

Shame as a Social Phenomenon

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Summary

Clinical psychologists are increasingly drawing on the concept of shame to inform therapeutic work. However, a comprehensive review of clinically-orientated research on shame over a five-year period revealed that this has mostly been restricted to the investigation of individual differences, conceptualising shame as an attribute of the individual.

It is argued that the notion of shame as a context-free intrapsychic variable has distracted clinical researchers from investigating shame as a lived emotional experience and has made the social constitution of shame less visible. As such, there is very little data available on the avoidance, management and repair of experiences of shame and little exploration of how shameful identities might emerge in particular social contexts. Several suggestions are made for alternative ways in which susceptibility to shame could be conceptualised, which consider the individual's social world and the importance of the roles or subject positions available.

To better inform clinical practice, research needs to focus more explicitly on the social and interpersonal processes which either enable or inhibit the avoidance, management and repair of shame. The implications of a more contextualised understanding of shame for practitioners include a willingness to (a) work with clients at achieving real changes in their social worlds and (b) to develop services which offer positive identities for users.

Experiences of shame and psychological problems

Feelings of shame are increasingly being recognised as a **significant clinical problem** and have been related to a range of difficulties experienced by clients including adjustment to trauma (Lee et al., 2001), social anxiety (Gilbert 1998), depression (Andrews & Hunter, 1997) and binge eating (Sanftner & Crowther, 1998).

Although shame might be considered a common emotional experience, Kaufman (1989) and other clinical theorists have suggested that shame can become particularly problematic for some individuals. He suggests that it is the subjective unpleasantness of shame, the derogation of the self and the potential for social disruption that makes frequent shaming so devastating:

“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)

Shame as a socially embedded phenomenon

Lindsay-Hartz and colleagues (1995) report one of the few phenomenological investigations of shame. Their summary of participants' accounts places the experience of shame firmly within a social realm from which the individual now wishes to retreat:

*“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...we are worthless; and our view of the world may shrink to one small detail. Upholding our ideals about who we want to be and maintaining our commitment to a **social determination of who we are**...we wish to hide, in order to **get out of the interpersonal realm** and escape our painful **exposure before the other.**” (Lindsay-Hartz et. al., 1995, p.278, emphases added)*

The **social origins** of shame have frequently been discussed in the literature:

- the standards by which we evaluate ourselves as shameful are **culturally given** (Lewis, 1993) and the experience of shame appears to vary **cross-culturally** (Fischer et al., 1999; Liem, 1997; Wallbott & Scherer, 1995);
- shame can have positive interpersonal effects such as **appeasement** (Gilbert 1997), **maintaining relationships** (Lewis 1987), communicating adherence to local **moral codes** (Harré, 1986);
- drawing on the work of **Sartre**, some have suggested that when we feel ashamed this is not simply a private evaluation of significant shortcomings. Instead we have an awareness of this judgement from another person's perspective (Crozier, 1998; Goss et al., 1994; Mollon, 1984);
- **evolutionary approaches** to shame (e.g. Gilbert & McGuire, 1998) emphasise the submissive nature of shameful behaviour and the importance of relative power in determining who is shamed;
- **sociologists** Scheff (1995) and Retzinger (1991) suggest that repetitive mutual shaming may occur in families where there is little direct communication of uncomfortable emotions and shame is responded to with veiled hostility and attempts to denigrate the other.

Moreover, **discursive approaches** to identity (e.g. Davies & Harré, 1990) would suggest that the subject position of ‘shameful’ is constructed through interaction in which meaning is negotiated *between* participants, and depends on the discursive resources available. For example, participants in a discussion of repeated drunkenness might draw on:

- (i) a medical discourse which constructs this as “illness”, or
- (ii) a discourse of macho behaviour which offers the position of “bit of a lad”, or
- (iii) a discourse of self-control, producing a position of “shamefully weak and unable”.

Across the interaction different positions might be offered, resisted or negotiated, implicating varied emotional experiences. Similarly, emotion experienced when we are alone could be understood to be constructed from culturally supplied discourses, in negotiation with a potential audience.

Therefore, from a variety of theoretical perspectives and epistemological positions it would be difficult to dispute the idea that shame is socially and culturally embedded and arises in interaction with others.

Clinical research does not reflect the socially embedded nature of shame

Given the above, it is of note that most of the clinical research on shame to date has focused on the notion of **dispositional shame** i.e. shame is often constructed and investigated as a property of the individual rather than of the social contexts in which it arises. The concept of dispositional shame, in its various forms, has been used as a way of marking out shame in clinical contexts as a different phenomenon from ‘normal’ shame:

Kaufman (1989) describes **internalised shame** as a shame-bound personality associated with generalised negative self-evaluations which emerges from frequent shaming during childhood.

Lewis (1971) differentiates **shame-proneness** from guilt-proneness arguing that the former leads to greater psychological problems because of the negative focus on the entire self rather than on one’s actions.

A **literature review** of a five year period (1997-2001) carried out by the current authors identified 43 clinically related empirical investigations of shame. The over-riding concern of most of these studies was to investigate the relationship between dispositional or chronic shame and either:

- (i) other traits or cognitive / behavioural styles
- (ii) measures of psychological problems
- (iii) retrospectively reported childhood experiences.

Only eight of the 43 studies approached shame as a potential response to situations which might be considered shaming, rather than as an embedded property of the individual. Only three of these were primarily concerned with the *nature* of actual experiences of shame in specific contexts i.e. recovery from substance use for mothers (Ehrmin, 2001), being a victim or perpetrator of domestic abuse (Eisokovits & Enosh, 1997), and emotional disclosure for psychotherapy clients (Macdonald & Morley, 2001). However, none of these studies explored the phenomenology of shame in any depth.

Problems arising from the research focus on dispositional shame

Because problematic shame has most often been investigated as an intrapsychic phenomenon using constructs such as cognitive style or personality structure we have **very little data** on the following:

- the role of **culture** factors in determining shamefulness;
- the **contexts** in which chronic shame may arise;
- the **phenomenology** of longer-lasting more problematic feelings of shame;
- the **management and repair** of shame and the role of interpersonal factors in this.

Alternative understandings of susceptibility to shame

We do not simply wish to emphasise the importance of investigating the social context as well as the person in understanding experiences of shame. We would argue instead that **in order to understand the person it is necessary to understand the social**. This is because a tendency to certain emotional experiences, in this case shame, might arise from aspects of the individual's interpersonal and social context. Recurrent or enduring shame is not always best understood as a property of the individual, as illustrated below.

Possible social factors which create susceptibility to shame:

- *Being positioned as shameful / stigmatised by dominant cultural discourses;*
- *Being considered shameful by other members of a significant group e.g. family;*
- *Perceived failure performing a long-term culturally endorsed role;*
- *Lack of social status which limits the availability of shame avoidance strategies (e.g. denial, shaming the shamer, redefining a situation);*
- *Living within a cultural or sub-cultural context where shame is shameful and therefore magnified and unarticulated.*

Implications of a more socially focused conceptualisation of shame for clinical psychologists:

1. Research

In order to better understand the experiences from which problematic shame might arise and the likely social contexts of these experiences we need to ask a number of **research questions** which have not often been addressed. Examples are shown below.

Do experiences of shame encountered in clinical practice (e.g. related to sexual abuse or visible stigmata) fit with the phenomenological descriptions of shame obtained from non-clinical research participants? How do individuals reconstruct stigmatising identities to resist a sense of shame? How do interpersonal processes such as forgiveness, disclosure and acceptance relate to the repair of shame? What is the relationship between social power and susceptibility to shame?.....

2. Therapeutic work

This needs to address the interpersonal dimensions of repair as well as phenomena such as self-schemas, shame-based interpretations of events or the ability to articulate and therefore tolerate painful feelings (e.g. Lee et al., 2001; Mollon, 1984). It may be useful to:

- (i) encourage clients to look at possibilities for **real change** within their lives, for example by mapping sources of material and social power (Hagan & Smail, 1997);
- (ii) involve **significant others** in therapeutic work in order to produce a more respectful family environment. Fossum and Mason (1986) argue that this is achieved by decreasing control, rigidity, perfectionism and blame.

3. Challenging sources of stigma and negative identity

This might involve:

- (i) taking an active role in **exposing** sources of **stigma** and publicising the psychological effects of these;
- (ii) challenging the restrictive and potentially shaming **identities** that are unintentionally constructed for clients within **mental health services**. Two examples of this are offered below.

Stigma and dementia

The concept of personhood and accompanying theory of dementia (Kitwood, 1997) has been instrumental in drawing attention to the ‘malignant social psychology’ of dementia care environments which deny personhood by stigmatising and invalidating their elderly clients. Although these processes have not usually been conceptualised in terms of shame or humiliation, this may be a useful way of understanding the consequent personal deterioration which Kitwood aims to challenge through Dementia Care Mapping.

Stigma and enduring mental health problems

Stigma in relation to enduring mental health problems is often discussed as if it were a social problem which could be 'cured' by public education. However, it may at least partly be related to negative and restrictive identities which are offered by some theoretical perspectives on clients' problems. For example the medical model emphasizes deficits and life-time limitations. In contrast, the 'recovery' model, which emphasises the potential for change and the positive use of the client's resources, offers an alternative and less potentially shaming identity.

Final comments

The purpose of this poster is not to deny that some people experience more of a problem with shame than others or that people who experience frequent shaming in childhood may be more likely to think negatively of themselves as adults than people who don't. However, what is being suggested is that the conceptualisation of these individual differences more or less exclusively in terms of intrapsychic variables fixed early in life has obscured the way in which emotional experiences such as shame are the product of real or potential social encounters and are determined by the ways of understanding oneself available in the individual's particular social and cultural context.

Research on dispositional shame has served a purpose in drawing clinicians' attention to the pertinence of this often hidden emotion for a large group of clients. However we would urge a degree of caution in adopting this approach, not least because therapeutic approaches which present socially constructed phenomena as individual problems can increase self-blame and isolation, the very subject matter of shame (Seu, 1998).

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