Commentary on "Shame and Community: Social Components in Depression"

The Role of Shame in Understanding and Treating Depression

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Thomas Scheff's article, "Shame and Community: Social Components in Depression," highlights a crucial but often overlooked factor that facilitates the understanding and treatment of affective disorders. As has been documented in the works of Helen Block Lewis (1971), Sylvan Tomkins (1987), and Donald Nathanson (1992), the structure of the coherent functioning self develops in the context of a healthy bonding with significant caregivers. This developing attachment forms the substrate on which a sense of community belonging is achieved. Anything that would interrupt the primary sense of human connection in critical phases of emotional development of a child can lead to intense and destructive feelings of shame.

Repetitive, chronic, or unresolved shame during the early phases of human development weakens the ability of an individual to deal with losses later in life. Although most people tend to think of shame as the emotion so familiar in its adult situational contexts, such as humiliation in a social setting or the deep feeling of alienation a person might experience after breaking an important social rule, in the psychiatric setting it is important to understand how shame begins in its developmental antecedents as a traumatically perceived rupture of the dyadic bond. Spitz (1965) identified this process in his direct observations of infants going through the "stranger anxiety" phase during the first year of life.

Scheff's article provides valuable advice for clinicians attempting to work with depressed patients who might otherwise be refractory to effective treatment. His emphasizing the manner by which situational factors in the onset and course of depression should be specifically examined to assess the degree to which a patient experiences them as a real or symbolic loss of a secure emotional bond with another person in their life serves to alert clinicians to the sensitivity of such patients to the seemingly minor losses and frustrations they may encounter in their treatment sessions or in the hospital setting. Patients often experience such losses as traumatic triggers of memories of earlier life experiences life, in a manner very similar to the "flashback" of a patient suffering from posttraumatic stress disorder.

Scheff is also correct in emphasizing the need for developing better research methods for assessing shame and alienation in patient populations. There has been some work in this regard, but much more needs to be accomplished. As an example of earlier work that tends to support Scheff's basis thesis, our group (Epstein, Fullerton, and Ursano 1994) found in a factor analysis of the General Health Questionnaire that one of the groupings of questions was organized around "shame-based" depression. The reason better assessment methods are needed is inherent in the nature of shame itself. A shamed person seeks cover. Most individuals develop powerful defenses to avoid experiencing the ego dis-

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ruptive affect of shame. Unless the clinician is specifically searching for them, shame affects are usually missed.

Finally, it is important to evaluate the process by which shame affects are projected onto the treating clinician during the psychotherapy process and the transference countertransference interaction. The withdrawn patient, the raging, attacking patient, the patient with a sense of entitlement, the overly shy patient, the arrogant patient, and the patient who invites the clinician to violate the boundaries of proper treatment methodology are all individuals likely to be using powerful defenses against experiencing internalized shame. When patients employ defense mechanisms like these, the profound emotional effect on clinicians frequently throws them off stride. For this reason, it behooves clinicians to be particularly aware of their own shame based issues when attempting to treat such patients (Epstein 1994).

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