Shame and later life

The 'discovery' of shame

Shame is rarely discussed in Western society - as a taboo it is often denied (Scheff, 1995). Whatever our age, we might confess our guilty secrets, angrily recount our humiliations and entertain with stories of our embarrassments, but we are likely to remain silent with regard to our shame. We are ashamed to be ashamed and embarrassed by the shame of others. However, researchers, theorists and therapists have recently been paying much more attention to shame than previously. For example, several research studies have purported to reveal a relationship between individual proclivity to shame and psychological problems such as eating disorders, depression, social anxiety, interpersonal problems, phobic anxiety and obsessive-compulsive disorder, (e.g. Allan et. al., 1994; Cook, 1996; Tangney, Wagner & Gramzow, 1992; Sanftner et. al. 1995). Shame, it would seem, is a key factor in the lives of many clients of mental health services and there have been no studies to date which have suggested that this painful emotion is something which we leave behind as we move through the lifespan. Within the psychoanalytic tradition Helen Block Lewis (1971, 1987a,b) has argued that childhood experiences of shame can be a powerful determinant of an internalised and painful sense of worthlessness which underlies later proneness to further shame and acts as a block on effective therapy, particularly when the feelings remain unacknowledged. Whilst this article will argue that intrapsychic models of shame have some limitations, Lewis' work is presented as an important and thought-provoking account, which challenges Freud's emphasis on guilt and has been influential in drawing our attention to the devastating pain of excessive shame.

Ideas about the nature of shame

So what exactly *is* shame and how would we know it if we saw it? Ideas have included the following:

"Shame may be understood as the affective-cognitive state that accompanies 'low self-esteem'"

(Lewis, 1987c, p.105)

"Shame is felt as an inner torment. It is the most poignant experience of the self by the self,……Shame is a wound made from the inside, dividing us from both ourselves and others"

(Kaufman, 1989, p.17)

"We experience this emotion when, upon viewing ourselves through the eyes of another, we realize that we are in fact who we do not want to be and that we cannot now be otherwise….we shrink in relation to our previous image of ourselves and we are exposed before the other….we are worthless; and our view of the world may shrink to one small detail….we wish to hide.."

(Lindsay-Hartz et. al., 1995, p.278)

A number of theorists have distinguished shame from guilt, describing the former as a negative evaluation of the whole self whilst guilt is concerned with the evaluation of a specific behaviour. As such, inferiority and helplessness are seen to be much more characteristic of shame and behaviour is likely to be avoidant rather than reparative (e.g. Lewis,1986, 1987a; Gilbert et. al.,1994). Although the experience of shame might be understood to have positive functions, for example in promoting conformity

or communicating submission or appeasement (Gilbert, 1997) or in maintaining attachments (Lewis 1987b), shame is usually described as painful, and frequent shame can be seen to be both disturbing and disabling.

However, the search for the fundamental nature and function of shame is problematic, as it seems to assume that shame is an identifiable entity which is universal and unvarying, irrespective of social context. Stearns (1995), among others, has cautioned against the assumption of emotional universals and notes the variability in emotional expression and experience across historical periods, locations and cultures. Therefore it might be more appropriate to conceive of shame as a culturally shared construct which we use both to shape and to make sense of our experience and actions, and which may or may not map onto innate biologically based impulses. As such we might expect some variability in experiences called 'shame', depending on the particular context.

Data from research in the UK and USA has largely supported Lewis, Kaufman and Lindsay-Hartz' descriptions of shame quoted above *(e.g. Gilbert et. al., 1994; Lindsay-Hartz et. al., 1995; Niedenthal et. al., 1994; Tangney, 1992; Tangney et. al., 1996)*. However, as the participants were drawn from a limited range of backgrounds, most being university students in the UK or USA, we must be careful about generalising to people in other situations. It is of particular note that only one of the studies recorded a handful of participants over 65 years. Therefore these studies should be seen as only a guide to what our clients *may* feel and do and how they might make sense of that experience.

Shame as a social emotion

With the above caution in mind, it is still fair to say that for many people feeling shamed seems to involve a sense of powerlessness, submission and inferiority, as illustrated by Gilbert et. al's table (1994 - *figure 1*), based on recent empirical work and theory. An inadequate self is experienced as if seen through the eyes of an 'other' who is more capable and powerful, but rejecting.

Figure 1 - Shame Experiences

Self (unable)	Other (able)
Object of scorn, disgust, ridicule, humiliation.	Source of scorn, contempt, ridicule, humiliation
Paralysed, helpless, passive, inhibited	Laughing, rejecting, active, uninhibited-free.
Inferior, smaller, weaker.	Superior, bigger, stronger.
Involuntary body response, rage, blush, tears, gaze avoidance.	Adult and in control.
Functioning poorly, mind going blank, desire to hide, conceal.	Functioning well but experiencing contempt.
Self in focal awareness.	Other in focal awareness

(Gilbert et. al., 1994 p. 26, adapted from Lewis, 1986)

To feel shamed therefore seems to be a social phenomenon. It usually refers not just to an experience of powerlessness but one of *relative* powerlessness. As such it describes a perceived relationship with other people as much as it denotes any kind of internal feeling and is even more obviously related to the social world than many emotions. A frequent feature of feeling ashamed is that we take on the identity of an inferior, powerless, helpless and contemptible being. From our perspective (though possibly not only ours) others are in control, rejecting and scorning us. We are outside that which is acceptable and experience ourselves as incapable of bringing about any change in this state of affairs. Our desire is to hide from a social world of which we are unworthy and we may seethe with frustrated rage and fury against the real or imagined critical other.

Various emotion theorists have characterised emotion generally, not just shame, as a social phenomenon. For example Averill (1982) describes emotion as a 'transitory social role' while Parkinson (1995) suggests that becoming emotional means making certain identity claims. Retzinger, one of the few people to investigate shame in interaction, explains that emotions are "deeply embedded in the moment-by-moment context in which they occur" (1995, p.1104).

From this perspective it seems questionable to attempt an understanding of the painful shame experienced by clients primarily through focusing on their personality or emotional / cognitive style and without reference to their social world and the circumstances in which they feel ashamed. However, a review of the research literature on shame indicates that while there has been a considerable wealth of studies investigating the measurement of shame-prone personality styles and their correlates, there have been very few studies which have looked at shame in its social context as a lived experience negotiated *between* actors. If we are to increase our understanding of such experiences, we need as both clinicians and researchers to locate shame firmly within an interpersonal and wider cultural context, paying particular attention to the relevance of social roles such as those based on gender

and age, in the enactment of shame. For example we need to ask what kind of roles are available to the person which encourage them to accept or reject a shamed identity and what kind of power differentials are operating in a potentially shaming situation. Looking beyond the immediate social context, we can only make sense of the ideas people hold about what is shaming with reference to culturally shared notions of morality and deviance. We are flawed because we are bad, inferior, grossly inappropriate or inadequate according to local norms and customs. In fact several theorists have suggested that shame *functions* to maintain conformity and that it acts as a signifier of our acceptance of local moral codes (e.g. Harre, 1986). This seems to be the case whether or not those local norms cause us damage and hurt.

Shame and the older person

So how does this relate to our work as clinical psychologists with older people struggling with feelings of shame? First I would like to highlight some of the sources of shame for older people in the UK, with particular reference to negative stereotypes of ageing. This will be used to illustrate the way in which experiences of shame are constructed within a social and cultural context. Secondly I will attempt to sketch out some of the clinical implications of understanding shame in later life as a social phenomenon.

Sources of shame for our clients may be many and varied, depending on their particular history and social context. Messages of worthlessness received during childhood (Gilbert et. al., 1996) can still be salient throughout adulthood, especially when echoed by care contexts where dependency is both encouraged and mocked. Recently we have become more aware of both the sequelae of earlier abuse and trauma (e.g. Hunt et. al., 1997) and the experience of currently abusive situations in later life (e.g. Kingston & Reay, 1996), both of which are fertile ground for feelings of shame and humiliation. As at all stages of the lifespan older people are subject to rejection and shaming via transgression of the numerous subtle rules in society which constitute appropriate behaviour for particular groups of people, though the nature of these rules may change over the lifespan. As is the case for our younger clients older people are also not immune to derogation and shaming on the basis of membership of a perceived outgroup, for example because of their sexuality or disability. Moreover, the act of becoming older, or rather passing the magic age of 65, is often perceived as denoting membership of an outgroup in itself. Therefore older people can suffer from the 'double jeopardy' of, for example, being discriminated against on the grounds of both gender *and* age in a manner which compounds the effects of each type of discrimination (Bytheway, 1995). If we refer again to the contrasting experiences of self and other in shame (fig. 1), particularly Gilbert et. al's first three comparisons, it would seem that older people are often positioned by popular images in the place of the unable and relatively powerless shamed self rather than the powerful humiliating other.

Many of my clients have echoed these ideas and conveyed their sense that to *be* older is shaming in itself. Most mental health service professionals working with older adults, could probably think of clients, particularly women, for whom the lined face in the mirror is a source of despair. Other clients, particularly men, may have talked of their sense of embarrassment or humiliation at their increased difficulty carrying out a familiar physical task. Many clients talk of feeling outraged and denigrated by the roles now made available to them and the prevention of their access to previously valued roles.

It is worth noting that reduced stamina or strength and wrinkled skin do not merit inferior status in all societies, particularly those which are less technological (Stuart-Hamilton, 1994). However, in the West there are many discourses which construct the experience of later life as one of undesirability and enfeebled disempowerment. An illustration of the salience of ageist discourses can be found in Rodin and Langer's (1980) series of experiments where identical behaviour was judged normal when displayed by a younger person but evidence of failing cognitive abilities in an older person.

Laws (1995) notes the importance of the body in making judgements about other people, including the person's age. The body is central in many ageist images and referred to in pejorative labels such as '*wrinklies',* or '*little old ladies'.* The dimensions used in making value judgements about bodies are often age-related, thus positioning older people in opposition to culturally valued images such as the healthy athlete, the speedy worker or a version of sexuality which equates desirability with youth. Instead, the older person is described as wrinkled rather than taut, weak rather than strong and frail rather than active. Featherstone and Hepworth (1993) note that since the time of the Ancient Greeks the West has associated youth, beauty and goodness. The implication here is that the aged body is not essentially shameful but is constructed as such, as particular symbolic meanings are given to certain changes in appearance. In his book 'Ageism' Bill Bytheway (1995) directs our attention to the preponderance of advertisements in which women in particular are exhorted to disguise any visible indications of bodily ageing. Numerous products are on offer which can help prevent us developing the shameful appearance of an older person. These are not products which necessarily improve our comfort or health, but simply disguise the aged body.

However, although ageing might be understood as a *potential* source of shame within a cultural context which offers many negative views of later life, older people should not be seen as helpless victims of shame. It is important to remember that the majority of people maintain a positive self-image into later life (Coleman, 1996). Although stereotypes of later life can frequently be problematic they are not solely negative and disempowering. Old age can be constructed as a source of experience and wisdom and the older person might occupy the position of matriarch, patriarch, sage or care-giver (Schmidt & Boland, 1986). Identities throughout the lifespan are constructed via a myriad of fluctuating discourses in which ageing may only play a peripheral part. Many people at whom the stereotypes of ageing are directed do not identify themselves as old and in many cases will be able to draw on a lifetime of experience and resources in managing and repairing negative emotional states. Unfortunately for other people the shame of ageing may be highly salient at times and this may be more common among those who seek our help. Longitudinal studies of self-esteem and adjustment in later life have indicated that a negative attitude to ageing is one of the predictors of later depression (Coleman et. al., 1993). For other recipients of our services who depend on institutional care, the environment in which they live can easily become shaming in a culture which values independence and autonomy. We are well aware of how institutional care for those with cognitive decline can be constructed in a manner which does not maintain the personhood of clients (Kitwood, 1993), and which positions the older person with dementia as a dependent, humiliated child.

Our response

To summarise, some of the emotional difficulties which our clients face might usefully be understood with reference to the idea of shame. The struggle with painful and

disabling feelings of shame can only be understood fully with reference to the interpersonal and wider cultural context of the shamed person. As such, some difficulties faced by older people can be seen not as problems of ageing but as problems which relate to the construction of ageing, both in the wider society and within the immediate environment of the older person. Therefore, whilst as therapists we certainly need to remain alert and sensitive to unacknowledged shame within one-to-one therapy we also need to work towards changing care environments which might be experienced as shaming by those who live in them. For example, some of the 'problem' behaviours or aggression which we are asked to assess might be usefully conceptualised as humiliated rage within a care environment which allows clients limited autonomy. Attempts to modify this behaviour by means of reinforcers might only serve to enhance the level of control exercised by care staff, resulting in further feelings of helplessness, shame and humiliation for the client, expressed in a seething rage. An illustration of this would be a recent situation where an elderly woman was reported to be hitting and haranguing ward-staff apparently without provocation, whenever they were carrying out personal care. Efforts to reward co-operative, non-aggressive behaviour were not producing the desired results and the staff felt hurt and annoyed. From the client's perspective, that of a proud ex-dance teacher, personal care was a source of humiliation and embarrassment, as were attempts to reward co-operative behaviour. In this situation, re-conceptualising the client's experience as shame or humiliated fury offered care-staff a means of making sense of her difficulties and provided a focus for their attempts to identify aspects of their own behaviour which may have been contributing to her outbursts.

However, if we recognise that representations of later life which position older people as passive, scorned, dependants can contribute to psychological difficulties, we sometimes need to move beyond the boundaries of direct clinical work when addressing sources of shame for our clients. As such, the development of services which enhance the image of older people should be seen as a *core* part of our response to their psychological difficulties and not merely the icing on a quality assured cake. Ageism should be resisted not only because it is unfair and unpleasant, but also because it may be intimately entwined with the very psychological difficulties we and our clients are working with.

Dawn Leeming, August 1998

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