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

Shame, Loss of Face, and Other Complexities: Which is Cause, Which is Effect, and How Does it Work?

HARRY C. HOLLOWAY

> "Every man has reminiscences which he would not tell to everyone, but only to his friends. He has other matters in his mind which he would not reveal even to his friends, but only to himself, and that in secret. But there are other things which a man is afraid to tell even to himself, and every decent man has a number of such things stored away in his mind"
>
> *Notes From the Underground*
> Fyodor Dostoyevsky

The shame and the consequences of shame are ubiquitous in our culture. Depression is one of the most common clinical manifestations of emotional distress and psychiatric illness in our society. Therefore, it is inevitable that they should be associated. Although shame is extensively discussed in various professional writings, perhaps its role in the dynamics of normal emotional responses and psychiatric illness has been under-emphasized. Certainly one aspect of shame related to the mentally ill—stigmatization—has been emphasized and is extensively discussed in the United States Surgeon General's recent report on mental illness in America (Satcher 1999). The shame associated with being diagnosed and treated for a psychiatric disease was cited in that report as a major factor in preventing individuals in need of psychiatric care from seeking that care. Survivor guilt is frequently seen in trauma survivors, and it is a manifestation of shame. Homosexual individuals may remain in the closet because of shame. Recently, a Chief of Naval Operations committed suicide rather than face the dishonor associated with accusations that he falsely represented his military awards (Wertheimer 1996). A president lied about his behavior with a presidential intern, was impeached and threatened with removal from office. He allegedly lied because he was ashamed to admit his behavior publicly.

The quotation from Dostoyevsky presented above draws attention to the ubiquity of shame in human affairs with the unfortunate omission that shame is as important in the lives of women as it is in men. When one examines this ubiquity with a bit more care, one discovers that shame is used to describe several phenomena and that the word has multiple meanings. First, shame can be used as both a verb and as a noun. Depending on the context of its usage it may mean quite different things to different groups.

There are those who see our age as shameless. They see sexual promiscuity and school violence as occurring because of a lack of shame in the perpetrator of the disapproved behavior. Others perceive the use of shame as destructive and stigmatizing. These individuals emphasize that the shamed individual may be enraged at their treatment and isolation from the social group. Without doubt, public reputation, honor and shameful attributions

Harry C. Holloway, MD, is Professor of Psychiatry and Neuroscience, Uniformed Service University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814–4799.

are still very much a part of our present society.

There is a tendency to use the term *shame* to convey different meanings and to affirm different values from subgroup to subgroup. Unfortunately, this tendency to utilize shame to describe various processes and with very different outcomes can result in contradictory claims. Many who derive their values from fundamentalist religions feel that those who are attracted to individuals of the same gender should feel shame. In contrast, many who hold to humanist values feel that militant homophobes should be ashamed of their militant intolerance.

Unfortunately, "Shame and Community: Social Components in Depression" by Thomas J. Scheff offers no operational definition of the shame experienced by the population of British patients observed in the 1960s. The depression that many of the older patients experienced is also not clearly described. The diagnosis is apparently based on a brief (35 to 45 minute) interview. No laboratory or physical evaluation is provided to rule out medical causes for the psychiatric complaints, even though the patient population is mostly older males who are at risk of depression secondary to a wide variety of endocrine, cardiovascular, neurological, and neoplastic diseases as well as traumatic injuries that could manifest as depressive symptoms.

The author reports that the social distance between doctor and patient was such that an attempt to engage in a more detailed evaluation would likely have been fruitless. We know that the author observed and made notes concerning the interaction occurring between doctor and patient. He also discussed the patients with their physician. This situation undoubtedly reflected the standard practice at that time. A foreigner and a stranger could observe and study the intimate exchange between a doctor and patient without concern for the autonomy of the patient.

Given the nature of this clinical encounter, one can only speculate about how free the patients felt to share secrets with the interviewing physicians. At least one of the patients reported a history of heavy alcohol consumption. The association of shame, denial and depression with drug use and drunkenness is well documented but given the structure of this setting one wonders whether adequate histories were provided. If the histories, which serve as the basis for causal attribution, are inaccurate, then the accuracy of the causal claims is problematic. The failure to create an accepting holding environment that assures respectful and supportive treatment may have made it very difficult for the patient to report experiences about which the patient is ashamed. Some of the shame and hopelessness experienced by these patients may have been the result of their being forced to seek care from a public medical institution that devalued them and their life experience.

This article focuses our professional and scientific attention on shame as a causal factor in depression. This raises questions about the nature of shame as a human experience and implicitly asks: "How might shame best be studied? How can information from these studies be used to develop more effective psychiatric treatment?" It is clear that the author conceives of depression as the end event of a complex process. Shame itself may be very complex. Shame is frequently present in my patients with Major Depressive Disorder but it is not clear that it occurs only in, or even more frequently in, patients with this diagnosis. This article provides no data about the relative frequency of the association of shame with various psychiatric disorders or of its association with other vicissitudes of life. Shame is also frequent in my patients with alcohol and substance abuse disorders, schizophrenic disorders, posttraumatic stress disorder, generalized anxiety disorder, panic disorder and other psychiatric disorders. It is frequently difficult to determine if shame has a role in the cause of these psychiatric disorders or if it is a consequence of the disorders. Given the common phenomenon of comorbidity, is shame more commonly a problem for patients with disorders that manifest depressive symptoms even when the syndrome is not primarily depressive? Some people appear to be ashamed of their manifest fearfulness and others of their psychotic symptoms. Some are particularly ashamed

of their lack of self-control—this is particularly true in patients with alcohol or drug disorders as well as Major Depressive Disorder. Nevertheless, these impressions are reported from a practice that is undoubtedly skewed in many important ways. In any case, the presence of shame can have important consequences for the provision of care and should be considered an important element in our fundamental understanding of the psychopathological process.

As has already been implied, shame also occurs in the course of human behaviors that appear to be unrelated to psychiatric disorder. I carried out a study of military advisor counterpart relationships in Thailand. The initial issue of interest in this participant observer study was the examination of the inadvertent induction of shame (called "loss of face") in the Thai counterpart. It was believed that advisors inadvertently acted in culturally insensitive ways that resulted in the counterpart losing face.

Initially I did a series of interviews concerning "face" with various Thai individuals of mixed demography both in and outside of the Thai military. Officers from Thailand had within their culture mechanisms that specified how one might lose and gain credit for one's behavior in the public arena. I was not able to verify that loss of face was inevitably a disaster for the Thai individuals and most Thai managed the loss or gain of face as a rather routine matter. On the other hand, Thai individuals had noticed that their American counterparts were quite preoccupied with threats of the loss of their reputation. It was the judgment of the Thai counterparts that the Americans were very preoccupied with their fear of performing poorly in the public arena.

When I directly observed advisor counterpart interactions, the preoccupation of the American advisors with producing error-free public performance was very apparent. The problem of fear of failure, and the accompanying shame, appeared to be a major problem for the American advisors. The mention of a failure on their fitness report was seen as career-ending. If failure occurred it was important to establish that your Thai counterpart, or better still, your Thai counterpart's superior, was responsible for the failure. I must confess that as I became more aware of the advisors' difficulties with shame I became increasingly aware of the importance of shame in my own life and in my professional career. It made me aware of the sociocultural determinates of behaviors that I usually failed to attend to.

As a result of this I became increasingly aware and interested in the occurrence and management of shame in American culture. It became obvious that shame was a prominent folk category that was used to describe the consequences of behavior that were manifest publicly or that might become manifest publicly. It was associated with a variety of emotions from anxiety, to rage, to depression and despair. Shame in this setting could be a transient normal response to a social failure or it could be manifest by social defensiveness and social withdrawal. Not infrequently, it had grave consequences for career advancement. Perhaps in the military the gravest failure had to do with any behavior that suggested cowardice. Cowardice extended from manifest flight from a physical threat to failure to have the courage of one's convictions. This included failing to stand up for one's self and one's rights. If individuals were mistreated by others—even if the mistreatment was known to be unjust—those who did not stand up for themselves might be stigmatized as losers. Numerous other behaviors were valued, including the capacity to please one's superiors and one's peers. Obviously one value could compete with another value for importance and, in certain cases, values could contradict each another.

For example, physical attractiveness and sexual potency were also valued in the military population I observed. Conventional family sexual moral values that emphasized abstinence outside of a marital pairing were valued as was successful pursuit of sexual conquests. One can see how these values come into conflict with each other. One value might be publicly expressed in a particular social arena and subgroup and be unacceptable in another. Young unmarried officers frequently treated their sexual conquests as badges of

honor. Development of a sexually transmitted disease could be on display in one subgroup as indicating potency and manifest in another by shame and avoidance of adequate treatment. Recurring drunkenness might be considered career enhancing when displayed at happy hour and a socially inappropriate career-ending event when displayed at the Embassy Reception. The opportunities for establishing a positive social reputation and acting in a shameful way were related in a sociocultural arena of considerable complexity.

A striking phenomenon associated with severe public shameful behavior was social isolation. This might be self-initiated, initiated by others, or both. The stigmatization associated with psychiatric disorders was an example. One might obtain psychiatric care for an anxiety disorder or depression, but if one was identified as being psychiatrically ill, shame and stigma were immediately problematic and isolating. Thus discretion was highly valued since it allowed people to keep secret those things required to be secret. From this perspective, homosexuality is acceptable as long as it is kept secret and the individual appears to affirm the heterosexuality of others.

It was extremely difficult to distinguish the causes from the effects of shame. For example, shame in this setting may be the consequence of trauma (e.g., survivor guilt). A person may drink ethanol to decrease dysphoric emotions associated with the shame, and then manifest shame of the inappropriate drunkenness. One consequence of shame that could decrease the availability of social supports was the tendency of shame to motivate social withdrawal and produce social isolation. A number of workers have demonstrated the protective effects of social supports in different psychiatric disorders including depression.

The relationship between shame and social supports is complex. A member of a tight, supportive elite unit might receive considerable personal support but this same unit could also encourage idealized expectations where a public failure could result in shame and withdrawal of those supports. Such a withdrawal may increase the likelihood of depression and, when associated with trauma, the simultaneous loss of social support may increase the risk of Posttraumatic Stress Disorder. Again, cause and effect are difficult to separate since the development of anxiety symptoms may themselves be associated with shame and increased personal isolation resulting in stigmatization and exclusion from the group.

When examining processes like social withdrawal, social isolation or hyperarousal as causal mechanisms, the biopsychosocial model is helpful for organizing the dimensions of the hypotheses to be tested. For example, Post, in his 1992 paper, suggested that environmental changes (e.g., changing social supports) might result in the activation of a particular gene or genes and that certain genes might be more prone to respond in ways that produce a psychophysiological cascade leading to an affective disorder. Repeated challenges might produce quantitative and/or qualitative changes that lower the threshold for the risk events. Whether or not Post's model correctly identifies a specific gene, it provides a testable set of hypotheses that can be falsified and, in principle, be used to formulate and test other hypotheses. Various hypotheses are possible: from the social domain, the domain of interpersonal interaction, the domain of pyschophysiological organization, or the molecular/genetic domain. A priori hypotheses that are limited, precisely formulated and highly specific can improve our understanding of the variance that the various independent social, psychological and biological variables contribute to our dependent variables. Hypotheses can be formulated within a domain (biological, social or psychological) and across domains to verify correlations and estimate the control of variance. Shame and its various manifestations needs to be addressed more effectively by our newer methods. For example:

- Neurosciences, in particular, the newer methods of direct imaging of the brain [e.g., positron emission tomography (PET) and functional magnetic resonance imaging (MRI)], and the methods for probing basic biological and molecular genetic factors of neural activity and developmental processes.

- Psychology by measuring behaviors, affective states and cognitive processes and capacities.
- Social methodologies that can operationally measure social support, critical social psychological relationships, and the structures of linguistic/semiotic processes critical to human communication and social life.

This conceptual approach can allow us to investigate a folk category like shame through social psychological, physiological and molecular/genetic biological mechanisms initiated by shame or that increase sensitivity to shame or its consequences. These studies require a high degree of methodological sophistication.This work requires both carefully formulated operational statements and collaborative, interdisciplinary critiques of all phases of the work. The complexities associated with understanding the human behavior that we call shame also requires examination of all phases of the work for bias. These biases may be cultural or determined by over-commitment to a specific scientific fashion. Professional ideological biases constitute a significant risk, as do those determined by the professional credentials of the investigator (e.g., is the investigator a psychoanalyst, molecular biologist, sociologist or nurse scientist?).

Until recently, biases in the neurosciences have limited our vision. One believed (that is, assumed) that in the absence of neurological disease the adult brain was a constant with perhaps a loss of tissue with aging. The rapid development of the young person's brain from the fetus through the first five years told most of the story of brain development with some supplemental chapters about sexual maturation. With the new techniques and careful studies, the neurosciences have demonstrated that neurons divide and synaptic plasticity extends into late adulthood and perhaps throughout life. The endogenous milieu and its regulatory mechanisms are changing and developing in response to behavioral and emotional experiences throughout life.

A primate model that may help our understanding of shame in the biological domain is social defeat occurring in the context of submission and dominance in male rhesus macaques (Bernstein, Rose, and Gordon 1974; Rose, Bernstein, and Gordon 1975). In troops of macaques where the hierarchy is unstable there are testosterone changes associated with changes in status. Loss of status suppresses the testosterone level (Sapolsky 1982). The fact that this change occurs in an unstable hierarchy but not in a stable one suggests the importance of context in understanding shame. In the hierarchy, status may be obtained by winning fights or being the close friend of an alpha male macaque that wins fights. The low level of testosterone produced by this hierarchy in at least some primates is associated with changes in secondary sex characteristics—factors that then affect the sexual responsivity of females (Setchell and Dixson 2001). Also, dominant animals that are very successful may fight less and risk less injury. Thus, behavioral outcomes affect endogenous physiology that in turn modifies the capacity to perform by influencing brain architecture, somatic physiology and somatic structure (Sapolsky 1993; Sapolsky, Alberts and Altmann 1997). Other work with baboons indicates that challenged animals of lower status respond with higher levels of cortisol. High cortisol levels are associated with loss of cells in the hypothalamus. Therefore, we must entertain the possibility that chronic social defeat, perhaps as a biological model for shame, is shaping the structure of our plastic human brain (Lehtinen 1998).

It is important to note that although these data on the macaques monkey may reveal something about the physiological consequences of shame in males, they tell us nothing about shame in females. [At least one feminist scholar has noted that men may be incapable of empathy with the experience of shame in women (Lehtinen 1998).] The issue of the role of shame in the lives of women must be addressed before we can generalize about its consequences from a male-only population. Fortunately, there is now a developing literature on the endocrine consequences of female-ranking

in primate groups (Stavisky, Adams, Watson, and Kaplan 2001).

In addition to considering the consequences of shame, it is important to consider shame at various times in the life cycle. The importance of shame in adolescence is widely accepted, but in fact there is no literature that systematically investigates the sensitivity of people to shame at various stages of development. It seems reasonable to assume that biological, social and psychological responses to shame and the relationship of shame to depression in particular will vary between developmental stages as well as between cultures.

Finally, there is the problem of what is called "shame" and how its definition changes as one moves from culture to culture and language to language. The description of shame in "as if" terms is common. Such metaphoric and symbolic statements may be influenced by religious and other deeply held cultural values.

Shame, after all, is something to be hidden and the process of avoidance and hiding shame can result in significant social isolation creating biological as well as psychological consequences. The significant and complex role of shame in psychopathology may be one of the most important and difficult to address.

To return to our patients, the importance of attending to a patient's shame in the management of psychiatric disorders cannot be overemphasized. Shame is a common phenomenon that can vary in its consequences from minimal to disastrous. Shame is associated with a wide variety of psychiatric illness both as a potential cause and a potential consequence of illness. The need to analyze shame and its context into more clearly defined entities is critical. The possibility of examining the consequences of shame in terms of psychophysiological changes (analogous to examining the consequences of social defeat), genetic/molecular mechanisms, and social cognitive and behavioral consequences requires a complex and well-organized effort that attends to developmental variables, cultural variables, and symbolic and semiotic issues. It seems likely that shame will be an important consideration in our understanding of depressive disorders as well as numerous other psychiatric disorders.

REFERENCES

BERNSTEIN, I. S., ROSE, R. M., AND GORDON, T. P. Behavioral and environmental events influencing primate testosterone levels. *Journal of Human Evolution* (1974) 3:517–25.

LEHTINEN, U. How does one know what shame is? Epistemology, emotions and forms of life in juxtaposition. *Hypatia* (1998) 13:56–78.

POST, R. M. Transduction of psychosocial stress into the neurobiology of recurrent affective disorder. *American Journal of Psychiatry* (1992) 149(8):999–1010.

ROSE, R. M., BERNSTEIN, I. S., AND GORDON, T. P. Consequences of social conflict on plasma testosterone levels in rhesus monkeys. *Psychosomatic Medicine* (1975) 40:60–70.

SAPOLSKY, R. M. The endocrine stress response and social status in the wild baboon. *Hormones and Behavior* (1982) 16:279–92.

SAPOLSKY, R. M. The Physiology of Dominance in Stable versus Unstable Hierarchies. In W. A. Mason and S. P. Mendoza (Eds.), *Primate Social Conflict* (pp. 171–204). State University of New York Press, New York, 1993.

SAPOLSKY, R. M., ALBERTS, S. C., ALTMANN, J. Hypercortisolism associated with social subordinance or social isolation among wild baboons. *Archives of General Psychiatry* (1997) 54(12): 1137–43.

SATCHER, D. *Mental Health: A Report of the Surgeon General*. Office of the Surgeon General, GPO 1999.

SETCHELL, J. M., AND DIXSON, A. F. Changes in the secondary sexual adornments of male mandrills (Mandrillus sphinx) are associated with gain and loss of alpha status. *Hormones and Behavior* (2001) 39:177–84; available online at http://www.idealibrary.com

STAVISKY, R. C., ADAMS, M. R., WATSON, S. L AND KAPLAN, J. R. Dominance, cortisol, and behavior in small groups of female cynomolgus monkeys (Macaca fascicularis). *Hormones and Behavior* (2001) 39:232–38; available online at http://www.idealibrary.com

WERTHEIMER, L. Boorda's suicide leaves large shoes for navy to fill. NPR: *All Things Considered*, 05–17-1996.