those with high self-reported self-esteem may have limited self-acceptance.

Other-blaming involves various levels of aggression and lack of empathy, from minor verbal abuse to outright violence. While empathy is an inborn prosocial trait, childhood experiences may teach a person to transmit emotional or physical pain to another rather than accept any feelings of shame.

While they can have a very high-conflict personal style, Other-blamers actually behave this way to avoid confrontation. Other-blamers do not like conflict because they dislike being challenged and told they are wrong. Conflict may bring shameful criticisms from another. They have three main ploys to deflect accountability: play the victim ("Everyone always picks on me!"), shut down and engage in "cold shoulder" tactics, or become overly confrontational to get others to back down.

Most Other-blamers exhibit minor behavioral problems but are rarely dangerous; however they are the personality type most likely to exhibit extreme behavioral problems — engaging in, abuse or even horrific crimes. Other-blamers occur in high numbers in the criminal justice system and in those engaging in greed and corruption in business and government. It is telling that what precipitates most mass shooting rampages is an incident where the gunman felt shamed. They may have been rejected by their wife when she finally filed for divorce, been fired, or flunked out of graduate school, as James Holmes, the Aurora, Colorado, movie theater mass killer did. Rather than handle shame in a healthy manner, these Other-blamers became angry and lashed out at others in violent retribution. They felt compelled to make someone else pay for their sense of inadequacy and failure.

I contend that the increasing number of mass shootings can be traced, certainly, to the availability of millions of guns in America, but also to poor shame tolerance and poor emotional intelligence caused by poor parenting techniques involving poor modeling of emotional intelligence, excessive shaming and excessive permissiveness.

In addition, the "self-esteem" movement and related permissive styles of parenting and educating meant that children were less often held accountable for their behaviors. Children who do not regularly practice being responsible, admitting faults, and experiencing failure, become adults who get upset or even enraged when they have those experiences.

The DSM makes no mention of these very obvious patterns of Other-blamer behavior and has no conceptual framework for explaining them. Yet to be able to predict these types of behaviors would be an invaluable benefit to a diagnostic or assessment system.

Specifics of Other-blamer Behavior

Children naturally are quite self-centered and it is healthy for them to go through narcissistic phases of development. However, extremes of the following shame-defensive behavior without balanced and age-appropriate episodes of healthy guilt should be a clinical concern.

Other-blamers exhibit a range of behaviors centered on defending against the experience of shame, that include lashing out at others to forestall, deny, defend against, or attack against criticism.

Blame-Shifting and Lack of Accountability

- difficulty accepting accountability, blame, or responsibility
- has difficulty admitting fault, apologizing, or being wrong
- low morals and ethics, poor character, shameless
- makes excuses
- directly or indirectly blame-shifts through accusations or projecting faults onto others
- violates laws and social norms
- lies excessively
- untrustworthy
- lacks self-awareness or self-reflection
- is opinionated, stubborn, and reluctant to change opinions
- has low prosocial skills, such as empathy, compassion, tolerance, generosity, etc.
- lacks a sense of remorse
- is vain, arrogant, haughty, and entitled
- is self-centered and self-absorbed
- feels superior and special, is highly competitive
- lacks gratitude
- greedy and selfish
- is irresponsible or lazy, under-functions, unwilling to work or do chores, is financially irresponsible
- plays the "victim" as a way to elicit pity, deflect the blame, and avoid accountability
- dramatic , exhibitionistic, or emotional behaviors, can act as "star" to get attention
- poor sense of humor
- is hostile, bullies, demeans, or criticizes others
- exploits or manipulates others
- is irritable, violent, abusive, angry, and aggressive
- intimidates and uses emotional or physical threats
- makes others feel they must "walk on eggshells" to placate them
- is reckless, impulsive and makes poor decisions
- poor frustration tolerance, quits tasks quickly, short attention span
- may lie or exaggerate achievements to seek approval
- loud, opinionated, bossy
- monopolizes conversations, rarely asks questions of others in conversation
- falsifies or exaggerates physical health symptoms to gain attention and sympathy
- uses emotional threats, such as suicide gestures or false moodiness to gain attention
- risk-taking, poor impulse control, poor understanding of consequences for behaviors
- may engage in substance abuse and addictions
- engages in self-deception about their addictions or behavioral problems
- emotional numbness, inner emptiness

Disorders in the DSM Indicating Predominantly Other-blamer Behavior:

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Conduct Disorder
- Delusional Disorder
- Factitious Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Oppositional Defiant Disorder

2. Self-blaming

People who engage in Self-blaming tend to internalize messages of self-criticism and self-correction rather than blame others. While this may serve them socially in the short term by placating others, it creates psychopathology, such as anxiety, depression, repressed anger, and high levels of shame.[44]

Many parents are surprised to consider the depth and breadth of their child's low self-worth, because they do not recognize shame as an emotion children experience. One patient, Avery, was not yet 5 but made comments such as,"I'm never going to be able to do it. I can't do it. I'm not special." She stated at one point: "I want to die," and "Nothing I do is OK. I'm just bad all the time." When she lost at a game we were playing, her core shame was obvious when she said: "Don't even look at me."

Self-blamers are on alert for clues that others disapprove of them. Self-blamers believe if they conduct a constant crusade of self-recrimination they will improve themselves and then present well to others.Self-blamers want others to like them, so they feel the need to please. They are generally conflict averse, unassertive, and hesitant to express their needs or wants. From an attachment perspective, Self-blamers are constantly trying to fix themselves to regain connection. Self-blamers are busy trying to manipulate others to control the flow of shameful, critical messages they are so afraid of receiving. If you don't love yourself, you will try to manage others as a way to get them to like you.

Self-blamers fear conflict because they often feel guilty for making the other person "feel bad." They want to protect the other person from any feelings of shame, which can be labeled enabling behavior.

Self-blamers often have an exaggerated sense of responsibility and guilt. They frequently ruminate and re-examine the past, re-living former embarrassments or failures. They worry about the future, imagining situations where they might fail, might disappoint others, or might be shamed. All of this time and energy spent worrying and not being present means they may have attentional issues, distractibility, difficulty focusing, and poor memory.

In children, Self-blaming can be highly illogical, because they have limited cognitive functioning or life experience with which to judge situations. One family was traveling overseas, which was already a stressful time, when a waiter dropped a tray in a restaurant. Their son, age six, panicked and then talked about the incident for months. The parents had assumed it was traumatic just because of the loud sound. I later discovered in talking to him that he had immediately blamed himself for the waiter's mistake and had spent months engaging in self-criticism for his imagined role in the incident.

Many Self-blamers are perfectionists because this trait helps them cope as they work to:

- Forestall or calm fears of failure
- Fit in with others
- Gain approval or avoid disapproval
- Avoid the shaming experience that criticism from others or that self-criticism would bring

When an Other-blamer parent or sibling scapegoats a family member it can lead to habits of unquestioningly accepting blame from others. The Self-blamer may not even realize the belief system of inadequacy they have un-

[44] Gilbert, P., and Miles, J.N.V. (1999) Sensitivity to Social Put-Down: it's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. Personality and Individual Differences 29 (2000) 767-774

wittingly accepted. They may not realize how reflexively or even proactively they react with internal messages of self-criticism.

Self-blamers tend to avoid vulnerability in relationships because of their deep feelings of unworthiness and fear of being seen as flawed.

Self-blaming is a painful lie told over and over to oneself. The lack of self-trust implicit in self-loathing is a betrayal. Self-blaming originates as self-protective and adaptive in an attempt to fit in and be loved. Sadly, a person ends up feeling unlovable to themself.

Specifics of Self-blamer Behaviors

Self-blaming behaviors indicate a fear of incoming criticism and often include attempts to forestall it, such as:

Blaming

- self-critical, self-recriminating, self-doubting
- hypersensitive to criticism, often reacting with tearfulness, blushing, dissociating, "freezing"
- preoccupied with avoiding embarrassment or ruminates about past embarrassment
- perceives criticism where there is none
- shoulders too much accountability for problems
- worries excessively about the effects of behaviors on others

Submissive, Placating, Conflict Avoiding

- excessive apologizing, nervous laughter, awkward smiling
- conforms, easily succumbs to peer pressure
- reluctant to express opinions or needs
- acts as a mediator or peacemaker
- "walks on eggshells" in relationships, deferring to the needs of others
- avoids negative emotions and conflict-laden situations
- enables behaviors of others by not being assertive or direct
- presents as fearful, helpless, weak
- can be afraid of being alone
- indecisive

Approval-Seeking

- overly concerned about the opinions of others
- fearful of failure, perfectionistic, over-achieving
- engages in excessive social comparative thinking
- over-achieving, productive, hard-working, perfectionistic
- may exaggerate achievements to gain approval
- eager for praise and recognition but may also be embarrassed at positive attention
- unable to accept compliments gracefully
- helpful and loyal to a fault
- over-commits, has difficulty saying "no"

Disorders in the DSM-IV Indicating Self-blamer Behavior:

- Dependent Personality Disorder
- Generalized Anxiety Disorder
- Illness Anxiety Disorder (formerly Hypochondria)
- Major Depressive Disorder
- Obsessive-Compulsive Disorder and Personality Disorder

- Panic Disorder
- Body Dysmorphic Disorder

Note: Bipolar Disorders and Borderline Personality Disorder appear to indicate alternating between Self-blaming/Depression and Other-blaming/Manic behaviors. These Manic behaviors appear to involve a lack of accountability (excessive and impulsive gambling, promiscuity, substance abuse, criminal behavior, aggression, etc.). In mania, the person feels omnipotent and blames others. Mania is evidence of arousal-based responses of high energy levels, emotional volatility, and lack of cognitive control. In contrast, depressive symptoms indicate a person who feels helpless, has low self-esteem, and blames himself for problems.

3. Blame Avoiding

Blame Avoiding behaviors are an attempt to avoid people or situations that trigger shame or to avoid the inner experience of shame. These types of people might resist closeness in relationships or steer clear of relationships entirely as a way to to prevent the possibility of embarrassing faultfinding. Their responses to shame rely on the "hiding" affects, such as self-isolating and shyness to avoid scrutiny and judgment of others. They may hide physically, socially or psychologically to avoid shame. In children, this may appear as excessive reliance on technology and avoidance of joining groups, sports teams, or normal peer play activities. Children may report fear of crowds and social settings, indicative of fear of judgment from others. They may have limited number or quality of friendships.

These personality types distance from relationships, choose solitary activities, get little pleasure from group activities or personal interactions, and seem indifferent to praise or criticism. They can be emotionally cold, detached, and show little emotional affect. They may have perfectionism, rigidity, and a preoccupation with rules, lists, and schedules. They may be inflexible about morality and ethics, adopting black-and-white thought patterns. A tendency to be suspicious and paranoid indicates hyper-vigilance to perceived threats. They may believe that others are talking about them or making judgments about them. They may lash out in anger when threatened or cornered (a "fight" response), but generally avoidance is the preferred tactic.

Agoraphobia, hoarding, limited friendships or primary relationships, and sexual abstinence can be adult behaviors.

Disorders in the DSM-IV Indicating Blame Avoiding Behavior

- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Schizoaffective Disorder
- Avoidant Personality Disorder
- Paranoid Personality Disorder
- Autism Spectrum Disorder

Chapter 4: Five Factors That Cause Shame Sensitivity

This shame-focused model identifies Five Causative Factors that are seen as leading to most human emotional and behavioral dysfunctions:

Factor 1. The Primal Threat Response

Factor 2. Fear of Social Exclusion

Factor 3. Shame as an Attempt to Prevent Social Exclusion

Factor 4. Trauma

Factor 5. Attachment Status

While shame is a naturally occurring emotion and essential to social and moral functioning, these five factors can create a perfect storm that exacerbates shame intolerance and leads to emotional and behavioral dysfunction. Nearly all mental disorders can actually be conceptualized as shame intolerance disorders or unhealthy blame-shifting behaviors.

The first three of these factors affect everyone to one degree or another, while factors 4 and 5 are exacerbated 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-focused case formulation model.

Many other authors and researchers, largely unnamed and uncredited here, have advanced our understanding of these Five Causative Factors. I am clearly standing on the shoulders of many giants, as the saying goes.

Below is a summary, with each factor explained in more detail to follow. Clinicians can use this simplified list to assess clients and create a case formulation.

Five Causative Factors of Shame Intolerance

These responses exist on a continuum.

Factor 1: The threat response determines how, when, and why a person assesses and responds to fearful or threatening situations, whether these situations are physical, emotional, or social threats, either real or imagined.

1. Hyper-vigilant or hypo-vigilant in threat assessing
2. Hyper-reactive or hypo-reactive in threat responding
3. Balanced and appropriate levels, timing, and reasons for threat assessment and responsiveness

Factor 2: Fear of social exclusion determines:

1. Level of approval seeking or fear of disapproval
2. Hierarchy preferences in relationships (view of other as threat)
    1. Dominant
    2. Submissive/Passive
    3. Avoidant
    4. Balanced or Flexible Hierarchy Preferences

Factor 3: Shame sensitivity determines:

1. View of self as unworthy, inadequate, and shameful
2. Blame-Shifting Styles
    1. Other-blaming
    2. Self-blaming
    3. Blame Avoiding
    4. Self-accepting or healthy shame tolerance

Factor 4: Trauma determines:

1. View of other and relationships as:
    1. Rejecting, threatening, and unsafe (emotionally or physically)
    2. Accepting, comforting, and safe
2. View of self as:
    1. Rejecting, threatening, and unsafe
    2. Accepting, comforting, and safe
3. This view of self and other leads to a reaction to threat (Factor 1):
    1. Hyper-vigilant or hypo-vigilant to threat
    2. Hyper-reactive or hypo-reactive in their threat responses
    3. Balanced threat assessment and responsiveness

Factor 5: Attachment Status determines:

1. View of self and other
    1. View of other and relationships as:
        1. Rejecting, threatening, and unsafe
        2. Accepting, comforting, and safe
    2. View of self as:
        1. Rejecting, threatening, and unsafe
        2. Accepting, comforting, and safe
2. These views of self and other lead to attachment patterns of:
    1. Insecure: Avoidant
    2. Insecure: Anxious
    3. Insecure: Disorganized/Mixed
    4. Secure or Self-attached

Factor 1. The Primal Threat Response

All humans respond to threatening situations with a predictable response pattern commonly referred to as "fight-or-flight."

Since Walter Cannon identified fight-or-flight behaviors in humans in 1915 we have recognized that people have a primal response to fear, just as all animals do.[45] We now know that fight-or-flight is an inaccurate description, although a useful alliterative shorthand. The fear responses are generally considered:

1. Avoidance of the threat (if possible)

2. Freeze (to avoid detection)

3. Flight / mobilization away from threat (Sympathetic Nervous System)

4. Fight / Dominance / mobilization toward threat (Sympathetic Nervous System)

5. Fold or Fawn / Submission and Immobilization (Dorsal Vagal Response)

When humans detect a threat, the signals go to a part of the brain called the amygdala that handles emotional processing. The amygdala sends signals to the hypothalamus, which triggers the adrenal glands to release hormones such as epinephrine (adrenaline) and cortisol. The body instantly responds with physical changes, such as increased blood flow, faster heart rate, rapid breathing, and sweating, all preparing the body to quickly retreat or attack. This process happens at a biochemical level that we are unaware of, yet is so powerful it allows us to instantly jump out of the way of a runaway car.

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45 Cannon, W.B. (1915). Bodily Changes in Pain, Hunger, Fear and Rage: An Account of Recent Researches into the Function of Emotional Excitement.

Because the threat response system is designed for survival, it is our default response, meaning we easily and quickly are triggered by fears and may react unthinkingly. Our brains are designed to be sensitive to things that may harm us and so we tend to over-estimate dangers.

These hormonal responses also heighten the emotions. When you feel threatened, your emotions will be on high alert and can easily be hijacked. If you have ever been in a car accident or similar experience, you may recall the sensation of your heart pounding and palms getting clammy. You may have been quick to anger – did you want to yell at the other driver even if the accident was your fault? Later, you may have felt shaky and tearful as the stress hormones decreased in your nervous system. You may not have realized you were at the mercy of a primal survival reaction.

The many physiological responses to fear show that these biological facts are much more telling as a cause of "mental illness":

- When triggered into the fight-or-flight mode the brain produces cortisol. Overproduction of cortisol in children who are exposed to stress has now been shown to cause brain damage. Research published in the journal *Society of Biological Psychiatry* (Carrion, Weems, et.al., (2001) compared children and adolescents with and without post-traumatic stress disorder using MRI studies to see the changes in vital brain regions. They found that traumatized children had a lack of symmetry between the two halves of the prefrontal lobe and were smaller than "normal" test subjects.[46] With a damaged prefrontal cortex comes a myriad of problems in adulthood such as difficulty with impulse control and decision making. Examples of poor impulse control in the DSM include ADHD and bipolar mania, which may be a result of chronic exposure to stress and trauma.
- Early stress causes excess production of stress hormone cortisol and decreased production of dopamine and oxytocin, which aids in emotional regulation and emotional bonding. Dopamine controls movement, comprehension and social behaviors. Is it any wonder that children with behavioral problems have uncontrollable movements, impulsivity, inability to follow directions, difficulty with making friends, and inappropriate social behaviors such as arguing, tantrums, and fighting?
- Early trauma trains the threat system to be "sensitized" so that in the future small threats cause an overreaction. The brain's capacity to regulate mood, social interactions, and abstract thinking are weakened.
- Those exposed to chronically stressful environments tend to exhibit memory deficits, poor concentration and have inadequate blood flow to the brain.
- In anxious children a part of the brain called the hippocampus actually shrinks. This brain structure is important in memory processing and emotional reactions.

While the stress response is a very helpful skill if one is jumped by a tiger, it is also activated by emotional or social threats. Humans are social animals who have an inborn desire to be around other people, to be approved of by others, and to get along with others. When we feel victimized, rejected, criticized, judged, or shamed, this can make us worry that this connection to others is at risk triggering the fight-or-flight response.

The threat response also increases our tendency to be sensitive to and misperceive shame. When our limbic system is activated we tend to take things very personally. So when we perceive rejection or invalidation we use our limbic system, not our higher, more objective and reflective regions of the brain to appraise the situation.[47]

Shame is a primary or deep emotion, while anger is generally a secondary, or reactive, emotion. (Primary anger, also called indignation, occurs when we feel our rights or dignity have been violated.) When we feel shame and fear at the threat of exclusion — whether from our romantic partner or our social group or *ourself* — we may react with fear or anger. Those with poor shame tolerance may react with Self-blaming, Other-blaming, or Blame Avoidance.

Fear and other emotional reactions are also related to Factor 5 - Attachment Status. Fear, a survival response, restricts our ability to think wisely, to be observant of others, and to act in prosocial ways, such as be empathic. Fear for self-safety interferes with our ability to be compassionate for others and takes us out of a ventral vagal state and into the sympathetic nervous response. When we are chronically afraid, we spend our emotional and mental energy on self-protection, such as lashing out in "fight" response, retreating in "flight" response, or becoming

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46 Carrion, V.G., Weems, C.F., Eliez, S., Patwardhan, A., Brown, W., Ray, R. D., & Reiss, A.L. (2001) Attentuation of frontal asymmetry in pediatric posttraumatic stress disorder. Biological psychiatry, 50(12), 942-951

47 Hughes, D.A., & Baylin, J. (2012) Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment. New York: W.W. Norton, p. 97.

passive in "freeze" response. When we are reacting with survival responses we are not capable of being caring or empathic — even toward ourselves.

The threat response decreases our ability to notice things that are not important to survival. It also speeds up cognitions (racing thoughts) and physiology (racing heart rate). However, slowing down and being present are how humans are able to notice the emotional states of others — or themselves.

Therefore, if a person is anxiously focused on his own emotional upsets and worries, he does not have the cognitive or emotional bandwidth to attune to a partner's emotional status ("She looks upset.")

He may also then lack the ability to be responsive and empathic. This lack of attunement, responsiveness, and empathy leads to a lack of emotional connection in relationships, especially those with partners and children. Emotional disconnection or loss of attachment then triggers further fear, shame, and self-protective responses.

It is important to recognize that, for the same neurobiological reasons, fear takes us out of the ventral vagal "safety" zone and away from the ability to be self-aware, self-soothing, self-nurturing, and self-compassionate. We lose the ability to attune to our own emotional states and needs or respond empathically to ourselves. Perhaps we may even fully disconnect from ourselves in dissociation, emotional numbness, fugue states, schizoaffective behaviors, and the hopelessness of depression.

An understanding of the threat response can provide a way to reframe how we look at "mental disorders" that is more helpful than the DSM. Even a problem labeled as Major Depressive Disorder can be understood as influenced by the threat response. Patients with depressive symptoms also have high anxiety, which has confused many researchers and clinicians because the DSM attempts to label these as two distinct conditions. However, it is clear to most clinicians versed in the threat response that depressed people have been chronically triggered by emotional threats, especially internal messages of shame ("I am unworthy and unlovable."). An emotionally stressed out person does not get the physical release that normally occurs after escaping a predator. However, the human body is not designed to stay in an "alert" mode for an extended period of time. Chronic exposure to both the emotion of shame and the physiological aspects of fear eventually leads to the body and brain being overwhelmed by fear-related neurochemicals and hormones. The person gives up "fighting" or "fleeing." The result is the "fold" (dorsal vagal) response with symptoms of fatigue, helplessness, and hopelessness.

Depressive people come to believe they are unable to fix themselves through self-criticism, so they will forever be unlovable and unacceptable to others and to themselves. This experience of feeling unworthy and self-loathing results in depressive behaviors of isolation, lack of motivation, and suicidal thoughts. Ironically, it is the very act of self-criticism, done in an attempt to fix the self, that is causing the feelings of depression.

As Phillip Hickey, Ph.D., writes: "The feelings of hopelessness, anhedonia, worthlessness, and guilt, codified in the DSM as 'symptoms' of the 'illness of major depressive disorder' are in fact the eminently appropriate response to being *trapped* in an untenable but inescapable situation."[48] That untenable situation is the feeling of self-rejection that comes from constant self-judgment.

This type of conceptualization provides a paradigm for understanding and consolidating the many diagnoses in the DSM based on the threat response:

- Conditions such as anxiety, bipolar mania, ADHD, insomnia, and racing thoughts are examples of hyper-vigilance to and over-reactivity to threat. The body and mind have habituated and adapted to threatening situations with fear and resulting panic and fight-or-flight response. 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.
- Conditions such as depression and the depressive stage of bi-polar disorders are examples of hypo-vigilance and under-reactivity to threat, often as a result of chronic exposure to external threat or internal threats of self-shaming messages. The inhibitory (dorsal vagal) threat response is labeled as depression or avoidance behaviors.

These emotional and behavioral reactions can be seen in the affect or emotional expressiveness of clients. The extremes are:

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48 Hickey, P. (2016). The overdiagnosis of ADHD. Retrieved from http://behaviorismandmentalhealth.com/2016/06/28/the-overdiagnosis-of-adhd/

- hyper-reactive: dramatic, anxious, pressured speech, hypersensitivity to sensory experiences, irritability, pursuing for connection and attachment
- hypo-reactive: emotionally withdrawn or numb, lacking in empathy, limited cognitive processing, avoidant, flat affect, laconic, slowed verbal responsiveness, diminished sensory experiences

Fear is one of the most powerful emotions we experience and has wide-ranging effects on physiology, emotions, moods, attitudes, cognitions, and behaviors. Yet despite the volumes of research and factual evidence on the threat response and its tremendous primal influence on human emotions and physiology, the current disease model pays little attention to this fundamental fact when describing human behavior.

How can the profession continue to overlook the very obvious fact that alleged mental disorders of anxiety, depression, bi-polar disorder, PTSD, and ADHD are merely natural, protective responses to fear-provoking situations? Why should we label them as disorders, causing stigma and shame, and treat them with harmful, brain-altering drugs when these responses are merely hyper-vigilance to and over-reactivity to threat?

Wouldn't it make more sense to work to eliminate the fear-provoking situation in the person's life, such as an abusive parent, or teach the person to manage shame in a healthier way? More important, why not teach the person to moderate self-critical messages that provoke an internal sense of fear?

And, since all emotions are valuable responses, it makes one wonder: If fear is to be considered a "mental disorder," then why is happiness not labeled a "mental disorder"?

Consider also that the opposite of fight-or-flight behaviors is the tend-and-befriend response. These approach-type behaviors are also normal in all humans. Why should we consider fear a mental disorder unless we would also consider the approach behaviors as mental disorders? Both are completely normal emotions and behaviors.

It is time to reframe and de-stigmatize some mistaken beliefs about emotions: Fear is not a "mental disorder."

The shame-focused model is designed to help people understand the threat response and how it is triggered by self-shaming: It is not possible to feel safe with yourself if you loathe yourself. It is essential to stop automatically generating self-critical responses and unthinkingly reacting to them with fear. Finding compassionate acceptance for oneself is the first step to loving oneself and others and feeling emotionally safe.

In shame-focused family therapy, we conceptualize adult caregivers as the primary source of generating this compassionate acceptance so that the child learns to first experience emotional safety and soothing from parents, then to internalize this experience so they can provide it to themselves.

Factor 2. Fear of Social Exclusion

Evolution favors groups of animals that can cooperate and share. Hunting, fighting off predators, and caring for young are much easier as a community. The resulting benefits of safety, procreation, and communal resources help promote survival.

In individual terms: "If I share my antelope, my cooperation and generosity ensure that I can hang out with my tribe around the fire tonight and be safe. Tomorrow, when I do not find any food, perhaps you will be more likely to share with me."

Our ancestors who had an inborn urge to get along with others were less likely to get kicked out of the tribe. This increased their survival odds. Prosocial emotions and the resulting social behaviors are linked to evolution of the human species in this way.

It is easy to see that prosocial tend-and-befriend behaviors, such as nurturance, physical comfort, emotional support, altruism, reciprocity, conformity, and compliance are deeply engrained in human behavior because they are survival related.

The urge for social affiliation is so powerful it drives individual behavior today, even in the developed world, where we no longer need to band together to fight off a lion or fear we will die if we are kicked out of the tribe. Many of our human social codes and morals are engrained ways of encouraging us to fit in and group together.

This urge is so elemental that when we feel victimized, rejected, or shamed by our social group, it can trigger the threat response (Factor 1). When anticipating social disconnection, our primal brain believes our survival is at stake and responds.

This need to belong plays out in a strong natural desire to avoid feeling shamed, then rejected and cast out. As a result, when we believe we may be ostracized, we generally have predictable reactions, including fear, humility, submission, and compliance.

In modern society we now use the fear response system to react almost entirely to social, rather than physical threats. Neuroscientists now know that the same parts of the brain that evaluate physical pain are used to judge the emotional pain of social rejection.[49] In essence, to your brain a breakup with your girlfriend may feel the same as a bear charging at you.

Some sociologists even use the phrase "social death" to describe the phenomenon, which indicates the power of our fear of social shaming and exclusion.[50]

Shame-prone children can have elevated levels of fears of social judgment or have these fears at an unusually early age. While adolescents can be embarrassed by their parents, I am seeing children in elementary school who are overly concerned about their peers' judgments about their families or parents. Gregory had two mothers and was embarrassed by his family. He would become anxious and reactive if they attended school events or other social gatherings, but at home he expressed this as sullenness and avoidance.

Reframing Introverts and Extroverts

With this understanding of both the threat response and the fear of social exclusion, labels such as "introvert" and "extrovert" can be reconsidered. These are likely not innate, unchangeable traits, but merely learned responses. I, for one, was extremely shy as a child, yet in adulthood became very comfortable in social settings after I learned self-compassion and self-acceptance skills.

Introverts often speak of being uncomfortable and awkward at social events and feeling exhausted after a crowded party. They go home and collapse in fatigue after social events. Where I was once very shy and awkward in crowds, and frequently experienced the need to escape, I am now completely comfortable in social events and they energize rather than enervate me. What happened to change this supposedly permanent personality trait? I became self-accepting and therefore less fearful of social rejection or disapproval. Because I no longer flood my brain with messages of self-judgment, I am less sensitive to the judgments of others, real or perceived.

Introverts merely have elevated fear of the disapproval of others. They are excessively worried about the opinions of others, are highly self-critical, and are on guard for the reactions of others. The constant social judgment triggers the threat response, which is physically and emotionally exhausting.

In contrast, some extroverts may be those who have tipped their behavior toward being more approval seeking. They have learned social skills to appear comfortable at parties, but may still be anxious about the reactions of others.

Self-accepting people are at peace with themselves. They can choose a range of behaviors as appropriate. They can be quiet or outgoing in social settings as the situation requires. At the core, however, they are less emotionally reactive to the disapproval of others.

Loneliness

To humans, feeling socially isolated is toxic emotionally and physically. 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.[51] Conversely, the feeling of inclusion is physically healthy, bringing lower heart rates, improved sleep,

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[49] Ochsner, K.N., Zaki, J., Hanelin, J., Ludlow, D.H., Knierim, K., Ramachandran, T., et al. (2008) Your pain or mine? Common and distinct neural systems supporting the perception of pain in self and other. *Social Cognitive and Affective Neuroscience*, 3(2), 144-160.

[50] Ouwerkerk, J.W., et al., Avoiding the Social Death Penalty: Threat of Ostracism and Cooperation in Social Dilemmas, The 7th Annual Sydney Symposium of Social Psychology: The Social Outcast: Ostracism, Social Exclusion, Rejection, & Bullying, Mar. 16-18, 2004

[51] Hawkley, L.C.; Cacioppo, J.T. (2010). "Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanisms". *Annals of Behavioral Medicine* 40 (2): 218–27. doi:10.1007/s12160-010-9210-8. PMC 3874845. PMID 20652462

and reduced stress hormones, according to numerous medical studies. Other research shows that married people have lower rates of illness and live longer.[52]

Many cultural factors may have helped cause a fracturing of the sense of belonging. Social fragmentation, divorce, weakening of cultural institutions, high rates of mobility, technology, and social isolation due to living in single-family homes are factors. However, the most likely cause of excessive need for approval is a lack of secure attachment to primary caregivers starting at birth (Factor 5). Shame-based parenting that over-focuses on behavioral compliance and performance also provides a foundation of rejecting messages that can lead to an overwhelming need for approval and fear of disapproval.

In clinical settings, loneliness and the fear of being excluded underlie nearly all complaints of anxiety, depression, obsessive-compulsive disorder, and other psychological conditions. In terms of self-acceptance, we must consider that self-rejection is also emotionally painful. Self-shaming messages will be sensed as a judgment of unworthiness that triggers fear and may also trigger a heightened fear of social rejection.

Psychiatrists Jacqueline Olds, M.D., and Richard S. Schwartz, M.D., writing in *The Lonely American*, note that they began to notice that their patients' suffering was related largely to isolation and loneliness, irrespective of diagnostic label. Yet it was difficult for the patients to talk about their isolation, because the feeling filled them with deep shame.[53]

Paul Gilbert, Ph.D., has written extensively about social ranking behaviors and their link to shame, depression, and attachment behaviors. "Much of my own research in psychopathology has focused on the social ranking mentality because this mentality is about social power and threat: *striving* to be valued by others for social inclusion (or to exert control over others), *seeking* status in the eyes of others to be chosen in the competitions for social place, being highly sensitive to social comparisons with fears of 'not being good enough or inferior', and heightened shame sensitivity. Accentuation of this mentality increases vulnerability to various disorders via feeling defeated, inferior, subordinated, rejected, shamed or persecuted and the activation of defenses such as fearful submissiveness and social anxiety, depression and aggression. (Gilbert, 2004)"[54]

With just a few questions, it is easy for a clinician to discover that most clients have fears of being judged as inadequate and being rejected. In a clinical setting, most people with anxiety or depression have high levels of rejection sensitivity, or the tendency to "anxiously expect, readily perceive, and overreact" to social rejection.[55]

Under attachment theory (Factor 5), the resulting feelings and behaviors of anxious pursuing and avoidant withdrawing are labeled "attachment distress."

As a result of rejection sensitivity, people become fearful and also respond in three predictable ways in an attempt to manage these feelings of rejection and shame. (See Chapter 3.)

Considerable social psychology research has been done on the power of social affiliation or rejection sensitivity and its links to mood disorders.[56] [57] Yet the DSM never mentions this need as a major influence on human behavior or uses it in its diagnostic criteria.

It seems obvious to ask: Why is this evidence completely excluded from the DSM and from our explanations for human behavior? All the evidence confirms that fear of social exclusion is a natural human condition and, in fact, is a major reasons for human evolutionary survival and success. Because of this fact, loneliness and the need for human relationship and connection should never be considered a mental disorder.

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[52]Holt-Lunstad, J.; Smith, T. B.; Layton, J.B. (2010). Brayne, Carol, ed. "Social Relationships and Mortality Risk: A Meta-analytic Review". *PLoS Medicine* 7 (7): e1000316. doi:10.1371/journal.pmed.1000316. PMC 2910600. PMID 20668659

[53] Olds, J.M., & Schwartz, R.S. (2009) *The Lonely American: Drifting Apart in the Twenty-first Century.* Boston: Beacon Press, p. 4.

[54] Gilbert, P., ed. (2008). *Compassion: Conceptualisations, Research and Use in Psychotherapy.* London: Routledge, p. 17

[55] Downey, G., Feldman, S.I. (1996) "Implications of rejection sensitivity for intimate relationships." (PDF). *J Pers Soc Psychol* 70 (6): 1327–43. doi:10.1037/0022-3514.70.6.1327. PMID 8667172.

[56] Baumeister, R.F., and Tice, D.M. (1990). Point-Counterpoints: Anxiety and Social Exclusion. *Journal of Social and Clinical Psychology*: 9:2, 165-195. doi: 10.1521/jscp.1990.9.2.165

[57] Baumeister, R.F., Leary, M.R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychol Bull* 117 (3): 497–529. doi:10.1037/0033-2909.117.3.497. PMID 777765

Factor 3. Shame as an Attempt to Prevent Social Exclusion

If we want to be a trusted and accepted part of the tribe, our reputation becomes an important asset to our survival. For example, most of us do not want to be seen as cheaters, and therefore ostracized, so we are fair and generous with others in the hopes of boosting our reputation as good people. It becomes obvious that the need for social affiliation underlies many prosocial behaviors, including honesty, cooperation, reciprocity, obedience, generosity, and altruism..

It may seem counterintuitive, but the emotions of shame, guilt, embarrassment, and humiliation, are also prosocial emotions. They help prevent or control inappropriate behavior and encourage moral conduct. By feeling guilty when we do something wrong, we can learn to apologize and choose different behavior in the future, helping to ensure that we are accepted by society. Evolution designed guilt as a prosocial emotion to help us stay in good standing in relationships.

Remarkably, shame as an emotion arises very early in life as a self-conscious emotion characterized by fears of negative evaluation. This requires that we must be aware of ourselves as a separate person from others, which occurs around two years of age. Between two and three, we begin to become aware of ourselves in the eyes of others and the process of self-evaluation begins.

Many parents and clinicians are surprised that I say very young children feel shame and I can identify this emotion in their behaviors. Perhaps they have idealized childhood as a shame-free zone because they would like to idealize childhood as a zone of minimal self-shaming. The good news is we can, through self-acceptance, return to that feeling by managing our levels of self-criticism through self-compassion.

Shame and Fear

Because of the deeply primal and valued nature of our social relationships, a person's internally or externally originating shaming experience can lead to a reaction of fear (Factor 1) that causes:

- emotional under-regulation (which the DSM labels as ADHD, anxiety, oppositional defiant disorder, mania)
- emotional over-regulation (depression, social avoidance, schizoaffective disorder, autism) or
- a mix of under-regulation and over-regulation (bi-polar disorders, borderline personality disorder, and traits of autism)

The human brain has tremendous problem-solving abilities that can generate feelings of guilt and shame as a way to manage our social relationships. However, these abilities can lead to over-thinking in an attempt to correct and manage our behaviors.

Perfectionism and excessive anticipatory worry can be attempts to prevent situations that may bring on feelings of inadequacy and shame: "If I perform perfectly and plan perfectly, then I won't be criticized and then people will like and accept me. I won't have to get down on myself for failing. I won't experience that uncomfortable sensation of shame."

Rumination about past mistakes is a way for our brain to try to learn from these errors and feel safe. For many people, this over-thinking can lead to repetitive self-criticism, resulting in anxiety or depression.

This tendency to over-think and to be fearful of shaming experiences is especially prevalent in those who have been exposed to trauma (Factor 4) or lack secure attachment (Factor 5).

While the need for social belonging has its roots in an instinctual drive to survive, too many people today have been raised to rely on social approval far too heavily for a sense of their self-worth. Many people look externally for acceptance and have very little intrinsic self-acceptance. When they define themselves by the approval of others they are at the mercy of others for their self-worth. These emotionally dependent people are especially afraid of being cast out, giving them a nearly insatiable need for acceptance and approval.

Shame and Social Hierarchy

All social groups have a hierarchy that indicates who is in power and who is not. Research on social ranking behaviors indicates that members of a group understand hierarchies and express their compliance with the rankings with two broad behavioral choices:

- Down-ranking of the self
  - Placating or submissive behaviors
  - "Fawn" and "fold" actions of apologizing, groveling, and supplicating
  - Immobilization and inaction
  - Passivity and conflict avoiding
  - Shyness and social avoidance ("flight" from conflict)
- Up-ranking of the self
  - Dominating behaviors of intimidation and threats
  - Action, mobilization, or "fight" responses
  - Manipulation, coercion, and control
  - Physical and/or verbal aggression

Social rank theory argues that personal perceptions of one's social rank impact a range of social behaviors and affects. Gilbert found that shame is related to our social threat system, specifically due to negative self-evaluations.[58]

Shame-based thinking can drive social ranking and competitive behavior, as well as the need to prove oneself acceptable or desirable to others. The feeling of shame is most obviously expressed socially with submission or avoidant behaviors. Dominance, if due to unhealthy feelings of inferiority, can also be a sign of shame. Clinicians should be aware of patterns of a client's up-ranking or down-ranking driven by unhealthy shame.

Feelings of inferiority can be significant, because children are at the mercy of powerful adults, influential peers, and older or more dominant siblings. Children may feel disempowered, especially in certain family structures that use authoritarian parenting and control, sibling bullying, or excessive teasing and sarcasm. The child may cope by engaging in extremes of social down-ranking to manage the unbalanced family system or up-ranking to attempt to preserve ego function.

Parents or siblings who use excessive shame to down-rank a child may teach the child one of the three unhealthy shame intolerance patterns. When Self-blamers experience shame they engage in self-induced lowering of social rank as a way to protect themself from further abuse and earn favor from dominant others. Shame-related behaviors can include abject debasement, slinking away, lowering of the head, avoiding eye contact, and blushing. Self-debasing people assume that in the face of criticism or failure others will like them more if they are self-effacing. Other-blamers learned from their childhood experiences of shame to up-rank themselves; the resulting feeling of power and shame deflecting feels less degrading. They may develop antisocial behaviors, such as self-aggrandizement, greediness, control, cruelty, and entitlement. They may engage in coercive and manipulate behaviors, including bullying or abusive acts.

In this way shame is clearly linked to social rank theory and the innate tendency to assign oneself rank as a way to gain power or avoid conflict. By up-ranking or down-ranking oneself, one learns to fit in and make the social hierarchy function smoothly; however if driven by poor shame tolerance it can lead to maladaptive strategies.

Adolescents naturally undergo changes in social-affective brain processing, which causes heightened sensitivity to perceived peer evaluation, acceptance, and rejection. It is no surprise to anyone who has been a teenager that most teens have an increased need for peer connection and affiliation and high needs for belonging. They may up-rank and join "cool, popular kids" or engage in bullying. In contrast, they may down-rank with social anxiety, social avoidance, or self-isolation.

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[58] Gilbert, P. 1989. Human Nature and Suffering, Hove: Lawrence Erlbaum Associates.

Teenager Kacey came to therapy for anger issues. She had an older brother whom she described as "a jerk," and it appeared that the brother was very demeaning toward her. She had great difficulty admitting she was wrong or apologizing. In therapy she confided that she cannot tolerate "losing" to others by apologizing — a clear sign that she fears down-ranking herself. She states she can apologize to a friend, but not family members, especially her brother. She even struggled to say please and thank you to me during normal social interactions because it felt demeaning and weak. When a parent or sibling has demeaned a child, the child can become resistant to being in the submissive position in the family hierarchy.

These patterns of up-ranking and down-ranking can be complicated in families because children can be very intuitive about using coping strategies. One way I've seen this show up is in passive resistance to parental control through non-compliance. Children may refuse to be toilet trained or may have severe food restrictions. They seem to have learned that they can up-rank themselves into feelings of control and dominance of others by deciding what they want to do — or not do. I had a young adolescent who still only ate four foods — chicken nuggets, plain pasta, apples, and cheese sticks. He very clearly stated that no one else was going to decide for him what foods he was going to eat. This was not about sensory issues or food dislikes, but all about him learning this was a way to feel powerful and higher rank than others.

Of course, the therapeutic process will help children learn that compliance is not a blow to their self-worth. They need to learn that some give and take (and loss of social status) is a normal and necessary part of human life and human relationships. For children with very weak self-worth, however, social down-ranking can feel as if it is going to devastate their sense of self-integrity, so they will resist in various ways, such as refusing to eat food, do chores, or complete homework.

Some children have righteous feelings of rules infractions by others and a long memory of being harmed. This is likely because someone else infringed on their rights in the past and they experienced it as down-ranking. Someone else got the better of them and they didn't like this, so they remember it for a long time.

I've had children perseverate about a peer cutting in line two years ago or a sibling taking a toy a year ago. While this may seem like a minor incident, to a tuned-in therapist it is further evidence of a child who is easily slighted due to feelings of low self-worth. Any minor down-ranking — "She took the cookie I wanted!" — feels devastating and unacceptable, leading to perhaps years of resentment and vindictiveness.

It is important to recognize, however, that during the shaming experience of submission, fear is triggered. Shame signals the adrenal gland to release cortisol, the primary stress hormone, leading to increased heart rate and the flooding of major muscles with glucose — the physiological reactions to threat. Submission also includes the experience of immobilization or disempowerment and researchers have found that this feeling of helplessness (dorsal vagal state) during trauma is especially psychologically harmful.

Some couples and family therapy cases involve one family member who is exhibiting anxiety or depressive symptoms without any major stressors. However, clinicians would be advised to look for a partner or parent who is excessively dominating, coercive, or even abusive toward the emotionally distraught family member. Unhealthy, long-term submission to an abuser results in distress symptoms such as insomnia, poor focus, or anxiety. Often the abused person is a Self-blamer, so the external source of verbal abuse and blame validates and worsens their own beliefs of unworthiness and exacerbates self-shaming.

It is incomprehensible that these primal social responses are not mentioned in the DSM as factors influencing human behaviors. Clearly, dependent personality disorder should be viewed as a submissive or down-ranking behavior, while narcissistic and antisocial personalities disorders are up-ranking or dominating behaviors. In future diagnostic systems there should be much more awareness of the need to assess for social ranking patterns and their impact on emotional and behavioral health.

Factor 4. Trauma

Trauma is one of the most widely recognized external sources of emotional difficulty, especially following the Adverse Childhood Experiences Study (ACES) in the mid-1990s.[59] In this landmark epidemiological research

[59] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258. doi: 10.1016/s0749-3797(98)00017-8. PMID: 9635069.

study, the Kaiser Permanente health maintenance organization, along with the Centers for Disease Control and Prevention, surveyed 17,000 adult healthcare patients. They were asked 10 questions about their childhood experiences with physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, whether their mother was treated violently, household substance abuse, household mental illness, parental separation or divorce, or if a household member had been incarcerated.

The ACES study found that 1 in 11 middle-class adults had experienced six or more of these events, an exposure level far higher than had been anticipated. And of those who had six or more events, the resulting emotional, behavioral, and health consequences were staggering. These traumatized people were 4,600 percent more likely to become IV drug users. They were 30 times more likely to attempt suicide. Not only was their emotional functioning fragile, but their physical health was far more likely to involve chronic disease states largely as a result of high-risk behaviors, such as smoking, drug use, promiscuity, and over-eating. Stressed out people tend to adopt coping mechanisms, such as addictions or unhealthy emotional states, to manage their emotions.

During follow-up longitudinal studies, highly traumatized study participants were found to have had a life expectancy that was 20 years shorter than those who had not experienced such high levels of trauma. The unrelieved stress of living with the emotional damage of trauma causes chronic effects on the central nervous system, releasing pro-inflammatory biochemicals, and suppressing the immune system.

Trauma effects also show up in children and teens. A 2023 study found a strong positive dose-dependent correlation, although not causation, between ACEs and poor sleep, lowered academic achievement, and emotional and behavioral problems in children.[60]

Numerous studies have found a strong link between trauma, shame and psychopathology, such as PTSD, depressive symptoms, eroticism, and lower self-esteem in children and adolescents.[61] [62] [63] [64] [65] [66]

Based on such unquestionably clear results, trauma cannot be ignored as a cause of emotional, behavioral, and cognitive suffering. And yet the DSM makes essentially no accommodation for the effect of trauma, except for in diagnoses labeled as post-traumatic stress disorder and acute stress disorder. And even if significant events are noted as causal factors for these emotional states, by placing an official-sounding stamp on them it relegates the sufferer to a sense of passive patient status.

Traumas can be of many sources, but some of the most harmful are chronic developmental traumas occurring inside the childhood home, including:

- lack of attachment or bond to caregivers (Factor 5)
- rejecting, critical, or shaming parenting styles
- substance abusing parents
- depressed or anxious parents
- neglect, poverty, or chaotic home environments
- living with parents who were judgmental and harsh not warm and accepting

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[60] Qu G, Liu H, Han T, Zhang H, Ma S, Sun L, Qin Q, Chen M, Zhou X, Sun Y. Association between adverse childhood experiences and sleep quality, emotional and behavioral problems and academic achievement of children and adolescents. Eur Child Adolesc Psychiatry. 2024 Feb;33(2):527-538. doi: 10.1007/s00787-023-02185-w. Epub 2023 Mar 4. PMID: 36869931; PMCID: PMC9985439.

[61] Feiring, C., Taska, L.S., & Lewis, M. (1996) A process model for understanding adaptation to child sexual abuse: The role of shame in defining stigmatization. Child Abuse & Neglect, 20, 767-782.

[62] Alessandri, S.M., & Lewis, M. (1996) Development of self-conscious emotions in maltreated children. In M. Lewis & M. W. Sullivan (Eds.,), Emotional development in atypical children (pp. 185-201). Hillsdale, NJ: Lawrence Erlbaum

[63] Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology,* 104:277-285.

[64] Andrews, B. (1998). Shame and childhood abuse. In P. Gilbert & B.Andrews (Eds.), *Interpersonal behavior, psychopathology, and culture.* (Pp. 176-190). New York: Oxford University Press.

[65] Andrews, B., Berwin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology,* 109, 69-73.

[66] Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment,* 10:311-323.

- living with parents who ignored you, rejected you, did not respond to your emotions or were inconsistent and irrational when disciplining
- living with parents who were depressed, anxious, narcissistic, or self-absorbed
- living in a chaotic household with lots of yelling and arguing
- frequent moves
- witnessing or experiencing physical or verbal abuse
- experiencing emotional neglect
- witnessing or experiencing sexual abuse
- witnessing or experiencing domestic violence
- loss of either or both parents due to divorce, abandonment, or death
- inconsistent involvement by parents
- foster care or adoption
- poverty and insecurity
- being a member of a minority racial or ethnic group
- exposure to crime or family member in jail
- family member with mental illness
- exposure to excessive violence in media
- accidents, natural disasters, fires
- witnessing suicide or murder

Zoromba and colleagues outline this framework for categorizing types of traumas:

"(1) attachment traumas (e.g., abandonment of a child by parents);

(2) identity traumas, including personal identity trauma (e.g., rape, sexual or physical abuse, incest, and other betrayal traumas that violate one's autonomy), collective identity or shared trauma (e.g., slavery, discrimination, and targeted genocide), and role identity or self-actualization trauma (e.g., business failure, loss of life savings, sudden termination of employment, failure or dropping out of college or school);

(3) interdependence trauma that is secondary or indirect (e.g., viewing violence, exposure to media-related violence, or therapist compassion fatigue); and

(4) trauma that involves physical survival (e.g., assault and combat, life-threatening accident, or major natural disaster)."[67]

When assessing for these various types of trauma and their frequency and severity, this study also found that attachment trauma, related to early childhood experiences such as abandonment, was connected to psychosis, hallucinations, abnormal psychomotor behavior, and mania.

Fear-provoking experiences in childhood are especially powerful because they couple a sense of terror with a sense of helplessness, leading a child to believe he or she is unable to respond to frightening situations. This sense of powerlessness can continue into adulthood, resulting in depression, anxiety, and panic attacks.

Trauma and shame are closely linked. Perpetrators of sexual abuse often explicitly create shame and encourage secrecy in the victim as a strategy to protect the perpetrator. Blaming the victim by saying they instigated the sexual acts by wearing seductive clothes or craving the attention are other ways perpetrators provoke shame.

"In episodes of sexual or physical abuse, or neglect, the child can psychologically absorb shame from the adult responsible for the violation (Stadter, 2011). While the process of absorbing the perpetrator's shame may be maladaptive, the internalized sense of shame can also be protective in that it precludes a sense of powerlessness. The idea of being responsible for the violence can be less frightening than the idea of being vulnerable or unsafe (Cohen, Mandarin, & Deblinger, 2006). Similarly, children may carry the sense of shame more easily than the thought

[67] Zoromba, M. A., EL-Gazar, H. E., Rashed Elkalla, I. H., Amr, M., Ibrahim, N. (2024). Association between cumulative trauma and severity of psychotic symptoms among patients experiencing psychosis, *Archives of Psychiatric Nursing*, 51, 54-61. https://doi.org/10.1016/j.apnu.2024.05.008

of depending on a flawed or abusive parent (Crenshaw & Murdock, 2005). These dynamics can be compounded if the perpetrator or the family system remains in denial about the occurrence of the traumatic event or worse, overtly blames the child (Deblinger & Runyon, 2005; Stadter, 2011). Moreover, these dynamics can be exacerbated if the child feels he or she had some part to play in the traumatic event. For example, a sexually abused child may feel shame for feeling aroused by the abuse (Stadter, 2011)."[68]

Children experiencing trauma are often caught in a double bind: If they are being abused or neglected by a caregiver, then they are being harmed by the very person they should go to for comfort, leaving them alone to handle the trauma. Even emotional neglect can cause this response, as the child feels lonely, but cannot turn to parents for companionship because they are cold, distant, or self-absorbed.

Peter A. Levine, Ph.D., has written extensively on the effects of trauma, including in his excellent book, *In An Unspoken Voice: How the Body Releases Trauma and Restores Goodness.* He writes: "The younger, the more developmentally immature or insecurely attached the victim is, the more likely it is that he or she will respond to stress, threat and danger with paralysis rather than active struggle. People who lack solid early attachment bonding to a primary caregiver, and therefore lack a foundation of safety, are much more vulnerable to being victimized and traumatized and are more likely to develop the entrenched symptoms of shame, dissociation and depression."[69]

Childhood traumas, even just excessively judgmental parents, can lead a person to have feelings that:

- one is powerless to protect oneself
- the world and relationships are frightening and unsafe
- caregivers were not there to protect

The result can be:

- a high need for reassurance and connection to others coupled with a fear of trusting others, which can be confusing and emotionally draining (and may lead to borderline personality disorder traits)
- low self-worth coupled with a strong need for external approval
- hyper-vigilance for any signs of being rejected
- feeling overly needy for acceptance and approval
- high levels of perfectionism and self-criticism
- difficulty handling criticism, shame, and embarrassment
- lashing out in anger and blame of others or "lashing in" in Self-blame
- isolating and avoiding social contact
- seeing emotional threats where there are none
- "black-and-white" thinking, catastrophic thinking

A sense of dependence and insecurity can lead to feeling helpless and at the mercy of others. Couple this with feelings of inadequacy and it is a perfect recipe for being chronically fearful.

Even psychosis, long considered a "pure mental illness" of unknown origins, is being proven to have connections with trauma. A 2017 study found that "aspecific" childhood trauma, childhood emotional abuse, childhood physical neglect, and high perceived stress were significantly associated with "ultra-high-risk" for psychosis in adulthood.[70]

Trauma's impact on Self-Worth, Shame, and Rejection

For many people, it does not take a full-blown trauma, such as abuse, to develop the superhighway of neural connections in the emotional brain that lead to hyper-vigilance and hyperactivity. Parents and our culture may inadvertently teach a child that she is not worthy of love and acceptance.

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[68] Larrabee, L.S. (2016) Strategies to Alleviate Shame Within Traumatized Children, *Playtherapy*, Dec. 2016, 18-22

[69]Levine, Peter A. (2010 *In An Unspoken Voice: How the Body Releases Trauma and Restores Goodness*:, p. 60, Berkeley, CA:North Atlantic Books

[70] Fusar-Poli, P., Tantardini, M., Simone, S. D., Ramella-Cravaro, V., Oliver, D., Kingdon, J., . . . Mcguire, P. (2017). Deconstructing vulnerability for psychosis: Meta-analysis of environmental risk factors for psychosis in subjects at ultra high-risk. *European Psychiatry*, 40, 65-75. doi:10.1016/j.eurpsy.2016.09.003

Children need to feel accepted, loved, and protected — both physically and emotionally — by parents. Harsh, critical parents who focus only on enforcing compliance with behaviors inadvertently teach a child that she is unworthy of love and acceptance. Without secure attachment to a caregiver, children often grow up with impaired emotional development. They may develop insecurities, shame, and fears of being rejected by others. Shame-affiliated behaviors are often adopted as a survival strategy; children may fawn to diffuse abuse, comply to prevent future abuse, or develop toughness and rebelliousness.

They may then learn to engage in shame management strategies, such as perfectionism and self-criticism, to earn approval. In contrast, some children cope by adopting a narcissistic expectation of approval or sociopathic disavowal of the need for approval.

Developmental traumas are more damaging than random events, such as crimes or hurricanes, because this trauma is personal — someone (often a family member) *chose* to hurt *you*. Someone who should be providing security and comfort is instead harming you. This produces strong emotions of fear, certainly, but also shame, in the context of feeling psychologically alone and helpless. Feeling invisible while in great distress is what is so deeply hurtful.

In contrast, strong attachment bonds signal that someone will be there for us when we are in distress and will provide emotional healing.

The most common cause of chronic trauma is a negative parenting style, such as parents who are harsh, judgmental, verbally abusive, permissive, anxious, impatient, easily agitated, overly focused on behaviors, or under-focused on responding to a child's emotional states.

Mills et al (2010) found that children absorb the shaming attitude and language of authority figures during disciplinary interactions and incorporate this into their own self-image and self-talk.[71]

Children can learn that:

- parents are a source of fear, judgment, and rejection
- parents do not protect the child from fear-provoking situations or people
- parents are self-absorbed and seeking comfort for their own emotional or physical needs
- parents do not respond with emotional attunement to the child when he or she is fearful
- a child is helpless in the face of threat because of the natural dependency on parents.

Paul Gilbert summarizes how this experience can lead to fear of criticism later in adulthood: "Imagine a child's parent is often angry and calls them stupid. The child experiences the parent as threatening and dangerous, there will be arousal of panic/fearful emotions within the child, and these emotions will be associated with the words the parent uses (e.g. 'stupid'). Note too that the child cannot just run away or escape, so in that moment the child may feel trapped and that no one will rescue them. Another key emotion that follows on from the sense of 'no rescue' is feeling very alone. Fear, a sense of entrapment and aloneness are all emotional experiences being programmed into the child's brain. If this happens repeatedly that programming will become more fixed. So what do you think happens later in life when the child, who is now an adult, is criticised? They may well have a flush of these difficult emotions — that sense of shame, feelings of entrapment and aloneness/no rescue. These feelings may be overwhelming and complex. These are like body memories with feelings flushing through the person because of their original experiences. To cope with theses complex feelings the person might react in an angry way or withdraw, or even self-harm, but we can see that that is not their fault."[72]

Harshly critical parents who over-focus on behavioral compliance often try to gain a child's compliance with the use of judgment or shame, or with threats of abandonment or rejection. A child learns to judge, criticize, and essentially reject themself in an attempt to find acceptance and love.

In terms of self-acceptance, the problem with rejecting, unemotional, or neglectful parenting is simply this: If parents are not nice to you, how do you learn to be nice to yourself? And if you cannot be nice to yourself, how do

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[71] Mills, R.S.L., Arbeau, K.A., Lall, D.I.K., & De Jaeger, A.E. (2010) Parenting and child characteristics in the prediction of shame in early and middle childhood. *Merrill-Palmer Quarterly*, 56(4), 500-528. doi: 10.1353/mpq.2010.0001

[72] Gilbert, P. (2010) *Training Our Minds in, with, and for Compassion: An Introduction to Concepts and Compassion-Focused Exercises.* (Available at www.compassionfocusedtherapy.com), p. 14

you learn to be nice to others? How do you learn to trust that others can be nice to you? How do you learn to trust that you can be nice to yourself in the face of failure? Essentially the entire social world may appear to be an emotionally threatening place — even the relationship you have with yourself.

And if developmental trauma teaches a child that even his own self is threatening, he learns to shut down to his physical, emotional, and intuitive experiences. He learns to over-think, leading to worry and stress. He may also learns to under-feel, leading to an inability to generate prosocial emotions for himself or others.

This pattern is most observable clinically in couples and families, because a clinician can witness the lack of kindness between members. Most couples and families appear for therapy with relationship issues because they do not behave generously, thoughtfully, and compassionately toward others. I would suggest that a lack of compassion toward others is a major indicator of lack of self-compassion.

The source of this lack of prosocial skills is often parents who failed to provide appropriate emotional attunement and responsiveness, especially during the key attachment period of ages birth to three.

Researchers have extensively proven that trauma in childhood causes several significant effects:

- Adverse childhood experiences can alter the structural development of neural networks and the biochemistry of neuroendocrine systems.[73] The brainstem, or lower parts of the brain, are the more-primitive aspects of the organ and control survival-oriented body functions, such as breathing. The midbrain is involved more in social and emotional reactions, while the upper brain or cortex is most active in executive functions, such as thoughtful problem solving. The cortex is essential for regulating impulsivity, reactivity, and emotionality. Inputs from the body's sensory organs generally come into the lower brain, then move up toward the cortex. Anything, such as trauma, that compromises the development of the cortex limits the ability of the brain to regulate responses such as impulsivity, and may lead to poor decision making, poor emotional control, and poor social skills. People need a fully developed cortex to mindfully take charge of the necessary, but unruly, lower brain.[74]
- Stress can cause long-lasting changes in the brain that contribute to vulnerability to emotional and behavioral problems. One study in rats found that long-term stress seems to reduce the number of neurons and increase myelin production in the brain.[75] Stress turned stem cells into oligodendrocytes, which produce the myelin or grey matter in the brain, and reduced the number of stem cells that became neurons. People who have post-traumatic stress disorder have higher levels of grey matter in comparison to white matter in the brain. The study indicates that the amygdala and hippocampus may be better connected in those who are stressed, meaning that the fear response is faster. To make things worse, the connections to the thinking part of the brain, the prefrontal cortex, were reduced. Therefore, the reactive, impulsive operations in the brain would be heightened, and the rational, inhibitory pathways diminished. The authors postulate that this may provide the biological underpinnings of "mental disorders."
- Stressful experiences in childhood sensitize the brain and nervous system to threats. Traumatized individuals learn to "live in the limbic system," or emotional brain, and do not learn to engage the cortex to manage emotions, such as fear. Essentially, their set-point for anxiety is set too high. The hyper-aroused brain is then more easily hijacked by the threat response when an experience may be interpreted as more stressful than it really is.
- Because children developmentally lack the cognitive capacity and experience to manage strong emotions, childhood trauma victims learn patterns of emotional over-reactivity to threat. This response is a normal, self-protective response by a child whose cortex is not fully developed, is in an acute or chronic fear-provoking situation, and lacks adult support to care for his or her emotional state.
- Threats of social or emotional rejection or abandonment will be especially fear provoking.

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[73] Anda, R.F.; Felitti, V.J.; Bremner, J.D.; et al. (April 2006). "The enduring effects of abuse and related adverse experiences in childhood". *European Archives of Psychiatry and Clinical Neuroscience* 256 (3): 174–186. doi:10.1007/s00406-005-0624-4. PMC 3232061. PMID 16311898.

[74] https://www.youtube.com/watch?v=uOsgDkeH52o

[75] Chetty, S., Friedman, A.R., Taravosh-Lahn, K., Kirby, E.D., Mirescu, C. ,Guo, F., et al (2014) Stress and glucocorticoids promoted oligodendrogenesis in the adult hippocampus. *Molecular Psychiatry* 19, 1275-1283, Dec 2014, doi:10.1038/mp.2013.190

- Traumas that involve lack of attachment to caregivers, shame-based parenting, or neglect are more likely to lead to a sense of low self-worth and shame. Neglect and abuse victims believe that if parents did not protect them from or even caused abuse, then the child was not worthy of love and acceptance.

Vanessa Hastings, co-author of "Self-Acceptance: The Key to Recovery from Mental Illness," describes her personal experience of trauma as a child that led to anxiety and depression. Note the fight-or-flight experiences and Self-blaming in her recollection: "As a child growing up in a sometimes-volatile environment, I learned to prepare for the worst and remain on high alert so I could respond accordingly at the first sign of trouble. If I 'failed' to ward off negative outcomes — even those beyond my control — then I took berating not only from external sources but from myself, which exacerbated my anxiety and led to feelings of worthlessness. 'Success' at keeping the peace reinforced my reliance on this survival technique, which, like any repeated behavior or activity, deeply entrenched neural pathways in my impressionable young brain, setting the stage for a general mode of operation that caused more problems than it solved in the first twenty years of my adulthood."[76]

Trauma researcher Bessel van der Kolk, MD, found many psychological results of childhood trauma, including:

1. affect dysregulation: angry, upset, nervous

2. inability to concentrate

3. negative self-image

4. poor impulse control

5. aggression/risk taking[77]

It is clear that a person who is in fight-or-flight on a continual basis is going to have more difficulty regulating emotions. He will react more impulsively with fear responses, including "fighting" with anger or aggression, or will merely be nervous and upset. Fear also makes it difficult to concentrate due to hyper-vigilance.

Quite simply, trauma turns up the volume on many normal, adaptive human cognitive processes, emotions, and behaviors. Even lack of self-acceptance can be traced to trauma.Trauma and attachment trauma (Factor 5) combine to heighten the sensitivity of our natural human alarm system that signals social exclusion (Factor 2). Those who have been harmed, neglected, or rejected by others will be especially attuned for that rejection in the future.

Prior to the publication of DSM-5, van der Kolk and other thought leaders recommended inclusion of a diagnosis of Developmental Trauma Disorder to permit clinicians to validate the significance of chronic childhood trauma. The APA turned down these recommendations.[78]

One has to ask: Why is trauma relegated to just a couple of diagnoses in the DSM, such as PTSD? And why does the DSM completely disregard the impact of childhood developmental trauma, especially given the magnitude of the ACES results and other research on the neurobiology of trauma?

Factor 5. Attachment Status

Attachment theory is a very well-researched and well-accepted concept that explains that humans learn relationship patterns starting at birth based on levels of emotional attunement, responsiveness, warmth, and empathy of primary caregivers.

Psychologists recognize that attachment is the origin of emotional wellbeing. From our mother cooing and our father tickling our belly, we learn the fundamentals of relationships starting in infancy. Neuroscience is proving that these interactions also directly affect the health of our cognitive, emotional, social, behavioral, and even physical development. "Failure to thrive" occurs when orphans, for example, do not experience enough love. Attachment is such a powerful influence that it has been shown to change brain structure, which changes brain functioning throughout life.

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[76] Ashear, V., & Hastings, V. (2015) *Self-Acceptance: The Key to Recovery from Mental Illness*. Las Vegas, NV: Central Recovery Press, p. 6

[77] van der Kolk, B. (2005) *Psychiatric Annals*, pp. 401-408

[78] ibid.

When optimal parenting practices are used optimal child development occurs, resulting in the child's secure attachment relationship or bond with parents.[79]

A secure attachment pattern teaches a child to accept care and develop a sense of connection with others. This helps the child learn a positive model of how another person feels about him and creates an abiding sense of self-worth. It predicts that a person will likely grow into someone who has healthy, loving relationships with others and with himself.

"Bowlby (1988) viewed this behavioral system as extremely important for maintaining emotional stability, development of positive self-image, and formation of positive attitudes toward relationship partners and close relationships in general. Moreover, because optimal functioning of the attachment system facilitates relaxed and confident engagement in non-attachment activities, it supports the operation of other crucial behavioral systems, such as exploration and caregiving, and thereby broadens a person's perspectives and skills and fosters both mental health and self-actualization."[80]

The attachment relationship is an interactive mechanism for generating high levels of positive affect: joy, enjoyment, interest, and excitement. These are the "approach" emotions, the opposite of the "fear" emotions.

Secure attachment also gives a person the experience of trusting relationships, which underlies future behaviors involving empathy and control of aggression.

Importantly for mental health, those who experience secure attachment to caregivers are more able to develop secure self-attachment or self-acceptance. Those who believe that other people are a source of comfort and caring, not just rejection and pain, can hear criticism and can tolerate conflict in relationships without over-reacting with fear and emotionality. Simply, they can tolerate shame in healthy ways.

The fact that the medical model ignores human connection — the essence of human existence and emotional wellbeing — is astounding. Significantly, the DSM also ignores the impact of attachment on the relationship to the self. A shame-focused model posits that a lack of self-attachment or self-acceptance is the basis of much of what is currently labeled as mental illness.

Insecure Attachment Patterns

In contrast to healthy secure attachment, insecure attachment develops when a parent is emotionally or physically unavailable and is unable to develop a strong, nurturing bond with an infant. Being cut off from others is the ultimate danger signal to a helpless child. The result is stress or even primal terror at abandonment. If a child's stress is not co-regulated by an unavailable parent, the child is more easily aroused to fear. They also don't learn to develop the skills to self-soothe or turn to others for soothing.

Repeated ruptures in interpersonal bridges through these childhood misattunements n results in lowered brain integration between the right and left hemispheres. It also decreases nervous system regulation and decreases long-term access to the social engagement system of the ventral vagal system. The result is poor relationship skills. Insecure attachment in childhood leads to fear and emotional reactivity when a person perceives she will be abandoned or rejected, even later in life.

Eventually, a deep-seated fear may arise: "I am inadequate and unlovable."

Researchers believe that rejection sensitivity stems from early attachment relationships and parental rejection.[81] Shame can be understood, therefore, is an adaptive response to toxic shaming in childhood, rejection, and abandonment.

"To lay down (non-warm) feeling memories of being undesirable or only an object for the other creates considerable (implicit) uncertainty as to the ability to form (subsequent) safe relationships based on liking/being liked."[82]

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[79] Hughes, D. (2009) *Attachment-Focused Parenting.* New York: W.W. Norton, p. 5

[80] Gilbert, P., ed. (2008) *Compassion: Conceptualisations, Research and Use in Psychotherapy.* London: Routledge, p. 123

[81] Butler, J. C.; Doherty, M. S.; Potter, R. M. (2007). "Social antecedents and consequences of interpersonal rejection sensitivity" (PDF). *Personality and Individual differences* 43:1376–1385. doi:10.1016/j.paid.2007.04.006.

[82] Gilbert, P., ed. (2008) *Compassion: Conceptualisations, Research and Use in Psychotherapy.* London: Routledge, p. 31

If the child learns to view relationships as threatening, he will find himself consistently viewing himself as outside the social group. What is more shaming and fear-provoking than feeling unloved and unwanted by one's key social group — the family? (Factor 1, Factor 2, and Factor 3)

Sadly, those with insecure attachment fail to develop secure self-attachment, so they lack the emotional skills to truly comfort themselves and regulate their emotions.

Children and adults have the following broad responses to the distress of insecure attachment:

- avoidance or withdrawal
- anxious clinging or pursuing
- mixed or disorganized attachment with alternating avoidance and anxious patterns

Avoidance or withdrawal attachment status is an adaptive response to relationships that are threatening or rejecting or perceived to be so. In avoidant attachment patterns, the child learns to numb their emotions or turn inward to find emotional nurturing, rather than turn to others for safety, caring, and understanding. Because they are primed to fear vulnerability in relationships, they lose a key source of social and emotional support and soothing that is essential for humans. In extreme cases, individuals will withdraw from society completely in an attempt to manage the feeling of threat from others.

Clinging, pursuing, or anxious attachment patterns are self-described, identifiable largely through behaviors of seeking of connection and closeness or excessive fear of loss of relationship. In adults this can show up as submissive or appeasing behaviors, inability to be alone, serial relationships, tolerance for unhealthy relationships, lack of boundaries, jealousy, pursuing for reassurance, and self-doubt regarding relationships.

Sloman (2000) found that anxiously attached people use appeasement as an attachment security device.[83] Acting defeated or submissive (social down-ranking) is a tactic many people have learned to use in relationships to forestall conflict and achieve a sense of (false) attachment. More severe examples of this behavior are labeled as mood disorders by the DSM.

Anxious attachment patterns are very common and show the link between shame and attachment. Many people appear for therapy due to relationship issues and report feeling nervous about the relationship and are very clingy toward their partner. Most therapists will focus only on the anxiety symptoms and work on managing those, which is fine. But a bit of questioning is very likely to reveal that the person feels not good enough for the partner and is fearful the partner will choose someone else. Their low self-worth, which likely began with insecure attachment to parents, is what is causing the anxiety and clinging behavior. Because of a lack of self-acceptance, this person is pursuing relationships for reassurance and approval and has difficulty being alone.

Anxious and avoidant adult attachment patterns can be described in this way: Those who are too desperate for love cannot truly love, and those who are afraid to love cannot truly love. This definition indicates that the solution is to develop earned secure self-attachment or self-acceptance.

Insecure Attachment and Emotional Intelligence

With insecure attachment, a person fails, in some measure, to learn to speak the language of emotions and social connection — the unspoken, heart-felt way that humans seek and achieve a deep sense of belonging and acceptance.

"Insecurely attached people may be less inclined to feel empathy and compassion toward a distressed partner. Whereas an anxious person's egoistic focus on personal threats and unsatisfied attachment needs may draw important resources away from altruistically attending to a partner's needs, an avoidant person's lack of comfort with closeness and negative models of others may interfere with altruistic inclinations and inhibit compassionate responses to a partner's plight."[84]

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[83] Sloman, L. (2000). How involuntary defeat is related to depression. In L. Sloman & P. Gilbert (eds) *Subordination and Defeat: An Evolutionary Approach to Mood Disorders and Their Therapy*, pp. 47-66. Mahwah, NJ: Lawrence Erlbaum.

[84] Gilbert, P., ed. (2008) *Compassion: Conceptualisations, Research and Use in Psychotherapy.* London: Routledge, p. 127

In severe cases of avoidant attachment, a person may be extremely fearful of emotional connection. A sort of "freeze" response occurs. Social reciprocity skills suffer and a person may present with flat affect, awkward physical presence, poor eye contact, poor social skills, lack of spontaneity, and lack of emotionality — behaviors the DSM would label as autism spectrum disorder or schizoaffective disorder.

Emotional awareness, emotional regulation, self-acceptance, and self-compassion are key to self-attachment and good emotional health. If you fail to learn this language, you may struggle to connect not only to others, but also to your own emotions. The result? Difficulty listening to your inner self. Many people express a lack of self-understanding and self-trust — a lack of ability to know their own heart and desires. Sadly, this is a Catch-22 cycle. If you lack emotional intelligence and secure attachment to yourself, you may struggle to connect with others. By not relating with others you thereby lose the potential healing power of attachment and emotional connection that could help you overcome your insecure attachments. The good news is, as I can attest, it is possible to develop self-acceptance later in life without the help of a safe, comforting partner.

Attachment Trauma

While experiences such as war, natural disasters, and crime can certainly be traumatic, many experts now consider "attachment trauma" to be a more significant precursor of psychological distress.

Research shows that those with pre-existing anxiety due to insecure attachment have more severe reactions to later traumatic incidents, such as combat or crime, while those with secure attachment patterns seem to recover faster and more completely from situational or acute trauma.

Some of the most distressing types of trauma are those based on feeling rejected or abandoned by a caregiver or significant other. Clearly, outright neglect and abuse signal a parent who lacks empathy or emotional attunement to a child — a parent would not be inflicting this kind of pain if they noticed or cared about a child's distress.

The power of interpersonal trauma is likely due to the fact that it carries several very hurtful survival and attachment-related messages:

- "My loved one was not dependable in a time of emotional threat."
- "I am invisible to others and psychologically alone."
- "I have no way to manage strong emotions of fear and loneliness without the aid of a comforting other."
- "Others do not care for me, and I am unlovable."
- "Others are a source of threat and not protection."
- "I am helpless."

Many types of chronic developmental trauma (Factor 4), such as substance abusing parents and chaotic homes, lead to insecure attachment. A parent preoccupied with addictions, financial stress, relationship problems, lack of housing, or other issues may also not have the emotional presence to notice a child's distress and respond promptly, calmly, and lovingly. Attachment is about feeling that you exist in the mind of another. A depressed or anxious parent, who is preoccupied with getting his or her own emotional needs met may not have the emotional capacity to pay attention and fully attune to a child's emotional, social, or physical needs. The child learns she is peripheral or even unwanted. This can create a view of self as unworthy of love and connection and a view of others as untrustworthy and unsafe.

The most common developmental trauma is a parent who uses harsh, judgmental, shame-based parenting. Parents may reject aspects of a child's experience in ways that are dismissive of the child's sense of self or emotional judgments. ("There is nothing to be afraid of. Stop crying. Don't be a baby.") A parent being critical, rejecting, or unavailable when the child is experiencing something stressful is harmful.[85]

From an attachment perspective, this type of situation teaches a child that relationships are mostly about anger, shame, and rejection, not reassurance, comfort, closeness, or safety. It teaches a child to turn away from others and to respond self-protectively with fear.

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[85] Hughes, D. (2009) *Attachment-Focused Parenting.* New York: W.W. Norton. p. 57.

Kids who learn, in these types of experiences, they are not good enough tend to develop unhealthy ways of responding to shaming experiences. Because they have a self-image of being unlovable, they learn to work hard to manage shameful experiences using the shame management strategies.

Substitute or Depersonalized Attachments

Those who lack secure attachment patterns in childhood may later cope with the use of substitute attachments, such as hoarding, addictions, affairs, or excessive focus on work or hobbies.

These forms of depersonalized attachments are an attempt to create a sense of connection that does not involve a human connection. These strategies decrease the possibility of experiencing vulnerability, shame, and rejection. A vodka bottle both calms self-judgment and unworthiness and can never be the source of judgment and shame.

Even something such as infidelity in a relationship can be seen as an attempt to find emotional connection or attachment when the primary relationship has grown distant or is fear-provoking. In many cases I believe that affairs occur because an Other-blamer is sensitive to the criticism of his partner and seeks to create a fantasy bond with a partner who (he believes) will not criticize him. The affair is an attempt to keep him safe from shame. He withdraws from the partner who is criticizing him and tries to find unconditional acceptance with an idealized affair partner.

Addiction has been falsely labeled a disease of the brain and is alleged to be genetically based. However, research shows that trans-generational trauma and lack of attachment are very common in those who develop addictions. It is much more likely that addictions are merely a sign of insecure attachment in multiple generations of families. Each generation fails to get the soothing they need in childhood, so they grow up to look for soothing and emotional regulation through chemicals, rather than the "oxytocin fix" of a deeply loving relationship.

A common belief about substance abuse is that the younger you are when you start taking drugs it makes it harder to stop and leads to more long-term and severe problems. Some postulate that this is because the substance abuse changes the brain's reward-seeking behaviors. But what happens if we flip the paradigm? Perhaps kids start taking drugs younger because they are looking for a substitute attachment. Drugs calm the storms of the emotional brain that resulted from the feelings of rejection and hurt they experienced when their parents failed to provide a nurturing experience for them as children. If a person is securely attached, they do not need to go looking for something to fill the emotional void of feeling unloved and unworthy. Professor Bruce Alexander's research on "rat park" seems to confirm this. Rats who lived in a stimulating environment in close quarters with other rats did not get or stay addicted. Those isolated in cages became heavy users of drugs.

Johann Hari explains: "[H]uman beings have a deep need to bond and form connections. It's how we get our satisfaction. If we can't connect with each other, we will connect with anything we can find — the whirr of a roulette wheel or the prick of a syringe. He says we should stop talking about 'addiction' altogether, and instead call it 'bonding.' A heroin addict has bonded with heroin because she couldn't bond as fully with anything else. So the opposite of addiction is not sobriety. It is human connection."[86]

For those who have rejecting or traumatic experiences in childhood and subsequent adult patterns of insecure attachment, there is hope. It is possible to develop earned secure attachment, also known as self-acceptance, to generate internal emotional safety.

[86] https://www.huffingtonpost.com/johann-hari/the-real-cause-of-addicti_b_6506936.html

Chapter 5: The Shame-focused Model Connects the Five Causative Factors

The shame-focused model provides a way to understand human psychology and behavior as being largely driven by Five Causative Factors that together exacerbate shame sensitivity. These five factors, when simplified, show the connections between shame and fear, especially the fear of loss of attachment:

1. Humans respond with fear in predictable fight-or-flight ways.
2. Humans respond with shame and fear when threatened with social rejection.
3. Humans respond with shame to alter behavior in ways that preempt rejection.
4. Humans respond with shame and fear when experiencing developmental trauma.
5. Humans respond with shame and fear following attachment trauma and parental rejection.

Consider these Five Causative Factors as a perfect storm that leads individuals to feel intrinsically unworthy and shameful. Factors 1, 2, and 3 are naturally occurring human tendencies. Finding acceptance and avoiding ostracism are primal elements of our social nature as humans (Factor 2). And when we are afraid of rejection, we react with fight-or-flight fear responses (Factor 1), even if those fears are only caused by an emotional threat, such as criticism or humiliation (Factor 3).

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.

The shame-focused model is unique in that it combines these foundational ideas to form a compelling and innovative paradigm of human psychology. This paradigm is more scientifically valid than the DSM at explaining human thoughts and emotions and predicting human behavior. Unlike the DSM, it elucidates the effect of the causative factors on relationships with the self and others. 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.

If a person does not have healthy self-acceptance, judgmental messages are experienced as a threat. They will "attack" themself (Self-blaming) or "attack" others (Other-blaming). They may "flee" from themself and withdraw in despair ("depression") due to thoughts of unworthiness. It is untenable because they are attacker and attacked, making shame such a powerful explanatory factor in human behavior.

Based on the Five Causative Factors, it becomes quite clear that shame is a key underlying emotion that drives a large part of human behavior for both interpersonal and intrapersonal relationships.

Let's imagine a person who has been exposed to childhood trauma or had caregivers who were not able to provide loving attachment experiences. She may bring all of the following beliefs and behaviors into her relationships with herself and with others:

- She believes she is intrinsically unworthy of love and acceptance.
- She does not have healthy self-attachment, so she is highly fearful of any perceived abandonment by others. Even minor criticism may be experienced as rejecting.
- Relationships become fear-provoking because others are perceived as a source of judgment and shame. Even simple social exchanges may trigger fear and anxiety.
- She quickly and easily feels shame and inadequacy when rejected by others or herself.
- Any shameful experience may become easily equated with threat, and because the brain learned to be hijacked by fear through trauma, this leads to over-reactivity. A minor criticism or correction (e.g., "You forgot to take out the trash.") can, for some people, trigger threat-based responses of either avoidance, freeze, flight, fight, or fold.

- Because early trauma primed her to over-rely on her primitive limbic brain functions, she is less able to use higher brain functions of the cortex and she is less able to self-calm.
- As a result, she is less observant or mindful of her own thoughts or emotional needs. When she feels distressed, she may be unable to regulate her emotions, leading to a range of responses including anger, panic, withdrawing or self-attacking.
- Because she is in self-protective survival mode, she is less able to notice the emotional status of others.
- Self-critical messages ("I said the wrong thing! I am such an idiot!") trigger the fight-or-flight fear responses.
- Due to the negativity bias, she may perceive criticism everywhere and may have worst-case thinking, leading to a shame cycle of over-sensitivity to and over-reactivity to failure or inadequacy.
- Because she is in a chronically fearful state as a result of her lack of secure self-attachment, she is likely to be either pre-occupied with seeking connection in relationships or fearful of close connection or both. Clinging/pursuing or withdrawing/avoidance will occur, leading to chronic relationship problems, such as high levels of conflict and/or lack of connection.
- She may be intolerant of interpersonal conflict or connection because it is associated with high levels of shame.

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

The Shame-focused Model Connects Attachment and Shame

The shame-focused model emphasizes the link between the lack of secure attachment and intrinsic feelings of shame.

Attachment theory has been a powerful explanatory concept in psychology, especially with regard to inter-personal relationships. For example, Emotionally Focused Therapy (EFT) is an effective method of couple therapy that uses attachment theory to help explain why adult relationships become dysfunctional. However, EFT and other psychological theories and interventions do not connect insecure attachment and trauma to the development of high levels of shame, nor do they connect shame to other emotional or behavioral reactions.

How does poor emotional bonding in childhood lead to feelings of shame? Alan Schore has tracked how shame develops between ages seven months and 17 months during emotional mirroring with a caregiver.[87] If the mother responds too intensely it overwhelms the baby. If the mother under-responds or fails to respond at all, the baby learns hopelessness in the feeling of being disregarded or ignored. The key to developing attachment is not just for the parent to soothe during distress, but in the infant feeling understood and accepted, no matter her emotional state.

Inappropriate experiences of bonding with parents crates feelings of fear or lack of security, so that a child will look to reduce that feeling of distress.

Generally, when we feel unsafe, evolution has primed us to look for safety via emotional and physical connection with others. For a child, the natural place to look for security is with parents. Yet if there is a lack of secure attachment these are the very individuals who are not providing this basic need of emotional protection. They may even be rejecting and abandoning.

Perhaps because of his innate loyalty, a child feeling rejected by parents, even at an emotional level, will assume that he is inadequate or defective: "Something must be wrong with me if my parents don't love me." Feeling rejected a child reflexively looks inward and asks: "How can I fix what is wrong with me so that I can get the acceptance and emotional safety that I crave?" This entire process inherently holds a deeply fear-inducing message of inadequacy and shame: "I am unlovable and something in me needs to be fixed."

The loss of both connection to self and others can cause of an important source of human suffering — loneliness (Factor 2). Loneliness triggers further shame and a desire to rectify the situation through self-criticism. Children

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[87] Schore, A. (2003) *Affect regulation and the repair of the self*. New York: Norton

who consistently experience this loneliness, along with lack of warmth, nurturing, and empathy, learn to view relationships as threatening and possibly shame-invoking, which provokes the fear response (Factor 1). It is likely they will become less tolerant of shame, leading to the development of shame management strategies.

Shame is caused by attachment insecurity, but shame also powerfully activates attachment fears: "If I am not worthy, then I will not be lovable and I will always be alone. I don't want to be alone, so I will do anything to find connection to others." This may provoke unhealthy efforts to maintain a relationship, even if it is dysfunctional or abusive.

Conversely, shame may lead to avoidant attachment behaviors. Poorly attuned parents create feelings of unworthiness and rejection, and force a child to face feelings of shame all alone. The child distances from others in emotional self-protection, which makes her feel isolated and reinforces beliefs of being socially rejected, alone and inadequate: "I don't have friends, so I must be a unlikeable."

Therapy clients often state they choose to distance themselves from others because they do not want friends or family to see their flaws. They are ashamed of what they perceive to be innately shameful selves. Isolating behaviors damage relationships and compound the attachment injuries they experienced in their childhood.

A baseline of distrust may lead a person to express hostility and other negative emotions and behaviors toward a partner, along with less emotional disclosure.[88] This provokes distancing by the partner, leading to further loss of emotional intimacy, thus feeding feelings of rejection and low self-worth in both partners. They may be caught in a double bind of seeking connection, but also fearful of it, causing them to behave in ways that make it unlikely they will find the sense of closeness they so naturally desire.

Conversely, emotionally healthy individuals often engage in more emotional disclosure, which promotes closeness and connection.[89] Connection helps heal the fear of abandonment common to those who have suffered attachment trauma. When securely attached individuals experience conflict in relationships they do not reflexively and rigidly go directly to attachment fears ("Because you looked at that woman this means you don't love me and will leave me."). They tend to have a more flexible range of responses and are less fearful of being rejected and emotionally hurt.

In a clinical setting, assessing for insecure attachment patterns or developmental trauma in childhood can helpful in predicting and explaining a client's feelings of inadequacy.

The Shame-focused Model Connects Shame and Lack of Self-Attachment

The power of the shame-focused model is that it not only explains interpersonal relationships, but also helps explain a person's self-image and how that can result in emotional conditions such as anxiety and depression.

If you grow up not feeling loved and accepted by your parents, you may have difficulty feeling safe in relationships with others, but also a tendency feel unsafe with *yourself*. Lack of self-acceptance, learned from shaming or rejecting experiences with parents, is fundamentally also a self-betrayal and a self-rejection, which leads to further, ongoing shaming experiences at your own hands. Simply: If you loathe yourself, it is not possible to be comfortable with and accepting of yourself.

Self-shaming can be considered self-protective and adaptive in that it is an attempt to fit in and be loved. More importantly, it as a way to figure out how to love yourself. If you dislike yourself, you will attempt to "fix" that feeling in various ways.

However, self-loathing's chronic messages of self-criticism teach that perfection can never be attained, equating to a a pervasive experience of self-rejection. Therefore, when a person generates self-judgmental messages to "fix" themself, these also signal a threat that moves the body into the fear response. Stress neurochemicals are released, accompanied by thoughts and experiences of anxiety. A person will attack or "fight" herself in self-criticism, "flee" from themself (withdraw in disgust and depression), "fold" in helplessness, and have difficulty accepting herself, all because her vision of her innate self is not acceptable or worthy. They will experience all of the classic

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[88] Cordova, J.V.; Gee, C.B.; Warren, L.Z. (2005). "Emotional Skillfulness in Marriage: Intimacy As a Mediator of the Relationship Between Emotional Skillfulness and Marital Satisfaction". *Journal of Social and Clinical Psychology* 24 (2): 218–35. doi:10.1521/jscp.24.2.218.62270. INIST:16722763.

[89] Robles, T. F.; Slatcher, R. B.; Trombello, J. M.; McGinn, M. M. (2014). "Marital quality and health: A meta-analytic review". *Psychological Bulletin* 140 (1): 140–87. doi:10.1037/a0031859. PMC 3872512. PMID 23527470.

attachment distress behaviors of “pursue,” “attack,” “withdraw,” “despair,” and “criticize/correct” in the relationship with themself. For those with developmental trauma backgrounds who are more emotionally reactive, these responses are magnified and can result in rapid mood and behavioral changes, yet are nothing more than insecure self-attachment.

The shame-focused model also notes the loss of connection to one’s feelings and a lack of mindfulness that can result from this pattern of self-rejection. A self-critical person knows at a deep, intuitive level that she is not a worthless person, yet she keeps telling herself that she is in an attempt to resolve her beliefs of low self-worth. Eventually, she loses trust in her own intuition, leading to a fundamental lack of self-trust, engrained by patterns of self-betrayal. She learns to dismiss her own emotions, intuition, and perceptions, losing a powerful tool with which to engage in relationships and the world. Primal emotions are a very useful aid in discovering who is “friend or foe.”

If one is not self-accepting, the world looks frightening, relationships look frightening, and even one’s intrinsic self looks unknowable, unworthy, and perhaps even frightening. Yet most treatment perspectives fail because they do not address self-acceptance and self-compassion. It should be noted that the DSM fails to mention the significance of self-attachment or self-acceptance even once in its hundreds of pages.

The good news is: Self-acceptance is already a skill humans possess. We are not born to live chronically with fear, anxiety, and self-blaming. The shame-focused model is not about learning to adopt a different personality so much as getting rid of unhealthy learned habits. By uncovering one’s inherent self-attachment, one can become happier, more authentic, and have improved relationships with others and with oneself.

Chapter 6: Assessment and Case Formulation in a Shame-focused Model

Case formulation must involve a paradigm shift in the clinician's mind from behaviors as "symptoms of disease" to behaviors viewed as "adaptive and self-protective." Wile has written: "It is the therapist's task to grasp the 'hidden rationality' behind seemingly destructive or irrational responses."[90]

Rather than frame behaviors, cognitions, and emotions as illogical, clinicians must reframe them as completely logical given a person's experience with the five causative factors and the shame management strategies that resulted. Behaviors such as hyper-vigilance to threat, hyper-reactivity, beliefs of low self-worth, and fears of rejection make complete sense when viewed through a shame-focused lens.

In the shame-focused model I work from a family systems approach, de-emphasizing the child as the identified patient. With most families and children under approximately age 14 I conduct therapy that is focused on the family unit, not just on the identified child. Therefore, assessments must also be focused on the entire family.

This de-stigmatizes the child, but also appropriately addresses the cause of the child's shame sensitivity. No child wants to live mired in feelings of inadequacy — they learned this behavior from somewhere. Given that the parent/child relationship and home environment are the most powerful influences that teach social, emotional, and relational behaviors, this is the first place to look when assessing for sources of shame.

[90] Johnson, Susan M. (2004) *The Practice of Emotionally Focused Couple Therapy.* New York: Brunner-Routledge, p. 14

Assessment Summary

Assessment in the shame-focused model uses the Five Causative Factors as a framework rather than the arbitrary classifications and criteria of the DSM or ICD. Below is a summary assessment and case formulation matrix:

SHAME-FOCUSED MODEL ASSESSMENT and CASE FORMULATION MATRIX	Rank from 1-10, with 1 being healthiest functioning and 10 being unhealthiest level of behavior
ASSESSMENT PEARL:	**How does shame show up in this person's life?**
Factor 1: Fear/Threat System NOTES:	Assess balance between: ____Threat/Fear response ____Drive/Excitement response ____Soothing/Safety response (See: Compassion-Focused Therapy "Three Circle" model)
1. Threat Assessment or vigilance to threat How does the person **assess** real or perceived fear/threat situations, both physical and emotional? NOTES:	____Hyper-vigilance: overly sensitive to threat cues from relationships and environment; irrational and overblown fears and phobias of situations and objects; anxious; fearful; sleep problems; sensory issues; paranoia ____Hypo-vigilance: under-assesses threats, especially from dominant others in relationships; dismisses self-care and self-protection in emotional or physical situations; unaware of emotions in self and others. Co-dependence or tolerance of abusive or authoritarian (Other-blaming) behavior in partners and family members, lack of awareness of boundary violations, passiveness and submissiveness ____Balanced and Flexible Threat Assessment
2. Reactivity to Threat/Fear How does the person **respond** to real or perceived fear/threat situations, both physical and emotional? NOTES:	___Hyper-reactive: under-regulation of cognitions, emotions and behaviors. Behaviors include anxiety, impulsivity, jitteriness, exaggerated startle response, sensory sensitivity, difficulty concentrating, mood swings, "mania," aggression and poor anger control, emotional volatility, insomnia, hyperactivity, fidgeting, distractibility, phobias. ___Hypo-reactive: over-regulation of affect, emotions and behaviors. Behaviors include expressionless affect or limited range of emotional expression; "numb," "shut down" or "checked out" emotionally; dissociation under threat; "depressed"; under-responsive to the emotional needs of self and others; withdraws from relationships and emotional connection; slow or limited response to threats; lack of assertiveness and self-protection. ___Balanced and Flexible Threat Responsiveness
Factor 2: Fear of Social Exclusion NOTES:	____Approval seeking: high need for reassurance, achievement oriented, over-functioning to gain approval, narcissistic self-aggrandizing, "people pleasing," appeasing at the expense of personal boundaries, self-aggrandizing, vanity, boasting ____Disapproval avoidance: OCD, perfectionism, social fears and avoidance, few intimate relationships, fear of failure, risk averse, procrastination, under-functioning, etc. (Elevated Drive System Response) ____Balanced Fears of Social Exclusion
1. Assess for hierarchy preference in relationships or "view of other" and flexible or inflexible responding NOTES:	Social Mentality/Hierarchy ____Dominance toward others, intrusive boundaries, coercive or abusive in relationships, pre-emptive blaming of others, and lack of reciprocity ____Submission toward others, permeable boundaries, tolerance of coercive/abusive relationships, pre-emptive self-shaming and blaming ____Avoidant toward others, guardedness ____Balanced Hierarchy Preference (view of other is non-threatening), flexible responding with assertiveness and submission in appropriate ways, times, and levels.

SHAME-FOCUSED MODEL ASSESSMENT and CASE FORMULATION MATRIX	Rank from 1-10, with 1 being healthiest functioning and 10 being unhealthiest level of behavior
Factor 3: Shame: Assess for how a person handles relationships when feeling shamed, rejected, or excluded NOTES:	1. Blame-Shifting Strategies (Assess for predominant/default behavior or mixed behaviors, frequency of responses, intensity of responses.) ____Other-blaming ____Self-blaming ____Blame Avoiding ____Self-Accepting/Healthy Shame Tolerance
	Conduct Fears of Compassion Scale (P. Gilbert) ____Fear of compassion from other ____Fear of compassion for other ____Fear of compassion for self
	1. What self-critical messages or beliefs are predominant? _____ _____ _____ _____ 2. What fears of external disapproval are predominant? (Fear of failure at school or work, fear of failing at cheerleading, fear of being bullied, etc.) _____ _____ _____ _____ _____ 3. Frequency and severity of self-critical messages (May range from minor thoughts of self-doubt to active suicidality due to extreme self-loathing) _____ _____ _____ _____ _____
Factor 4: Trauma NOTES:	Assess for significant physically- or emotionally-threatening life experiences ACES SCORE _____ out of 10 PLUS: discrimination via: ___ race ___ gender or gender identity ___ sexual orientation ___ immigrant status ___ class or income level ___ other _____

SHAME-FOCUSED MODEL ASSESSMENT and CASE FORMULATION MATRIX	Rank from 1-10, with 1 being healthiest functioning and 10 being unhealthiest level of behavior
Factor 5: Attachment Style NOTES:	____Complete attachment assessment. Assess thoroughly for parental attachment styles and history of family of origin. See "Questions for Parental Self-Reflection," Siegel & Hartzell, 2014, p. 146, based on the Adult Attachment Interview. View of other and relationships as: ____Rejecting, threatening, and unsafe ____Accepting, comforting, and safe View of self as: ____Rejecting, threatening, and unsafe ____Accepting, comforting, and safe Attachment patterns of: ____Insecure: Avoidant ____Insecure: Anxious ____Insecure: Disorganized ____Secure or Self-attached
	Conduct family of origin history, especially for attachment-related trauma, including: ___Parenting style: ___ Authoritarian ___ Permissive ___ Authoritative / Democratic / Balanced ___ Parent(s) warm, loving, close, dependable ___ Child could turn to the parent for emotional support, connection, comfort ___ Parent(s) emotionally neglectful or emotionally withholding ___ Parent(s) harsh, dismissive, rejecting, critical, non-warm, shaming, behaviorally focused or punitive ___ Parent(s) inconsistent in attention or control ___ Parent(s) abandoned through addictions, over-focus on partner relationships, divorce, jail, scapegoating or favoritism ___ Child feared parental neglect, rejection, or abuse ___Parents separated or divorced. Did both parents maintain relationship with the child? ___ Parent had an affair, addiction or other attachment-based issue ___ Chaotic home life, instability, poverty, cultural/racial factors, frequent moves ___ Relationship between parents/stepparents: Modeled warm, affectionate, loving, mutually reciprocal relationships? ___ Parent had a personality disorder, depression, anxiety, postpartum depression, etc, even if not formally diagnosed ___Narcissistic sibling, bullying or abuse by sibling ___ Parentification of child
	____ Assess for trauma of Other-blaming parent/caregiver (narcissistic tendencies) ____ Assess for addicted parent, indicative of parental attachment history ____ Assess for psychological history of parent, indicative of parental attachment history

Case Studies

Following are case studies of children and families using a shame-focused model of assessment. Each chart lists presenting facts, history, and symptoms in the left column, as well as a DSM diagnosis under the medical model. In the right column are examples of ways the shame-focused model would conceptualize this presentation.

Client Presentation and History	Shame-focused Model Case Formulation
Connor was a 9-year-old male presenting with hyperactivity and attentional issues, along with disobedience directed only at his mother. He had a pattern of becoming angry when disciplined, alternating with clinging to his mother in fear. He texted or called incessantly when she left and did not calm down until she returned. He became enraged to the point of punching holes in the wall and slamming doors 100 times. Rages began as a toddler. His parents just went through a high-conflict divorce and their marriage was contentious for years. The father is a volatile, angry alcoholic and the mother is highly anxious, emotional, and ineffective as a parent. Traditional Diagnosis: Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD)	Oppositional behavior when criticized indicates oversensitivity to shame and difficulty hearing criticism and responding with equanimity. Connor clung because he was overly attentive to and solicitous of his mother, perhaps due attachment distress as she was his main attachment figure because he father was so abusive. He was oppositional to his mother because she was ineffective as a parent, so he had up-ranked himself to be the power figure in the family dynamic. Many clinicians might miss the clinging behaviors by overfocusing on the more obvious oppositional and ADHD behaviors. They are related. Connor was alternating between various responses in an attempt to find a solution that helped him calm down. He was lacking adult emotional coregulation and was seeking emotional connection that was not inherently present in his family. His demanding behaviors were also indicative of his power to control what his mother did.
ADHD symptoms included fidgeting, lack of focus, hyperactivity, difficulty doing homework, and homework refusal.	Hyperactivity, poor impulse control, and attentional symptoms are indicators of an elevated threat/arousal response, with hyper-awareness to threat (sensory sensitivity, distractibility) and hyper-reactivity to threat (fidgeting, emotional dysregulation). Clearly, something was making Connor worried and fearful. I see many clients with ADHD who also report shameful thoughts intervening while they are reading or doing homework (“I am a slow learner,” “I will never learn to do math,” “I don’t want to make a mistake,” etc). Internal self-shaming messages trigger the fear response, leading to distracted thinking, poor memory, low self-motivation, and poor performance.
His father was an alcoholic, had frequent rages, and routinely blamed others for his problems. He sometimes stormed off after arguments and was gone for days at a time.	The father was an Other-blamer who modeled poor shame tolerance. Connor had learned to copy his father’s rage and emotional dysregulation. Connor likely felt abandoned, physically and emotionally by a parent who was unable to regulate his own emotions. Connor had concluded that relationships are not about mutual caring, trust, and safety. Addictions are an indication of poor bonding in the addict’s childhood resulting in a substitute attachment pattern. Addicts often lack the experience of being compassionately cared for, making it unlikely that they will know how to connect with their children. Connor had also learned that conflict in relationships involved anger, and that issues and emotions are not mended but are left unresolved.
Connor raged to the point of blackout and reported enjoying feeling exhausted after his rages. He admitted escalating his anger to the point of rage so that he would eventually feel calmer.	Connor had had actually trained himself to become enraged because it led to an eventual reduction in stress neurochemicals and to feelings of calm.

Client Presentation and History	Shame-focused Model Case Formulation
Connor used to get good grades in school, but now gave up easily and had low motivation.	Homework and school resistance are indicative of avoidance of shame. He felt shame and it seemed emotionally safer to give up rather than try hard and fail. If he tried and got a low grade, this would merely confirm his perceived inadequacy.
When he was a toddler, Connor's parents used timeouts and other harsh punishments to enforce behavior.	Children who are isolated when they are angry are taught that normal emotions are shameful. Ostracizing a child will, of course, trigger primal fears of being cut off from care. Timeouts isolate a child during emotional distress and force them to self-soothe at an inappropriately early age. Parents should provide emotional comfort and soothing instead of timeouts. Using post hoc punishments forces a child to use the cortex at a moment when they are emotional and at an age when this brain area is not fully developed. Children will then fail to behave correctly, leading to feelings of shame. They think: "Why can't I control myself?", even though this is not an age-normal behavior, especially when a child is upset.
Connor became enraged when corrected, especially when his mother was getting ready to leave the home. He lashed out at siblings, argued, and was oppositional about inconsequential issues. He said "no" to everything parents suggested, pursued parents to argue with them endlessly, and could not back down.	If a child becomes dysregulated when disciplined, it is a sign he cannot tolerate shame, making this the cause of oppositional behavior. Connor had many Other-blaming traits, as did his father. Most parents and therapists focus on the behavior only, not the causative emotion. They try behavioral approaches and medications, both of which trigger 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. I am powerless to change." Using the shame-focused paradigm, therapists normalize this behavior as fear-based and then place the blame where it should be — with the parents. Children naturally want to please parents. If they are oppositional they may have given up on gaining parental approval. A child who lacks prosocial emotions, such as caring and empathy, is a child who has not been treated with care and empathy. A child who cannot care for others is in "survival mode" and "living in the limbic system," making prosocial emotions very difficult to generate, as the mid-brain and cortex are essentially offline during primal threat experiences. Lack of prosocial emotions also speaks of a lack of self-compassion: A person who has given up caring about others likely also has given up caring about himself.
Connor banged his head on walls. He stated he would kill himself or asked, "Why don't you just kill me?" He stated he was hurting inside. Connor said he felt he was "stupid, crazy, a psychopath, and everything is wrong with me."	Suicidality and self-loathing are clearly indicative of Self-blaming behaviors. His statements were obvious commentary about shame, self-judgment, and low self-worth. Many children alternate between the three shame management strategies, trying to find a solution to handle their painful emotions and thoughts.
Connor's mother was highly anxious in presentation, had extremely pressured speech, fidgeted excessively, and cried easily in Connor's presence.	Starting in infancy children are very attuned to a parent's emotional state. Anxious or depressed parents communicate these emotional states to a child nonverbally, triggering the child's threat response system. A child subconsciously becomes vigilant: "If my parent is worried, perhaps we are in danger." Parents must be calm to help a child be calm. Anxious or depressed parents are also less likely to be attuned to a child's needs because they are highly focused on getting their own emotional and attachment needs met.

Client Presentation and History	Shame-focused Model Case Formulation
Connor's mother had a permissive parenting style. She was not firm and assertive, often because she felt guilty about the divorce. She told Connor he was the "man of the house" now that the father was not present. His father was minimally involved in Connor's life and worked a lot, leaving Connor to feel abandoned.	The mother's weak, permissive parenting style signaled she was not in charge and she even said as much. Connor felt pressure to be "a man," so he made attempts to act in charge by mimicking his father's extreme behaviors of tantrums, rage, and defiance. Ironically, he then got punished for acting out and then blamed himself for his failure.
Connor's parents over-focused on behaviors and under-focused on emotions.	Parents who emphasize behavioral correction often fail to recognize the importance of emotional attunement. Children are just learning how to behave. So when parents over-focus on behaviors a child learns he only gets approval through good behavior. When he misbehaves in normal ways, but his parents over-react, he then experiences failure and shame. He concludes he is unworthy of love. Under-focus on emotions leads to insecure attachment, further reinforcing messages of unworthiness.
His mother was highly intrusive in supervising his homework, chores, etc. She wanted to rescue Connor from his feelings and was afraid of his strong emotions.	Intrusive parenting signals to a child that he cannot perform on his own and leads to feelings of inadequacy, fears of failure and, eventually, low motivation. Many children have low motivation because they fear failure and parents rescue them.
Both parents denigrated each other, telling Connor that the other parent was a "bad parent." His father told Connor his mother did not want him or his siblings.	Messages of abandonment from parents are clearly going to trigger an attachment fear in a child. Connor had learned that neither parent could be relied on for a sense of safety. He had learned that parents will vindictively destroy relationships, even with those they say they love — a message of betrayal and distrust. This may cause him to be cautious about relationships and emotional closeness in adulthood. Parental conflict and divorce lead to divided loyalty. But as a child Connor naturally had difficulty blaming his parents for these confusing feelings, so he believed he must blame himself. He may also try Self-blaming or submissive strategies to win the approval of parents.
His mother cried in front of Connor, overshared about marital conflict and divorce, and overshared about the failings of his father.	His mother could not handle her own emotional state, signaling Connor that she was not there for him and that he must defer to her emotional needs — a path toward insecure attachment. A child is not equipped to manage a parent's oversharing of adult situations. Parents who cannot resolve their own attachment needs are not likely to raise securely attached children. Children in this situation often become parentified, feeling responsible for their parents' emotions, behaviors or overall functioning.
When his father called on the phone and asked "How was your day," Connor became irritated because "Dad asks too many questions."	When I pursued this idea more deeply with Connor, he said that when his father asked questions it "makes me afraid I'll give the wrong answer." Look for any signs of perfectionism or fear of failure as clues to shame.
Connor did not like it when others got upset, especially his mother.	He felt he was a burden because he made others upset, a sign of Self-blaming behaviors.

Client Presentation and History	Shame-focused Model Case Formulation
Olivia, 12, presented as much younger in appearance and behavior than her biological age, yet was also overly serious in thoughts and actions. She wore brands of clothing favored by much younger girls, despite the teasing of peers. She had quirky affect, poor eye contact, and perseverated on unusual topics. She carried a book with her everywhere, could play video games and read for long periods of time, was a good student and an accomplished artist, and could engage in therapy compliantly. She was on Zoloft and has been on many ADHD medications. Previous diagnoses given by other clinicians were: 1) Autism Spectrum Disorder 2) Generalized Anxiety Disorder 3) Attention Deficit/Hyperactivity Disorder - Inattentive	While other clinicians had diagnosed Olivia with anxiety, attentional and autism spectrum disorders, her behaviors actually largely stem from the emotions of shame and fear, as we'll see. She was actually not inattentive, because she could read for hours and focus on her artwork consistently.
Olivia had a wide range of anxiety symptoms, including racing thoughts, insomnia every night, and extreme fidgeting. She was hypersensitive to sensory stimulation, jumpy when touched even by her parents, and did not like physical contact.	Hyper-vigilance and hyper-reactivity indicate high anxiety and fear. Racing thoughts, rumination, and worry are ways that the problem-solving brain uses to try to make sense of the world and feel safe. Safety for people who are highly Self-blaming often means trying to figure out what they need to do to get others to like them and approve of them. Comparative thinking and focus on the reactions of others is a "scanning for danger" response looking for signs of rejection or judgment.
She was intolerant of change and uncertainty, had black-and-white thinking, became easily dysregulated during transitions, and needed reassurance about change and uncertainty.	Fear causes humans to want to quickly determine risk. Concrete or "black-and-white" thinking is a coping skill to speed decision making and reduce uncertainty. However, it is indicative of a child in elevated anxious state. Olivia's fears of new situations were due to a fear of making social errors, then experiencing the shame of self-criticism or the disapproval of others.
She had panic attacks in crowds and would refuse to go to events with her family.	When questioned about panic attacks in crowds, Olivia noted sensory over-sensitivity, indicating chronic high levels of fear. But she also stated that she thought she once heard someone call her name in a crowd and she began to worry that she had done something wrong. This is indicative of Self-blaming and negativity bias, which is common due to chronic threat response.
Olivia had difficulty making and keeping friends. She regularly "snitched" on other students for breaking the rules and lectured them on their behavior. She focused on correcting kids who talked in class. She was highly suspicious of peers whispering behind her back.	Shame-intolerance includes "black-and-white" thinking and being highly judgmental or moralistic about others. Clinicians should watch for clients who are very opinionated, critical of others, and intolerant of others' failings. Other-blaming behaviors often occur in conjunction with Self-blaming thought, especially in children who have not yet consolidated behavioral patterns. Some of Olivia's hypersensitivity to noise and distractions occurred because she felt that if peers were talking in class she would miss what the teacher was saying and she would be less prepared for schoolwork (fear of failure). This made her lash out at peers and correct them. But she also fears others talking about her because of her fear of judgment and social disapproval.
When asked how she felt when she is corrected, Olivia stated that she felt "like a five-year-old, retarded, and not a good person."	Being criticized triggers unworthiness, indicative of poor shame tolerance and lack of self-compassion.

Client Presentation and History	Shame-focused Model Case Formulation
Olivia could become argumentative with parents alternating with shutting down and blanking out during conversations.	Olivia alternated between the sympathetic fear response of "fight" and the dorsal vagal or parasympathetic response of "fold" or "freeze." When overwhelmed she dissociated.
She tended to lecture and pontificate on subjects in an overly dramatic manner, rather than relate reciprocally. Her voice was loud and intense, and she frequently interrupted adults. She had difficulty attending to her emotions or physical sensations.	Those who have not had the experience of warm parental attachment and emotional attunement often over-focus on facts and information and under-focus on emotional interaction with others. They have not learned the value of emotional connection, with its sensations of safety, comfort, and kindness, making it difficult for them to attend to their own emotional needs or the needs of others. Conversations with them may feel superficial or unsatisfying.
For years Olivia had resisted brushing her teeth, even though she is generally not oppositional.	This is a good example of how even minor behavioral problems can indicate deeper emotional issues. At first this symptom did not seem to be related to shame, but Olivia finally acknowledged that she had as a very young child eaten toothpaste and experienced a stomach ache. So she irrationally connected this experience with her fears of school failure. She developed a fear of getting a stomach ache in school from the toothpaste, which would interfere with her school performance. Her high levels of shame led to her fear failure, which led to what appeared to be a very unrelated irrational "oppositional" behavior.
Olivia was looking at a magazine article on dolphins in the waiting room. She volunteered: "I don't like dolphins and whales or mammals because they are social animals. I like fish because they are solitary animals and don't depend on anyone else. Depending on others is bad. I like animals that can function on their own. They are not a burden to others or waste resources."	In this unexpected and forthright statement we get a very clear window into her avoidant attachment patterns. Insecure attachment can lead to a fear of dependency. Clinicians should look for what appear to be inconsequential comments as an opening to fears of dependency or vulnerability that indicate insecure attachment. This was a great opportunity for a discussion on relationships and interdependence.
When asked how she felt when she was criticized or corrected, Olivia was able to state that she felt "like a five-year-old, retarded, and not a good person."	Being criticized triggers shame and global unworthiness, indicative of poor shame tolerance and lack of self-acceptance.
As therapy progressed, Olivia was able to note fears that "everybody hates me." She stated she had given up on getting others to like her. As a result, she over-focused on school success.	Inside the child who appears to be intolerant of others, (autistic and lacking in social skills) may be someone who is highly sensitive to rejection. Fear of disapproval made her both Self-blaming and avoidant of social interactions. She had determined that success in school is one avenue to approval from others — and perhaps self-acceptance.
She was judgmental about others who lacked her level of "self-control."	Her fear of being judged by others made her judge herself harshly, which lead to racing thoughts and obsessive perfectionism. She felt if she was so hard on herself, then why were others also not just as hard on themselves? She could not understand the behavior of others who were not as self-critical as she was. Her poor tolerance for imperfection in others was a sign that she dod not tolerate imperfection in herself.

Client Presentation and History	Shame-focused Model Case Formulation
Reported insomnia symptoms.	Olivia reported an anxiety cycle based on her beliefs of inadequacy and fear of failure: She worried about completing her homework and feared she would have to stay up late to complete it, which would cause her to be sleepy in school. She catastrophized that she would fall behind and but also be too tired to study after school, which would make her stay up too late, and the cycle would repeat. Therapists who focus only on cognitive or behavioral interventions to manage insomnia will miss the underlying emotion of shame and how it triggers fears of failure and inadequacy.
She was socially awkward and accident prone. She feared strangers and preferred to avoid social situations.	Olivia was highly fearful of strangers, yet overly talkative with acquaintances. In therapy she noted her social fear and awkwardness came from her fear of "saying the wrong thing," indicative of self-shaming. Those who lack self-acceptance are often accident prone and physically uncomfortable in their bodies, because it is as if they are continually self-censoring and over-thinking in an attempt to avoid making mistakes. As a result, they are not "in the moment," spontaneous, and relaxed, making them more prone to mistakes and accidents.
Olivia had been on a range of medication since she was 5 for ADHD. At intake she had been on Zoloft for 2 years. For years, Olivia had picked at the skin on her fingers and hands incessantly to the point of bleeding.	Olivia admitted that the skin-picking was calming to her and put her in a "trance," a common reaction of those who self-harm in various ways. While these behaviors can be part of her underlying anxiety, tics and obsessive behaviors are also evident in 50% of children who have been medicated with stimulants. After seeing Olivia and her parents in therapy and reaching a plateau with treatment, I recommended Olivia's parents talk to their psychiatrist about titrating down the use of Zoloft. Within just a few weeks Olivia's tics ceased. Many of her remaining mood and behavioral symptoms were alleviated. She was more relaxed and social, less anxious, less serious, and seemed "lighter" overall.

Client Presentation and History	Shame-focused Model Case Formulation
Xhiang was a 14-year-old female referred to therapy by her parents for concerns about a wide range of issues. Their concerns were largely about how these affected her school performance. They reported she had poor focus and attention, inability to focus on instructions in school, distractibility, fidgeting, irritability, feeling overwhelmed with "everything" in schoolwork and socially. Xhiang worried about falling behind with schoolwork, but she also procrastinated and "shut down mentally." She struggled with retaining information. Had sensory issues and was sensitive to noise. In peer relationships she became very upset if things did not go according to plan. She had high fears of loss of control. She reported insomnia for years, despite four years of Trazadone at bedtime. Reported depression since seventh grade at variable levels and did not feel content, felt dread most days, low motivation, and "strong feelings" (frequent crying, uncontrollable laughing), which interfered with ADLs and social relationships. She was passively suicidal often in elementary school, despite being popular and successful academically and athletically. Had obsessed over grades all her academic career but reported decreased worry about grades recently. Was easily upset at grades that were B level. Since elementary school had stayed up very late to study, worried constantly about being underprepared, and compared her grades to others. Diagnoses given by a psychiatrist: Attention-deficit/Hyperactivity Disorder, Generalized Anxiety Disorder, Obsessive/Compulsive Disorder At intake was prescribed Adderall XR 5 mg, Prozac 40 mg, Trazodone 50 mg at bedtime. Had been on many medications since second grade with no or minimal effect, given the level of symptomology at intake.	Xhiang is like many over-functioning middle school and high school students (and young adults) who have a mixture of attentional and mood disorder symptoms that can be confusing to clinicians. Keeping in mind the vagal system, we can recognize that she had functioned in the sympathetic system for many years, then had increasing depression or dorsal vagal responses in more recent years as the anxiety symptoms had not resolved. The use of Adderall can increase "anxiety symptoms," by stimulating the nervous system, so that is a confounding element to an accurate diagnosis. Anti-depressants can also increase anxiety and irritability, which can present as baseline symptoms, but are actually drug effects. Xhiang also complained often about fatigue, which could be an effect of the Trazadone, but also could be due to chronic stress, which causes fatigue or "cortisol crash."
In third grade Xhiang won a "smartest kid in the class" award and this became a source of positive self-identity. She put pressure on herself to win it again the following year. Xhiang recalled incidents of winning highest GPA in 3rd through 5th grades, leading her to strive to repeat this accolade and develop an image as studious. She felt she was popular because she was intelligent and feared if her grades dropped she would lose friends. In fifth grade she frequently stayed up to 2 am studying and her parents did not stop this.	The fact that elementary schools would give out an award for "smartest kid" or would published the highest GPAs is quite shocking. These systems create excessive comparative thinking, self-judgments, and feelings of inadequacy. It is no wonder kids like Xhiang develop addictive approval-seeking responses to perform to achieve peer or adult approval. Here we can see how a fear of social exclusion results in drivenness to perform and achieve.
Xhiang was over-regulated and overly responsible for her age, but then was also highly anxious and could become dysregulated easily over minor problems, such as a change in schedule or running late. She had to feel prepared for every situation and have predictability to feel calm. She had fears of letting others down.	With her high responsibility, Xhiang behaved more like a 30-year than a 14-year-old. Interventions included improving playfulness and spontaneity in contrast to productivity and over-responsibility. I provided education on stress as a cause of fatigue due to over-regulation and worry. Look for ways to encourage and validate the risk taking and flexibility skills of growth mindset to reduce rigidity in thinking and behaviors. Encourage relaxation, playfulness, gratitude and joy. Even in therapy, I often toss a soft toy with these clients, tell jokes, or make funny faces or silly noises.

Client Presentation and History	Shame-focused Model Case Formulation
Xhiang exhibited very high drivenness largely focused on school performance so that she could get into the "right" university. Her father, a doctor, began pressuring her to prepare for college applications in middle school. Her private school regularly had meetings with school counselors who advised students to be involved in numerous activities and sports to get accepted into the best colleges. She believed she must "always be productive" and had guilt when she was not. (Her father worked excessively and did not relax.) She felt hopeless that academic pressure would never be relieved and her whole life would be "horrible." She did not exercise because she feared she would become compulsive about it.	Xhiang felt guilty for not striving enough, then became panicked about the results. When we think about healthy human functioning, it should involve wisdom and balance. Xhiang was 100 percent in drive mode, driven by guilt, with little ability to self-regulate and relax. Clinicians can educate on the drive state, compared with soothing and fear states using Paul Gilbert's "three-circle" model. Children can be taught to be aware of their emotional state and learn to shift to a soothing state. Xhiang had engaged in drivenness for so many years, fostered by her parents and school culture, that she had great difficulty adjusting. Given that fear of failure is the motivator, there can be many blocks and resistances to moderating the drive state. As a Self-blamer, she also engaged in excessive judgment and guilt when she failed to work as hard as she expected she should, which led to further attempts to pressure herself to work hard and study. Clinicians can discuss use of fear-based motivation versus self-compassion (wanting to succeed versus scared to fail).
Xhiang alternated between describing herself as "anxious" and "depressed."	Xhiang, like many anxious kids, had such a high baseline for their anxiety, that she mislabeled boredom or even neutral mood as "depression." These children are so used to being over-stimulated by their environment and over-scheduled lifestyle, or by their own mental drivenness, that they feel under stimulated if their life is merely normal. Many also then judge themselves using medicalized language as being "depressed," resulting in more anxiety.
Xhiang reported feeling "sad and lost" during summer vacation due to the absence of structure of school. She struggled to set her own schedules for hobbies or exercise.	Children who are hyper-focused on meeting externally set goals, such as in school or sports, often lack intrinsic motivation, They may not find personal satisfaction in learning a new hobby or reading for pleasure because it is not attached to a measurable goal set by others. Many also crave external validation because they have not learned to validate themselves through pride and self-acceptance. These type of children often have rigid expectations for careers, colleges they will attend, and life paths. If not guided by a homework deadline or an authority figure, this child may not know how to self-direct toward a goal. Interventions can include allowing the teen to make plans and schedules. Explore personal goals, beliefs, values and wishes: "What do you like?" "Which is your favorite?" or "If you could do anything in the world what would it be?" Build playfulness, spontaneity, joy, pleasure in learning, curiosity, etc. Look for any ways they can increase autonomy and agency.
Xhiang overanalyzed herself constantly and engaged in frequent self-reference ("I must take eye contact," "I need to listen to others better," and "Why don't I connect with others?"). She struggled with mindfulness and staying in the moment, but often worried that she would be anxious or sad in a situation, so she avoided that situation.	I worked with Xhiang for months on her self-judgments using compassion-based interventions and mindfulness skills. These are practices that can be tailored to age-appropriate levels. However, often in talk therapy at any age, you can gently point out in session when a child wanders off into anticipatory worry or rumination about the past.

Client Presentation and History	Shame-focused Model Case Formulation
Xhiang reported hyper-vigilance for and hyper-awareness to the emotions of others. She was overly empathic and overly focused on the needs of others. Xhiang stated it was selfish to think about herself. She became highly distressed if there was conflict in her peer relationships, which, of course, is a frequent occurrence in groups of high school females.	Because of her over-responsibility and her people-pleasing traits, Xhiang had taken on responsibility as the mediator for her group of friends. She had a strong urge to fix relationships if there was any conflict and became upset if the conflict lingered. She also feared losing friends and placated others if they were upset about her. While clinicians can validate empathy as a skill, moderation is the goal. Excessive guilt and self-abnegation are not necessary for healthy functioning. Conversations about specific peer relationships can be used to teach setting emotional boundaries with friends. Don't be afraid to educate very explicitly on the emotions of guilt, self-blame, and excessive empathy.
Xhiang makes decisions for her older sister and even for her parents at times. At age 15 she helped her adult sister get a job and helped her choose outfits. Xhiang edited her sister's high school essays while she was in middle school. Xhiang felt responsible for helping her sister make friends and felt she must do activities with her if her sister was bored. She felt guilty if she was busy with homework and could not help her sister.	After a couple of months of exploring her family dynamics, it turned out that Xhiang's older sister was also highly focused on school performance, had worried about getting into college, and still lived at home during college, so that her daily worries about grades continued to impact Xhiang. Her sister had also struggled with anxiety and depression for years. She had an explosive temper, was entitled, and made aggressive demands of the family. Their parents seemed to cater to the sister due to her apparent emotional fragility and dominance in the family hierarchy. Her sister's need to under function came first in the family system, leaving Xhiang to fill the function of caretaker and over-responsible member of the family. This created anxiety for a young adolescent and led to over-thinking and over-functioning far beyond her years. She was both parentified and enmeshed in her family system. The contrast was interesting, in that she was an overly responsible child who was forced to be decisive with family issues, but also was very indecisive with personal decisions.
Xhiang could not accept compliments. She would cry after sports in elementary school because she felt she let everyone down with her performance. This led her to quit many activities.	Don't be surprised that high levels of self-judgment may start at very young ages. When children are self-critical, this becomes their mental focus, and overwhelms any joy they get from playing sports or having fun at robotics club.
Xhiang constantly verbalized about her emotional state and moods. She overanalyzed her emotions and questioned why she felt a certain way, asking "What is wrong with me?"	Xhiang is a product of a generation of children raised to identify their own "mental disorders" and discuss them openly. While there is some benefit to more open awareness, this can also bring stigma and self-criticism. Because Xhiang was told several diagnostic labels when she was very young, she thought frequently about how she was feeling and why. She believed every mood change had to be analyzed and considered from a diagnostic perspective. Friends also talked about mental health issues excessively, self-diagnosed, and over-shared about every feeling and thought. Interventions included reframing from "why is this happening to me" to simple acceptance of an emotional state that will quickly pass. I often use a "curious detective" visual to help kids be open-minded and non-judgmental about their emotions and thoughts. We practice reactions of "Hmm, that's interesting," rather than "Why is this happening" or "This shouldn't be happening to me." Mindfulness skills teach disengaging from over-attachment to thoughts and feelings.

Client Presentation and History	Shame-focused Model Case Formulation
She had fear of changes in schedules with extreme anxious reactions of screaming and crying in new situations.	Her fear of failure showed up in a need to be prepared or over-prepared for almost all aspects of her life. She over-studied for tests, rehearsed conversations in her head before having them, and worried about traveling because she feared she wouldn't know what to do.
She distrusted her judgment and intuitions, and was indecisive. She over-relied on the opinions of others. She was afraid about making the "right choice" so she dreaded choices, even small ones, such as should I crochet or watch a movie?	Many Self-blamers and over-thinkers lack confidence in their thoughts, feelings, and decisions, largely due to fear of failure. Xhiang's mother frequently questioned Xhiang's decisions, so this exacerbated her fear of decision making. Clinicians should work in a granular focus with clients and explore their fears of taking action — likely because they fear it will be the wrong choice and then they will engage in self-criticism for that choice. By teaching self-compassion, clinicians can help clients see that they will have less fear of decisions because they will meet themselves with kindness no matter how the decision turns out. Most people have excessive guilt and fears of making poor choices because of fears about being unhappy with their choice and then judging themselves harshly. A person who needs reassurance for decisions is lacking in self-reassurance skills.
Xhiang once stated she was scared to reflect on herself because "I will find out what is wrong with me or no one will like me."	This comment showed that Xhiang even blocked herself from self-awareness due to shame, which was notable because Xhiang was often quite insightful and mature for her age. Interventions include engaging in self-description exercises and practicing any form of self-reflection, self-awareness, and self-trust.
Xhiang reported feelings of alienation and feeling "different." She strived to fit in to reduce these experiences. She had a dread of school and social situations due to comparative thinking. The resulting high levels of fatigue were partly due to the Trazodone and antidepressants she was on, but also because she spent so much time hyper-vigilant for judgment of others and in judging herself.	I find it helpful to educate on developmental stages, especially the increase in comparative thinking in the teens as a way to fit in, feel accepted, and reduce judgment. This normalizes these thoughts and helps kids see it will not always feel this important to them. I also show that self-shaming to fit in is driven by the need to feel loved — a normal human need.
Her peers over-shared about emotions, mental health concerns, stress over grades, etc. Peers "freaked out" before tests and compared grades constantly.	I worked to get Xhiang to improve emotional boundaries with her peers and be less invested in every complaint and stressor that they shared. Her over-responsibility and excessive guilt meant that she took on too many of their concerns and tried to fix them.
Xhiang reported having insomnia for years. She got 7-9 hours of sleep in high school, which is barely sufficient, but in middle school she got 3-4 hours per night due to insomnia and worry. Because she dreaded school and the accompanying worry, she developed a habit as a child of engaging in self-agitation to stay awake at night as long as possible to avoid waking up the next day — so she could skip school and "enjoy the peace." Parents did not enforce bedtimes.	Xhiang would report an avoidance strategy with school and then sleep related to her anxiety associated with school performance. Overall she had very poor sleep hygiene. Her self-agitation merely trained her to be even more anxious than she already was. After a few months, I urged that Xhiang's parents work with their psychiatrist to wean her off Adderall, which helped decrease the hyper-focus and poor sleep.
Parents were heavily invested in the medical model, talked often about Xhiang's "symptoms" and medication needs, pursued repeated MRIs and other assessments, and even suggested a diagnosis that Xhiang was autistic. Xhiang came to therapy believing that her brain chemistry couldn't be changed. Her parents were very concerned that taking her off medications would affect her school performance.	Shifting the paradigm for Xhiang took many months, to get her to accept that she could manage her own emotions and thoughts without the need for medications. Her parents did not share this view, however, and Xhiang was kept on medications for years. Interventions should include frequent reminders that emotions are temporary states and can, first, be accepted and also can be regulated. Her REM sleep patterns were likely severely disrupted after 6 years of Trazodone use by the time she was 17.

Family/Parent Treatment Protocol

My treatment protocol begins before the first session when I email information for parents on the process and policies of therapy in this model. The following is part of that handout.

Family therapy will require:

1) Parents/stepparents/caregivers will attend the first two sessions. Children will attend only part of each session.
2) Children will be expected to sit quietly in the waiting room alone for part of the session. If they are not able to do so, please let me know.
3) At least one parent/caregiver is expected to attend most therapy sessions with the child unless we decide to move forward only with individual sessions for the child. Each parent should each try to attend at least 1 out of 3 sessions with the child.
4) Both parents/caregivers are to attend parenting sessions every 4 sessions (approximately).
5) Parents are to read suggested material outside of therapy sessions.
6) Please be open minded and implement suggested parenting changes that are designed to help your child.
7) Please explain to children that the FAMILY is attending therapy and do not say that the CHILD is the focus or problem. Avoid focusing on the child as the "problem." Discussions about therapy should focus on the FAMILY making changes.
8) Do not describe behavioral or emotional problems in diagnostic terms: "You have ADHD" or "You're depressed." Use emotion words ("You are feeling energized/sad") to decrease stigmatizing and shame.
9) If you choose to put your child on psychiatric medications (which I do not recommend — see my website for details on why), please do not talk about these drugs with the child as "fixing your problem" or "fixing your brain chemistry" or "you need these drugs to help you behave." The drugs might alter emotional states by sedating (antidepressants) or creating a hyper-aroused state (ADHD drugs), but there is nothing broken about the child's brain chemistry to be fixed. They can learn to manage their emotions and behaviors without drugs. Framing drugs as a solution trains children to look externally for solutions, which is the opposite of what we are attempting to do in therapy. It also teaches a drug-seeking mentality.
10) Tell your children that you will meet with me alone to provide background on the FAMILY problems and learn to be better parents. This models accountability and decreases shame and stigma for the child.
11) After an individual therapy session, avoid asking the child what went on. There will (generally) be no confidentiality contract between child and therapist. We are working to build transparent communication and closeness within the family unit, not secrecy. However, asking about therapy can feel intrusive to a child. Avoid asking: "Did you have fun? Did you talk about X problem? What did Ms. West tell you to do about your bedwetting?" Kids usually won't say much enlightening, but just something like "we played with dolls." They will not understand what I was assessing for or the lessons that might have been slipped into play therapy.
12) You can ask at any time for a parent-only session or partial session if you have concerns to report.

If you do not agree to these treatment guidelines, please contact me to cancel your intake assessment and get recommendations for another therapist. If you do agree to these guidelines, below is a general protocol for what will most likely happen during the course of family therapy and suggestions to make the most of this treatment.

TREATMENT PROTOCOL

1) First two sessions are largely assessment and parenting education sessions. Child will attend part of each session.
2) Next 3-4 sessions are 25 minutes (approximately) with therapist, parent(s) and child, then 25 minutes with child and therapist only.
3) Session 5 or 6 is parents only to review progress, reassess, continue parenting education.
4) This pattern will repeat throughout the length of therapy. Most family therapy lasts 3-6 months of weekly sessions.
5) Tell children openly you will be meeting with me to discuss family issues. Tell the child that each session will usually involve some time with a parent and some time alone with the therapist.

Sessions will generally involve:

1) Talk Time of 20-30 minutes with 1-2 parents, child, and therapist, then 20-30 minutes with child and therapist. During Talk Time:
    1) Talk openly but warmly about behavioral and emotional problems.
    2) Goal is to address emotional and behavioral problems, but with the fundamental focus on building trust, safeness, attachment in and out of therapy.
    3) Start by mentioning fun/good things the family did together in the past week.
    4) Don't focus entirely on negative behaviors, and do not use excessive shaming language so that therapy is difficult for the child. Don't rattle off a long list of behavioral problems. Instead mention one and focus on solutions the family can address together. Maximum, we will address 3 problems per session (e.g., tantrums when told to brush teeth, not getting out of bed when told, and managing anxiety when at school).
    5) When appropriate, admit mistakes as parents and offer to make changes yourself to model compromise and accountability.
    6) Practice observing the child's emotional reaction, especially watching for shame. (See blog on "How to Help Children Handle Shame" on Resources page/Parenting at www.HarperWest.co
    7) When you observe an emotion, use reflective listening to note this emotion. (See "Reflective Listening" on Resources page/Parenting at HarperWest.co
    8) Discuss privately with me how to handle discussion of difficult issues (e.g., toileting, health issues, sexual abuse) until later sessions when the child feels safer in therapy.
2) Time with parents may also involve play activities as a family. Guidelines for parents:
    1) Playtime is to encourage imaginary activities, story telling, playfulness, and spontaneity. It will allow the child to work through emotional issues of the subconscious by decreasing the inhibitions of the "thinking brain."
    2) When asked to be involved in play therapy, engage in creative, imaginative, and narrative play (telling a story with characters and plot). Be spontaneous and don't overthink things.
    3) I often use sand tray therapy where each person will take turns telling part of a story using characters. Pick characters quickly, don't over-think it. Keep it playful, free flowing, and spontaneous. We're not looking for "perfection". This will help the child access more emotional content without intellectualizing and working to please parents/therapist. You will also be modeling being OK with making mistakes and not getting things "perfect."
    4) Do not over-react if your child engages in a narrative that might be disturbing to you, such as being very violent with a character or having a story narrative that involves a lot about death or sexual topics. Your reaction will stifle the child's experience and teach them that these subjects are uncomfortable or forbidden. Play therapy is designed to allow a child the freedom to express difficult thoughts, emotions, and experiences in a safe manner and setting. Play is generally symbolic and not literal — your child may have no interest in killing someone, for example, but is just expressing anger or a desire to have more power or control.
    5) To allow a full play experience for your child, minimize your opinions, thoughts, words. Speak little, allow for quiet. Allow the child to be the center focus of play therapy.
    6) Attune to the child's experience with your emotional presence. Don't overwhelm the child by being too exuberant and involved.
    7) Watch what I do and how I interact with your child. I will often reflect occasionally what the child is doing or saying in a neutral way: "You're putting the tiger on top of the hill."
    8) If the child seems stuck, avoid offering advice, but maybe offer a question: "Then what did the tiger do?" Try not to be too directive or intrusive. For example, don't ask "Why is the tiger doing that?" or tell the child what to do with the tiger.
    9) Always consider the mindset that we want therapy to be a safe, warm, positive experience.

I look forward to working with your family. Feel free to ask me any questions at any time about the treatment plan. We are a collaborative team working for the benefit of your child/children, so keeping open communication is essential.

As the handout mentions, I see the parents/guardians for most of the first intake assessment session for children under the age of 13 or 14. Insurance payers often require that the child be present for part of the intake assess-

ment. For teens I see both parents and child for a history for the first part of the session then meet with the teen only.

Whatever format you use, I believe that how clinicians manage the crucial early minutes of introductory sessions sets the tone for the course of therapy, helps build the therapeutic relationship, helps mitigate shame, and may increase client retention rates.

It is certainly normal for clients, especially children, to be nervous in the first session, particularly if they have never attended therapy. As clinicians it is easy to lose sight of a new client's perspective because we are so comfortable with the process. Think back to your first time as a therapy patient. What would you have wanted from the therapist to help you manage the experience, especially feelings of anxiety, uncertainty, and embarrassment? Here are my suggestions for making the first therapy session as comfortable as possible for anxious clients.

1. Be warm and nonjudgmental.

Clinicians should first recognize the fact that dread, shame, and embarrassment are likely the predominant emotions for nearly all new clients. In compassion-focused therapy we say that compassion is the antidote to shame, so clinicians can do a lot to alleviate a client's emotional distress by being warm and nonjudgmental. I use a communication style that is approachable, but direct and matter-of-fact, because we know that avoiding topics to protect a person from embarrassment merely makes shame more toxic.

Don't overlook the basics of a friendly smile and small talk. I use humor, as appropriate, to be more approachable and to minimize hierarchy and power differences.

2. Acknowledge and normalize embarrassment and shame.

I openly acknowledge and normalize the likely experience of embarrassment and give children and parents agency to manage it: "Most people are nervous or awkward coming to therapy, so I imagine that you are too. Please let me know if anything I ask makes you especially uncomfortable or embarrassed. We may address difficult topics, but I want to do it in a way that is helpful to you. Please let me know if there is anything I can do or any question I can answer to help you feel more at ease."

Gently approaching feelings of embarrassment can be a powerful tool. It also hints at therapy interventions you will use in future sessions of addressing emotions and behaviors as they occur in the room.

Parents are often especially embarrassed bringing a child into therapy, because they naturally feel they have failed as parents in some way. Reassure them by saying something that highlights positive character traits and models acceptance: "Good for you for trying to get help for this difficult situation with your family. That takes courage."

I also like to engender hope: "Most family therapy doesn't last too long, because it can be fairly easy to shift a child's behaviors once we're all working in the same direction. Children actually want to please parents, so if we can improve family bonds, I'm sure we'll be successful pretty quickly and your family could be in a much better place in just a couple of months or so." Notice my use of the word "family" rather than stigmatizing the child as the identified patient. This reinforces to the parents that they will not be just dropping their child off to be fixed by me. They will be directly involved as well.

3. Use orienting language to alleviate uncertainty.

When we think about shame-inducing experiences, they are often new situations where one might make a mistake and feel embarrassed. Even adults, especially those who have never been in therapy, have little understanding of elements that may be very obvious and comfortable to a clinician, such as how long sessions last. To reduce fears of uncertainty in initial sessions I use orienting language to alert clients to what to expect. Orienting language involves explaining what will happen in the first and subsequent sessions and why. This helps clients relax and be less guarded against making a mistake.

Children have no understanding of therapy, so explain simply and briefly what will go on in the first session and subsequent sessions. I like to highlight that I will be working with the parents to improve how they relate to the child, the parents and child together, and the child individually. I mention that they get to play with games and toys, which usually improves their view of therapy. I never identify the child as the main focus of therapy.

I say: "This first session will involve you telling me about the family and why you are here. We have about an hour in this session to get a sense of your concerns, your goals, and some of your background. I'll meet with both [parents and child] for about 25 minutes. Then I'll talk to [the child] for about 25 minutes. I'm going to take notes on my laptop in this session because it is faster for me, but I don't use it regularly. We'll start with a general question about what is leading you to consider therapy right now, but then I'll also have some specific questions about things like your family background and your child's developmental and medical history. Don't worry that you have to tell things to me in an organized way or that you have to tell me everything in this session. We will then discuss if you'd like to schedule future sessions."

4. De-stigmatize and de-pathologize to reduce shame.

Although psychotherapy is much more accepted today, many people are ashamed that they are seeking help. Many families come to therapy after having a pediatrician send them to a psychiatrist or psychologist for an assessment and medication. Children often come in with several diagnoses from other clinicians and already on medications.

Families have had previous clinicians announce a diagnosis or, as is very common today, many people self-diagnose via internet searches. This scenario primes them to feel stigmatized by labels that pathologize normal human emotions. Clinicians should listen for expressions of shame about attending therapy or about a diagnosis. Ask directly about a client's beliefs on this topic so you can educate about the harms of the DSM. I find that a brief explanation about the lack of scientific rationale for medications and the disease model of mental health is deshaming and provokes feelings of relief in clients.

I believe that clinicians should be very circumspect about sharing diagnostic labels. I never tell people their diagnosis because I believe this exacerbates feelings of shame and judgment and hinders the process of self-acceptance and self-compassion, which should be at the heart of the therapy process. Shame-focused therapy emphasizes the use of non-medicalized terminology and normalizes mental health conditions as understandable emotional experiences that arise out of a person's life experiences and traumas.

I recognize clinicians may have to provide a diagnosis for insurance billing, but I would compartmentalize that label. I don't put diagnoses on my process notes that I review before each session. In fact, I often forget the diagnosis I've given a child — that is how irrelevant it is for me using the shame-focused model.

Child Assessment

Because shame is the master emotion driving nearly all behavior — especially dysfunctional behaviors of Other-blaming, Self-blaming and Blame Avoiding — it is essential that clinicians learn to identify shame in the child. (Later in this chapter I'll discuss parent, family, and sibling assessments.)

Shame has some immediate physical manifestations that aid assessment:

- Downcast eyes and avoiding eye contact, turning away with body posture
- Slumped shoulders
- Blushing
- Anxiety, racing heart
- Stuttering speech
- Inability to think clearly
- Dissociating, feeling paralyzed, emotional shutdown
- "Fawning" or submissive behaviors
- Anger, resentment, victimhood
- Sullenness, refusal to talk, non-compliance, leaving the room
- Avoiding talking about a subject, deflecting

"Symptoms" or Signals of Shame Sensitivity?

As will be obvious in the list that follows, there is a very wide range of child behaviors that get labeled as "symptoms" of "mental disorders," but are very likely signs of shame sensitivity. Don't be confused by a presentation that includes diverse behaviors; children often use a variety of shame management strategies.

Clinicians would be advised to listen fully to all history and background given by parents and caregivers. Don't latch on to the first symptom you hear about and hone in on a diagnosis that matches: "He's full of energy and can't sit still: Must be ADHD!" You may miss very helpful facts that provide deeper understanding of the primary emotional state driving behavior.

Look beyond the child's symptoms to their life experiences, especially those that may have made them feel different or less than. Assess for low-income status, immigrant status, racial identity, religious differences, gender or sexual identity, chronic illness, or physical difference or disability. Even coming from a divorced family, despite its ubiquity in society, can make a child feel different from peers.

Ask the parents when a specific behaviors occurs and you will likely see it is after the child has been corrected or criticized.

Here is a typical (fictionalized) child presentation statement from an intake assessment: Jaden Smith is an 8-year, 9-month male referred to therapy by his father and stepmother for concerns about anger, oppositional behavior, and tantrums that started at age two but which have recently increased to become disruptive at school and home. Parents report he exhibits excessive anger, screaming, and crying in inappropriate settings. Jaden is also forgetful, aloof, and has poor focus. He becomes dissociated and acts "checked out" and "hyper focused on something else" when challenged or corrected. Has low self-worth and makes very self-deprecating statements ("Tell me I'm the worst person in the world." "I hate my brain.") Is hyperactive, has high energy levels, is pressured in speech and behavior. Can appear "goofy" and clingy. Had sensory issues when younger of disliking tight clothing and fearing loud noises.

Using the DSM's arbitrary list of disorders, this child could be diagnosed with attention-deficit/hyperactivity disorder, dysthymia or depression, and oppositional-defiant disorder. In reality, he has shame intolerance issues that are being exhibited in a diverse set of behaviors and reactions. For example, a child who is hyperactive or oppositional can easily be identified as emotionally reactive, agitated, and sensitive to threat. Since this looks like "fight-or-flight," it also signals a clinician how to treat it. This child is fearful. He needs a calm environment and to learn to calm himself in any environment. The source of this fear may be feelings of unworthiness. Therapists can look for lack of attachment to parents, along with poor parenting skills that hinder secure attachment and increase feelings of fear. Parents may be shaming the child, also triggering his unworthiness, fear, and hyperactivity.

In other cases, a child may have a history of varied behaviors throughout his life. From a very young age, Mark did not integrate well socially or emotionally. He did not have the "terrible twos," with normal levels of emotional outbursts. Instead, he was almost overly compliant at a young age. However, around age 4 he suddenly became very oppositional. He had an behavior plan at school because his anger was so severe there were times when seclusion and restraint were necessary. He repeated kindergarten and matured somewhat, so that by third grade he was more average in his behaviors. Now nine, he is described as "a really good kid, really well intentioned, smart, very funny." However, he also appears to become depressive and chooses to isolate and withdraw. Mark alternates in mood between very happy and confident, and irritable, tense, and even weepy. He reports intrusive thoughts that come and go. Some thoughts involve a general fear he may "do something bad" or "something bad happening." We can see that Mark may have early in his life engaged in oppositional or Other-blamer behaviors and now is more Self-blaming and depressive. The current issue is important, but the history can indicate a pattern of poor shame tolerance, although with differing presenting behaviors.

These descriptions are broad concepts that should be applied in age-appropriate ways to individual children. Clinicians should, of course, bear in mind developmental norms. For example, most six-year-olds go through a phase of being fearful of criticism and can be know-it-alls, which are in service of development of their self-concept. Watch for long-standing patterns of extremes of behavior that are not age-normative.

Following is a list of specific "symptoms" or presentations that are linked to poor shame tolerance (in alphabetical order):

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Academic performance that is widely variable: Barring cognitive deficits or neurodevelopment conditions such as dyslexia, assess for academic performance that may vary widely between subjects or may suddenly fall. This can be a sign of resistance to intrusive parents or to fear of failure. Many students are not challenged much in elementary school and get easy As. Then when they arrive in middle school or high school the coursework gets more difficult and they suddenly have to work harder to get an A. This can be a shock to their shame tolerance. They have no skills to cope with the "failure" of getting a B, so they start to engage in avoidance (ignoring or forgetting to turn in homework), low motivation, low persistence on task, or refusal to study. Often parents then get over-involved with checking and reminding, which can provoke more feelings of shame.
Anger, hostility, opposition, and excessive arguing: Just as with adults, children externalize with anger directed at others (Other-blamers). They may argue persistently over minor issues rather than change their opinion and capitulate. It should also be noted that children have good instincts for when they are being treated harshly or abusively and may push back with indignation.
Anxiety or fearfulness: Just as in adults, worry is often a sign of low self-worth. If a child feels inadequate, she will be hyper-vigilant for social exclusion or feelings of unworthiness. In children, anxieties often are expressed as specific fears, such as fear of the dark or thunderstorms. Some children become anxious as an adaptive, passive response to a dominating, authoritarian parent. The child is on guard and "walking on eggshells" to avoid doing something wrong and triggering a parent's shaming reaction. The child has adopted a survival strategy of constant submission, but this leads to feelings of helplessness, powerlessness, and lack of self-efficacy. When facing an uncertain outside world, they feel disempowered to handle it, which is expressed as specific or generalized anxiety. Childhood anxiety can arise if they feel rejected by the parents, so that the child becomes anxious because they fear further rejection. Sometimes a child's anxiety can be a learned experience of parent's anxiety and expressed worry. I find many parents today, themselves raised exposed to "stranger danger" and school shootings, vocalize worry about frightening events in the world.
Autism spectrum disorder traits: While causes of autism spectrum disorder may be complex, research shows that those with ASD have less proneness to guilt and other prosocial emotions. Additionally, the study found that children with more-severe ASD symptomatology were more prone to hubristic pride — what might be considered Other-blamer traits. The ASD behaviors of low affect and avoidance of social engagement might be an avoidance of disapproval that causes a freeze response in social settings.
Avoidance of school or social settings: A 10-year-old child dreaded school and yet did well academically and socially. She revealed a difficult memory of failing a test in second grade and feeling deeply embarrassed. On the surface she was compliant and nice, but internalized feelings of dread, avoidance, and anxiety. School avoidance can indicate a child who has already adopted a pattern of Self-blaming and may be trying to avoid situations that might provoke judgment or inadequacy.
Boredom, ennui, and low vitality: A child who alleges to be frequently bored and disinterested or who presents with low energy may be avoiding finding interest in activities or friendships as a way to avoid taking risks. Low vitality may also be a way of expressing superiority, as in "I'm better than you so I don't have any interest in boring things like you do." I've worked with adolescents who have developed detachment to express rebellion against intrusive parents who force interest in things or over-schedule the child. Often a bored child has a sibling who is an over-achiever.
Bossiness and rigid rule following: Sylvie got into trouble at school and angered peers because she compulsively told them when they weren't behaving well or following rules to her standards. She shushed them when they talked in class and loudly corrected them if they didn't line up correctly for recess. Her tattling to the teacher made her unpopular. Peers named her "The Corrector." Bossiness can be confused with bullying, but they are slightly different. Bossiness is less about dominance and more about wanting things to be perfect. Bossy children are more likely to have predominantly Self-blaming traits, whereas bullies have more Other-blamer tendencies. Bossiness is often a sign of the child's inner monologue: Do this, don't do that, follow the rules, be perfect. This internal messaging is so powerful the child will start to externalize and act like a sheepdog, corralling classmates or overcorrecting and parenting siblings. These kids are highly rigid with themselves about following the rules, so they expect the same high standards of others.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Bullying: Children who dominate others almost certainly are copying parents who unfairly exert power and dominance. They like the feeling of being powerful because others are less likely to question them and provoke shame. Parental rejection can also provoke a child to feel weak, shameful, and powerless. The child may attempt to compensate by up-ranking himself. Children quickly learn that dominance and angry, externalizing behaviors feel protective of shame. Their brain becomes habituated to anger as a safe experience because it relieves feelings of unworthiness and powerlessness.
Comparative thinking and narratives: Watch for stories that involve excessive comparisons to others. This might be a self-aggrandizing story about how they are the best baseball player on the team or how they beat their brother at a video game. In contrast, some kids may become anxious and self-deprecating as they worry about who got the best grade on a math test. All humans engage in social ranking assessments. High levels of social comparison are even considered normal in teens. Excessive social judgments in younger children are more unusual. Be sure to assess for exposure to adults who engage in social comparison either directed at the child or the child witnessing this behavior being directed at others. Feelings of inferiority heighten social comparison patterns. Other-blamers will compare themselves with others as a way to feel superior. This can appear as the grandiosity, self-aggrandizement, entitlement, and vanity of classic narcissism. Self-blamers can become highly comparative as well, but attack themselves to correct flaws and be viewed as acceptable.
Compliant and submissive: Self-blamers are generally people-pleasers who are highly compliant and submissive toward authority figures. While this is an easy child to parent, the child might be anxious. Be sure to assess for parent personalities that may be more authoritarian or narcissistic. Children raised in these homes develop submissiveness as a way to cope with a dominating, abusive, or self-absorbed parent.
Defiance and refusal to submit or listen to authority: Some children will express the sense that if they give in to a parent's requests to do a chore that this feels like losing — a clear indication that their shame has been triggered and they feel down-ranked merely by doing a task. Children may defy rules because to submit to authority feels like an admission of fault and a loss of social standing. Often this behavior occurs only if others are watching, because the child is more embarrassed at being disciplined and shamed in front of peers or siblings. Usually one or both parents also struggles with submitting to others.
Deflection with humor or odd behaviors: I worked with one family where the child would react oddly when disciplined — by making faces or strange 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 they were doling out. He had learned to divert from overwhelming shame with odd behaviors. One child would even growl, hiss, and act like a monster, but he only did this after his sister called him an embarrassing name. Children may also use these behaviors as manipulative attempts to divert parents from holding them accountable.
Deflection with vague and tangential narratives: This is a more subtle assessment marker, but can indicate Other-blamer traits. Watch for a child who frequently changes the subject when being questioned or whose explanations for behavioral problems are vague. This may at first appear merely to be a sign of an easily distracted child who is excited to tell you a new story. But it could also be a child carefully diverting from a subject they'd rather not discuss — such as an embarrassing behavioral issue.
Dissociation and lack of reciprocity: Children who have experienced relational or complex trauma have concluded 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 struggle to read or respond to social cues in reciprocal ways; flat or constricted affect; and low expressed positive emotions of joy, relaxation, or playfulness. Some children will blank out during sessions when they feel especially threatened, ashamed, or fearful.
Dreams or intrusive thoughts: Because feelings of unworthiness are disempowering experiences, watch for dreams or intrusive thoughts on that theme. I've heard children talk about dreams of losing a limb, going blind, and of not having teeth. Self-blaming children may already have guilt and fears of doing something wrong that show up in dreams or specific fears, such as being afraid of accidentally hurting someone.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Eating disorders: Anorexia and bulimia are widely recognized as shame-based, with sufferers often expressing dislike of their body and a high need for social approval regarding their appearance. Blythin et al found that individuals with anorexia and bulimia nervosa typically experience higher levels of shame compared to controls. Moreover, shame is positively correlated with the severity of symptoms and the onset of eating disorder-related difficulties.
Emotional fragility and excessive crying: Highly sensitive children may respond to discipline, criticism, or direction with over-reactions such as running off, hiding, 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.
Emotional regulation deficits: All children struggle with cognitive control and emotional regulation skills. However, children with low self-worth live chronically in a world of fear, dread, and anxiety. Nearly any situation is a possible threat — playing with a friend may mean they could get teased, learning to ride a bike may bring feelings of failure, losing a game may bring feelings of embarrassment. A child in constant fear of shame is a child who will be anxious and hyper-vigilant — leading to even worse emotional regulation.
Entitlement and demanding behaviors: When children are victims of adult mistakes they begin to feel destructively entitled. Permissive parents, of course, can also train children to be demanding and entitled. Other-blamer traits can be exhibited in stereotypical narcissistic ways with inappropriate demands. A child may state expectations that they are above the law and may feel put upon if they are asked to do chores or be on time for curfew.
Excuses and inconsistent narratives: Just as in adult assessment, clinicians should have a finely tuned ear for granular details in narratives. Look for excuses that make no sense: "I couldn't line up on time because my lunchbox was open." Have the child explain a situation several times and watch for shifting facts and narratives that may indicate shame-based lying. Kids will not be very expert at these defenses, compared with adults who have honed the skill, so it will not take much detective work to spot holes in their stories. However, do not point these out immediately to a child, especially early in therapy, to avoid provoking shame that may not be well managed. This is useful mostly as an assessment tool.
Fear of being "bullied" or teased: No one likes being teased, but shame-sensitive children have an especially strong dislike of being laughed at and will be hyper-vigilant to this experience. Because the schools have adopted a low tolerance for bullying and teach students about the subject, some children will latch onto this label and over-use it to describe even minor conflicts with peers. Listen for frequent complaints of being bullied and have them narrate the incident. You'll likely see the child is over-reacting and over-sensitive to age-normal social interactions.
Risk avoidance: I worked with one girl who refused to even engage in simple deep breathing exercises that I was teaching because she feared "getting it wrong and being laughed at." Young children should be reasonably afraid of new experiences that may be dangerous, such as going down a slide or jumping off a dock into a lake. Healthy fear keeps one safe. However, excessive fear of risk taking can indicate fear of failure. Children quickly learn that if they try a new skill and struggle or fail, they will harshly criticize themselves and/or be berated or teased by parents or siblings. The solution they often choose is to avoid the potential for shaming and not to try at all.
Grandiosity, boasting, and gloating: Narcissistic behaviors can take root in childhood with self up-ranking, bragging, and an excessive need to win and be superior. One assessment I use with children is to ask them "What are you good at?" If they struggle to give any answer and are excessively humble, they are likely more of a Self-blamer. If they list many skills they are good at it might be a sign they are more of a grandiose Other-blamer. You can also ask: "What are you not good at?" This should give clues as to their ability to accurately self-assess and be appropriately humble.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Hyper-competitiveness: While it is normal for children to enjoy winning and for them to be competitive in games of all types, watch for an excessive reaction to losing or failure. Signs include cheating, anger, gloating or pouting during games. They may get in trouble at school for arguing excessively during recess and poor peer relationships. During play therapy assess whether they attempt to change the rules in their favor as the game progresses. Assess for poor sportsmanship when losing. An inability to lose gracefully at a game can be normal for young children, but if distress over this is at elevated levels or chronic into older elementary years, it can be a sign of self-worth that is contingent on success, achievement, and praise. Poor sportsmanship will negatively impact peer relationships. Watch for excessive use of comparative and competitive language. The good news is this can be easily addressed in play therapy by engaging in competitive activities and games with the child. Listen for complaints that "I never win," even though they won in the previous game or previous session. Ask them what is going on beneath the anger at losing — is there embarrassment?
Hyperactivity and distractibility only in social settings: Parents may report children who are overly active, overly social, 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 for the reaction or lack of reaction of peers. The child is scanning the environment for social cues that indicate rejection or approval. 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 had distracting thoughts when co-workers walked by his office: "Do they need me? Are they mad at me? Are they ignoring me?" Children have similar experiences, but are unlikely to admit it, especially since the "ADHD" label is so well known that children and parents are quick to cling to this explanation, which prevents a deeper dive into the causes of the attentional issues.
Hyperactivity, impulsivity, and attentional problems: At one level, ADHD symptoms are indicators of an elevated threat response, with hyper-vigilance to danger (sensory sensitivity, lack of focus, scanning for danger) 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 often 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.
Hypersensitivity to criticism or direction: When a child has a tantrum, inquire about what happened just beforehand. Often they were asked to do something reasonable, such as complete a chore or behave appropriately, but this triggered feelings of failure. I had a young child say that even being reminded to brush her teeth made her feel stupid, as if she should already remember to do this task. I describe shame situations for children (and adults) as like a bucket. If they are filling their shame bucket constantly with self-doubts and self-judgments, then when a parent comes along and offers normal, calm discipline or a reminder, such as "You need to feed the cat," the child's shame bucket is full and this small correction feels overwhelming.
Indecisiveness: One child I worked with struggled to make even simple decisions, such as whether to do a puzzle or play a game. When we explored this, she noted that she got distressed because she didn't want to make the wrong decision and that "Mom wouldn't like my decision." A child who has been excessively shamed and over-corrected becomes good at self-rejection and self-criticism, which can make them highly eager for approval from others. Hence, even making a minor decision leads to paralysis as they weigh the outcomes: "Will someone judge and reject me for this decision? Will I judge myself for this decision?" Over time a child (and later an adult) loses sight of her own sense of self, her own needs and values, and has little ability to set boundaries with others. Choices feel not like freedom, but instead a paralyzing threat.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Infantilization: Owen would become very rude toward his mother, exhibiting Other-blamer defensive anger, but then would quickly appear to regress into infantilized behavior. Even though he was a very large seven-year-old, he would suddenly talk in a babyish lisp and his body language would match that of a toddler. He often carried a large stuffed animal toy around with him in public as a prop for these regressed behaviors. He brought this toy to the first two therapy sessions, then stopped, I assume because he felt safe and perhaps did not need that comfort object. Some children avoid normal maturity and regress to baby-talk, cling to stuffed toys or "blankies," and demand hugs or cuddling. This can be a way to find comfort to manage anxiety related to shame. Many times, however, it will only occur when parents are getting ready to discipline the child, so the child manipulatively tries to elicit sympathy to avoid discipline. Usually this infantile behavior gets met by parents with shaming comments, such as "Stop acting like a baby?" I've worked with children who announced, "I don't want to get older" because they knew this would involve higher expectations and accountability.
Insecurities about appearance: Younger and younger children are feeling unhappy about their weight and appearance — even some boys and even at the very young age of five. I recently worked with several elementary age boys who were highly focused on their looks, such as wearing the popular white Crocs or brand-name slides, the front flip hair style, and branded shirts. One boy refused to wear a T-shirt, shorts or bathing suit because he felt too skinny. I've heard several boys in late elementary school state that they believed they should have muscles like pro athletes do — clearly learned from media, superhero movies, and violent video games. Mason, age nine, was brought to therapy because he was having tantrums every morning before school. Turned out he got up 90 minutes before school to shower and style his hair in the front flip style, including using numerous hair products, a blow drier, and a curling iron. If his hair didn't turn out perfectly he would become distraught and angry, often refusing to go to school. Focusing on behavioral changes ("Try a new hair style") may not work until the underlying insecurities about looks are addressed. It's unfortunate this fear of being judged by others, which used to begin in adolescence, has crept into such young ages.
Intellectual grandiosity and hyper-focus on one subject: Henry obsessed about soccer. He didn't hesitate to share the trivial facts and history of the game with his soccer teammates, so they named him "Henry the Historian." His annoying behavior made it difficult for him to make friends. Olivia's father loved car racing, so she became enamored of the subject as well, telling everyone she met about Formula One drivers or engine specifications. These kids want to be experts because that feeling of success brings confidence and superiority over others. They've learned that being questioned feels unsettling; yet on their specialty topic no one can question them because they are the expert, so they get some relief from feelings of inadequacy. It can also bring feelings of connection to a parent who shares the same interests.
Lack of accountability: This behavior can start very young. One child, age six, 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 a definite sign of shame intolerance. If a child consistently struggles to admit fault for very obvious mistakes or choices, this is problematic and indicates Other-blamer behaviors.
Lack of self-care, rebellion, poor decision making: Children who lack warm, attentive, responsive parents often do not learn to be warm, attentive, and responsive to themselves. They may not do what is in their best interest and may not engage in healthy self-care. They may have poor school performance or have little interest in sports or other activities. Consider if this is overall passivity and lack of planning for their future or more active rebellion, that may include substance abuse, promiscuity, or criminal behavior. It is always sad to see adolescents not making good choices because they do not care for themselves — likely because their parents never cared properly for them when younger.
Laziness, poor self-discipline, irresponsibility: Learning to face mistakes with equanimity and accountability is a key skill for fully functioning adulthood and happy relationships. Laziness, poor self-discipline, and irresponsibility stem from parents who do not model these and struggle to consistently and appropriately hold children responsible.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Low self-worth or defeated behaviors: Children may occasionally make overt statements about their negative self image, but children are more likely to make comparative statements, such as, "I'm not as smart as Alexis," or "I'm the worst player on my soccer team." Some will self-label as a "problem child" because of their frequent behavioral issues.
Lying: Other-blamers who fear being held accountable may be especially prone to lying. Notice if this reaches a level that is not normal for the child's age. Unfortunately, many parents will unintentionally exacerbate a child's tendencies toward lying by being highly shaming if the child does make a mistake. This gives the child more incentive to lie in the future to avoid potential shame.
Mediocrity, lack of curiosity, low desire to learn: Shame can motivate a child to be mediocre, but for various reasons. Some kids may want to avoid failing at new tasks or skills, as already discussed, so they don't strive hard at school or other activities. Those with more Self-blaming traits may be hoping to avoid the spotlight, so they underperform, which has the secondary benefit of lowering the expectations of parents and teachers in the future. In addition, underperforming may be child's response to a jealous, competitive, and narcissistic (Other-blamer) parent or sibling. Most children are quite intuitive about how to manage their family system. If they sense a parent or siblings is insecure and would be threatened by a successful family member, the child may unconsciously decide to underperform to avoid provoking an angry reaction in the envious, insecure narcissist.
Negativity, name calling, teasing, and sarcasm: Clinicians should watch for excessive name calling and teasing that serves to socially up-rank the self and down-rank others. Children may also unwittingly engage in labeling others with their own self-beliefs — an outward projection of thoughts of inadequacy that can be a helpful window into a child's core beliefs. Some families routinely engage in teasing and sarcasm and this should be addressed in parenting education. In one case, I struggled to figure out the cause of a child's low self-worth until I saw the father tease the daughter in therapy and learned that the entire family engaged in sarcasm and very personal teasing on a daily basis.
Obsessive thoughts and compulsions: Watch for an excessive focus on being being orderly and craving routines and structure. Note unusual inflexibility, such as an insistence at following tasks in a certain order: "I have to brush my teeth first, then put on my pajamas." Often there may be "meltdowns" if the order is altered in any way. This can indicate a comfort with predictability because it ensures that tasks are done "right."
Over-achieving: Saniya came to therapy because she would become anxious on Sunday nights. I learned that the school released a new homework packet online at midnight on Sundays and she would jump out of bed on Monday morning and rush to complete the entire week's worth of homework before school. Saniya would become panicked and angry if she couldn't do homework correctly and or finish it all before school on Mondays. No amount of explaining by her parents that she had all week to complete the packet would dissuade her. She also refused to wear pajamas and insisted on wearing school clothes to bed on Sunday night so she could save time in the morning. She would sleep poorly on Sunday nights as she worried about completing the homework in one day. While this might be viewed as admirable behaviors of a responsible and diligent child, it is excessive for an elementary school student.
Pathological Demand Avoidance: Some school personnel have started using a new, fabricated diagnostic term for shame intolerance: pathological demand avoidance. This term indicates a child who refuses to comply with demands or instructions. However, we have learned that this behavior is almost certainly because the child feels shame or weakness, or experiences down-ranking when told what to do. They may also be using non-compliance to avoid failure. The result is either avoidance, extremely passive compliance, passive or overt refusal, or oppositional and defiant behavior. Although the DSM fails to address the impact of shame intolerance on human behavior, we don't need a new pathologizing label for simple shame intolerance. What we need is a more accurate mental health paradigm that de-pathologizes normal human emotional reactions, especially for children.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Perfectionism and fear of failure: 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. He would refuse to transition to a new task until the first task was done perfectly and would have a tantrum if forced to stop. Clinicians should watch for perfectionism or slow task completion as signals a child is working hard to avoid failure and shame. One child became irritated when his father simply asked, "How was your day?" He revealed that when his father asked questions "it makes me afraid I'll give the wrong answer." I once was reading a book with an eight-year-old and asked him to read a page. He stated he couldn't read, which surprised me, because his parents had not reported this. I let it slide, because it was one of my first sessions with him and I didn't want to question him in case it was true. Yet 10 minutes later he easily read game instructions. He was so afraid of failure when I asked him to read that he denied even being able to. Failure is a powerful fear.
Poor peer relationships (limited in quality, number or duration): Children with low self-worth may self-isolate from peers to avoid peer rejection. Other-blamers have difficulty in relationships because when shame is intolerable they turn off social compromise skills. Watch for reports that normal, age-appropriate conflicts cause the child to become angry at peers or reject peers. This may show up as irrational beliefs that peers dislike them or as jealousy if a friend makes a new friend or plays with someone else. Watch for a child reporting feelings of persecution and that peers are "picking on me." They may report strong feelings that friends are not dependable or judgmental. I often find that a shame-sensitive child is over-sensitive to normal peer interactions. Watch for inappropriate social skills, such as being too abrupt at joining groups or demanding that friends play they way he wants to or follow his rules. Poor social skills can be a sign a child is over-eager to get peers to like them. Peers might find a child annoying because he adopts repetitive behaviors or jokes in an attempt to connect with peers. In contrast, a child who has given up on caring what others think of them may engage in bullying or other hostile behaviors.
Procrastination, poor persistence, low effort, poor frustration tolerance, low motivation, and lack of resilience: Some homework refusal and school resistance can be normal. However, an elevated defeatist mentality may be indicative of shame avoidance and the "fold" response. A child may be giving up due to low self-worth and a fear of failure in an attempt avoid feelings of shame. Likely cognitions include: "Why should I try? I'm not smart anyway. It's not worth it. I'll fail anyway and look like a fool." Or, "Why should I try? If I fail my mom will yell at me for a bad grade and I'll feel terrible and guilty. Not turning in the homework seems like a smarter choice." Not trying can also aid in justification: "If I don't even try and then fail, I can tell myself it wasn't really my fault." I've had children admit that the reason they didn't turn in homework — which was already completed — was because they feared getting a low grade. Failing by not turning it in felt less shameful than failing by earning the grade. 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. Unfortunately, this lack of persistence often results in additional shame from teachers and parents who increase pressure on academic performance. Clinicians should assess for variable aspects of frustration tolerance: Can the child persist with easy tasks but not with difficult tasks? This may signal they are giving up when things get tough and they think they will not succeed. Watch for variable persistence in different settings, such as a child who can work hard on their tennis team, but gives up easily with schoolwork. They may have concluded that they are good at tennis, so will continue to try hard, but are not good at academics, so quitting is the best strategy to avoid shame.
Quitting tasks and activities: It is a difficult challenge for parents to determine if they should let a child quit an activity. A child may say they don't enjoy an activity anymore, but is letting them quit teaching them a healthy lesson in resilience and persistence? Perhaps parents should honor this wisdom of a child who knows they have no musical ability or aren't tall enough for volleyball. Clinicians can look for a child who wants to quit too easily, such as quitting the soccer team after only one practice.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Responsible and overly serious, inability to relax and be playful: Self-blamers often present as worried and overly responsible, sometimes for themselves, but also for others. Some children become parentified, taking on worry about a parent's emotional state, substance use issues, job security, or financial issues. Others may be given responsibility for siblings, especially if parents work or are addicted or low functioning. One middle schooler I saw was a twin and the twins had the same classes. During the Covid pandemic they also were in virtual classes together at home. My client was overly worried about her own performance and fretted excessively about homework completion and grades. Her twin brother was much more relaxed about his performance and often put off homework until the night before it was due. He would ask his sister to help him with homework, sometimes even waking her up after she had gone to bed. She started to believe that she was responsible for his success and would stay up late to help him.
Rushing on tasks: Related to hyper-competitiveness, this is a more unusual presentation of shame intolerance. I saw one young man who had decided that getting done first on school tests and projects was his marker for superiority over classmates, not the grade. He craved the feeling of success when he finished first, which boosted his feelings of worthiness. He had difficulty seeing his strategy was actually leading to lower grades. He could control when he finished, but might have felt that he couldn't control the grade. Rushing is often identified as an ADHD symptom, but may be a shame-based issue.
Self down-ranking and submissiveness: In contrast to hyper-competitiveness, some children present as very lackadaisical about winning, perhaps indicative of Self-blaming. This may appear at first to be a sign of good sportsmanship or a mild temperament, but when paired with other shame-related behaviors, it can be concerning. Parents may report this behavior or you can assess in play therapy. The child may appear disinterested in games and may consistently gravitate toward puzzles or playing with toys. They may outright refuse to play games if you insist or may hesitate to keep score. Another shame avoidance strategy is to make minimal effort to learn the rules. This gives them an out when they lose or make a bad play. They may not play with strategy or deliberation and reasonable competitiveness. I often use the block tower game Jenga in play therapy because it is easy to learn and the surprise factor in losing helps me assess for a child's instant reactions to disappointment. Midway through a Jenga game, many children will announce that they want to pull out a block and see if the tower will still stand, similar to the magic trick of pulling a tablecloth out from under dishes. In actuality this is a way to get out of playing a game they think they will lose. This always makes the tower topple, but I watch for feelings of relief that the stress of competition is over. I worked with one child who consistently engaged in oddly high risk-taking during games, but with very poor judgment given her overall intelligence. I believe this was an attempt to position herself as having an excuse if she lost.
Sensory and somatic issues: An elevated threat response system uses hyper-sensitivity to sensory inputs as part of the survival arsenal. As a result, children may develop somatic complaints, such as stomach aches, headaches, fatigue, poor sleep, or just feeling vaguely unwell. They may dislike certain foods based on texture or smell. Loud sounds or crowds may overwhelm their nervous system. This hyper-vigilance means they may struggle to focus and concentrate in school classrooms which are often very loud. Classrooms also involve possible social threat of rejection or judgment. The child's harsh inner critic or the judgments of teachers, peers or parents may be the only trigger for anxious somatic symptoms.
Shyness and poor eye contact: A kid with low self-esteem and confidence may adopt a submissive posture, resulting in poor eye contact and poor social skills. Some parents make the mistake of forcing a child to make eye contact when the child has done something wrong. I had one parent who would hold their son's shoulders and force him to look at them during punishments. Then they would scold him for his lack of eye contact — exacerbating his shame at a very difficult time. His poor eye contact was the result of shame and deference, not disrespect.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Social anxiety: Parents may report a child who gets overwhelmed in group settings, perhaps to the point of dissociation. There may be problems with somaticizing prior to attending school or social events, such as complaining of stomach aches or headaches. These may be real somatic experiences or malingering in an attempt to get out of an event. Remember Gavin from the start of the book? Gavin's bad behaviors got him kicked out of two daycare centers. At the second daycare on his first day he froze at the door and screamed, "I don't want to go to this school." Because he had been disciplined in the past so often, he had already learned to dread new situations — where he might be criticized, lose his temper, and be labeled as "the bad kid." So he developed anxiety about situations where this might occur. I've found that many children are afraid of new social settings because they may not know the appropriate behaviors that are expected: "Where do we sit in church?", or "Will I have to jump off the diving board at a pool party?" Many children entering middle school report fears of not finding their way to classes on time or forgetting their locker combination. While normal, these fears can be debilitating if present in children with minimal resilience and shame tolerance.
Socializing and "frequent out of chairs" in school: Some children engage in excessive joking, clowning, and disruptions in school. They might have disciplinary notices about not being focused because they are looking around class and not doing schoolwork. Ask about this behavior and you may learn they are looking to see whose eye they can catch so they can make a joke. I've had several cases where the child complained about others making noise and that this distracts him and he can't focus. I deduced, though, that he was the source of the distraction and he was blaming others for his own faults. Consulting with the schools can also provide insight, as they may confirm that the child is looking around and causing disruptions. This is not "distracted" ADHD behavior, but is driven by the child's craving for peer approval.
Suicidal thoughts and self harm: As mentioned in Factor 3, teens and pre-teens are especially sensitive to being ostracized. Their brains are developing in ways that increase sensitivity to these experiences. They become hyper-vigilant to signs of peer rejection and hyper-reactive to real or perceived feelings of exclusion, difference, or feeling inferior to others. Most adolescents work very hard to gain acceptance by conforming to current social, behavioral, and appearance norms. Sadath et al conclude that "humiliation and shame may play even more of a distilled role during periods of interpersonal stress in activating a suicidal process than it might in later adulthood. For instance, the experience of humiliation or shame may deepen the perception of social alienation or thwarted belongingness among adolescent peers, intensify the experience of perceived burdensomeness, and activate capability for self-harm." Other studies have found associations between shame and self-injurious behavior, suicidal ideation, and suicide attempts. Even children as young as four have expressed self-loathing and acted out self-harm, such as hitting themselves, scratching themselves, or banging their head on walls. I've heard children make statements that are clearly indicative of self-loathing, such as, "Why don't you just kill me" and "I want to put a pencil through my neck and bleed to death." Unfortunately, many clinicians and parents will become distressed at this behavior and miss the real causes. They will over-react and quickly hospitalize and medicate, leading a child down a stigmatized path of being a "mental patient," perhaps for years, when all that was needed was a compassionate therapist with a shame-focused approach.
Sullenness and uncooperativeness: When forced to submit to parents or teachers, children may cooperate grudgingly to signal their resentment at being shamed or blamed. Despite complying, they may repeat messages of Other-blaming to themselves ("This was not my fault" or "The teacher is a jerk.") The long-term result can be lack of accountability overtly expressed as anger and blame shifting.
Victimhood: Children commonly describe teachers or parents as "mean", but clinicians should be on the lookout for patterns in narratives of consistently blaming others and feeling persecuted. Note a child who takes things too personally, cannot take a joke, constantly feels picked on by peers and siblings, and thinks everyone is "mean" or "unfair." The stories often don't make logical sense or hold together under questioning. Victimhood can also be displayed when a child engages in manipulative crying when criticized, disciplined, or corrected. They have learned to use this to trigger a parent's guilt and, they hope, reduce punishment. I had a parent say: "He's in a puddle of tears and I just hate to make things worse for him," even though the crying was obviously manipulative. This type of crying will stop immediately when the punishment has been lifted or the child gets what they want.

"SYMPTOM" LIST WITH SHAME-FOCUSED EXPLANATION
Violent threats: In this age of zero-tolerance for school safety issues, parents, school personnel, and clinicians must be careful not to overreact to a young child who makes violent threats toward peers. Certainly, it is important to assessing for access to guns, but it is unlikely that a young child will act on these threats. Instead, clinicians would be served by recognizing that threats may be angry lashing out, likely due to feeling judged or rejected. The local elementary school referred a child to me who had wished out loud that his friend would die and said "I hope you get shot." As we discussed this incident, it became clear that Javier had said he wanted his friend to die after he was laughed at during recess. His shame had been triggered and he over-reacted with a violent threat.

Assessment of Parents and Siblings

Initial Assessment Session

In addition to the above assessments of the child's behaviors and emotions, clinicians should consider the impact of parents' personalities, parenting styles, and emotional functioning, as well as the family history on the child. Here are a few suggestions:

1. Assess for attachment history
    1. Were/are the parents married, never married? Are their relationships stable?
    2. Is/was a parent addicted and emotionally neglectful as a result?
    3. Is/was a parent narcissistic, anxious, or depressed in ways that left the child feeling ignored?
    4. Was the child wanted?
    5. Were there pre-natal stressors?
    6. Immigration history or frequent moves or estrangements can indicate a loss of extended family attachments and cultural heritage
    7. Is the child adopted, in a foster family, or in a blended/stepfamily?
2. Assess for child and family trauma history, especially family or relational trauma, such as witnessing interpersonal violence
3. Assess for general family functioning, structure, and stability
    1. What are family rules and who enforces them and how?
    2. Do children have chores and what happens if they don't complete them?
    3. What is the general lifestyle? Do family members get sufficient movement and exercise, are meals planned and eaten together, is the family prompt or do they rush to appointments, are sleep schedules enforced, is the family relaxed or pressured, does the family play together, etc.?
    4. How does the family respond to stressors of births, marriages, illness, job loss, death, etc.?
4. Assess for parental shame intolerance issues
    1. Do parents hold themselves accountable? How do parents model shame tolerance?
    2. Are they Other-blamers, Self-blamers, or Blame Avoiders?
    3. Does child's behavior remind you of either parent?
5. Assess relationships between siblings (including step-siblings and half-siblings).
    1. Does a sibling have extreme behavioral, substance abuse, or health problems that demand attention of parents?

2. Is a sibling a severe Other-blamer who bullies others, acts entitled, flouts rules, or demands attention?
3. Is there a loss of relationship with a sibling through death, abandonment, or estrangement?
4. Do parents engage in favoritism among siblings? Who is the black sheep or the golden child or the forgotten child?
5. Is there a wide range of functioning (academic, behavioral, emotional, social) among siblings?

An important early step is to assess whether the parents/caregivers are capable of engaging in family therapy and parenting education in ways that are helpful to the child. Some parents struggle with poor emotional regulation skills, poor shame tolerance, and limited self-awareness. They may not be able to moderate their responses in session. Parents with their own trauma and attachment histories may not know what healthy parenting looks and sounds like. They may be unable to engage in empathic and attuned parenting in session or at home. Those with abusive behaviors or moderate to severe narcissistic traits would be harmful to the child if included in family sessions. Some parents have limited ability to consider parenting changes, because they have Other-blamer traits and are likely to be defensive toward a clinician's suggestions.

In cases of divorce, an Other-blamer parent can be so focused on alienating the children from the former spouse that their agenda is in competition with family therapy goals.

Clinicians should very carefully consider if one or both parents can participate in ways that build warmth, trust, and emotional responsiveness with their child. If a person isn't capable of, at the very least, the intention to engage in a loving and kind way, family therapy can do more harm than good. If that is the case, do not proceed with the family therapy protocol. Perhaps the parents can engage in separate parenting sessions. Meetings with the child would be individual sessions only.

In the early sessions, clinicians should be detectives to assess for shame triggers and ways parents may be exacerbating poor shame tolerance. One way to do this is to have parents and children dive deeper when describing a behavioral incident. Don't just stop at the superficial description of behaviors, but be persistent in questioning about the granular details of the incident. For example, if parents report that a child threw a tantrum before getting in the car to go to school ask: "What happened right before he started crying and throwing his backpack on the ground?" Or: "What happened right before he said he was the stupidest kid ever?" Often the clinician will discover a shaming experience that triggered the angry or self-deprecating reaction. Most likely the child will have been corrected or disciplined in some way. Perhaps he made the family late because wasn't putting his shoes on fast enough or forgot his homework upstairs.

Listen to what the parents said to the child or how they said it to ascertain if the parents are being too harsh or the child is too sensitive or some combination of the two.

Keep in mind that parental corrections do not have to be harshly critical or overtly abusive. In some families, the pattern of shaming is so entrenched and the child already so sensitive to shame, that just a gentle suggestion that he should hurry up may trigger a deep sense of self-hatred ("I'm the slowest and stupidest kid ever") or angry defiance ("You can't boss me around. I'm never going to school again.") or sluggish non-responding with procrastination and avoidance (repeatedly"forgetting" to get her homework).

Observe how parents and children interact in session. Many parents have no problem in the first few minutes of the initial session describing a lengthy list of the child's faults — in front of the child. This can only be felt as deeply humiliating to the child. Watch the child's affective responding and the parent's likely failure to notice or consider the child's humiliation. This alone can be quite telling of a probable pattern of excessive shaming, including public shaming, and a lack of empathy and emotional awareness and attunement by parents. Clinicians may need to quickly assess that taking the history separate from the child is important to reduce shame.

Other parents, overly eager to protect a child's emotional state, are extremely vague in narrating the presenting problem and history. These parents also need to be segregated from the child during history taking and given encouragement to speak plainly.

Even what seems like an inconsequential story in a family or parenting session can reveal things about a parent's style of interacting with a child. Let's say you're working with the child on his fear of monsters under the bed. A dismissive parent may say something like: "Oh, don't be silly. There are no monsters anywhere. Grow up and get

over it. You just need to go to bed." Obviously, this dismissiveness of the child's experience can be felt as rejecting. A better way of interacting would be for the parent to use skills of reflective listening, emotional attunement, and warm responsiveness. Training the parent in these skills is essential, of course, but clinicians can also model this kind of response: "Oh, I understand you were scared. It is scary to be in bed alone sometimes when you're a kid, right? I remember when I was a kid and I got scared of the creepy dragon in the closet. I wonder if when this happens again you and your parents could go turn on the light and scare off that monster. You could give the monster a silly name so you know he's just not scary at all."

Inquire about patterns in communication that can trigger shame in a child. One that may fly under the radar is the excessive use of sarcasm by parents and siblings. Younger children don't understand humor in the same way that adults do and struggle not to personalize an experience of being teased. Even if parents are merely being sarcastic when discussing others, not the child, it can train a child to view relationships with others as involving judgment and putdowns. Educate parents on the harmful nature of facetious or sarcastic comments used regularly in family communication. This isn't too say that humor is banned, but deprecatory humor toward others is to be minimized.

At some point in therapy, it may be helpful to check on how teachers and schools engage with the child. Some teachers inadvertently use shame-based styles of punishment. For some children, even a mildly harsh or shaming style of behavior control can trigger feelings of inadequacy, then fear, perhaps escalating into anger or tantrums. The policy at some schools is to remove a student to the office when they misbehave, an act of public shaming that is probably beyond a child's ability to cope. Another form of public shaming is the use of "clipping" or reward systems that publicly identify which children are acting out. Heavy-handed public shaming may lead to unhealthy levels of guilt and shame.

Parenting Styles and Their Impact on a Child's Shame Tolerance

All child experience normal struggles with feelings of inadequacy when learning new behavioral, academic, or social skills. Shame-deficient families have a great impact on whether a child learns to tolerate these shame provoking situations in healthy ways.

Often, the biggest problem is parents who do not model or teach emotional regulation in moments of shame, so a young child does not build skills to manage this difficult experience. Parents who engage in Other-blaming behaviors are especially harmful when it comes to exemplifying inappropriate shame coping skills.

In these families chronic shame has become a learned response, provoking feelings of not being safe with confrontations, honesty, and accountability. The child learns maladaptive responses, such as self-blaming, defensive anger, or withdrawing.

Parenting styles can be difficult to ascertain in a clinical setting away from the home environment. Clinicians can observe during the assessment how parents generally respond to a child. Therapists may have to ask specifically about parenting styles. Three main styles are considered as general guidelines: authoritarian, permissive, and authoritative or democratic. Following is a very brief description of several styles. Consult parenting books for more in-depth descriptions.

Democratic or Authoritative Parenting

The ideal form of parenting uses age-appropriate and developmentally appropriate expectations to give children responsibility for self-control, task completion, and relationship norms. Focus is on the relationship, using warm, but firm, communication. The expectations are for prosocial behaviors, such as mutual respect, cooperation, kindness, and reciprocity. Children tend to gain healthy skills at responsibility, cooperation, independence, respect for rules and authority, and problem solving in their own lives and in relationships. Importantly, parents use age-appropriate levels of discipline, criticism and shame, focusing on educating and guiding rather than punishing and shaming. They hold children accountable for age-appropriate behaviors with a balance of firmness and love. Parents should be firm but loving in their correcting comments, and seek to provoke some guilt in the child, but not use excessive shaming. Emotional support should be balanced with encouraging resilience. Parents teach shame tolerance by being available to help the youngster work through experiences of guilt when they make a mistake.

Parents, most importantly, consistently model and teach healthy shame tolerance skills in children. Only when parents learn to tolerate shame themselves are they comfortable teaching a child how to be appropriately ashamed of bad behaviors, how to express accountability, and how to stop behaving in shameful ways.

Authoritarian, Autocratic, or Punitive Parenting

Caroline was a smart, verbal 9-year-old girl, yet when I asked her how old she would be on her upcoming birthday, she began acting oddly and couldn't answer. When pressed she said she would still be nine. I knew she had no cognitive deficits so I considered that some children can become paralyzed when asked difficult questions for fear of having the wrong answer — but this was not a difficult question. I wondered why she was denying turning ten. With a bit more questioning her fear of failure appeared as the reason. She stated adamantly that she didn't want a birthday party because turning 10 would mean she was older and she had failed to be successful at behavioral changes that she was in therapy to address. Her authoritarian father frequently used the phrase "Stop acting like a baby." Caroline had fears that if she turned 10 and still "acted like a baby," this would further provoke her father's anger and punishments.

Communication from authoritarian parents can be humiliating, hurtful, disrespectful, or even verbally abusive. They believe they must be forceful, controlling, and adversarial with children. The power dynamic is often about parents winning and children losing. This type of parent focuses on issuing orders and demanding respect. They believe the job of parents is to manage children and solve their problems for them. Authoritarian parents, because they are insecure, often feel disrespected even when a child makes a reasonable request.

A common trait of authoritarian parents is to be harshly judgmental and have unreasonable expectations. While children need to hear criticism about inappropriate behaviors, overly harsh or overly frequent criticism creates children who are hypersensitive to criticism, discipline, or correction. Parents fail to realize the irony that the more they shame their child, the less likely it is the child will learn to handle healthy levels of shame and guilt. A child cannot learn from guilt if they have developed defenses to it.

Children respond to autocratic parenting in two main ways: 1) anger, defiance rebellion, and stubbornness, or 2) fearful submission, avoidance and withdrawal. Children may become thin-skinned and internalize in Self-blame or become thick-skinned, to the point that they may feel no remorse for their actions and may develop antisocial tendencies. Strict parents direct excessive amounts of criticism, guilt, and shame at children, overwhelming their ability to handle these experiences, so they cope with the use of Other-blamer strategies. Harsh, controlling, and authoritarian parents can create narcissistic children by teaching them that "might makes right."

If clinicians suspect a punitive style of parenting in a family it may be necessary to assess for the use of physical violence in the home. Some parents may confess to this as a reason they are entering therapy — they hit their child and feel very guilty about this. Others will deny spanking or physical violence or will mention it in passing because it is a normal and expected occurrence. You may choose to investigate further when alone with the child. Use creative questioning along with observing play therapy themes that involve violence.

As an intervention, it may be helpful to educate parents that spanking has been extensively researched and found to be detrimental to children. Straus et al summarize research on over 7,000 U.S. families and data from 32 different countries that found that 90 percent of the studies agree that spanking is not good for children.[91] Spanking harms mental development, weakens emotional ties between parents and children, and increases the risk children will be violent to other children and to adult partners.

With an authoritarian parent, the child experiences excessive control and overwhelming shame. Children will carry this inner critic into adulthood, manifesting as feelings of worthlessness, guilt, low self-confidence, and anxiety or depression. It may also show up as lack of independence, lack of self-direction and agency, and inability to make decisions. Children need to first experience the compassion of a caregiver so that they can internalize this experience and be a compassionate caregiver to themselves in adulthood.

Some children of heavy-handed parents become narcissistic as a way to cope and disperse their own feelings of insecurity. They model the narcissist's grandiosity, impetuousness, self-centeredness, vindictiveness, and lack of empathy.

Straus, M. A., Douglas, E. M., & Medeiros, R. A. (2014). *The primordial violence: Spanking children, psychological development, violence, and crime.* Routledge/Taylor & Francis Group.

Permissive Parenting

Permissive parents believe that children will cooperate when they understand that cooperation is the right thing to do. Power is often ceded to the children who engage in lots of negotiating, excuses, and willfulness. Children begin to believe that they don't have to follow rules and may act entitled and demanding. The power dynamic may look like the parents are serving the children. This may be obvious in how parents and children communicate and interact. In the therapy hour, I often see children ordering parents where to sit, issuing commands to parents or to me, and speaking very disrespectfully.

Permissive parents rarely stick to punishments and consequences consistently. Children of permissive parents may fail to develop mature functioning, motivation, autonomy, and independence because they are not held accountable for normal tasks such as chores, homework, and age-appropriate self-control. The permissive parents are probably doing all the work of being responsible, so that the child does not have to hold themselves accountable.

Kurtz and Ketcham note: "If [parents] ignore the consequences of irresponsible actions by claiming or asking for unconditional forgiveness, then forgiveness loses its significance — it comes to be interpreted as not caring… When behavior, no matter how selfish or bizarre or hurtful, is repeatedly met with what is intended to be unconditional forgiveness, one must wonder whether 'who I am' or 'what I do' matters at all. What is needed in such instances is not unconditional forgiveness but confrontation."[92]

Children of permissive parents also tend to test limits, challenge authority, defy rules, and ignore parental directions. Because permissive parents often negotiate too frequently with children, the children learn they can wear parents down with arguing, anger, martyrdom, or emotional meltdowns that induce parental guilt.

When children are brought in for issues with excessive arguing and refusal to submit to authority, assess for parents who argue or negotiate with children. In one case, Bradley had developed the habit of frequently asking his parents why he couldn't do something. His parents would answer, setting up a negotiating/arguing pattern that often escalated into heated conflict. Bradley would become angry and violent, which earned him further shame.

After excessive negotiating, permissive parents may decide at some point they've had enough. The child, however, has had success with a strategy of persistence and eventually getting his way, so he has no motivation to stop arguing. When the parents shut down the argument, he becomes angry. If he gets in trouble for his outburst, it creates a shame-provoking experience of "losing the argument." Parents don't realize that this entire scenario just strengthened the child's Other-blaming tendencies by making him feel unfairly punished; he likely sulked with thoughts of injustice and blamed others for his own failures.

One goal of parenting is to develop children who have a healthy balance between self-interest and community interest. However, many children in today's hyper-individualistic Western cultures do not learn how to subsume personal needs and cooperate in relationships or in social groups. Permissive parents create self-interested children who may lack empathy for the needs of others.

Permissive parents are sensitive to shame, so they feel "bad" when disciplining children, even if those corrections are healthy for a child, such as telling them to be home by a curfew or do their homework. Permissive parents may try to protect children from guilt by not setting or enforcing consistent rules and may bail children out of problems. While this may be easier in the short term, children need to learn to follow rules and accept consequences, otherwise they will struggle to navigate the adult world that is filled with laws and norms. With weaker parents, a strong-willed child learns that if he pushes back parents cave in because they are afraid to hold the child accountable. The parent becomes submissive in the face of a domineering child, which exacerbates a child's Other-blamer tendencies, rather than moderating them.

Some passive parents fool themselves that they are forceful parents because they ignore a difficult child's behaviors and only correct the easier sibling who gives no pushback. Obviously, children often notice this unfair parenting style and the over-corrected child becomes resentful and the under-corrected and favored child becomes an entitled Other-blamer.

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[92] Kurtz, E., and Ketcham, K. (2002) *The Spirituality of Imperfection: Storytelling and the Search for Meaning.* Bantam, p 224

In addition, I find that parents and schools, perhaps through efforts to boost self-esteem may coddle children. A child who never loses or never gets anything but an A in school doesn't have an opportunity to learn how to handle imperfection or failure with resilience.

In one family, both parents worked and felt guilty about that, so they allowed the children to do anything that made them happy. They let the kids play video games for hours and spoiled them with gifts. Their son Carter learned to manipulatively cry when told to quit gaming. The father interpreted this as Carter being "depressed" so he gave in to Carter's demands.

Permissive parents often overuse rewards to garner child compliance. While rewards may at times be helpful and meaningful as a way to get children to work toward a goal, I've seen this backfire. I worked with Dallas and his parents on his severe food restrictions and limited palate of eating only a few types of foods. I ruled out risk aversion as a reason, as Dallas was a very confident child who was not afraid of trying new things in the rest of his life. It turns out Dallas was opposed to being "forced" to do anything, including eating new foods, unless there was a reward attached. His parents had almost exclusively used enticements to get him to behave, so his philosophy was that no adults could "make" him do something without awarding a prize for his behavior. He had concluded that if there was no reward it was equivalent to him being "forced" to do something. In his mind no reward was actually a punishment. Obviously, I recommended that the family cease rewards-based parenting.

Intrusive Parents

As someone who was raised in the 1960s, I find it interesting that the pendulum has swung from the free range-style of child rearing that I experienced to one that is now much more intrusive and over-protective. I grew up playing independently outdoors much of the time. I rode my bike miles and played in woods and fields more than a mile from home throughout elementary school. Starting in seventh grade I routinely rode my bike three miles to school. Everyone walked or rode the bus; parents never dropped their kids at school.

Today, children are rarely out of sight of their parents and get constant safety messages regarding strangers and crime. Even riding a school bus is considered too dangerous, so parents spend 45 minutes sitting in drop-off and pick-up car lines every day.

While over-controlling parents are often well-intentioned, they can have many immediate and long-lasting effects on a child's psychological wellbeing.

Intrusive parents can be most quickly identified by their tendency to be verbose. They talk too much *at* their children, often expressing high levels of worry or behavioral corrections. In setting high standards they overtly or covertly pressure children to perform. By focusing on the child's behaviors, they may be somewhat unconcerned or unaware about the child's thoughts or feelings.

I met one mother, father, and daughter in my waiting room for their second therapy appointment. In the thirty seconds it took the family to walk to my office, I heard the mother say all of this to the child: "Give me your backpack," "No, here, take your water bottle," "Stand up straight," "Sit over here, not over there," "Don't be scared," and "Now be sure to talk to Ms. West about everything we talked about." I had already met with the parents first to get the history of the situation and they had described that their seven-year-old daughter was argumentative with the parents, refused to use the toilet, and was still wearing pull-ups all day and night. In witnessing this family in action for less than a minute, I had a pretty good clue as to the reason for the child's problems with enuresis and encopresis. Intrusive parents can provoke in children a need to exert control and gain a sense of autonomy, perhaps through behaviors such as refusing to toilet train, as this child had. Others may become picky eaters or refuse to eat. In adolescence this may show up as the eating disorders of anorexia or bulimia, extreme rebelliousness, and promiscuous sexual behavior.

When the focus is on safety, intrusive parents can create anxious children. If you work with a child who has general and specific fears, check if the parent is overly verbal about safety issues, such as frequently saying, "Be careful," or "Watch out for…" Over-protective parents may not let children take risks and fail, which then communicates to the child that they are incompetent and that the world is dangerous.

Intrusive parents can create over-striving children when the focus is on school performance. I have had many cases where the parents are involved daily in the child's schoolwork, checking for completed homework, doing the child's homework with them, and asking anxiously about every day's school experience. These parents create

shame by implying that the child is not capable of managing their own tasks and responsibilities, which decreases feelings of autonomy, agency, and self-worth. Rather than teach the child "you can do it," these parents communicate that the child is incapable of handling life. The result can be either a child who is overly striving and anxious or a teen who is low-performing, unmotivated, and "forgets" to turn in homework. Clinicians may read this as "depressive symptoms," but the cause can be intrusive parents who have taught a child dependence, helplessness, and a lack of resilience.

In families with one child, parents can over-focus on that child in ways that negatively impact development. I have seen parents in family therapy sessions stare at a child intensively, even when he is not talking, to the point that the parents rarely even look at me. This may appear that they are very concerned and attentive, but it puts an intense spotlight on the child that causes anxiety. The child learns she is the center of the parent's universe, but this is too much of a burden and emotional stressor. She quickly ascertains she has to please the parent or that perhaps there is something wrong with her, which causes self-doubt, self-criticism, shame, and anxiety.

While I'm not advocating we go back to having large families (the planet can't handle it!), in larger families the spotlight is shared among other siblings in ways that decrease attention on mistakes and faults, allowing children more space to learn and grow in normal ways.

I find that many intrusive parents themselves have low self-worth and feel inadequate as a result of their childhood experiences and traumas. This leads them to try to find reflected glory in the performance of their children as a way to improve their own self-worth. Conversely, they fear the judgments of others if their children misbehave or underperform in public.

Sadly, a parent's poor shame tolerance is then passed on to the next generation. Over-control causes children to question themselves and their skills, leading to feelings of inadequacy and self-doubt that may continue for a lifetime.

Children Re-Exerting Control and Seeking Autonomy

Children have a natural developmental drive to build independence and autonomy. Intrusive parents communicate the opposite — that a child is helplessness and should be dependent. Children adapt in various ways — some become overtly rebellious, some passively non-compliant, and others excessively compliant.

Many teenagers of intrusive parents unconsciously adopt the strategy of low performance, often in the form of refusing to do homework or chores. This then turns into a battle of the wills, with the parents nagging and yelling and the teenager resisting and passively failing to perform. The parent's nagging piles on shame and blame that compounds the teen's feelings of avoidance regarding homework or chores.

Some children say they repeatedly "just forget" to turn in homework, but clinicians can engage in some persistent inquiry, which will often turn up the fact that the teacher announced that homework should be turn in, for example, and the child blatantly did not turn it it.

I work with many young adults who seem to have no opinions of their own, are passive in relationships, and struggle to make life decisions without significant input from others — a likely sign that they were over-parented as children. Overly compliant children can become dependent on others in adulthood, which may lead to abusive, coercive relationships.

Of course, we can look at both submissive and oppositional behavioral strategies as adaptive for children. They may be merely attempting to exert control to protect their own sense of self-value. Shame is a painful emotion and young children will work to find ways to avoid or manage this experience, even if it means they walk around with poopy diapers until age seven or engage in daily screaming matches with their parents.

How To Stop Being An Intrusive Parent

Alison Gopnik in her book, "The Gardener and the Carpenter," says many parents today view their children as entities they can mold into a specific image. They act like carpenters who are over-involved as parents trying to construct children into successful adults. Instead, they should be more like gardeners, providing good conditions and letting the "plants" just grow themselves.

Gopnik differentiates between behavioral control and psychological control, noting that the latter is when parents attempt to manage how a child feels. "Psychological control refers to intruding into children's emotional and psy-

chological development. Controlling parents are unresponsive to their children's emotional and psychological needs. They constrain, invalidate, and manipulate the kids' psychological experience. They also stifle independent expression of emotions. These controlling parents manipulate children's feelings, thoughts or ideas through the parent-child relationship using guilt, love withdrawal, showing disappointment, disapproval and shaming. In addition, they want to keep their kids emotionally dependent on them."

Clinicians can recommend these strategies to reduce intrusive parenting:

- Stop talking too much. Parents can be mindful of how much they talk and how often they offer their opinion or instructions. Silence allows a child to think, consider their own opinions and feelings, and formulate their own solutions.
- Stop focusing so much time and attention on the child. Parents should go about their life and business. Not all conversations or activities must center on the child. This will dial down the spotlight effect.
- Parents can learn to be kind and compassionate to themselves. Parenting, as with many things in life, might best be approached with less striving and effort for best results. Parents may need help seeing that if they let go of the need to control their child they may improve the relationship.

Mixed Styles of Parenting in a Family

In a two-parent home, what happens when one parents is one style and the other parent a different style? A common combination seen in family therapy is one permissive and one authoritarian parent. I often think this is the perfect combination to create an Other-blamer child. The permissive parent fails to hold the child accountable and gives the child permission to escape from blame and shame too often. The authoritarian parent is heavy-handed in their use of shame, leading the child to deflect from this emotion because it is too overwhelming and painful. The child quickly learns to escape the authoritarian parent by playing the victim with the permissive parent who over-protects and enables under-functioning by allowing the child to make excuses. The result is a child who is not taught to feel the moral emotions in a way that is helpful in guiding their behavior. They only learn that shame is painful and must be dealt with through avoidance, excuses, justifications, and rationalizations.

In homes with one permissive and one authoritarian parent they often exacerbate each other's parenting styles. If the permissive parent is too soft with a child, the authoritarian parent feels they must be even more strict, which triggers the permissive parent to coddle even more, and the cycle repeats.

There are other types of parenting that create shame, such as non-protective parents who do not shield children from abuse, neglect, or adult situations. Children can assume they are not worthy of protection and begin to internalize messages of unworthiness.

Dismissive parents, through their lack of emotionality and warmth, send signals that a child does not matter. Cold and invulnerable, this type of parent invalidates a child's feelings through non-warm emotional interactions and emotional neglect. The child often experiences little emotional connection with the parent and struggles to feel seen, loved, understood, and accepted. Children raised in this way often feel like a burden or feel lonely, even in the midst of a busy, active family home. They hope someone notices their pain and loneliness, but rarely speak out to ask for it, because they correctly sense this request will be met with neglect or overt dismissal of their needs. Clinicians can watch for dreams or play therapy themes of fantasies that the child will be found by "my real family" or that they were adopted and will be returned to their birth parents.

The Negative Impact of Narcissistic Parents

Many of the above-mentioned parenting styles are fairly obvious and most clinicians will recognize them. A narcissistic parent, however, can mask behaviors in therapy and may go undetected by clinicians, so it is important to assess for this personality type and its negative impact on the creation of shame in children.

Narcissistic or Other-blaming parents are very often the source of childhood behavioral and emotional problems, so clinicians should not be afraid to assess for this trait in a clear-eyed manner. This doesn't mean you should tell parents they are narcissists or state a diagnosis of them if they are not the identified patient. It merely means to hold an awareness of parental character and personality in your mind, because this type of parent can create many problems for children.

Other-blamers are also very likely to resist parenting education, as it provokes feelings of inadequacy. Therefore, an early understanding of the type of parent you are dealing with can help plan interventions, such as whether to

include them in family therapy or parenting education. If you do engage in parenting education with a narcissist, be prepared to do so very slowly and with numerous validations for the parent's current skills and good intentions. Avoid any shaming messages toward a narcissist to avoid them getting defensive. In family therapy, be very ready to intervene if the narcissistic parent behaves in ways that are critical, shaming, dismissive, or non-warm toward a child.

In general, an Other-blaming parent lacks many important parenting skills that children need, especially in the early years, such as empathy, emotional regulation, selflessness, and patience. The immaturity of a narcissist means they will be self-focused on getting their own emotional needs met; the child's needs will fall to the wayside. Severely narcissistic parents will be overtly cruel, rejecting, and abusive in ways that are clearly harmful. Overall, the result is a child who develops low self-confidence, unworthiness, unhealthy models of relationships, and poor self-concept.

If we consider the basic nature of healthy parent/child attachments, it requires a parent who can engage in calm, altruistic, and warm caretaking. Responsiveness to the child's needs is essential, yet many narcissists lack this basic skill because they are too caught up in seeking to get their own emotional needs met. Quite simply, narcissists exhibit antisocial traits, whereas a child needs high levels of prosocial traits in a parent.

Hoxhaj found that narcissism in a parent could "serve as a barrier to [healthy] attachment and [had] the potential for profound and lasting influences on self-esteem in adulthood."[93] Another study informally linked narcissistic parenting to childhood experiences related to "low trust, feelings of shame, commitment difficulties, and poor relationship strategies."[94]

A narcissist's transactional model of relationships and their inability to love unconditionally means that the child will experience the foundational relationship of their life as involving power, control, and hierarchy, rather than altruism, reciprocity, and acceptance.

Because children learn by observing, a parent who models an inability to admit fault is a powerful negative influence. Children of Other-blamers likely have had few experiences of a parent who apologizes or repairs relationships when something goes wrong. Imagine a scenario where a mother is always running late in the mornings taking the children to school. A child points out this obvious fact and says he doesn't want to be tardy again because it embarrasses him. When the mother reacts in defensive anger, the child learns unhelpful lessons — that he cannot criticize his mother and that admitting fault is uncomfortable. He sees that angry lashing out gets others to back down. Now imagine that this mother's behavior is repeated daily in numerous small ways — lying about the fact that she bought milk when she didn't, blaming the other parent for putting the trash cans "in the way" as the reason she ran into them with the car, etc. With a narcissistic parent, the child may rarely see modeled a healthy way to handle shame by admitting fault, expressing regret, honoring the harms done to others, and changing behavior.

Development of a narcissistic child can, of course, be traced to certain parenting strategies and personalities; narcissists are made, not born. In one of my cases, the parents came to therapy having identified that a major cause of their son's behavioral problem was the grandmother who was living with them who was a severe narcissist. Their son, Jesus, had throughout his first six years experienced his grandmother being verbally abusive to him and his parents. She would on a daily basis engage in blame-shifting and guilt-tripping. The grandmother didn't listen to others and didn't follow through with changes in behavior. She retaliated against family members when she was proven wrong. She cheated at games to guarantee she won, even when playing with Jesus. It was no surprise that Jesus would also cheat at games, refuse to admit he was wrong, and hold grudges. Jesus, too, had to be repeatedly asked to do things and he would fail to comply. The grandmother was actively modeling a lack of accountability, constant boundary violations, and poor shame tolerance.

Shame sensitive caregivers signal to their children that the adults cannot handle the truth. As a result, the children become highly attuned to the emotional state of the parent and learn to protect the parents from shame and accountability. In one family, children Jessie and Deandre were very reticent in therapy. It turned out they were

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[93] Hoxhaj, B. (2023). The impact and the consequences of a narcissist parent on the child's development and mental health. *AS-Proceedings*, 1(1), 131-142

[94] Lyons, M., Brewer, G., Hartley, A.M., Blinkhorn, V. (2003) "Never Learned to Love Properly": A Qualitative Study Exploring Romantic Relationship Experiences in Adult Children of Narcissistic Parents. *Social Sciences*. 12(3):159. https://doi.org/10.3390/socsci12030159

afraid to talk about their father for fear it would get back to him. I asked if he had ever said anything about this, and they denied it. They had just intuited, based on his other reactions to criticism, that he would be sensitive to criticism of his parenting by a therapist. So they colluded to protect him from feelings of shame. Children who are more concerned about their father's emotional wellbeing can grow up to be overly attuned to the needs of others, have limited self-awareness and self-protection, and be passive in response to boundary violations. What is now labeled a "highly sensitive person" is often someone raised in a home with a parent whose emotional needs came first and who reacted poorly when confronted.

Narcissistic parents cannot tolerate shame, yet they are often highly shaming and critical toward others. They often adopt an authoritarian style of parenting because they want to project strength, control, and dominance so that the child will not challenge them. They will often state that a child is being disrespectful. While this can be true, be aware that an Other-blamer will view even a different opinion as disrespect. Their shame sensitivity makes them hear any contrary viewpoint as unacceptable. Insecure parents often demand respect because they fear criticism.

"A parent who respects himself doesn't need to buttress his security by demanding respect from his child.. Secure in himself, he will not feel his authority threatened and will accept his child – at times – showing lack of respect for him, as particularly young children are occasionally apt to do. He knows that if it happens, it is due to immaturity of judgment, which time and experience will eventually correct. On the other hand, a demand for respect reveals to the child an insecure parent who lacks the conviction that this will be given to him naturally. What is demanded is given grudgingly, if it all, and is always experienced, consciously or unconsciously, as stemming from the demanding person's inner insecurity. Who would want to model himself in the image of such a person? Unfortunately, the child of insecure parents often grows up like them. Even if he doesn't internalize and thus adopt the attitude of his parents, the lack of self-confident parents is enough to make the child grow into an insecure person."[95]

Narcissistic parents demand that a child be a positive reflection on the parent, putting the child in service of the parent's need for approval. Narc parents also project their own inadequacies onto their children, such as a mother with body image issues who constantly nags her daughter to lose weight. Assess for parents who judge children on body shape, appearance, athletic ability, or academic performance. This may show up as comparative language, overt shaming, or inability to praise a child. Children need an mirror in the form of compliments and realistic interpretations of their skills so that they can internalize these messages and form an accurate self-image. Narcissistic parents are reluctant to compliment others and, instead, are likely to inaccurately label and demean a child. The child will struggle to develop a realistic sense of self and skills.

In general, narcissistic parents make children ashamed of their normal needs, emotions, and problems. One family told the story of their daughter's disappointment at having to leave a playground, which she expressed in normative ways with sighing and one small comment that she was disappointed. The father could not just let her comments pass, but interpreted them as criticism, so he yelled at her for disrespecting him. This reaction, repeated over time, taught the daughter to disregard her feelings: "I can't be disappointed, because dad will get mad."

Some children show up in therapy already having learned that relationships are not to be trusted. They may present as having few or distant peer relationships, fears of being judged by others, social anxiety, and difficulty with conflict or vulnerability.

In contrast to parents who over-shame, some narcissistic parents subconsciously seek to protect children from shame. The narcissist knows how painful this emotion is and projects this desire to be shielded from shame onto the child. The resulting permissive parenting style will show up as families with few rules or inconsistently enforced rules. Being a friend to the child is more important to a narcissistic parent, so the parent gives in, bribes a child with gifts or favors, and treats a child more as a peer. A parent who wants the approval of their children will fail to provide reasonable guidance and structure. I work with many parents who co-sleep with children until they are 10, 11 or even older because they are afraid to upset the child by making them sleep alone. Even while talking in therapy you may notice a parent who rescues a child from feelings of guilt in the conversation by providing him with excuses for his behavior or downplaying the severity of behaviors.

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[95] Bettelheim, B. (1987) A Good Enough Parent: A Book on Child-rearing. New York, NY: Knopf, p. 105

Other impacts of narcissistic or Other-blamer parents:

- Children may dissociate from their feelings and bodily experiences. Watch for a child with few opinions or preferences, hesitant verbal output, inability to identify feelings or somatic experiences, and generalized passivity and deference.
- Children may lash out often with tantrums, anger, defiance, emotional dysregulation, and oppositional behaviors. They likely saw these same actions modeled by a parent, because narcissists are notoriously prone to emotional volatility, defensiveness, and anger. Not only does this cause emotional dysregulation in the child, but he learns that these traits are permissible.
- Children who lie, manipulate, and bully. You might also be able to deduce that a parent has the same behaviors.

Assessing for parenting styles and personalities can be a very helpful shortcut to understanding a child's emotional and behavioral strategies. Often these are directly copied from parents or learned as adaptive tactics to attempt to thrive (emotionally or relationally or physically) in the environment they find themselves in.

Sibling Assessment

Robin came to me in her mid-20s and on the surface she seemed to function very well: She had gotten good grades in her engineering degree program and was beginning her career with a well-paid job. Although she was pleasant and personable, there was a guardedness to her that made it difficult for her to form friendships or intimate relationships. She admitted she worked too much, was perfectionistic, and was very hard on herself, which indicated issues with low self-worth and lack of self-compassion.

As we began working on these issues, it came to light that she lived with her adult brother who barely held down a low-paying job, did not chip in to the household finances, played video games all night, and was a complete slob around the apartment. As we dug further back into her childhood, Robin reported that her brother was a difficult child, then became a troubled teen who did a lot of drugs and got arrested several times. He had argued constantly with their parents, who struggled to manage his behaviors. When I asked how she talked to him about the current issues of chores and finances, it turned out she was scared to confront him and just did all the chores and paid most bills herself to avoid conflict.

As we sorted out her family dynamics, Robin came to learn that as a child she had unconsciously come to believe she had to be the good, happy child. She had to downplay her own emotional needs — maybe even the need to be a little bit bad or unhappy or rebellious once in awhile — because her brother occupied the behavioral niche of the "bad" child. The caring, prosocial aspects of her personality were obvious as she unconsciously chose to not overburden her parents with her needs. Unsurprisingly, she is afraid of setting boundaries or "burdening" her brother as an adult by demanding that he step up and do his share of chores or pay half the bills.

As a child, she witnessed her brother misbehaving, so she intuited the lesson that his behavior got him a lot of negative attention. But she also learned that she got less attention of any kind. Many victims of Other-blamer siblings develop habits of passively waiting for attention, love, or the cessation of abuse in their childhoods.

Sibling relationships can be impactful, especially because siblings may spend more time together than they do with parents. Therapists can learn a lot clinically by examining sibling relationships and the family dynamics that create them. This means it is very important to assess the entire family system, including siblings, step-siblings, half-siblings, others who live in the home, and important caregivers and relatives. Ask parents about how each person gets along with the others and about personality traits. With the child separated from the parents, ask these same questions of the child. Have the child draw pictures of family members and describe their personalities.

A sibling assessment may take some active inquiry work, as parents may label some behaviors as "normal sibling rivalry." Liam, 6, came to therapy because of oppositional language and disruptive behavior. Liam became defiant, hostile, and mean, and would call his mother names ("You are stupid."). He could be bossy and often in a bad mood. He was difficult to settle at the end of day and became "wild, mean, and wound up before bedtime." Turns out this was after he had spent several hours with his sister. His parents eventually reported that his sister, four years older, was very mean and called Liam stupid on a daily basis.

Do not assume, however, that an elder sibling is more likely to be controlling of younger siblings; younger siblings who are bullies can especially fly under the radar.

Be on the lookout for a brother or sister with physical health, mental health, or substance abuse issues. It is important to identify how this impacts the other siblings, such as by monopolizing all the parents' attention and energy and creating unfilled needs for attention and love.

How Does a Narcissistic Sibling Affect the Personality of a Brother or Sister?

While it can be difficult to comprehend that a sibling can engage in abuse, I believe that narcissistic or Other-blamer siblings have a very negative effect on the personality of a brother or sister. A sibling relationship is expected to be close and loving, so that when it is not, it can be life-altering for the victim. I am estranged from my narcissistic sister and believe that the lessons I learned from her in childhood and early adulthood altered my personality and life choices, making me submissive, lacking in confidence, and tolerant of abuse in adult relationships. This is what makes me the angriest about narcissistic abuse at any age — antisocial people train their victims to deny themselves the very thing that makes us prosocial and human — loving, connected, interdependent relationships.

Sibling interactions are often minimally supervised. Very unhealthy power dynamics can develop without adults being aware. My brother, sister, and I grew up in the 1960s and 1970s when children had a lot of time together apart from adult supervision. Theoretically, this gives children a chance to learn to work things out on their own, which can foster healthy conflict resolution skills. However, if one child is a domineering Other-blamer, it can be the perfect environment to create an abusive relationship between siblings. If parents fail to notice this dynamic, these behavioral patterns can become entrenched in children. I was shy and younger than my sister, so was naturally deferential. I believe, though, that her domineering personality was strengthened by my parents' failure to check it. This situation was complicated by my mother's family history, which affected her parenting decisions. She was four years older than her sister and was raised on a farm with no friends living nearby. She was very lonely as a child, so I know she had her own children close together in age so that we could play together and have closer relationships. I'm sure she overlooked much of our arguing because she felt that at least we were playing together.

Parents who are passive, emotionally neglectful, or uninvolved can cause great harm, even without overt abuse, because they do not protect a weaker child. In many cases they are more focused on protecting the stronger child, specifically protecting them from shame. For the victim of the sibling abuse, it can create a sense of being unprotected and, hence, unworthy.

Looking back, I see that my parents tried very hard to be fair. When we argued they would issue equal reprimands to all the combatants and mostly just told us to stop arguing. I am aware now that my parents were actually very conflict averse. I don't have clear memories, given the passing of time, but I wonder if they turned a blind eye to the pattern of my sister regularly being the source of the conflicts and my brother and I being taken advantage of. I suspect they had learned early on that my sister was difficult to discipline and avoided doing so, instead claiming to be "fair" and doling out "equal" punishments. I wonder if they should they have been more direct and reprimanded the child who was perhaps being insulting and domineering to her siblings (and parents), My brother recalls my mother coming to him in despair over not being able to have any influence on my sister's bad behaviors.

Family members may eventually learn that nothing seems to control the Other-blamer child and can give up trying. Parents may abdicate their responsibility and let the defiant child rule the home. The unprotected siblings do not have a choice in this situation and are forced to accept that the parent will not protect them from the abusive sibling. They cope the best way they know how, often with even more passive and compliant behaviors.

Some parents may turn to one child to help control and parent the difficult sibling or siblings, creating a parentified child who can take this overly responsible mentality into adulthood. Sometimes an eldest child is forced to provide childcare for younger siblings as a result of a parent's long work hours, poverty, substance abuse, or single parenting. To make it worse, a sibling may copy an under-functioning, narcissistic parent and become low-functioning and irresponsible, adding more burden to the caretaking sibling. I've worked with early elementary age children who expressed high levels of responsibility and anxiety about their sibling or general family functioning.

Victims of narcissistic family systems learn that their family members will not dependably respond with warmth when asked for help. Consequently, although they still crave attention and love, as all children do, they've learned to give up hoping for it to arrive.

Narcissists have many other wide-ranging psychological impacts on their siblings. Most notably, they train their brothers and sisters to be more Self-blaming, leading to lifelong proneness to excessive guilt and shame.The years of a narc sibling's overt or covert emotional control leads to unhealthy patterns of self-sacrificing, submission, and tolerance of abuse. Narc siblings train their brothers and sisters to engage in enabling or codependent behaviors.

A common way of coping with a narcissistic sibling is that the "good child" overcompensates and becomes perfectionistic in the hopes of gaining attention or at least not being the difficult burden that the narcissistic child is. Traits of excessive and misplaced guilt, over-achieving, perfectionism, excessive rule-following or even obsessive-compulsive traits ("If I follow all these rules I'll be rewarded!") can result.

Because narcs behave in distrustful ways, by lying, conniving and manipulating, victims cope by becoming emotionally guarded and concerned about being taken advantage of. Narcissists see vulnerability not as a gateway to intimacy, but as a weakness to exploit. Victims may present with an avoidant attachment pattern, which shows up in excessive self-protection and independence, difficulties with expressing vulnerability, general distrust in relationships, and fear of rejection.

Narcissistic siblings may act helpless, dependent, and childlike as a way to elicit care and attention from caregivers. This leads their brothers or sisters to overcompensate by avoiding dependence or a need for care. This sibling may express fear of being a burden to others. Many Self-blaming victims of narcs develop an aversion to asking for help, being selfish, or being demanding like the narcissist. In contrast to the antisocial narcissist, the pendulum swings far over into the prosocial traits, such as selflessness and generosity. But these "givers" may lack the ability to say no to the "takers" of the world and may be excessively people pleasing.

Watch for children who do not ask for help and instead passively wait for someone to notice that they need either emotional or physical comfort. Clinicians can ask this type of child: "What did you do when you were sad/angry/upset/hurt? Did you go to your parent for a hug?" You may notice a fear of dependence that is not age appropriate for the child.

Other-blamer siblings may not allow brothers and sisters to set and maintain healthy boundaries.

Victims learn that their needs and opinions are deprioritized in deference to the narc sibling's. I've treated many adult victims of narcs who cannot make simple life decisions because they don't know their own preferences and have no clear values. As a result, they wander through life not making active choices, passively accepting what is given them or what others tell them to do.

Chronic emotional manipulation, gaslighting, and emotional neglect cause the victim to be self-doubting. I use the label Other-blamer because this highlights the conversational experience of all blame being flipped toward the victim, creating a deep and abiding sense of self-doubt.

Other-blamers are nearly always judgmental and opinionated about the choices of others — even choices that are inconsequential. Watch for an Other-blamer sibling who is hypercritical. This pattern makes victims hypersensitive to criticism, leading to Self-blaming as a preemptive attempt to correct faults and avoid shame. Very submissive children may engage in placating crying when criticized and have difficulty hearing feedback. Fear of failure and risk taking, which appears as perfectionism and drivenness on tasks or personal appearance, may result. Self-blamers may also exhibit problems with obsessions, compulsions, and anxiety.

Other-blamers often use teasing to covertly weaken and destroy the self-confidence of siblings. Watch for families that engage in intellectual debates, sarcasm or sardonic teasing. Thinly veiled personal attacks can be played off as a joke and make it difficult for a child to identify abuse. As in many narcissistic relationships, the narc often claims "I was just joking," as a way to gaslight and excuse emotional abuse. Monitor for parents who also engage in these types of communication.

When Other-blamers use harsh shaming and blaming it leads to a paralyzing fear of the judgments of others in victims. While all humans have a natural tendency to seek approval and avoid disapproval, Self-blamers may have been trained by narc family members to be highly attuned to the opinions of others. In the therapy room,

this often shows up as social anxiety. Children will report concerns with entering social settings, going to new environments, or joining with peer groups. The underlying fear is that they might not know how to function in this new setting and so will be judged harshly by others. This is an example where behavioral therapy may not work. It isn't actually the physical situation, such as the playground at recess, that is causing the fear. Instead, it is the inner critic that gets triggered, often repeating an abusive parent or sibling's words that say the child isn't clever enough, athletic enough, or good enough to manage the new scenario.

Narcs are good at casting blame and shame, sowing doubt and withholding love, so that the victim sibling develops low self-worth — a global sense that she is flawed, unlovable, and different than others. This deep sense of defectiveness leads to psychological problems.

The victims of narcissistic siblings walk a tightrope regarding achievement. They cannot appear to be more accomplished than the narcissist. Often the Self-blamer downplays their talents and successes in hopes that the Other-blamer does not feel inferior. This protection of the Other-blamer's ego can even lead to self-sabotage. I've had clients who stayed overweight their whole life to avoid being thinner or better looking than their narc sibling. Self-blamers may make decisions about careers or relationships that seem incomprehensible, but not when seen through the lens of the need to self-denigrate to spare the narcissist's sense of self.

Watch for "conversational narcissists." Does one or more family members dominate conversations and over-talk others?

Overt grandiose Other-blamers crave attention. I've seen small children who presented as very opinionated even on topics about which they know little. While many children enjoy feel smart and bold, in excess this is a red flag for Other-blamer traits of grandiosity.

Victim siblings often move in the opposite direction, becoming shy, excessively humble, and socially avoidant. While some children are more naturally introverted, children may gravitate toward being quiet and socially restricted if a more dominant and grandiose sibling is garnering all the attention. Children intuit that there isn't room in the family system for two attention-seeking siblings. A child can subconsciously "niche-pick" and choose shyness and passivity as a strategy to both avoid the more dominant sibling's abuse and gain the parent's attention and approval. Parents may unwittingly exacerbate this situation by giving attention to the grandiose sibling and ignoring the humble sibling.

In contrast to shyness, many victims of narc siblings can develop explosive anger, usually when they have been pushed to an extreme. They may have tolerated mistreatment and boundary violations for years, and then react in self-protective indignation because they don't want to be stepped on any longer. Be careful when assessing, because the Other-blamer sibling may be very clever at hiding the goading, teasing, or subtle manipulation that prompts the victim to react. I've treated families where the identified patient was the child with "anger problems," yet some investigation revealed a very covertly manipulative Other-blamer sibling that provoked the anger.

Victims of emotional abuse often struggle to accept compliments, partly because they have low self-worth and disbelieve any positive messages, but also because they are guarded and distrustful having learned that other people lie and deceive. "Is this compliment real or just a way to break down my barriers so that you can manipulate me again?" Give children compliments in therapy and see how they respond.

Because narcs are so competitive, they teach their victims to be uncompetitive. Healthy competition is beneficial in child development, but the sore-loser narcissist may make their siblings fearful of winning.

Other-blamers believe there is a limited amount of love to go around and they greedily go about getting more than their fair share. Narcs are often inexplicably jealous of siblings. They smear and undercut siblings to parents in an attempt to look good and claw for desperately needed love, attention, or money.

Watch for families that are not warm or affectionate, where they rarely say "I love you" or "I care about you." This tends to produce children who have an unfulfilled need for love — either Self-blamers who have retreated inward and are hopeless about receiving love, or Other-blamers who blatantly demand and coerce attention and affection.

In extreme cases, some narc siblings will be so exploitative and coercive that they will abuse their siblings physically or sexually, just to enjoy a sense of dominance and control.

If a sibling is difficult and a parent is conflict averse in the face of the defiance, the submissive child learns to be passive, which creates tolerance of abuse in adult relationships. The victim sibling may develop a belief that relationships are one-sided and that others will not protect them from abuse.

It is so very sad that the wounded and traumatized narcissistic child inadvertently harms and traumatizes his or her siblings. We can be understanding that they do this in an attempt to get their own emotional needs met, but, as all narcs do, they sow emotional destruction in the relationships around them. It is sad, too, that the victims are left without the close, loving, supportive relationship of a brother or sister — a deep, relational trauma and loss that can affect their sense of self and safety in relationships throughout their life.

We know that social and relational experiences of young children are developmentally significant. The relational models they witness via daily, repetitive experiences within a family are paradigms they carry into adulthood. Preventing future domestic violence and abusive relationships can begin with interventions in family systems.

Clinicians should be alert for unbalanced levels of dominance or submission in the sibling relationships. Assess for sibling relationship quality, what happens when there is conflict, and how parents handle this conflict. Many parents let children resolve conflicts on their own, and this can often be a good strategy, except for when one sibling is much older, stronger physically, or emotionally abusive. Listen for repeated stories of bullying or excessive teasing and sarcasm. Watch for patterns of arguments that end with one sibling winning and another sibling giving in consistently. Other-blaming siblings can also be quite adept at “freezing out” and ignoring another sibling, building patterns of emotional control through withholding attention and affection. This style of conflict often goes unnoticed by parents.

A more dominating Other-blamer child is likely to be brought to therapy for issues with arguing, violence, opposition, and defiant behaviors. However, Self-blamer children who express excessive responsibility, guilt, shyness, passivity, or sensitivity may have an Other-blamer sibling who is creating a pattern of blame shifting toward the more submissive sibling. In therapy I am often very direct with parents about the need to stand up to a sibling and rebalance the relationships.

Chapter 7: Treatment Planning in the Shame-focused Model

The shame-focused model links causation (five causative factors) with resulting behaviors (three shame management strategies). As a result, case formulation is logical and flows directly and intuitively toward treatment planning and interventions. In essence, if shame is the underlying cause of behavioral problems, it becomes clear that the main focus of therapy is to help children and teens learn to manage this emotion in healthy ways so that they reduce reliance on unproductive shame management strategies.

Ideally, therapeutic interventions are focused on the entire family system. If they are capable, parents should be aided in improving their skills to engage with balanced, age-appropriate levels of shame directed toward children and to build attachment relationships.

Interventions with children will help them develop improved awareness of and tolerance of shame. Therapists can compassionately, but directly, address the client's experience of shame and the resulting blaming behaviors. Specific objectives can include behavioral changes, such as decreasing numbers of tantrums or improving peer relationships, but the golden thread in interventions is to consider the primary emotion of shame and how it triggers these behaviors.

After assessing for parenting style, clinicians can provide education to moderate the permissive, authoritarian, intrusive, non-warm, or disengaged parent. All parents need education on the emotion of shame in children and how to address it — either by dialing up the accountability (permissive parents) or dialing back the shaming and verbal abuse (authoritarian parents). Helping parents gain emotional regulation skills so that they can make wise parenting decisions in the moment is essential. Most parents have their own shame issues which may be beyond the scope of child or family therapy. Clinicians may recommend individual therapy for parents to build their emotional awareness and regulation skills. Following are examples of goals for children and parents.

Sample Goals for Children

- Patient will learn to observe, label, experience, and control emotions and cognitions through the use of mindfulness techniques, cognitive and behavioral engagement and control, and self-calming techniques.
- Patient will gain improved self-compassion with which to respond to emotional experiences.
- Patient will gain a sense of self-worth, self-acceptance, and self-compassion that will permit a reduction in self-loathing, a reduction in the fear of judgment of others, and a reduction in the need for approval of others and/or fear of disapproval of others.
- Patient will have improved self-worth and self-acceptance so that fears of social rejection and judgment do not cause anxiety.
- Patient will have decreased internalizing and externalizing behaviors when ashamed, resulting in decreased behavioral issues at home, increased self-confidence, increased persistence and frustration tolerance, and increased ability to be accountable when criticized.
- Patient will have improved self-worth, resulting in balanced, non-reactive and self-reflective approaches to managing shame, without excessive internalizing, externalizing or avoidance of blame or accountability.
- Patient will have decreased internalizing and externalizing behaviors when ashamed or guilty, resulting in decreased anxiety and behavioral issues at home, school, or other settings.
- Patient will learn resilience, positive thinking, and growth mindset skills.
- Patient will learn somatic awareness and emotional regulation strategies to improve sensory modulation skills and decrease sensory sensitivity.
- Patient will have improved personal accountability, so that they function in ADLs with responsibility, accountability, and integrity.
- Patient will have improved ability to tolerate criticism, failure, and shame so that these experiences do not cause them to blame-shift, deflect, deny or avoid personal relationships, personal accountability, or social involvements.
- Patient will have decreased behaviors of hyper-activity and inattentiveness so they are able to participate in school and social activities in age-appropriate ways, are able to engage with social relationships appropriately, and are able to comply with parental guidelines at home.

- Patient will have improved shame tolerance, resulting in reduced ADHD symptoms, so that frequency, intensity and duration of emotional and behavioral dysregulation does not impair daily emotional, occupational, academic, and social functioning.
- Patient will have improved self-worth, so that fears of inadequacy and rejection do not create or exacerbate anxiety and behavioral problems.
- Patient will have improved ability to tolerate failure, criticism, and feelings of unworthiness, leading to reduced anxiety, improved attentional skills, and improved behavioral regulation.
- Patient will learn and exhibit growth mindset skills, including reduced fear of failure, reduced social comparative thinking, improved risk taking, and improved persistence on tasks.
- Patient will have improved behaviors, with age-appropriate emotional regulation skills.
- Patient will reduce oppositional and defiant behaviors when triggered by shame.
- Patient will learn to tolerate normal parent or teacher directives as non-shaming.
- Patient will have improved feelings of self-worth and self-compassion, reduced thoughts of self-criticism, and improved ability to regulate emotions of shame and fear, especially as they relate to fear of failure in academics.
- Patient will have improved intrinsic motivation, and improved ability to forecast the consequences of their actions and a compassionate response to their future self in current decisions.
- Patient will have improved self-worth and reduced self-criticism as evidenced by reduced anxiety, reduced procrastination, reduced perfectionism, and reduced fear of failure.

Sample Goals for Parents and Family

- Parents will learn the effect of shame-based parenting on the development of child behavioral and emotional problems. Parents will learn improved parenting skills that reduce the use of harsh criticism, judgment, and shame.
- Parents will learn to identify their parenting style and learn to moderate their parenting choices to engage in healthy interactions with their child, notably regarding the use of shame-based parenting styles.
- Parents will reduce authoritarian/permissive/dismissive parenting styles and learn to engage in more authoritative parenting skills.
- Parents will have improved understanding of child developmental needs, especially in regard to emotional and social comfort and reassurance.
- Parents will increase their use of reflective listening and affective awareness of child's emotional needs.
- Parents will have improved parenting behaviors, with reduced anxiety, anger, behavioral focus, and harsh overpressured verbal output.
- Parents will understand the effect of their verbal and parenting style on patient's sense of self-worth.
- Family will have improved attachment, emotional attunement, empathy, emotional responsiveness, and communication skills.
- Parents will have improved skills to interact with the patient in a way that encourages the patient's emotional recognition, emotional expression, and feelings of interpersonal acceptance.
- Parents will learn the value of emotional attunement and warm responsiveness.
- Parents will engage in appropriate emotional and behavioral regulation.
- Parents will have improved emotional intelligence skills and improved self-awareness, resulting in improved skills in emotional attunement, responsiveness, and expressiveness.
- Parents will learn to identify primary prosocial emotions in the child and respond with appropriate attachment-inducing attunement and behaviors to decrease child's shame and build shame tolerance and resilience.
- Parents will decrease behaviorally focused parenting and discipline and increase emotional attunement, warmth and responsiveness.

Chapter 8: Interventions in the Shame-focused Model

Therapist's Role: Gaining Self-Awareness of Your Own Shame Issues

Successful interventions start with a clinician's own self-awareness and shame tolerance. As the saying goes, a client can only go as far as the therapist has been, and this is especially true as it relates to shame.

Clinicians must first address their own shame intolerance and learn healthy self-acceptance. If you skip this step in personal growth you may not recognize shame easily. You may instinctively avoid the topic with clients, just as you avoid addressing it in yourself. I believe that if clinicians do not know how to handle shame, they may attempt to protect clients by avoiding addressing shameful topics and behaviors for fear of triggering the client's shame or anger. If a client is blame-shifting, avoiding accountability, or becoming defensively angry, you may feel uncomfortable pointing these behaviors out and then diving into the root cause. Your job as a therapist is to help uncover these behavior patterns, not enable them. Clinicians must be able to tolerate shame themselves, so that they do not steer away from shame in others.

Allan N. Schore writes of the clinician relationship: "Noting that shame dynamics are hidden in both members of the therapeutic dyad, Kilgore (2003) concludes, 'We hide our shame…from others because we want others to be blind to what we cannot tolerate seeing' (p. 286). Mann (2010) writes that visual shame affect stemming from unconscious early traumatic experiences reemerges in the clinical setting, along with the defenses that disguise the searing painful affect. Because the anticipatory dread of scornful gaze can cause mortification, it is accompanied by gaze aversion. Mann concludes that transference-countertransference exchanges of enactments, though susceptible to mutual projective identification that set off reciprocal shaming in order to turn the tables on the shame, are essential to working through traumatic shame dynamics."[96]

Bromberg writes: "The task that is most important, and simultaneously most difficult for the [therapist], is to watch for signs of dissociated shame both in himself and in his patient — shame that is being evoked by the therapeutic process itself in ways that the [therapist] would just as soon not have to face… The reason that seemingly repeated enactments are struggled with over and over again the therapy is that the [therapist] is over and over pulled into the same enactment to the degree he is not attending to the arousal of shame. Rusch et al. (2007) … conclude that treatment must address not only the explicit but also the implicit aspects of shame, and that 'The failure to recognize shame within the patient-therapist relationship and the central role of shame in the patient's inner experience jeopardizes the success of any psychotherapy.'"[97]

Meditation teacher Pema Chödrön writes: "Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others."

Following are listed specific personal skills for clinicians to hone before using shame-focused therapy:

1. Build your own ability to tolerate shame with self-compassion. Practice daily mindfulness meditation. Learn self-compassion skills, practices, and concepts and integrate them into your life, so you can easily and organically communicate these to clients. (See books and training programs by Paul Gilbert, Kristen Neff, Chris Germer, etc.)
2. Learn to hold yourself accountable through self-discipline — the true marker of shame tolerance. Only those who can speak forthrightly to themselves and make personal changes can lead others down that path. If you lack self-discipline in an area of your life, it is important that you address this issue. If you enable yourself, you will enable others.
3. Notice if your desire is to relieve patients of shame or bypass feelings of shame. Protecting clients signals to them that they need to be protected. Leaning in to a topic and addressing it directly signals that you can tolerate this experience and that you believe they can as well. Healthy guilt is normal and even helpful. If you avoid addressing shame, clients will take note unconsciously and will not offer up their fears and vulnerabilities in session.

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[96] Schore, A. (2012) *The Science of the Art of Psychotherapy.* W.W. Norton: NY, NY p. 98

[97] Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys.* Analytic Press. p. 80

4. Reflect on and discuss with your therapist or supervisor your family attachment history, emotional patterns, and relational patterns that were impacted by shame. Is your "anxiety" or "depression" actually due to high levels of shame and a lack of self-compassion?
5. Reflect on your shame management strategies: Are you an Other-blamer, Self-blamer, or Blame Avoider? How can you improve your shame tolerance and decrease emotional reactivity? How can you respond to yourself and others with compassion?
6. Model self-acceptance, humility, and healthy shame tolerance. For example, freely and promptly apologize when you make a mistake. Tell a story of when you failed and how you handled that experience. Use appropriate self-disclosure to share about the benefits of the experience of self-compassion.
7. Model calm, mindful, self-aware behavior. If you are anxious, your clients will feel that anxiety.
8. Be sure you have completely discarded the "neurochemical imbalance" theory and accept that child behavioral struggles are adaptive responses to difficult life or family situations. This prepares your mind to regard the client in a non-judgmental and non-shaming way. Rather than "diagnose an illness," therapists should help parents formulate a new, compassionate narrative about the child's life. A youngster's emotional reactions and behaviors are due to expected reactions to shame and fear, insecure attachment status, and trauma. Educate that the child's actions make complete sense as self-protective and adaptive behaviors.

Interventions for Families and Parents

Family therapy and parenting education should be the mainstay of shame-focused interventions. As noted previously, parents are ideally included early and often in the form of parenting sessions and family sessions. As noted in Chapter 6 on Family/Parent Assessment, I make it very clear in my verbal instructions and in a written handout that therapy will not involve them dropping their child off for me to "fix."

I believe in involving parents because they have tremendous influence in a child's emotional and psychological development, because the child generally wants to please the parent. This provides hope and empowers parents to engage in suggested parenting tactics. Educating parents on their power to influence their child is a powerful way to get them on board with the process of family therapy.

Clinicians who do not include parents in the therapy process may have limited success. While building a bond with a clinician may in some ways help a child, what they really need is an improved relationship with their primary caregivers.With a stronger bond or attachment within the family unit, the child feels loved and respected in ways that reduce anxiety and improve behaviors.

I often get referred child cases and learn that the previous therapist never met with the parents and did no parenting education. As mentioned previously, there are times when this is the right choice with parents who are not able to stay emotionally regulated in therapy. Some Other-blamer parents cannot accept any direction on their parenting skills. Clinicians should determine whether a parent is able to be coached.

For an exceedingly small number of families there may be no parenting or relationship issues to address, although this is extremely unlikely if a child presents with behavioral and emotional problems. Continue assessing and being a curious detective for shame to determine what is really happening in that family. I have had cases where the family was actually healthy, but the child's issues came from an unknown acute trauma, such as sexual molestation, that the parents were not aware of.

In families with an older teen and parents who are unwilling or unlikely to engage well in family therapy, individual therapy with the child may be the best choice.

However, if you have decided not to talk to parents initially, I'd suggest revisiting this decision during the course of therapy. I believe that most parents have good intentions and can be slowly and patiently taught skills to improve their relational and parenting styles.

As mentioned previously, communicating to the family that parents will be involved in therapy in various ways de-stigmatizes the child as "the problem" and gains buy-in from parents toward a solution.

In family sessions, model interacting with the child in a balanced, firm, compassionate way so parents witness this. You will want to be warm and kind, but also hold the child and parents accountable in very matter-of-fact

ways. By modeling your own skilled responses and managing those of the family in sessions the child and parents learn to do this themselves at home.

A key element of family sessions is to ensure the repair process occurs following shaming experiences for the child. This allows them to begin to trust that if they do something wrong they will still be loved by their parents and accepted by you. Guiding the family to this repair outcome at the end of each family therapy session is essential. Conclude each session with a positive assessment of the work done, the efforts the family put in, and their resilience in addressing these difficult situations. Honor and validate the love they feel for each other that allows them to come to therapy, stay present, and work on solutions.

Work hard to get parents to understand that children who act out due to shame are merely struggling to regulate their emotions. Parents must understand that shame is motivated by the desire to be loved. This is not a "bad kid." Their child is fearful of being unlovable and their difficult behavior is the result. What do we do with scared kids? We love them, comfort them, and help them calm down.

Be sure to directly address parental shame at the start of the first session. Be cautious to avoid excessively shaming words or phrases. Highlight the parent's involvement, that the child is not the primary focus of the problem, and that there is hope. "I know it can be difficult to come here to get help with your child. It might even feel like you haven't done things right as parents. But I'm just glad you're here. So many people don't come for help. Your good intentions mean so much and I'm sure together we can quickly get this family on the right track."

Certainly do NOT suggest medicating a child for what is almost certainly just a reaction to feelings of unworthiness and low self-esteem. Keep front and center in your mind that a child who feels bad or ashamed of themselves is NOT suffering from a chemical imbalance that needs to be medicated. They need skills to feel better about themselves and parents who help them in the process. Medication will only confirm for the child he is different and flawed, worsening his self-worth issues. Some parents will ask about medications. Be prepared to address these questions with facts, as well as validating to the parents that they are trying to find solutions. My website (www.HarperWest.co) has numerous resources on medication facts and informed consent.

Second Session: Parents Only

In the second session I prefer to meet only with the parents. For about half the session I focus on assessments, including:

- Assessment of parents' childhood attachment history and their parents' parenting styles. Merely asking these types of questions can prompt parents to consider (perhaps for the first time) why they make certain parenting choices. (For parents who want to learn more, I recommend "Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive," by Daniel J. Siegel, MD, and Mary Hartzel)
- Assessment of history of divorces, separations, blended families, and remarriages and how family dynamics changed as a result.
- How does the child relate to stepparents, step-siblings, half-siblings?
- Shame assessment: How does the child handle criticism or normal/minor discipline? How do parents and siblings react to criticism? You can often follow this with education on shame management strategies.
- Conduct assessment of parenting styles followed by education.
- Assess for quality of marital relationship: What interactions between parents is the child witnessing? Do parents argue and fail to resolve conflicts equitably? Do they passively avoid conflict? Do they harshly or coldly withdraw and withhold affection? Are one or both parents Other-blamers who cannot compromise or admit fault and does the child regularly witnesses this? Have parents threatened divorce in front of the children?
- Are there family values that influence the situation? Are there ethnic, racial, cultural, religious/spiritual, or lifestyle issues that are important to the family? For example, does their religion teach that a man has the right to dominate a woman and force her to obey and submit to his will? Do parents have cultural or religious beliefs that make them embarrassed about a child's sexual orientation or gender identity so that they are harshly critical and rejecting?
- What supports are available outside the family, such as extended family, religious organizations, neighbors, friends, teachers, coaches, etc.
- If intergenerational traumas are relevant, conduct further assessment.

- If the child has experienced significant chronic or acute trauma, have the parents complete an ACES trauma assessment or similar assessment tool.

In session two, I review the protocol for treatment and ensure that a parent or both parents will be present for certain sessions. I educate parents how the family sessions will be conducted. I tell them I do not want them to start subsequent sessions by listing all the child's behavioral problems of the past week. If the parents do go down this road in future sessions, quickly interrupt and take charge so that the child's shame is managed and so that therapy does not just become another place the child "fails" and is shamed.

Parenting Education Interventions

Spend about half of session two on parenting education. Parenting education should generally be conducted without the child present. However, smaller lessons can be inserted into family therapy sessions. For example, if a parent is unskilled at warm, patient interactions, ask them to slow down and repeat a comment to the child in a different tone of voice.

Integrating parenting education sessions early in the therapy process and then regularly throughout the duration of therapy requires that clinicians be prepared to provide specific guidance on parenting styles, emotional attunement and responsiveness, attachment patterns, shame awareness, compassion skills, and listening and communication skills. I have resources and handout materials prepared before sessions on specific topics the parents are likely to need. I may direct parents to my website or I will email them further resources after sessions as needed.

Some parents require education on the basic concept of attachment theory — that the foundational role of parenting is to have the child experience a healthy, safe, warm relationship with the parent. This allows the child to go on to have a healthy, safe, warm relationship with themself and then with others.

Have parents consider if what they are doing on a daily basis is strengthening the relationship or harming it. For parents who are too harsh, aggressive, directive, and non-warm, have them pause after telling about an incident (maybe they yelled at a child for leaving the garage door open). Have them consider this question: "Is what you were doing in that moment making your child feel safe or scared?" Follow up with a question to build emotional awareness: "How could you tell if your child was safe or scared? How could you tell if your child was ashamed?" Many parents have no idea how to answer either of these questions because they have never considered the child's experience. Shame is an emotion like any other, yet most parents have no idea when they are shaming their children — because they likely struggle from poor shame awareness themselves.

In families with permissive parents, you may have to work to strengthen parental authority. A lack of firm, clear direction from parents can make children anxious and disconnected in their relationship because the child doesn't trust a parent to keep them safe with healthy guidelines.

Because most people do not think about or learn about shame, education about the prosocial emotions and how they present in children is the primary focus. Describe the four Shame Management Strategies using normalizing language.

Briefly describe concepts from evolutionary psychology and the value of prosocial emotions. This can help parents see the value of guilt as a way to reconnect and be loved. I even say it is good that the child feels guilt, because this helps them behave in socially appropriate ways, helps them be accountable, and helps them get along with others. The skill for most parents is to moderate their use of shame in ways that allows the child to tolerate it based on their shame sensitivities and reactions.

Many parents today over-talk in general, but especially about feelings. They've heard that it is good for children to identify and talk about their feelings. Unfortunately, what often happens is this conversation is attempted in the midst of a child who is overwhelmed with shame. I've had parents say that their child plugs their ears and says "stop talking." I discover that the parent is "trying to get him to talk about his feelings" immediately after the child was disciplined for a misbehavior. Clearly, he is feeling ashamed and dysregulated — not a good time to invite him to be self-reflective, vulnerable, and self-revealing. My overall rule is for parents to talk less and listen more. If they want to talk about feelings, it should only be when the child is calm, receptive, and in age appropriate ways.

Never pathologize when educating. Do not use DSM diagnostic labels, even if parents report the child has been diagnosed by a pediatrician, psychiatrist, or school psychologist. Teach parents about the failures of the DSM and the lack of scientific value of these labels. Their child is not suffering from a chemical imbalance, but a lack of skill in emotional regulation with shame (and perhaps other emotions). Watch for parents who want to use a DSM label as an excuse for the child's behavior and as a way to excuse themselves: "He has ADHD and that's why he can't focus enough to clean his room. There isn't anything we can do but put him on medication."

Generally work to normalize and validate the parents' experiences: "Many families have difficulty with bedtime routines. Technology is such an addictive experience for children. It's hard to pull them away, isn't it?" Use validation frequently to honor the parent's frustration and anger at the child's behavioral struggles. Provide hope, though, that these issues can be resolved — with active parental involvement.

Avoid letting the parents over-focus on the child's identified problem or behaviors. Remind them that emotions often drive behaviors. You can also find a way to normalize a presenting problem: "Lots of *families* have this type of concern."

I educate on how certain parenting styles can worsen shame intolerance in children. This education should be customized to the child and family situation.

Other parenting education topics for the second session or early in treatment:

- Parents must learn to stop excessive shaming and blaming. Too many parents think of discipline as punishment, when they should think of it as education. (The word "discipline" is based on the Greek word "disciple," meaning "learner.") Children will sense the difference in approaches. Parents must, of course, correct and guide a child. However, consistent use of harsh punishment will be felt as a shaming attack.
- Teach reflective listening skills to improve a child's sense of being heard, seen, and valued by parents. See my website's resources page for a handout. (www.HarperWest.co)
- Emphasize that parents must model healthy shame tolerance and accountability. Children learn shame-based behavior through the behaviors of parents with their own history of shame.[98] Children learn best by watching and copying, not by being lectured at. Parents should model failing with grace, learning a new skill without fear of embarrassment, or admitting fault and apologizing. If parents argue excessively, this exemplifies to children that being wrong is a painful, shameful experience to be avoided at all costs. Parents should model asking for help, admitting they do not know an answer, and backing down in an argument. These are essential reciprocity skills for all relationships. Accountability is tied to empathy, because if we care about others, we apologize and repair relationships. Accountability also teaches a child to acquiesce to authority, a natural part of all relationships whether it is a friend, spouse, boss, teacher, police officer, or drill sergeant. If a child does not learn to manage conflict, their relationships may become high conflict or conflict avoiding, neither of which is healthy.
- Educate on the neurobiology of the threat response to normalize the experience of anxiety and improve awareness of emotional regulation patterns (hyper-vigilance or hypo-vigilance and hyper-reactive or hypo-reactive).
- Educate on childhood attachment patterns and trauma and their effect on neurological development that increases hyper-vigilance to and hyper-reactivity to threat. This can promote insight and normalize fear/shame responses. All children have a fundamental fear of being rejected by parents and losing attachment connections. Shame is a feeling of being not good enough and then ostracized by the social group (parents). It is obvious that this will inherently trigger anxiety, emotional dysregulation, and behavioral problems in children. Parents must not verbally reject a child, threaten to abandon, or excessively criticize and shame. Harsh parenting will merely increase the likelihood that a child will be fearful of parental rejection, then develop poor shame tolerance, leading to Other-blaming, Self-blaming and Blame Avoidance. Therapists should strive to get parents to truly feel the pain of their child's sense of unworthiness and rejection when they are shamed. This often succeeds in getting parents to change their shame-based parenting styles. You may want to prompt parents to remember what it was like when their parents shamed them and use this as motivation to change their own parenting behaviors.

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[98] Stadter, M., (2011) The in*ner world of shaming and ashamed; An object relations perceptive and therapeutic approach. In R. L. Dearing & J. P. Tangney (eds.),* Shame and the therapy hour (pp. 45-68). Washington, D.C.: American Psychological Association

- If you have assessed that a parent's emotional state is highly anxious or depressed, this needs to be addressed. Educate on the social transmission of moods. Many people are completely unaware of the concept of "emotional contagion." The human brain is exquisitely honed through evolution to attune to and respond to the emotions of others. Children's emotional brains are fully developed at birth, while their cognitive development lags. This makes them more susceptible to emotional stressors. Children will ascertain a parent's mood and calibrate their mood to match. The result may be an anxious child who has experienced no known traumas, just exposure to an anxious parent. Children are highly intuitive and sense a parent's lack of attunement, especially if a parent is anxious, depressed, or distracted due to relationship problems or other stressors. Parents must learn emotional intelligence skills of being self-aware and being more calm and present.
- Parents can model, support, and teach emotional regulation to children. There are many skills clinicians can offer to parents to help them stay regulated and then pass this skill to a child. A child develops empathy by experiencing empathy from their parents and feeling reassured when they are experiencing emotional distress or disappointments.
- Teach that shame should be doled out in tiny amounts. When parents issue judgmental comments such as, "You never get ready on time," they need to be aware of how this shames and labels a child in a negative way.
- Help parents see how they can create safety and reduce fear in the household. Regularly have parents consider: "Is what I am doing making my child feel safe or scared?" Does the child feel an emotional threat when parents are harsh, rejecting, impatient, or angry? Build a parent's empathy by asking: "If you were a scared, insecure child how would you react to a parent yelling, shaming, hitting, spanking, or threatening?"
- Help parents recognize the stressful double bind for a child harsh parenting creates: "When your child is afraid, his instincts tell him to go to you for soothing. But when you are a source of fear this gives your child confusing messages and leads to significant problems in brain and behavioral development."
- Although commonly used, timeouts can be experienced by children as fear- and shame-provoking. Generally, children don't have the skills in early childhood to process through feelings of guilt in compassionate and resilient ways by themselves. Timeouts isolate a child alone with thoughts of self-criticism rehearsing one of the shame management strategies exactly when they need comfort and emotional regulation assistance from an adult. Some children will silently rage against being disciplined, engraining themes of martyrdom, retribution, and blaming shifting. Others with Self-blaming tendencies might mentally berate themselves, leading to anxiety and depression.
- Parents must establish household rules for respectful behavior such as, "No yelling, bullying, teasing, put-downs or name-calling of any kind in our home."
- Train parents to be solution-oriented. They must consistently speak the language of change and be positive. They can "catch their children at their best" and give compliments. They need to be open-minded, flexible, and improvise parenting solutions.
- Many parents pursue kids during arguments and continue lecturing, when the child merely wants to be left alone to calm down. Parents must learn when to talk about the situation and provide guidance, which is usually only after the child is emotionally regulated.
- Men often fail to consider how their physicality and voice naturally intimidate others, especially young children. Men may need coaching on how to soften their vocal intensity and physical presence and be more approachable.
- For children with issues of defiance and opposition, by the time they come to therapy they have been labeled as the problem. Explore with parents their underlying emotions. The child may trigger a parent's fears of conflict and fears of being a bad parent.
- Educate on the neurobiology of negative self-cognitions that trigger the internal fear response system. Self-criticism switches on the amygdala, leading to a release of cortisol and epinephrine. When the self is attacker and attacked, there is nowhere to turn for safety and comfort.

Teaching Parental Attunement to Emotions

One of the saddest experiences I have in a family session is watching a parent completely ignore a child's emotional experience. In one case, Aliesha, 9, had reluctantly followed her parents into my office and slumped into a chair. Her parents immediately launched into a description of her latest behaviors and their concerns about how this would cause her to flunk a grade and be held back in school. This might seem like a normal family therapy scenario, and to her parents this was their usual mode of communicating and relating, but to me it was disheartening. Her parents completely failed to notice Aliesha's experience or respond to it with warmth and support. Aliesha was left to manage the powerful emotion of shame by herself.

What did I see happening here that the parents did not? I saw a child reluctant to attend therapy because she was ashamed of her behaviors and she knew her parents would pile on more blame. I saw that Aliesha could not make eye contact with me or her parents. (And her parents weren't looking at her at all anyway.) Her body language was dejected and defeated and she never attempted to say anything in her defense.

I often use these moments to get the parents to slow down, stop their chronicling of misbehaviors, and look at their child. It is often uncomfortable for them to be asked to attune to their child because they so rarely do. I asked Aliesha's parents to observe and guess what her emotions were. This may have been the first time Aliesha had ever had her parents engage with her in a connected, empathic way. Is it any wonder she was misbehaving? She thought she had lost all hope of a loving relationship with them.

A key to good parenting is attuning to a child's emotions — noticing what is happening in the moment and then responding to it with appropriately. Helping the child regulate emotions happens next. But this process cannot begin without the parent first noticing the child's experiences.

It is essential to teach parents how to be emotionally aware and attuned. Have them look past behaviors and ask: What is my child feeling right now? This will give them clues as to how to respond. A distressed and upset child needs soothing and comfort. An ashamed child does not need more shame. If a child feels guilty, they don't need discipline; allow healthy guilt do the teaching and give a child space, time, and support to process that experience.

An angry child needs their anger recognized so that they connect self-protective anger and boundaries in relationships. Certainly, parents must also regulate a child's inappropriate expressions of anger: "We don't allow hitting in this family." Help parents recognize that a child must be emotionally calm and regulated before they can hear behavioral corrections.

Engaging in family therapy enactments is a powerful intervention. I often ask a parent to observe the child's affect and reflect on how the child might feel at that very moment. Hopefully, the parent will remember your prior lessons on shame and emotional attunement and responsiveness. If not, gently guide them to guess the child's secondary emotions of anger, sadness, disconnection. Maybe the parent can then deduce their child's primary emotions of embarrassment and unworthiness. The child may even state that they feel they can never do anything right for their parents. Creating these enactments in therapy breaks the normal pattern of communication that parents criticize and nag and children feel disrespected and ashamed. The parents begin to see their impact on the child and how the child feels hurt and even unloved. Later, you can work to have the child see their impact on the parents' behavior: "When you don't clean your room your parents do get frustrated and remind you to do this chore."

Using a model from Emotionally Focused Therapy for Couples, we can help parents and children recognize that they are triggering each other to behave in ways that are counterproductive for the health of the relationship. Parental excessive shaming is triggering the child's shame to the point they are unable to cope and self-regulate, resulting in behaviors such as angry tantrums and narcissistic self-protection or Self-blaming, self-harming and self-loathing.

PARTNER _____

What I Do _____

What Do I Think to Myself
About Me: _____
About You: _____

Secondary Emotions (Anger, Withdrawing, etc)

_____

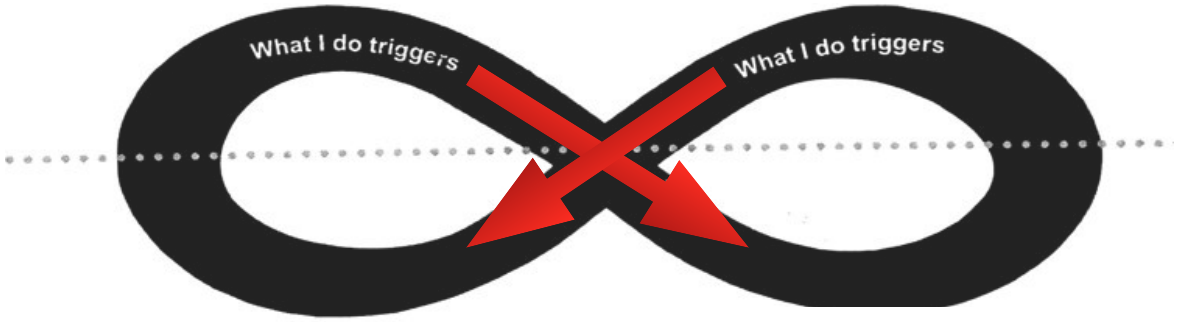
PARTNER _____

What I Do _____

What Do I Think to Myself
About Me: _____
About You: _____

Secondary Emotions (Anger, Withdrawing, etc)

_____



How I Feel Inside / Primary Emotions (Hurt, Rejected, Sad, Isolated, Ashamed, etc)

_____

Attachment Needs (Belonging, Love, Connection, Worth)

_____

How I Feel Inside / Primary Emotions (Hurt, Rejected, Sad, Isolated, Ashamed, etc)

_____

Attachment Needs (Belonging, Love, Connection, Worth)

_____

Recognizing Shame in Parent/Child Interactions

I like to say that shame should be dosed out with an eyedropper — not in gallon buckets. Parents should recognize that if a child is feeling shame, they do not need to pile on any more criticism. When they do, the child will learn to get really good at unhealthy responses to shame. Parents increase the chances the child will be either excessively Self-blaming or the child will become well defended against shame and become Other-blaming or Blame Avoiding.

Parents fail to realize the irony that the more they shame their child, the less likely it is the child will feel healthy levels of shame and guilt, which are needed for normal, prosocial functioning.

I had one family where the child would react oddly when disciplined, by making faces or 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 training him to divert from shame with these odd behaviors, rather than experience the emotion in healthy ways.

Parents must get good at noticing how a child experiences and expresses shame, so they can avoid piling it on. The instant you know a child feels guilty, you can stop disciplining because they get it!

Most parents don't recognize shame because they are unable to recognize this emotion in themselves. Our society teaches most people to disconnect from painful experiences, especially feelings of unworthiness. Clinicians may find opportunities to work with parents to learn their own reactions to embarrassment and guilt, so that they can then lean in, rather than avoid, their child's difficult emotions.

Ongoing Family Therapy

Beginning in the third session, I recommend that most therapy sessions involve meeting with the parents and child for the first half of the session. Because children likely have no context for what happens in therapy, be sure to include the child in education about the process of therapy to orient them and reduce their worry. I explain that I will meet with them and their parents for about 25 minutes and then with the child only for some activities and talking.

I tell them I have already met with the parents individually and will continue to do so with and without the child. The child will be anticipating and dreading the parent-only meetings, assuming that they will be talked about in embarrassing ways. Confront this assumption head on and normalize it, as clinicians should with all potentially shaming experiences in therapy. I acknowledge that therapy might feel embarrassing and the child might be uncomfortable that I am talking to their parents about their flaws. In doing this, I am already working to de-stigmatize shame by discussing it openly and easily. I normalize their feelings of fear and uncertainty and ask if they have any concerns.

Say: "During the course of therapy I will sometimes meet with you individually, sometimes with just your parents, and sometimes with all of you. I want you to know we might talk about you in the parent meetings, but we're doing so just to try to help everyone get along in the family. I know it might feel embarrassing to have me talk to your parents about you, but we're doing it to help. I hope that makes sense. What questions do you have?" (Notice use of an open-ended question.)

Next, discuss goals for each family member and for the family as a unit.

In subsequent sessions, I like to start with small talk about positive family-oriented topics, such as what fun things happened in the family in the past week. I then ask what was successful in the family related to goals. Perhaps the parents yelled less often or the child was less angry when she didn't get her way. This will inevitably lead to a discussion of a specific behavioral issue. Be careful at this junction not to allow the parents to become too harsh, critical, or long-winded in their complaints. Titrating the child's shame is the clinician's main role here.

Briefly get the facts from both parent and child on what happened when the child forgot to turn in five homework assignments or threw their tablet across the room when told to turn it off. However, quickly turn the family's attention away from issues of compliance to how they are interacting. How did they each respond during the interaction at home? How did these responses trigger another family member's response and so on. Using the EFCT infinity loop model, slowly and patiently get each person to dive down to gain awareness of their emotional reactions, notably shame and their fears of unworthiness and rejection. Ideally, children will become increasingly comfortable with expressing their primary emotions and attachment fears and needs and these emotions will be warmly responded to by the parents.

Especially helpful are enactments where both the child and parent express contrition, regret, and accountability. Because of shame intolerance patterns in the family, it can be challenging to slowly guide each family member through a reparative process where both admit they are somewhat at fault. Perhaps the child hasn't cleaned her bedroom, but the parents also nagged about this in unhelpful ways. Work to get the child to promise to do better at cleaning and the parents to promise to do better by allowing her some autonomy, such as deciding how or when she cleans.

Regularly remind children throughout therapy sessions that these meetings are not just to focus on the child's behaviors, but also to talk about the family and correct parenting problems. Frame goals around the family getting better together and getting along. Even if child behaviors are severe, model reframing the problem similar to this type of language: "This is a really hard problem and I bet you want help so you don't keep getting in trouble for this. I hope that by coming here we can all figure this out together."

Engaging in some minor corrections toward parents in front of the child may be especially helpful. It signals to the child that someone is standing up to parents — possibly a new phenomenon for a child in an authoritarian household. It models reciprocal relationships and problem solving through mutual accountability. Children see that parents can and should be corrected. Hopefully, due to your prior coaching, the parent graciously accepts this correction and promises to change. In terms of shame tolerance skills, this scenario can be extremely reparative and educational for both parent and child. The child internalizes that even adults make mistakes, need guidance,

and must change behaviors — this isn't just a "kid thing." If you only work with the child it does not offer these opportunities for the child to witness the parents being held accountable.

Additional interventions in subsequent sessions can include:

- Give compliments to family members readily, especially about character traits, so that they feel positive about therapy: "Sounds like you were very patient with your younger sister," or "Your mom is trying hard to be a better listener, isn't she?" This also models for the parents how to interact with the child in warm, reflective ways that enhance the child's sense of self. Practice having family members compliment each other genuinely.
- Have parents admit their mistakes and apologize to the child to model good shame tolerance.
- If there are conflicts, as much as possible process them through to apology and repair in each session.
- Parents and therapists can work to develop the child's growth mindset, for example by praising hard work versus praising achievement. Children with shame intolerance often have very poor persistence and frustration tolerance on tasks. Educate parents to praise character traits, not outcomes, such as grades or hockey goals.
- Suggest family meetings to discuss problems and set family rules on chores. These meetings can build reciprocity, mutuality, and fairness in the family hierarchy. They can strengthen healthy negotiation skills and teach children about accountability and autonomy. Kids can even hold parents accountable for their failure to do chores!

Until there is a sense of safety and alliance in therapy, do not excessively shame the child. In later sessions, when the child feels more comfortable addressing their behavioral problems, you can begin to more directly point out specific issues and work to correct them with the family's involvement. However, clinicians should model from the start the general philosophy that potentially embarrassing subjects are going to be directly addressed, modeling healthy shame tolerance and accountability. When I develop a strong relationship with a child, we can even start to joke about the topic:

Child: "I yelled at another kid on the playground again last week. Even though I know we talked about me not doing that."

Therapist: "Oh, was that another one of these times when that nasty emotion of embarrassment took charge? Let me guess… you missed another soccer goal. And I'll bet that kid Andy laughed at you, too. Ugh, that must have been tough."

Common Family Issues

How One Sentence Can Teach a Child Shame and Low Self-Worth

The power of shame is so great that just one sentence, used repeatedly in parenting, might teach a child to feel ashamed and lead to a lifetime of low self-worth.

Let's examine a common scenario: A child misbehaves by throwing a toy, then starts having a tantrum, and maybe starts to really lose control of his emotions. The parents try to manage the situation, stop the behavior, and teach a lesson. These are all laudable goals, but they may backfire.

One common question parents ask kids in these moments is: "Why did you do it?" I believe this "why" question is the cause of a lot of emotional problems for children.

First, parents need to understand that kids' brains are not fully developed. They are born with a full complement of "emotional" brain, but very little "thinking" brain. The "thinking" brain develops until the age of 25. This means that when they are young, they have poor cognitive ability to reason, be logical, understand the consequences of their actions, or fully consider the impact of their behaviors on others.

We also need to recognize that when any human is in the midst of an emotional meltdown and has become dysregulated, they have less ability to think clearly. The "emotional" brain takes over and the "thinking" brain does not function well. For a child this is especially true, given their brain development. To ask a child to use higher-level thinking, especially when he is in an emotional state (tantrum), is not age appropriate. Even adults don't think logically when they are enraged.

If a parent asks "Why did you do it" in the midst of a child's tantrum, here is what can go awry:

This question demands that a child switch from their emotional brain to their thinking brain in the midst of emotional distress. This is nearly impossible for a child to do. And — let's state the obvious — there is rarely a good reason children throw toys or hit their siblings. So the "why" question immediately sets a child up for feelings of failure and shame. He thinks: "I have no reason for what I did. I should be able to say why I did it, but I can't. So I must be stupid. I am disappointing my parents. And why can't I calm down like my parents want me to? I'm out of control. I must be crazy and my brain is defective." Although this may seem extreme, I have had many children express these exact thoughts to me during therapy sessions, so I know they think this way.

Psychologist and parenting expert Bruno Bettelheim in his book "A Good Enough Parent," describes it this way: "An adult can easily out reason a child without even realizing that he is doing it, the parent's reasoning power being so much greater than that of the child, who is unable to marshal his arguments in a convincing way. But the grown-up's superior ability to argue and his greater command of relevant facts – so convincing to the parent – can be experienced by the child, as simply the beating down of his opinion. And many a child, knowing from past experience that his parents will have his way, is angry or unhappy in advance about the outcome he expects, and is prevented by his feelings from both stating his arguments and from understanding those of his parent. So the child feels outreasoned, and to be outreasoned is a frustrating and debilitating experience."[99] (p. 49) And is a shaming and down-ranking experience, I would suggest. The adult "wins" the argument, but the child feels the "loss" as a sense of failure and humiliation. While his resentment may be suppressed for today, it will either be internalized in self-hatred or externalized later in hatred of his parents for the shaming they put him through.

Bettelheim continues: "So it is that many of our questions, which we asked because we wanted to understand our child, cause confusion for him and ourselves. Since 'I don't know' is a statement of incompetence, he resents having to say it, and because he now feels ignorant, and inept as result of the questioning, he blames his confusion on the parent who interrogated him."[100] A child who is regularly humiliated and down-ranked in this way can become an Other-blamer who humiliates and down-ranks others.

In these interactions, kids may not get soothing and calming for their "big, scary emotions." When children are emotionally upset they first and mainly need comfort. Parents must be the calm, safe place where children can go to get understanding and comfort. If, in those moments, parents focus instead on correcting behaviors and punishing, the child never gets to feel the safety of emotional regulation. Kids need emotional attunement from parents first to enable them to calm down and think logically. This teaches them to attune to their own emotions and calm themselves down. This is a lesson for a lifetime of emotional health that is far more powerful than any behavioral lesson parents may teach. Children who can regulate their emotions properly will also behave properly.

Parents often divert to logical discussions because they are uncomfortable with emotions of any kind. They feel shame because their child is misbehaving and they want their own shameful feelings to go away. So they avoid discussing emotions, instead focusing on behaviors. What does this teach a child? That emotions are embarrassing, distressing, and should be avoided at all costs. What message does this send a child who is emotional? That he is defective, leading to thoughts of Self-blame.

Regular exposure to the "why" questions and behaviorally focused parenting can form children who have very negative feelings of self-worth. When they do a small thing wrong and parents punish, it triggers a strong shame reaction. Repeat this on a daily basis for years and you have a recipe for a person who has thoughts of low self-worth and has not been coached on how to control his emotions — a toxic combination.

Parents must get out of their logical adult brain and try to focus on a child's emotions and less on the behaviors. Behaviors of a child should mostly be used as a clue to what is going on emotionally. Certainly it is appropriate when a child is calm to ask about why they did something and help them process their thoughts and behaviors.

And consider this: Do you ever ask a child why they did some good behavior, such as cleaning their room unprompted or being nice to their sibling? You may praise those behaviors, but you don't question the motivation. So a child knows the "why did you do that" question implies disapproval.

Over-Explaining and Lecturing

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[99] Bettelheim, B. (1987) A Good Enough Parent: A Book on Child-rearing. New York, NY: Knopf, p. 94

[100] Bettelheim, B. (1987) A Good Enough Parent: A Book on Child-rearing. New York, NY: Knopf, p. 94

Close on the heels of the "Why did you do that" question is often over-explaining and lecturing. When a kid says "I don't know," the parent feels compelled to offer a logical explanation about why the choice was a bad one.

I work in a region of the country where there are a lot of parents working as engineers, IT specialists, and business managers — jobs that demand logical thinking. Carrie, age 8, came to me because she was extremely argumentative, oppositional, and defiant. She was very verbal and had an answer for everything. It wasn't until I started working with both parents that I learned that the father, an engineer, would in a loud voice explain to Carrie everything she did wrong — for over an hour. He, too, had an answer for everything! Carrie, a smart girl, would feel overwhelming shame, but had no other way to manage that except in the very same way her father did — by arguing and explaining her position.

I tell parents that they must use shame very judiciously, without long lectures or explanations. If parents can see embarrassment in the child's reactions, affect, or words in any small way, then they should stop talking! Let the child feel the natural consequences of guilt. They may want to circle back later to gently talk about that feeling of embarrassment and what it taught the child. Piling on guilt when a child is upset, angry, or crying is only going to teach them to engage in one of the unhealthy shame management strategies.

Don't Train Your Child to Lie and Feel Ashamed

Another way parents train their children to be ashamed is by setting them up to lie. Consider this scenario: A teen has the iron in her hand and is standing by the dining room table. There is no ironing board in sight. The mother asks: "Are you thinking of ironing in here on the dining room table?" It seems clear that the mother knows the answer to her question and so does her daughter. The evidence is clear!

What usually happens? The teen lies blatantly, saying that she wasn't going to iron on the table. This is laughable, given that the iron is in her hand. But why did she lie? To avoid the experience of shame. Admitting she made a mistake is too painful, as she has learned already in life, so she has to lie to save herself from embarrassment. The parent will call her out for this obvious lie and the teen then gets to feel the shame of lying and will probably get angry at herself for that failure, too.

Some parents then pile on by asking: "Why can't you just admit you're wrong?" This is a double whammy of shaming about lying and irrationality. Parents need to be taught that all humans, especially children, behave illogically, especially when they are trying to protect their sense of self from feelings of inadequacy. Parents see stubbornness and react to that, rather than understanding the deeper emotional motivations.

Some parents then try to teach bigger lessons by saying: "We can't trust you when you lie." While this is true, it creates fears of rejection in the child.

I advise that parents should not ask questions to things they already know the answer to. This just sets a child up to lie, but then also triggers additional shame. In this scenario, a parents should simply say: "Don't iron on the table." Or "Go set up the ironing board, please." Or better: "Where is the correct place to iron?" The tone of voice should be calm, matter-of-fact or humorous and light. Just walk away after saying it. If you linger then the shame is increased. Allow the child to process their mistake on their own without additional shaming.

Family Play Therapy

With younger children, early in therapy I have the family engage in group sand tray activities. This is better tolerated than talk therapy by shame-sensitive children. It also allows me to assess how parents engage with children: Are they intrusive and overly involved with telling a child what to do and how to do it? Are they cold or dismissive or critical? Do they defer to the child excessively or are the parents too authoritarian? Do they warmly attune to the child or do the parents have their own agenda?

One sand tray activity that can provide insight to the clinician is to have each family member pick out three characters from a selection of sand tray objects and characters — animals, humans, household objects, and mythical creatures. Give instructions for the family to tell a narrative story with a beginning, middle, and end. The child starts using one character and begins to tell the story: "Once upon a time…" Each family member then takes a turn narrating a brief element of the story and adding their characters to the narrative line and to the sand tray. I will sometimes give the child a character to use in the narrative if I want to assess something. For example, if their

grandmother recently died, I might hand the child a figure of an elderly woman and watch for themes that arise in the storyline.

During sand tray play therapy, consider:

- Are pieces placed in front of that person only or integrated with family member's pieces?
- Does the story narrative link together from person to person (indicative of mutuality and interdependence) or does each person abruptly change the plot to suit their own needs? Does the family work together well in moving the story forward? When does the story abruptly change and who changed the plot?
- Do they refer only to their pieces or include others in the storyline?
- Do they make eye contact, interact warmly, and cooperate? Or not?
- Have the family give the story a title at the end.
- Discuss what each person liked or disliked about the story.

Repeat family sand tray interactions several times to see if assessed patterns hold up. These sessions give the family a unique way to interact with each other that does not involve their normal patterns of "parents criticize, children react to the criticism."

Mindful Self-compassion as an Intervention

Mindfulness trains a person to slow down, observe, and pay attention to thoughts, feelings and experiences. It works to reduce unthinking emotional reaction — rushing from shame to defensiveness and anger — that people must become aware of to permit wisdom and personal growth.

Self-compassion skills enable clients to meet the experience of self-loathing with kindness and understanding, which helps provide a safe internal environment for change. If the self is no longer a threat, change becomes possible.

Children can learn to stop automatically shaming themselves, which by itself reduces their fear response independent of external shaming or traumatic experiences.

Fortunately, there already exists a large body of research on the effectiveness of mindfulness and development of self-compassion as a treatment for feelings of low self-worth and lack of self-acceptance. These skills are helpful because they specifically target the core emotions of shame and fear driving most problems of thinking, feeling, and behaving.

Numerous authors and researchers have pulled from Eastern teachings and traditions and expounded on the effectiveness of mindfulness and compassion. Kristen Neff [101] and Christopher Germer [102] have developed Mindful Self-Compassion training based on their research. Paul Gilbert has written and researched extensively, developing a group therapy program of "Compassionate Mind Training" along with colleague Sue Proctor. [103]

Mindfulness expert Daniel J. Siegel has published several books on meditation and its effects and use in therapy. Siegel has noted that regular practice of mindfulness brings the same benefits of healthy emotional and physical regulation or control, attunement with others, insight, and empathy that are associated with childhood histories of secure attachment. "Mindfulness has been shown to be effective in healing insecure attachment."[104] Siegel also has written: "The purpose of both psychotherapy and mindfulness practice is to provide this internalized secure base. Attunement, whether it is internal in mindfulness, or interpersonal in attachment, is what leads to a sense of secure base."[105]

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[101] Neff, Kristin, PhD: For a complete list of publications: http://self-compassion.org/the-research/

[102] Germer, Christopher, PhD: For a complete list of publications: www.mindfulselfcompassion.org

[103] Gilbert, P, & Procter, S (2006) Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach. *Clinical Psychology and Psychotherapy*, 13, 335-379. DOI: 10.1002/cpp.507

[104] Siegel, D.J. (2010) *The Mindful Therapist: A Clinician's Guide to Mindsight and Neural Integration. New York:* W.W. Norton

[105] Seigel, D.J. (2010) *Mindsight: The New Science of Personal Transformation.* New York: Random House

Parents and children can both learn simple meditation practices. Children can learn the flower and candle breathing practice (breath in and smell the flower, blow out the candle slowly). Practices of "clench and relax" and "slump and stand tall" posture exercises can improve bodily awareness. Hyperactive children can simply practice sitting still for 5-10 breaths. Clinicians should develop a repertoire of child-focused mindfulness practices.

Parents and children can learn the mindfulness lesson that paying attention in the present moment to the workings of our minds helps us be less likely to be swept away by emotions. I often use the simplistic model of a "thinking' and "emotional" brain. Mindfulness strengthens the thinking brain to improve decision making, empathy, compassion, and prosocial behaviors to prevent the emotional brain from hijacking the thinking brain. Without re-engaging the cortex to manage fear-provoking thoughts we are going to have difficulty engaging with compassion. Clinicians should have a solid understanding of mindfulness and self-compassion practices and concepts so they can be integrated into therapy sessions organically.

In the past 30 years, significant writing and research has been done on the effectiveness of mindfulness, meditation, compassion-based therapies, physical exercise, yoga, somatic therapy, the mind-body connection, and other related concepts. Yet the DSM makes not one nod to any of these concepts or what they reveal about the human mind, emotions, motivations, physiology, and behaviors. If mindful self-compassion is so successful at relieving emotional and behavioral problems, would that not indicate that low self-acceptance and a sensitivity to shame might be at the root of much of our human suffering?

Interventions for Children

Once you have met with the parents individually and the family at least once, you can set up a schedule of meetings with family and the child. With adolescents you may have several individual sessions with the teen, then a family session.

As with any type of therapy, building the relationship is key to success. Obviously, clinicians should establish a safe, accepting environment so that the child can re-create attachment models of dependability and soothing with the parents. As such, clinicians should hold a frame that the entire therapeutic experience should be safe enough that the child's shame is down-regulated and they are in their ventral vagal state much of the time. This will allow a decrease in shame defensive behaviors and an increased ability to tolerate vulnerability. The goal is to decouple shame from the experience of threat or fear.

As previously discussed, clinicians should develop an interpersonal style that uses warmth, compassion, and patience. Because of the inherent authority in the clinician role, I use humor as a way to relax children and teens and relate to them in a more socially equal manner.

Most children will be uncomfortable and embarrassed in therapy, especially if they know their parents will be bringing up a behavioral problem from the past week. But this offers clinicians an opportunity to process the emotion of shame in the moment. In a soft tone of voice, say: "Before we even get too far along, I'd really like to just slow down and see if we can check in with how you're feeling. [Most kids won't know or will refuse to say, but you can likely identify anger, sullenness, trepidation, downcast eyes, or other signs of shame.] I'm just guessing that you're maybe worried about what we're going to talk about and probably embarrassed. Does that sound about right? You're embarrassed to talk about this problem in front of me and worried how that's going to go. No problem. That's completely normal. Nobody really likes to be criticized in front of a stranger. But we'll work it through together and figure it out. I'm just here to try to help you and your family figure things out so everything goes more smoothly in the family."

Use phenomenological techniques throughout sessions to get at the experience of shame in the moment. Look for ways the child may be expressing shame and unworthiness through words or actions — including what is unsaid or covered up. Then if you see an opening, slow down and heighten this experience to unearth the likely feelings of shame or guilt.

For example, if a child mentions feeling "sad" about misbehaving, I slow down my vocal speed, soften my tone, and gently probe this experience to see if the patient can identify that they are embarrassed in some way. Use inquiry skills to question or suggest emotions or thoughts. Often children cannot be very self-reflecting, so I may have to hazard a guess. I do this tentatively and with a disclaimer that I could be wrong: "I'm just guessing here, and I could be completely off base, so let me know if I am, but I'm wondering if maybe you were feeling a little

bit embarrassed for…" Do not over-talk or over-explain, as this will likely worsen feelings of discomfort and shame. Allow space for the child to work through their emotions without pressing them too hard. Walk them slowly through their emotional awareness process to identify the feelings of shame at being criticized, and then their internalization or externalization of shame and self-criticism.

Learn to recognize the body language of shame, including blushing, fidgeting, downcast eyes, hesitant or vague narratives, changing the topic, poor eye contact, slumped shoulders, placating tears, blame-shifting and defensive anger. For example, it is important to recognize that most people who cry in therapy do so from embarrassment, not sadness.

Listen for statements that indicate low self-worth or fears of judgment as doorways into further exploration. These are not always obvious, but include: "I'm the stupidest/smallest/least athletic kid in my class," "It doesn't matter what I think," "My brother is always better at sports than me," etc.

Be careful not to inadvertently trigger a child's shame. Avoid asking questions such as: "Why did you do that?" or "What were you thinking?" Rather than ask why, get the child to consider alternatives in problem solving. Ask: "What else could you have done?"or "What did you learn?" or "What would you do different next time?" Integrate interventions to build mindfulness and self-compassion: "What did you say to yourself in that moment after you messed up in the spelling bee? How did that feel when you said that to yourself? What could you have said to yourself that wouldn't have been so mean and judgy?"

You can also try to build the child's empathy (often lacking in shame-intolerance patterns) by asking them to consider the other person: "I wonder how Easton felt when you threw the ball at his head so hard?"

Just as discussed previously with assessment and diagnosis, never tell a child a diagnosis or talk about "your mental health disorder." Never engage in pathologizing, such as saying, "Something is wrong with your brain," or "You have a disease of the brain." Tell parents to follow the same rules: Do not use mental health labels or say that the child is permanently affected by a chemical imbalance of the brain or that psychiatric medications fix the brain.

Consistently communicate a growth mindset — that the child has the capability to learn to make changes. Framing should focus on emotions and the ability to control emotions with the thinking brain.

If the child is reluctant to attend therapy, normalize and connect by addressing this directly, but relating to the child: "I understand why you wouldn't want to come to therapy. You're not sure what will go on here *and* it's a really nice day outside. I'd rather be outside playing too! But we're here, so let's try to make the most of it." This type of conversation indirectly models cognitive redirecting of the inner voice toward positivity and resilience.

Interventions for Other-blamers, Self-blamers, or Blame Avoiders will vary considerably. The art of working with shame in children (and adults) is to artfully balance when to be accepting and warm and when to be firm and hold someone accountable. This is first based on the strength of the therapeutic relationship and then on the client's shame strategies and severity of shame sensitivity. In general, early in the therapeutic process, there should be more focus on acceptance and validation, with increased levels of accountability as the number of sessions increases. This will also be based on age: older children should be able to handle accountability better than younger children, but this depends very much on the child.

- Self-blamers: Self-blamers generally have excessive guilt and responsibility, so you may want to decrease accountability. With some highly over-achieving and perfectionistic children, I've had them build skills in play and spontaneity, which they lack. Work to address their worry about what others think and comparative thinking. Reduce their approval-seeking and submissive tendencies. They tend to lack confidence and self-awareness and are overly humble, so building self-identity is essential. Give them compliments and praise.
- Other-blamers: Clinicians must be more direct in confronting a lack of accountability in Other-blamers. Their lack of accountability is what causes problems for them in relationships. Teach Other-blamers to be more empathic and worry more about what others think. Slow down emotional exploration to help them learn that underneath their defensive anger and boasting is fear and shame. If they can experience admitting this to a therapist, it can be an emotionally corrective experience. They can learn that admitting shame is not the devastating blow they perceive it to be. Therapists must be sure to point out the primary and secondary emotions and validate when patients do finally express shame and fear.

- Blame Avoiders: Blame Avoiders often lack prosocial skills and emotional intelligence. Fear of criticism and shame causes them to shut down or numb out to emotional experiences. It may take patience to reduce their guardedness and get them to be vulnerable.
- Because children generally use all of these strategies at various times, clinicians need to be very skilled at shifting from warmth to firmness. For example, I may be talking in a very friendly manner to a child, but when she puts her shoes on my office furniture I firmly remind her that the rule is no shoes on the chairs. I then shift back to our conversation. This also helps children realize that handling criticism is just a normal part of life.

Those with any of the three types of maladaptive behaviors can benefit from education on shame as an emotion that merely needs to be regulated and managed with the help of our rational brain. If a child has done something wrong, I lead a discussion on how much guilt they should feel for this behavior and how long they should feel it. I'll have them put a 0-10 ranking on the guilt they should feel. I'll then remind them that guilt is there to help us learn to do better next time, not to punish ourselves endlessly for a simple mistake or error in judgment.

For more behaviorally challenged clients, this shifting from warm to firm may involve multiple sessions and more corrective responses. One teenager with a history of attachment trauma and long-term residential placement routinely tested limits in therapy in smaller ways, some of which I let slide, others of which I addressed. One day she began swearing loudly, stormed out of the office and slammed the door, disrupting the entire office. I addressed this first with her mother, then had them both come in for a meeting where I laid down firm rules, with failure to comply meaning she would get an escalation of care, possibly back to residential treatment. I had her write a letter to each clinician in the office to apologize to them and their clients and a letter to me. This very strong-willed teen changed instantly and became more compliant and appropriate in her behaviors in session. It was a risky decision for me, but I knew that she had been testing her parents and every therapist she'd come up against. As an Other-blamer she needed to feel some accountability. An epilogue: She came back to me as a 26-year-old patient raving about how that incident when I held her accountable changed her life for the better.

Later in therapy, when a child does open up about their shameful mistakes or problems, use lots of validation for this new skill: "I know it is difficult for you to be here, opening up to me, and admitting that you have this problem with getting angry in school. It takes a lot of courage to admit that you are having this problem. Good for you."

Following is a sample dialogue regarding a behavioral problem that uses a shame-focused focus to guide the conversation.

DIALOGUE	ANALYSIS
Therapist: So after your mom scolded you for not cleaning your room, how did that feel?	Start with a simple exploration of behavioral choices and resulting emotions. Most kids, especially early in therapy, will not talk about feelings, but will revert to merely arguing about their mother's behaviors or words.
Child: I was mad at her. She's mean and my room wasn't that messy.	Child identifies secondary emotion of anger and engages in externalization of shame by blaming mother and making excuses.
T: You got mad because you didn't think you should have to clean your room. But your family does have rules about no clothes and toys on the floor, right?	You may try to hold the child accountable depending on the child's shame sensitivity. If the child gets reactive you can work on identifying that process.

DIALOGUE	ANALYSIS
C: Well, maybe…I probably knew I should clean my room and when I slammed my door that was too much. Mom hates it when I slam the door. OR: C: Well, maybe… But my mom is still mean for making me do chores when I wanted to play with my friends!	Depending on the child and the progress in therapy, they may be able to be accountable for their behaviors. If not, you may decide to return to it in future sessions, depending on the emotional state of the child and their history. When working on building shame tolerance you must titrate exposure to shame very slowly. You may want to end the conversation here with a brief acknowledgment that the child knew the rules and was accountable to a degree. OR: They will likely continue the pattern of blame shifting and excuses they engaged in with the parent, probably even coming up with a new justification. The child makes a tiny effort to be accountable, but still feels compelled to offload some of the blame to his mother and cannot tolerate full accountability. This is face-saving. Depending on the stage of therapy, you can decide on how much you want to hold them accountable. If they admit any accountability, focus on that. As you work more with the child, you can more directly point out the blame shifting, justifications, and excuses.
T: OK, that's actually pretty awesome that you can own your part of this and how you reacted. That's really mature of you and responsible. I'm so proud of you that you could admit that maybe you should have done what your mom asked of you. Even if she is "completely nuts" for making you do chores!	The therapist shares a joke with the child to align with him and lighten the mood. Children love to be described as mature, so use this word whenever possible. It brings feelings of pride that reinforce good behaviors and counteract shame. Sow (well-earned) compliments and validations freely.
T: So it seems like you can be accountable in here with me, which is great. But I'm wondering if we can go back and play detective with what happened with your mom. If I understand correctly, you didn't think your room was dirty and you wanted to play with friends so when your mom told you to clean your room you were disappointed and frustrated. But next you got angry and blamed her. But maybe I'm wondering if you were also a little embarrassed that you hadn't cleaned your room. You knew that you probably should have cleaned your room like your mom said and like the family rules require?	Using the EFCT infinity loop concept, review the emotions and communication process so that the child can recognize primary and secondary emotions, especially shame as a driver of their reactions. Slow down and break down each part of this scenario and the emotional component. Validate the child's partial effort at holding himself responsible then "tie the bow" by re-narrating the primary and secondary emotions and cognitions so the child understands the layers of experience.
C: Well, maybe I over-reacted because I felt guilty about not cleaning my room like I'm supposed to.	This is an ideal scenario exemplifying later stages of treatment, where the child can be accountable and identify guilt.
T: It's awesome that you can identify and talk about both feeling ashamed and then angry. We've discussed how painful that big emotion of embarrassment is, right? Makes it so hard to talk about, huh? It's easy for us to get angry when we feel embarrassed or guilty. Good job for sticking with the conversation here today. That shows you can handle that big icky emotion of shame.	If the child can acknowledge feeling embarrassed, then validate that capability and again review the connection between the primary and secondary emotions and behaviors. Connect their shame tolerance to the present moment experience of talking in therapy.
T: Thanks for hanging with me as we talked about this tough stuff. You're getting to be a pro with learning to manage all these big feelings. I'm proud of you! I know you care about your mom and want to do what's right, but sometimes your feelings just get in the way of that good intention.	Always repair and end the conversation on a positive note highlighting and validating the child's skills. Mention positive character traits such as pride, maturity, emotional regulation, and being a good person.

After you've done this in a few sessions, you may also add in the more complex idea that feeling guilty is a good thing: "I'm actually glad you feel sad and guilty. What!? I know that sounds strange to want to feel those bad, icky feelings. But it just means you are normal! There is nothing wrong with feeling guilty. In fact, it's good. We need guilt to teach us to change our behavior when it's not so great. So don't be afraid of feeling guilty, just use it as a sign that you might need to rethink your choices next time around."

Provide education on the dual nature of prosocial emotions: "These feelings like shame can help people behave in 'good' ways, but they can also cause people to feel different or awkward and to talk negatively toward themselves in hurtful ways." Most children are very aware of the concept and experience of bullying, so it can be helpful to reframe Self-blame as "bullying yourself." Explore how a child feels when they are bullying themselves.

For children with good emotional awareness and skills you may be able to get them to reflect on how it felt in the moment to go through that process of emotional deepening with you.

This process can also be done with family members in the room to highlight both sides of the infinity loop process to show how parents and children trigger each other.

Interventions for younger children:

1. As previously discussed, in the first session strive to make the experience non-threatening and pleasant. Build the alliance by making small talk about the child's hobbies, friends, sports, pets, and family. Normalize their feelings of nervousness, fear, and shame at being in a new situation like therapy. Use this as an opportunity to briefly educate on embarrassment and shame as normal, healthy emotions that will be discussed in therapy.
2. At subsequent sessions, be sure to welcome the child warmly and note how the child has meaning for your life: "I was looking forward to seeing you today" or "I am so glad you came today" or "I thought about you over the past week and wondered how you were doing." Remember birthdays, events, tryouts, and homework assignments and bring them up. Remember activities from last week's session and revisit them. At the end of the session say, "I really enjoyed seeing you today and spending time with you." You are imprinting compassionate thoughts for the child to internalize.
3. In many families, a child's opinions matter very little. Each week ask: "What activities did you do with your family this past week? What did you like about school today? Did you visit or play with friends? What was the most fun/boring/silly thing you did today?" In other families, the children have too much opportunity to express opinions. Often, they come to therapy talking nonstop. These children must be redirected to be less self-absorbed and more reciprocal and curious about others. You may have to teach basic conversational skills of listening, asking questions, empathy, and reciprocity.
4. Play therapy can be very helpful as an assessment and interventional tool. Most children today do not engage in active, creative play and transition largely to screen time and video games at a very early age. Play can teach, without the child's awareness, skills of persistence, risk tolerance, losing with grace, and emotional regulation. After these skills have been learned in the enjoyable experience of play, they are then ported into life as integrated habits. "Through play, more than any other activity, the child achieves mastery of the external world. He learns how to manipulate and control its objects as he builds with blocks. He gains mastery of his own body as he skips and hops and jumps. He deals with psychological problems by reenacting those difficulties he has encountered in reality, as when he inflicts on his toy animal a painful experience that he himself has suffered. And he learns about social relations as he begins to realize that he must adjust himself to others if satisfying play is to continue."[106]
5. With children of all ages I ask them questions that both assess for shame tolerance and offer opportunities for discussions. I'll have children tell:
    1. Something new they've learned today or in the last week (it can be very small or silly, such as "I learned I don't like butter pecan ice cream.")
    2. A risk they've taken
    3. A mistake they've made
    4. An embarrassing moment they had
    5. A regret over something they did or did not do
    6. Something that they did that makes them proud

[106] Bettelheim, B. (1987) A Good Enough Parent: A Book on Child-rearing. New York, NY: Knopf, (p. 202)

6. If the child is capable of some emotional awareness discuss how it felt to talk about these things here with you: "Was it embarrassing? Were you afraid what I would think?" Be gentle and progress slowly when working with these tender experiences and vulnerabilities.
7. Include in these discussions ideas of common humanity used in compassion-based interventions — that we all make mistakes and have failures.
8. Most children are very black-and-white thinkers, but fear-based and shame-based thinking is especially so. If a child makes a statement, such as "Everyone hates me," be sure to dive in and ask them to consider the situation from different perspectives. This reintegrates left and right hemispheres of the brain and encourages logical consideration.
9. Reduce the use of simplistic personal opinions. If you say, "You've got nothing to be ashamed of," this leaves the child feeling ashamed for feeling ashamed and decreases a sense of agency and autonomy in the child. The adult therapist is telling them what to do and how to feel. Many shame-prone people are resistant to accepting solutions or even reassurance or compassion; this feels foreign to them or even threatening if they have attachment traumas.
10. Most children do not have an accurate self-image. The following art therapy exercise can help and can be repeated through therapy, first as an assessment and then as an intervention tool. Have the child draw themselves, leaving space around the picture. Next have them list their character and personality traits. Start by having them generate whatever first comes to them. Notice if this is easy or difficult and the types of words they use. Younger children will rarely be able to do this on their own. Provide suggestions and guidance. Have a list of common character traits handy to use as a guide. Then observe their reactions as you suggest character traits they likely did not consider — both positive and negative attributes — such as kind, generous, patient, selfish, lazy, impatient, loud, funny, etc. After they are done, process through what that was like to either struggle to accurately label themselves or to realize they do have a wide range of character traits.
11. Identify the inner critic: Some children might be able to self-reflect and notice thoughts of self-doubt or self-criticism. Have them draw a picture of themselves. (I have a whiteboard easel at kid level in my office and they love drawing on it.) Then have them add thought bubbles of things they say to themselves that are hurtful or judgmental. Ask about specific situations: "What did you tell yourself when you didn't get asked to play four-square at recess with the other kids?" You may have to write these for younger children. Encourage them instead to use private speech in a positive and compassionate way. Help them reframe using compassionate words, tone of voice, and intentions.
12. Read books with kids on shame and compassion, such as: *A Kid's Book of Shame*, by Jamie Letourneau; *Shame Mud* by Jamie Jenson; *It's OK: Being Kind to Yourself When Things Feel Hard*, by Wendy O'Leary; *The Girl Who Never Made Mistakes*, by Mark Pete and Gary Rubinstein; *Moody Cow Learns Compassion* and *Moody Cow Meditates*, by Kerry Lee MacLean. The book entitled *Trying*, by Kobi Yamada, which is beautifully illustrated, addresses growth mindset issues of persistence through failure. With all these books, be sure to follow up the next session and ask: What did you try and persist at? What embarrassed you recently? What is a mistake you made? How did you handle it? When were you you kind to yourself this past week?
13. Don't be afraid to teach explicitly about the prosocial emotions, as this normalizes addressing them and decreases avoidance. Many lists of emotions used by parents and teachers don't include shame and guilt. I've read entire books on feelings for adults that don't mention shame.
14. Acknowledge when children respond to difficult topics: "You were able to tell me a lot about that situation," or "I know it was uncomfortable," or "I understand that you feel…"
15. Highlight, deepen, and contrast feelings of pride and shame as they come up organically in conversations. Interventions can include helping children label and identify times when they feel pride. You can ask: "When did you feel pride at doing something well or doing something right? When did you feel you did not make a good choice and did something wrong?" I use the word pride or ask about this feeling, as it is an emotion that is counter to shame and gives children a "reward" feeling when they complete a task or make a good choice. It is important for them to begin to notice and really absorb feelings of healthy pride at accomplishment, because this teaches them the value of persisting through difficult moments. Teach about pride as an antidote to

shame. As with any emotion, have them explore the somatic experiences of these feelings. For Self-blamers, give them permission to really feel proud and not dismiss or downplay this experience. If they are procrastinating on schoolwork, for example, discuss this as likely due to having low levels of pride. If they lack awareness of this emotion, they will lack motivation to gain the reward of feeling proud.

16. Clinicians can give a child a compliment and observe how they react. Do they divert, dismiss, ignore? Do they become boastful and grandiose? Do they graciously accept it? Some children even become uncomfortable or even tearful when hearing compliments, likely a sign they rarely receive praise from parents and are desperate to receive this warmth. You can then process what it felt like to receive praise. If the child says the compliment felt good, this is an opportunity to provide education on compassion. "It felt good to get a compliment from me, so that must mean you like that experience of reassurance and praise. What would it be like to give yourself compliments? Would it feel nice to get that reassurance and praise from you?" Have the child practice giving themself compliments and identifying positive character traits. You can also have them give compliments to others, as this is sign of sending compassion to others and popular children often exhibit this skill. In families where negativity may reign, have the child construct a "compliment box" and take it home to have all family members put in a compliment each day about another family member. The family can pull the compliments out once a week and read them aloud.
17. Explore risks they have taken or are afraid to take. Often just talking about this subject in a relaxed manner, without urging any new risk taking, can be helpful for a fearful child.
18. Many shame-prone children have insecurities that lead to high levels of comparative thinking, competitiveness, and a need to be better than others. They might talk about being the best on their soccer team or reading more books than anyone else in their class. To decrease comparative thinking and build a sense of common humanity, try the following project. Have them write a peer's name at the top of a sheet. Then have your client list ways they are similar. Then have them write a compliment about this person. Repeat with other peers or with siblings. This should build the skill of seeing commonalities, rather than differences, and the skill of giving compliments to others.
19. An intervention I like to use both with the parents present and without (depending on the family) is the "Tell me the story of your life" exercise. Ask the child to tell the story of their life starting with "Once upon a time," to get them in the story telling mode. After you have prompted parents privately on how to give compliments and identify a child's character traits and growth mindset skills, then have parents tell the story of the child's life.
20. For children with negative attitudes, process alternate views of life, including positive events, strengths the child has gained, and relationships that are positive.
21. Sand tray therapy can help a child work through personal conflicts, fears, insecurities, and family dynamics.
22. Tell stories: For children with fear of making mistakes, the creative process of storytelling can help free them from being "perfect." Create a fun, fearless atmosphere where anything is possible in the storytelling mode, so the child is less bound up in doing things correctly. You can tell stories without any props, or use puppets, stuffed toys, sand tray characters, or other objects as prompts. I have a set of dice with drawings on each face and these are used as prompts for a storyline.
23. Puzzles: Some children need help with executive function skills of organizing, developing a plan, slowing down to focus their attention, being deliberate, etc. Talk to them about how they feel when starting out on a puzzle: Overwhelmed, unsure, afraid they won't get it done? How do they feel when working on it: Frustrated? Disorganized and without a plan? Then integrate growth mindset concepts: "It can feel frustrating, but how could you reconsider that? Seems to me like you've got about half the puzzle pieces already done!" Or: "You're trying so hard. Think how proud you'll feel when you finish."
24. Simple board games such as Shoots and Ladders and Sorry teach good sportsmanship when handling setbacks. Playing board games can improve character and relationships because they provide a state of controlled conflict by requiring practice at taking turns, following rules, being fair, and winning or losing gracefully.

25. Do not let a child cheat or pout when losing without addressing this behavior. When the child loses, directly discuss how it feels and how they can work through these feelings. Many children take it personally when they lose, but need to understand that many simple board and card games are based largely on luck, with very little or no strategy.
26. Help children and families practice gratitude. They can list three things they are grateful for every night at bedtime or at the dinner table.
27. Engage in parts work: Children can usually understand that part of them thinks and feels one way, while they may also have contrasting thoughts and feelings. Help them accept and understand all their parts: "Seems like one part of you knows that teasing your little brother is wrong and then another part of you enjoys it, but then another part of you feel ashamed about that behavior."
28. Some over-regulated and anxious children need loosening up, so I'll toss a small stuffed animal or ball between us as we engage in small talk. This brings a sense of play that relaxes and distracts them. One version of this tossing game adds in shame and accountability lessons. Each time someone catches the ball or toy they have to say something they did that was a mistake, was embarrassing, or was a negative thought. This models for the child that you, too, make mistakes and can admit them and the experience is suffused with play, not excessive shame.
29. "My Superpowers" is an exercise you can use for assessment or education. Guide the child in listing their superpowers, focusing on character traits: kind, imaginative, creative, smart, hard working, brave, persistent, funny, good friend, etc. Most children will struggle with this, as these are not traits their parents reflect back for them to observe. Write these down yourself as the child is brainstorming to allow them to think freely. Afterward, have the child write their superpowers on a a sheet of paper to take home (add some artwork of these traits to make it a fun project).
30. If a child has been told a diagnosis or has been in therapy before, be sure to directly ask what they know or have been told. Address their beliefs about the diagnosis or medications they've been given and re-educate to de-pathologize.
31. Normalize their past behaviors as emotions that need regulating and skills they haven't learned yet. Say: "I'm here to help you come to understand yourself better so you choose behaviors, feelings, thoughts that are helpful to you and your family."
32. For children who dislike school, the therapist may consider having them play teacher and ask questions of the therapist/student. This enables a role reversal that may shift perceptions. It gives the therapist a chance to model making mistakes and not knowing the answer.

Growth Mindset Interventions

Build growth mindset by addressing issues of persistence, risk taking, frustration tolerance, and positive attitude.

Have the child list or draw pictures of skills that highlight competence, but also a growth mindset: "I am already good at___. I'm proud of learning _____ I want to learn how to___. I'm not good at _____ YET." Have them rate how much effort it took to learn the skills they are good at and predict how much effort it will take to learn the new skills.

One family and/or child activity to encourage growth mindset is to engage in repeated answers to the statement "I haven't learned ___ *yet*."

Discuss and do projects that reinforce affirmations, such as:

- I can do hard things!
- Learning new things is my superpower!
- I am curious.
- I strive to do my best.
- Problem solving is a skill I can learn.
- Trying new things is fun and courageous.

- Challenges are for me!
- Practice makes me better.
- I believe in myself.

Have the child tell a "Me at My Best Story" and/or draw a picture that shows accomplishments they are proud of. This promotes agency thinking, pathway thinking, and how a child activates themself to pursue a goal.

For children who struggle to complete tasks or comply with parental directives, it can helpful to try the "Plan Your Perfect Day Story," where the child identifies activities they need to perform. Parents can integrate this by engaging in a nightly plan for how to make the child's next day successful, including what needs to be accomplished and identifying pleasurable and meaningful activities.

A Prediction Chart can also empower children to recognize that they have agency over their problematic behaviors. Have the child draw a week's calendar of seven boxes. Then have the child predict when they will engage in the problematic behavior — encourage them to be very honest, even if they say they will do it every day for the next week. The child takes the chart home or you can keep it. Review what happened the next week. Sometimes a child learns they can exert control and address their behaviors, which may be a counteractive to intrusive and controlling parents.

Interventions for Adolescents and Pre-Adolescents

Peers and peer culture have always been very influential for teens and preteens, as they work very hard to define themselves and simultaneously fit in and stand out. Because social media has significantly heightened group pressure, clinicians should assess for this factor and address it in interventions.

In most schools, the culture around academic pressure has shifted significantly from previous decades. When I was a child or teen we never shared our grade point averages or our test scores. Today, even elementary school-age children are frequently comparing their grades on homework or tests. They check online daily for their cumulative grade point average. For the over-achiever types, clinicians may want to check if this culture is the norm for them.

I openly discuss with teens ways to disengage from peers who worry excessively and openly about tests and grades. I have advocated that perhaps they lead a culture change to stop discussing grades or exaggerating about how tough tests were or anxiously worrying before tests. I had one case where an eighth grader, Dylan, had very high anxiety about academic performance. It turned out his best friend was highly competitive and constantly asked Dylan what his grades were. Dylan and I discussed how he could encourage his friend to talk about grades much less often. Changing that one peer interaction significantly helped Dylan's anxiety.

Adolescents with low self-worth often have inaccurate self-awareness and can be overly humble. They usually struggle to describe themselves, especially regarding character traits and values. Building self-identity can start with simple exercises of having a teen list their interests and hobbies. Move on to a list of character traits, then perhaps discuss values, beliefs, and morals. Challenge those who are self-effacing to lean in to descriptions that might feel to them to be grandiose.

Educate to improve awareness of and acceptance of negative self-image and thoughts of low self-worth. Regularly ask questions about a client's internal self-talk: "What did you tell yourself at that moment when you tripped and fell on the auditorium stage? How did that feel?" And to add in a piece of self-compassion training: "How else could you have responded to your pain in that moment?"

As mentioned previously, integrate lessons on the emotion of pride. If a child won't permit themself to experience this emotion, this gives them little motivation to work hard toward the intrinsic reward of feeling proud.

For an adolescent who presents as depressed, withdrawn, and non-communicative, explore their attachment history with parents. You will likely find an insecure attachment because of family disruptions or lack of parental skills at bonding and attunement. For these children, you can assess whether the parents have the ability to gain skills in this area and join in family therapy to build the bond with the child. If not, the therapeutic relationship can be a place for the child to experience acceptance and compassion. Because the child did not get proper experiences of emotional connection from parents, they likely lack a healthy sense of self. Their competencies and character may not have been honored or were overtly dismissed by parents. Parents perhaps saw differences of opin-

ion as unacceptable, so the children learned they, themselves, were unacceptable. Relationship breaks may not have been not repaired, and differences were viewed as a threat to the relationship. All of this can be remodeled in therapy.

With older teens, individual sessions can use explorations of messages they received from parents on issues such as perfectionism, feeling "not good enough," criticism, humility, and pride.

Older teens can learn any of the skills in mindful self-compassion used with adults.

Teach Accountability

A 16-year-old boy who procrastinated badly on completing chores and homework once told me: "I don't want to hurt my feelings, so I coddle myself." He exhibited great insight into shame, even if he didn't name it. He correctly intuited that he gave himself free passes as a way to avoid accountability.

Many families do not talk openly about consequences of behaviors and the importance of accountability. Therapists can describe accountability and the steps toward accepting responsibility: recognizing and admitting fault, apologizing, and seeking to correct the wrong by changing behavior. This lesson can be reinforced in therapy sessions as issues arise where the child is not taking accountability at home or in school.

One of the best ways to teach it, however, is to hold children accountable right in session if they do something wrong, such as put their feet on the furniture or play on their cellphone. Do so with minimal shaming and with active repair of the relationship. Unfortunately, many therapists are afraid to call clients out for personal behaviors that might be inappropriate. However, protecting children from shame only teaches them bad shame management habits. You will not be helping the child.

Normalize the emotional experience of these interactions. With a child say: "I'm sure you know that breaking all those crayons was wrong. But I think we need to talk about that, even if that feels uncomfortable for you." Then slowly and gently label emotions and somatic experiences with the child so they learn to handle the embarrassment of being held accountable for the behavior.

I worked with a young teen who was picking at his acne and squeezing his pimples during session — a lot. This was disgusting and I spent a couple of sessions trying to ignore it and see if it got better when he was more relaxed. But I finally had to speak up. I gently said: "John, I don't want to embarrass you, but there is no way to say this except honestly. You picking at your acne so much is really quite unsettling and distracting to me. I think I'm not alone in this experience and I'm guessing that your peers might also find this more than a bit gross, really. How about we work on some mindfulness and calming skills to help you address this habit. Let's practice mindfully holding your hands still, rather than mindlessly picking at your pimples."

If there are behavioral issues to work on, start with assessing for a child's lack of accountability. For example, if the child isn't doing chores, you could ask: "What happens when you forget to feed and water the dogs?" Watch for excuses and blame shifting as signs of shame and lack of accountability. One boy said the following in rapid succession, as if he was trying out all of his excuses to see which one would stick: "The dogs hide the water bowl and I can't see the water in the bowl and I have to feed the dogs two kinds of food and that distracts me and we remodeled the kitchen for two months and so I forgot." What, you forgot to feed the dogs for two months? And how exactly does a dog hide a water bowl? As we discussed each of these excuses his rationalizations got even worse!

Don't be afraid to call out excuses for what they are. Do so in a manner that is appropriate for the child. You may need to be gentle and compassionate, use humor, or be quite direct. I've even chuckled and said: "That sure sounds like a whole lotta excuses to me!"

Discuss excuses and justifications by flipping it around: "How would it sound if a friend on your soccer team said: 'I didn't make that goal because the grass was too long, the sun was in my eyes, and my shoes were tied too tight!' Sounds like excuses right? Doesn't sound good, does it? Sounds kind of lame."

With younger children you probably need to go over exactly what accountability looks like: "So we know that when you make excuses your parents get mad. How do you think your parents would respond if you said: 'You are right. I totally forgot to feed and water the dogs. I'll do it right now and try really hard to remember. In fact

I'm going to set a reminder on my phone.'" Remember that children may not witness family members modeling accountability.

Most children will admit that their parents would like them to be more responsible. I say: "I know it can be difficult to admit a mistake and accept responsibility. But this is a skill that mature young people and adults have, so practicing it now when you're younger is a great thing to do. How could you practice being mature?"

Some children, already quite skilled at Other-blaming, will have great difficulty with accountability. One child came to therapy after an incident of hitting a peer and being disciplined by the school principal. We had talked about it for awhile when I asked: "What did you learn from this?" He stated he learned nothing. This is a sign that he has gotten very good at externalizing shame. He feels no guilt and therefore can learn no lessons from his mistakes.

With an Other-blamer watch for their reaction when they are held accountable by you or a family member. In front of a therapist many Other-blamers will not become overtly angry, but their irritation is obvious in their facial expressions and body language. Explore this by asking: "You seemed to get irritated when your mom mentioned that the school counselor had called her about you hitting Joey. What was that like for you when she said that here in front of me?" The Other-blamer may easily agree to his anger and displeasure, but the deeper work is in helping him improve awareness of his primary emotion of shame.

While I do plan specific interventions before each session, I also know I have to be flexible to respond to what current issues parents or children might bring in that week. Check your case formulation summary sheet to reorient yourself to the child's main shame issues and be ready to shift gears in interventions, but always with the goal of building the child's ability to decouple shame and fear.

Chapter 9: Conclusion

I strongly believe that understanding the power of shame allows us to honor the real motivation for most human behavior — which is finding love from others and from oneself. We all innately crave acceptance. Humans are not designed to live crippled by self-criticism, shame, and fear.

The neurobiology of shame tells us that someone engaging in excessive self-judgment is constantly triggering their social threat system, which can lead to anxiety, depression, and rejection sensitivity. When childhood attachment traumas worsen self-rejection, it is an especially deep wound.

If shame is the cause of most emotional distress, then it is clear that compassionate self-acceptance is the answer. The good news is that research proves that compassion strengthens the ability to self-soothe via the social engagement system. Self-acceptance is a skill we can all improve upon, with many positive results for mental health. 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.

Helping children gain self-acceptance improves their ability to tolerate shame with equanimity by decoupling shame from fear. This leads to improved outcomes compared to the drug and behavioral interventions of the medical model.

I hope readers have learned that the mental health profession is ethically bound to disengage from reliance on the DSM/ICD and the medical model. 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-compassion improves shame tolerance. Case conceptualization and treatment planning for clinicians would be significantly simpler, yet more effective, under a shame-focused case formulation model. The result: Therapists can help children find long-term solutions to anxiety, depression, and other emotional problems, all without the use of harmful medications.

By strengthening a child's inherent self-attachment through improved shame tolerance, therapists can guide children to be happier, more secure, and more compassionate.

I hope you find the shame-focused model valuable and feel empowered to use these concepts in your therapy sessions.

Feel free to contact me at harperwest@me.com if you have any comments on this book, so that I can continue to improve it for others. For additional resources and blogs on shame, compassion, and parenting, go to www.harperwest.co

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