Experiencing a Shame Response as a Precursor to Violence

Herbert E. Thomas, MD

The shame response is a primitive physiological response to a rejection of oneself by another. The discomfort of this response may vary from intense physical pain to one that is barely noticeable, if at all. When this pain is sufficient, it causes anger that may be directed outward against another or inward against oneself. The intensity of the shame response, hence the intensity of the pain and anger, is related to the significance of the other, the significance of witnesses to the rejection, one's vulnerability, whether or not the rejection is of oneself or an aspect of oneself, and if the rejection comes as a surprise. When most intense (i.e., most painful), the shame response may include a tightness of the throat, nausea, stomach pain, and a sense that the contents of one's chest and abdomen are collapsing, exploding, or imploding. In reviewing what preceded an act of violence, it is necessary to determine whether the assailant had experienced a shame response and how intense it was. Understanding that a shame response can lead to anger and violence allows for the prevention of violence. This requires that individuals do not experience rejections that are so painful as to lead to violence.

I propose the hypothesis that, when many individuals become violent, they pass through three separate and distinct stages, each of which can be studied. The first stage is that of experiencing a rejection by another individual, the second is the experiencing of a shame response, and the third stage is the development of anger. When an act of violence has occurred, careful questioning of the actor can elucidate all three, as all are subject to recall.

In the first stage, that of experiencing a rejection, several elements interact in such a way as to determine the intensity of the rejection for that particular individual. These elements include the significance to the subject of the individual experienced as rejecting,[1,2] the significance of the witness(es) to the rejection, the vulnerability of the one rejected, whether or not the rejection is of the whole self or only an aspect of the self, and most especially, the degree of surprise involved.

Vulnerability is most acute when what is rejected is the same as that which the individual rejects in himself. The workaholic who secretly harbors the idea that he is lazy is vulnerable to a rejection of himself as lazy. Expressed another way, the more the rejection mirrors one's self-

Dr. Thomas is affiliated with Western Psychiatric Institute and Clinic, and St. Francis Medical Center, Pittsburgh, PA. Address correspondence to: Herbert E. Thomas, MD, 2 Woodland Road, Edgeworth, PA 15143.

criticism, the greater its intensity. As to the element of surprise, the more sudden it is, the more likely one's defenses will be overwhelmed. The end of this first stage is marked by the individual's realization that he has experienced a rejection.

The second stage involves a primitive physiological response, the shame response, the intensity of which is directly proportional to the intensity of the rejection. The shame response can be extremely painful or barely noticeable, if at all. In its more intense form, the shame response includes the following sensations, to varying degrees: feeling stunned or shocked, a new sensation in the skin of the face and neck, a tightness of the throat, stomach pain, nausea, a sensation of the contents of one's chest and abdomen falling or imploding, and, when most severe, a sensation that one's upper chest is exploding outward and the fear that one will be left with a gaping hole. The end of this stage is the individual's awareness of anger.

The third stage is marked by anger that escalates in direct proportion to the intensity of the pain experienced during the shame response. However, numerous other factors may also influence the intensity of the response to this pain. Various psychological and somatic factors need to be considered, such as the amount of regression present, the degree of anesthesia caused by alcohol, the serum level of lithium carbonate in a manic patient, and brain dysrhythmias.

The anger may be directed at the one experienced as rejecting, it may be displaced onto a less significant other, or it may be turned against the self. Whatever the case may be, it is when the anger overwhelms the individual's defenses against behaving violently that acting out occurs.

When a person acts out violently, there is a discharge of energy that allows him or her to return to the state of equilibrium present before the experience of rejection. The pain of the second stage, however, that of the shame response, is only partially dissipated by the violent behavior. Depending on the significance of the rejection, the residual pain is repressed to a greater or lesser degree. Most especially, in the same way that anxiety related to traumatic stress is not forgotten, neither is this residual pain forgotten.

For those who have committed acts of violence, it is the second stage, that of the shame response, that is most difficult to recall, often because it may have been very brief. Initially they will say they were simply angered by the rejection. This is not unexpected. Their concern is with the violence, not with feelings that might have preceded it. Likewise, witnesses to the episode, as well as interviewers after the fact, will focus on the intensity of the anger and the related threat of violence. Only when the focus is redirected to what took place between the moment of the rejection and the ensuing anger can the particular character of the shame response be explored.

In sum, the anger that one feels as a result of a significant rejection is not caused by that rejection. Rather, the anger is a reaction to the pain that one endures consequent to the rejection (i.e., the pain of the shame response).

Clinical Evidence of the Shame Response

Case 1. A 36-year-old woman recalled an event that took place in her family's apartment when she was 9.5 years old. She recounted the event in the course of her therapy with great clarity.

One Saturday morning, rising late from her bed, she walked toward the kitchen only to become aware that her parents were talking about her. On hearing her mother ask a question of her father that she interpreted as meaning her mother believed her to be "crazy," she silently withdrew to her room. There, in order to obtain relief from the overwhelming pain she felt in her chest and abdomen, she climbed into bed and assumed a fetal position.

During the course of the next three years, she raged at her mother, who, on being asked, denied ever thinking of her daughter as "crazy." After several visits to a psychiatrist, the girl was told at the age of 12.5 years that she was going to a hospital for a check-up. Once there, she was interviewed by a psychiatrist who said that, as it was late Friday afternoon, he would see her again Monday. It was a private psychiatric hospital in the mid-1950s.

Over the weekend an older patient befriended her and, learning of her problem of repeated outbursts of anger, urged her to stop them as she would most likely be given a course of electroconvulsive therapy at the hospital. She never expressed anger again and was discharged from the hospital on the following Monday. Only in therapy did she reveal the intensity of the pain she had experienced when listening to her mother and father talking about her. Part of her thought she was "crazy."

Case 2. A 43-year-old woman in intensive psychotherapy became enraged at the therapist for having said "the most cruel and cutting remark" she ever could have imagined, "not once but three times." She further saw no evidence that he was aware of how deeply he had hurt her.

What the therapist had said was that if she behaved at work the way she behaved in the office, it was obvious why she was having problems. His remarks were prompted by certain expressions of her anger, which he had interpreted as proof of a negative transference. These included statements that he did not listen to her, that he ignored her point of view, that he was a male chauvinist, that he was arrogant, and so on.

During one session the woman's anguish and rage became so all-encompassing that her therapist finally asked her exactly what had occurred between the so-called "cutting remark" and the moment she became aware of her anger. Only then did she describe experiencing in her upper chest a pain so intense that she thought her chest would literally explode outward, leaving a gaping hole.

Case 3. A young man was working in his pizza shop about nine o'clock one evening. His ex-girlfriend, who had left him for a new boyfriend, dropped by to discuss a bill for furniture they had bought when they had intended to live together. When he learned that the new boyfriend was waiting outside, he ordered her to leave the shop and began drinking

malt liquor, which he continued to do for several hours. Because of recent robberies, he carried a gun in the belt of his trousers.

After going home to change his clothes around 11 o'clock, he drove to a swimming pool in a nearby park. The pool was closed, yet he knew it was where his ex-girlfriend and her new boyfriend both worked. He vandalized it, cutting phone wires and throwing poolside furniture into the pool. He next drove to an area where he had parked with her in the past, also in the park, and found the couple sitting on a bench. Approaching them, he entered into a long discussion about her returning to live with him. After perhaps 15 minutes, he turned and retraced his steps to his car. As he was doing so, he heard a barely audible remark followed by laughter. Enraged, he drew his pistol, turned and fired at the couple as he approached them, killing the man and wounding her. When later questioned, he described feeling an intense pain in his chest and abdomen immediately following the barely audible remark and the ensuing laughter.

Preventing the Shame Response

If one accepts the idea that the shame response causes anger, which may in turn be acted out violently, then one needs to focus on insuring that another does not experience rejection of a kind that will precipitate a shame response. In the following encounters, normally likely to produce a shame response, an effort was made to accept rather than reject the other.

Encounter A. A number of years ago, in a staff cafeteria of a maximum security prison, two senior administrators and a psychiatrist were sitting at a table when they were approached by an inmate waiter carrying a pot of coffee. He had managed somehow to obtain a chef's hat, adding a comic touch to the setting. With a fresh white shirt, white trousers, a white apron, and a white towel folded over his left forearm, he approached the table, smiling and bowing as he offered everyone a cup of coffee. Unknown to him, the conversation at the table, an extremely anxious one, concerned the threat of an imminent riot. In response to his offer, he was showered with a string of curses from one of the senior administrators.

The inmate stopped abruptly. A red flush spread upward from his shirt collar and across his neck and face, and he stared in disbelief at the man who had rejected him. He then backed slowly away from the table and retreated behind the cafeteria counter. I was the psychiatrist at the table, and I was facing him. The other two men had their backs to him. The inmate stared at me and I stared back at him. As we did so, a much shorter man, a steward, approached the inmate and asked him why he was standing there. The inmate placed his large arm around the steward's neck and lifted him off the floor, where he dangled, a cigar in his mouth and his arms hanging by his sides. The steward stared at me and I at him. The inmate stared at me and I at him. With all the energy I could muster, I grinned at both of them as widely as I could, and both men grinned back at me. After what seemed like a very long time, the inmate lowered the steward to the

floor, and the steward shook himself and went about his business as if nothing had happened. The inmate also went about his work. As for the two administrators, they were unaware of what had occurred.

Encounter B. One afternoon in a small building inside the walls of a maximum security prison, a number of inmates had gathered for group therapy with a psychiatrist (myself) and a female psychologist; I was told that someone wanted to see me. Waiting in the hall was an inmate I knew well. He was clearly very disturbed and held a large club in his hand. The man could only repeat over and over: "What are you doing to me?"

I gazed at this man straight in the eyes, showed no emotion whatsoever, and talked quietly about how he was obviously troubled. The man then discharged his anger by throwing the club violently at a wall. He then threw over several large pieces of furniture. Once having "exploded" in this way, he became completely calm.

At only one point did the level of dangerousness suddenly escalate. This was when another inmate, standing next to me, said: "Now come on, Dan." The man with the club turned toward him with vastly increased anger. Only when I told the other man to mind his own affairs, did the subject return to focusing his anger on me. In the context of our relationship, the second man was much more at risk than I because of the tendency for anger to be displaced onto a less significant other.

Encounter C. Several weeks after the events just described, the female psychologist who had observed all of what had occurred outside the group therapy room found herself in a comparable situation. As she worked in her office in a court psychiatric clinic, a huge man, unknown to her, entered her office. The clinic was otherwise deserted. The man announced that if she did not marry him at once, he would throw her out of the window, which was several stories above the street. She promptly stood up to better look directly into his eyes. She then began talking to him, showing no emotion.

It was apparent that the man was psychotic and highly delusional. Realizing that the delusions all related in some way or other to scripture, she explained that she was "betrothed" and thus could not marry him. He was clearly taken aback at this development and, as they talked together, he began to calm down. After what I am sure seemed a very long time to her, he turned and left the office.

Discussion

It is not difficult to understand why a phenomenon as powerful as the shame response has gone unrecognized in studies of dangerousness. What attracts attention is the intensity of the anger that precedes violent behavior. Also, to ask a person who has acted violently to look at what precipitated the anger is to ask him to focus on the rejection and to experience, once again, the pain that ensued.

Acts such as child molestation are frequently as abhorrent to the perpetrator as they are to other people. A man having raped a small child may kill his victim not only to escape arrest but also to avoid the rejection he would experience and hence the pain of the shame response, knowing that others would learn from the child

what he had done. Similarly, in one case, years after being sent to prison for murder, a man explained the cause of his violence for the first time. He said that he had killed his girlfriend because she knew his sexual preferences and he believed that, if she reported them to friends, they would reject him. In effect, he destroyed her life, as well as his own, to protect himself from the pain that would follow these rejections.

Archaic Greece[3] and modern Japan[4] have been referred to by some authors as examples of shame-sensitive cultures, whereas America has been considered a guilt-sensitive culture. In the former countries elaborate patterns were developed to protect the individual from experiencing rejection.

At the siege of Troy, a charioteer made what was considered the unpardonable error of stepping down from his chariot during a battle. Rather than experience rejection at the hands of his friends, he explained that the act occurred while he was in a state of *ate*, the word used to describe one's mind being possessed by a god having descended from Mount Olympus. He could not be rejected; if anyone was to blame, it was the god.[3]

When a Japanese man of social prominence says goodby to his staff, his behavior seems bent on insuring that none will experience rejection. By the time everyone is spoken to, everyone's hand is shaken, and everyone has been bowed to, no one could possibly feel left out.[4]

In contrast to archaic Greece and modern Japan, American patterns of behavior have not protected the individual against rejection. Until recently, widespread legally sanctioned segregation existed in this country as a manifestation of racism. The rejection that it entailed was visible enough, but the pain of the shame response was not. When the ensuing anger was turned outward, violent behavior resulted. More often it was turned inward, thereby fostering depression, withdrawal, and avoidance.

Conclusion

When an act of violence occurs in a hospital setting, a prison, or anywhere, there should be a careful review of the events that led up to it. Most importantly, the one who committed the violent act should participate in that review. A recognition of the seriousness to him of the rejection, not in the words that were used but in terms of the pain experienced, will educate both the staff and the actor. In conducting such a review the staff may begin to understand how a remark that is seemingly innocuous, but is experienced by the subject as an intense rejection, may be enough to trigger a painful shame response in one individual, whereas the same remark, not perceived as a rejection may be of no consequence to another individual.

A focus on the shame response does not preclude the need to attend to other factors that might have contributed to the violence. Every medical condition, from a manic excitement to the phenomenon of kindling, needs to be considered and, where present, given the weight it deserves in any diagnostic formulation of what caused the violence.[5,6] Yet whatever medical conditions may be present, the three stages of experienced rejection,

shame response, and anger deserve careful study in any review process.[7]

References

1. Edwards JG, Jones D, Reid W, Chu C: Physical assaults in a psychiatric unit of a general hospital. Am J Psychiatry 145:1568–71, 1988
2. Carmel H, Hunter M: Psychiatrists injured by patient attacks. Bull Am Acad Psychiatry Law 19:309–16, 1991
3. Dodds ER: The Greeks and the Irrational. Berkeley and Los Angeles: University of California Press, 1951
4. Benedict R: The Chrysanthemum and the Sword. New York: New American Library, 1946
5. Roth L (ed.): Clinical Treatment of the Violent Person. New York: Guilford Press, 1987
6. Tardiff K: Concise Guide to Assessment and Management of Violent Patients. Washington, DC: American Psychiatric Press, 1989
7. Toch H, Adams K: The Disturbed Violent Offender. New Haven and London: Yale University Press, 1989