

Shame Plays Key Role in Psychopathology of Youth

BY SHARON WORCESTER
Southeast Bureau

MIAMI BEACH — Pathologic defenses against shame often lie at the heart of adolescent psychopathology. That's why helping patients understand and accept shame as a universal experience can promote healing, Dr. Alan Wofsey said at the annual meeting of the American Society for Adolescent Psychiatry.

"Some of humanity's most baffling and destructive behaviors are well understood as responses to shame and humiliation," said Dr. Wofsey, citing excerpts from Adolf Hitler's "Mein Kampf" and the gothic rock singer Marilyn Manson's autobiography "The Long Hard Road Out of Hell." These works offer examples of how the shame and humiliation of adolescence can lead to pathology and even to a "commitment to evil," as he considers to be the case with these two authors, he said at the meeting, which was cosponsored by the University of Texas at Dallas.

Shame as the root of adolescent psychopathology is a concept that many therapists suspect, but haven't quite formulated. Most therapists who treat adolescents have an intuitive sense of the impact of adolescent shame, he explained, but a deeper understanding of its role can enable the therapist to maintain his or her bearings even when confronted with the most difficult adolescent, as well as to provide a healing presence for the adolescent, said Dr. Wofsey, a psychiatrist in private practice in Wynnewood, Pa., and chief of psychiatry at Lankenau Hospital there.

"Any clinician who can convey a clear understanding of the dynamics of shame and humiliation quickly gains the attention and interest of the patient, because whatever the issues, feeling understood is crucial for these adolescents," he said, explaining that adolescents still have a "healthy dose of magical thinking" and are impressed with therapists who can seem to read their minds in this way.

Affect theory provides a context for understanding shame, and a tool that

illustrates healthy and pathologic responses to shame is the Compass of Shame, developed by Dr. Donald Nathanson ("Shame and Pride: Affect, Sex, and the Birth of the Self," [New York: W.W. Norton & Co., 1992]), said Dr. Wofsey, also of the University of Pennsylvania, Philadelphia.

The compass illustrates four basic ways that individuals respond to shame, and explains the healthy and pathologic poles for each.

The first defensive style is labeled



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DR. WOFSEY

"Attack Self." This mechanism seeks to relieve shame via solace and support, Dr. Wofsey said. The healthy pole might involve poking good-natured fun at oneself to appear humble and appealing. The pathologic pole might involve self-demeaning talk, self-hatred, self-mutilation, or even suicide, all of which convey a sense of control that is preferable to being a passive victim of humiliation.

"Attack Other" is another defensive style, which at its healthy pole involves alleviation of humiliation by defending oneself, and its pathologic pole can involve sarcasm, bullying, or even assault, racism, or genocide.

"Shame Avoidance," also known as grandiosity, can be applied healthfully by bettering oneself through hard work, or it can be applied pathologically through a "workaholic" perfectionism often seen in eating disorders, for example.

The fourth alternative on the compass is "Withdrawal," which at its healthiest involves "beating a strategic retreat to understand where one went wrong and to regroup," Dr. Wofsey said. At its pathologic pole lies a "running and hiding" mechanism for fleeing challenges in most areas of life.

These concepts can be used to help youth reframe how they think about feelings and to recognize how many social, psychological, and political problems result from unhealthy defenses against shame. They also can be used to teach them that feelings are powerful tools for living.

Explaining the dynamics of shame to youth is one instance of providing an owner's manual for the affect system, he said.

Shame is a damper to the emotional system, often existing in precarious balance with affect of interest and excitement. If these are high, shame tends to be low and vice versa, he explained, adding that in the healthy adolescent, shame does not limit the interest and excitement of learning or the joy of self-expression.

Keeping affect at the center of the treatment approach is the key to successful outcomes, because nothing reaches the conscious mind without stimulating affect, and nothing reaches memory without generating an emotional response.

Providing a healing presence by understanding the role of shame and its defenses is an important aspect in treating an adolescent. One can inspire hope by validating these experiences, thus mobilizing and maintaining a compelling therapeutic alliance, he said.

Specific principles for managing adolescent patients include addressing the shame defenses that directly endanger the patient or others, providing empathy and validation for coping with narcissistic rage, improving the social bonds that lessen the shame of isolation, teaching healthier methods of affect management, and replacing toxic shame scripts with healthier "damage-repair" and "commitment scripts," Dr. Wofsey said.

A failure to validate an adolescent's feelings of shame can be one of the main reasons why therapy doesn't work in certain cases, he suggested.

"When we acknowledge the common human propensity toward shame with which we all struggle, growth becomes possible," he said. ■

Neurobiologic Basis for The Power of Shame

Dr. Wofsey's premise about the role of shame in adolescent psychopathology is bolstered by neurobiologic findings in this population.

For example, research has shown that the frontal lobes lack adult status until the mid-20s, and this, combined with the fact that the limbic system is in full force during adolescence, means teens have "industrial-strength affects and drive—without the cognitive horsepower to harness them," he explained.

Also of interest is that serotonin levels drop in adolescence—a factor with major implications for early adolescence. Studies of cerebral spinal fluid, brain imaging scans, and brain autopsy results in suicide completers show that low serotonin is associated with a lower threshold to acting on both suicidal and aggressive impulses.

Lower serotonin levels also have also been shown to make one more prone to moodiness, anxiety, panic, minor and major depression, obsessive compulsive disorder, social phobia, and a number of impulse disorders and addictions.

Furthermore, primate studies suggest that serotonin levels correlate with self-esteem and dominance/submission patterns.

Shame and humiliation have been acknowledged by mainstream psychiatry as predisposing factors in major depression and generalized anxiety. The fact that selective serotonin reuptake inhibitors have been shown to improve self-esteem in anxious and depressed patients lends further credence to the role of shame in adolescent psychopathology, Dr. Wofsey said.

"Perhaps this is another way of saying that humiliation can lower serotonin levels and make one more prone to a witch's brew of psychopathology. This neurobiologic substrate may provide some underpinnings for my contention that many adolescents are wrestling with shame-related, self-esteem-related problems, and that serotonin dysfunction may be behind that," he added.

Adding to the adolescent conundrum is the fact that melatonin in adolescence spikes late at night and lingers into the morning.

The result is a "sleep-deprived cadre of teenage zombies in our high schools," he said.

Risk Factors for Depression Identified in Adolescent IBD

BY SHERRY BOSCHERT
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SALT LAKE CITY — Watch for signs of depression in adolescents with inflammatory bowel disease, especially if they are older, have more severe disease, are on steroids, or report family conflict, Dr. Eva Szigethy said.

A study of 141 adolescents with Crohn's disease and 52 with ulcerative colitis seen in a pediatric gastroenterology clinic used a slew of assessment tools to measure disease severity, screen

for depression, and assess psychosocial factors in the patients' lives. A total of 43 patients with a Child Depression Inventory score of 9 or greater (suggesting increased risk for depression) underwent a comprehensive psychiatric evaluation using the Kiddie Schedule for Affective Disorders and Schizophrenia.

Of the 43, 2 had major depression, 14 had minor depression, and 27 had depressive symptoms, Dr. Szigethy said at a poster presentation at the annual meeting of the North American Society

for Pediatric Gastroenterology, Hepatology, and Nutrition.

Patients who self-reported poor family functioning, poor personal health, or poor physical functioning were more likely to be depressed. The patients on steroids—especially higher doses—had more depression. Disease severity and older age were risk factors for depression, she and her associates reported.

"The whole idea is to pick up depression before it becomes a full-blown, clinical, major depression and becomes function-

ally incapacitating," Dr. Szigethy, a pediatric psychiatrist at the University of Pittsburgh who is also in the university medical center's inflammatory bowel disease program, said in an interview.

Risk factors for depression need to be assessed routinely in outpatient pediatric clinics to enhance comprehensive care for these patients, the investigators concluded.

Untreated depression increases the likelihood that patients with inflammatory bowel disease will not adhere to medication regi-

mens, leading to treatment failure, other studies have shown.

Unlike some other studies that suggested an association between parental psychopathology and depression risk in adolescents with inflammatory bowel disease, the current study found no significant effect of parental history of depression, parental psychopathology, or life stressors on the youth's risk for depression.

The investigators also plan to study patients who are younger than the 11- to 17-year-olds in the current study. ■