

# SH@ME IN CYBERSPACE<sup>1</sup>

## Relations without faces. The e-media and eating disorders

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### ABSTRACT

This article discusses relationships in computer-mediated communication, with particular reference to online therapy as an approach in consulting and clinical work with eating disorders. Anonymity is a dynamic force in developing relationships on the Internet, and advantages and disadvantages of anonymity are discussed. Shame is introduced as a central concept to understand the pros and cons of interaction in cyberspace, and eating disorders are discussed as “shame-based syndromes”. Finally, the article proposes guidelines for therapeutic activity in computer-mediated communication and future work for ensuring quality.

### INTRODUCTION

New technologies for communicating open up new possibilities for therapy and consultations. Online therapy shatters three of the traditional basic premises of therapeutic interaction:

- 1) Visible contact.
- 2) Talking.
- 3) Synchronous – “real time” – interaction.

Online clinical work offers an “elasticity of communication” that includes several factors, such as flexibility of location and time, varying levels of synchronicity, and flexibility to employ various online channels of contact.

There is a mutual relationship between medium and comprehension, between *technos* and reflection. Each major change in communication technology has changed man and human relationships. This was the case when writing and printing was introduced, and it applies to digital networks. In *Phaedo*, Plato famously objected to the introduction of writing as opposed to speech, because, as he pointed out, writing reduces the richness of communication since it makes it impossible to read the speaker’s tone and bodily posture. Furthermore, he saw that if agreements were made at a distance, they would not be as binding as agreements sealed by the spoken word. He also thought that people would lose their ability to remember important events. Of course, all of this was true, but Plato could not foresee that, thanks to writing, we would gain a wider range of communication, new ways of making contracts at a distance, and a whole new cultural memory (Dreyfus, 2001).

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<sup>1</sup> This article was published in European Eating Disorders Review, May-June, 2003, 11 (3), 155-169. We want to thank the author and the journal for permission to reprint the article here.

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Investigating how computer mediated communication changes relationships and creates therapeutic possibilities – cybertherapy – presents both a practical and a conceptual challenge. Who can benefit from the different types of services made possible in these new e-media? What kind of relationships will develop through telepresence? The stimulating theoretical challenge is to enrich our understanding of what are effective therapeutic relationships. Clients and therapists form relationships, but their bodies are unapproachable, at least from a conventional understanding of the human body. Compared with traditional therapy there is a basic change in the *inter-corporeality*, to use a concept from the French body philosopher and phenomenologist Maurice Merleau-Ponty (1963). What are the possible consequences of such changes in general, but with particular reference to therapies with disorders where preoccupation with bodily appearances is fundamental?

This article is based on three assumptions:

- Anonymity and invisibility are dynamic forces in the new computer-mediated communications, like Internet and e-mail. We share intimacy without sharing facial and bodily expressions. It is closeness through distance.
- Shame is a very relevant concept for discussing the pros and cons in these new electronically based ways of communicating. The very nature of shame is connected to self-observation, to see oneself through other peoples' eyes. Shame is connected to being looked at by others, real or imagined. What about shame when there is no gaze?
- Shame is a central affect in eating disorders. Shame in eating disorders may have many qualities and expressions, but very often it includes body shame.

## ON SHAME

Shame is something we want, and something we do not want. Even if we perhaps immediately think of shame as something negative, we probably associate *shamelessness* with something worse. Shame represents a withdrawal. It may be argued that shame is an affective response helping us to adapt (Tomkins, 1987; Gilbert & Andrews, 1998). The withdrawal may be interpreted as a protection against being hurt when confronted with violations in relations, or when there is a lack of response. A central shame theorist, Silvan Tomkins, describes shame as an innate affective reaction to a sudden reduction of positive affects of *enjoyment-joy* and *interest-excitement* (Tomkins, 1987). The withdrawal represents an effort to terminate or change the character of the relationship. Such a reaction may protect against invasion of the self, and thus helps to preserve relations and the sense of identity. But in deep and severe shame this kind of protection is self-destructive. Deep shame is a dys-regulation of self-esteem. The shame reaction has itself turned to a major problem. The shameful withdraws in such a way that he or she excludes him/herself from nurturing and healing relations.

Hence, there is a need for distinctions. There are many possible distinctions; immature and mature shame, external and internal, pathological and non-pathological etc. In this context I make a distinction between good and bad shame, a positive sense of shame and a negative sense of shame. This distinction is inspired by the psychoanalyst Leon Wurmser, in his book *The masks of shame* (1981).

*A positive sense of shame.* This is respect for other people and for oneself; Goethe's "Ehrfurcht vor sich selbst" (1829/1969). This sense of shame is discretion, tact and what Nietzsche calls a refusal "to touch, lick and finger everything, a nobility in taste and tact and respect" (1885/1976, my translation). Shame represents *self-observation*, which activates the cultural norms inherent in good manners. It is what the existentialist philosopher Søren Kierkegaard called being "external" to oneself, to see oneself in a wider perspective (Quortrop 1996). A good sense of shame protects social bonds, and regulates intimacy. Shame defines borders for privacy. And a good sense of shame may be moderating, not losing our selves in ideas about our own grandiosity.

*A negative sense of shame.* Deep shame is the pain of not seeing oneself worthy of love. Deep shame, in this context, is more than isolated remembrances of humiliations. Deep shame is a basic and frequently recurring affect. Shame is not only connected to normative self-observation, but also to compromising oneself, the fear of being revealed as a person with negative qualities. One may blush when one is alone, but the character of shame is profoundly relational. Deep shame is withdrawal and loneliness, but it always creates fantasies about "the other". In *Being and nothingness* Jean-Paul Sartre writes (1980): "The shame is a shame over oneself towards the other, the two structures are inseparable". It may be the concrete others, with their scorn. Or it may be the idea about the others, their rejection.

### Shame in therapeutic relationships

Deep shame threatens therapeutic relationships. Shame is a communication obstructing further communication.

The acute shame reaction may be experienced as great pain. Few other affects are felt as dramatically as shame. It is experienced as an implosion and sudden destruction. Both Jean-Paul Sartre and Charles Darwin write about the shame reaction disturbing our cognitive capacities. Sartre writes about a disturbance so strong that it is felt as an "inner haemorrhage". Darwin writes about "the bewilderment of the mind"; one is not able to say what one wants to say (Skårderud, 2001).

Shame is linked to silence. One does not want to talk about what is shameful. Deep shame challenges the basic principles in psychotherapeutic work: faith in the dialogue and faith in the therapeutic relationship as health promoting. Shame is withdrawal in a context where both aim and method are openness and getting closer. Shame is anti-dialogue, and the therapist may feel excluded. Hence, shame may be difficult to discover in relationships, because it is hidden. Those who feel anxiety or grief may experience sympathy and care. The shameful expects contempt.

Severe body shame, like preoccupation with being fat, may interfere with the patient's concentration and presence in the therapeutic dialogue. The body, not concretely but as an emotional and cognitive disturbance, is a hindrance to an open and free dialogue. From eating disorders we know that not only the patient's body, but also the therapist's body may represent a disturbance. The patient with anorexia may find it difficult to trust the obese therapist, or the skinny dietician.

### The psychology of shame

Surprisingly, relatively little has been written about shame in the history of psychology and psychiatry. Its absence until recently has been striking. As literature, psychoanalysis has been the most colourful among the schools of psychology, with myths, rich metaphors and exciting pathographies. But the narratives using the concept of shame have been few. Classical psychoanalysis has guided our interest towards guilt, with Sophokles' tragedy about King Oedipus as the core metaphor. The guilty self has stood in the light of the shameful self. An exception among the psychoanalytical classics is Alfred Adler, with his descriptions of inferiority feelings and the inferiority complex (1958).

However, during the last decades we have witnessed the rise of a shame psychology. Among the most central authors we find Helen Merrel Lynd (1958), Helen Block Lewis (1971), Silvan Tomkins (1962, 1963, 1987, 1991, 1992), Leon Wurmser (1981, 1987) and Donald L. Nathanson (1987). From having been ignored in psychology, shame is now about to be accepted as a central affect (Gilbert & Andrews, 1998). How come?

One possible explanation for the gradual appearance of shame in the professions of psychology and psychiatry is that it is a cultural expression of individualization in late modernity. The historian Christopher Lasch claims in his very last book, *The revolt of the elites and the betrayal of democracy*, (1993), that shame is out of fashion. He refers to the reduction of taboos in Western culture, in phenomena like sex, economy and behaviour. Superficially, he may be correct. More profoundly, I think he is wrong. In my interpretation shame does not disappear in modern societies, but it is less accessible and prominent as a collective discourse about right or wrong, good or bad. The history of modern Western shame is not the history of lost shame, but of transported shame. It is a transport from collective norms to more individualised norms, towards individual psychology. It is the process of making shame more private. Thus, it is not necessarily a matter of less shame, but of different forms of shame. Such a transport may lead to the loss of traditional language about shame, making it more taciturn. From being a collective moral issue, it has increasingly become a psychological, and hence, a therapeutic issue (Wyller, 2001; Skårderud, 2001).

Another explanation concerns theory: Shame is about the regulation of self-esteem. A good understanding of shame demands good theoretical models of the psychological *self*, of the organization and development of the self. As a relevant example, in the contemporary psychoanalytical tradition of self psychology, based on the work of the Austrian-American psychoanalyst Heinz Kohut, shame is described as the central affect (1971, 1977, 1984).

A third possible explanation for the growing literature on the psychology of shame is the increased awareness of so-called *shame-based syndromes* (Kaufman, 1989). In shame-based syndromes like drug and substance abuse, addictions, reactions after violation and abuse, the feeling of shame is often both origin and consequence. Eating disorders are one of the main examples of shame-based syndromes.

## **ON SHAME IN EATING DISORDERS**

In eating disorders shame may be both primary and secondary (Goss & Gilbert, 2002). And it is difficult to distinguish between shame as cause or consequence, when these mutually reinforce each other. A basic sense of shame may lead to more shame via the behavioural expressions of an eating disorder (Burney & Irwin, 2000; Skårderud, 2001).

*Cause.* As a dys-regulation of self esteem, shame may be a basic affect in the development of the eating disorder. Based on dissatisfaction one seeks to change, to recreate oneself. Eating disorders are disorders where the body both concretely– as body shame (Gilbert & Miles 2002) – and as symbol, is the seat of the dissatisfaction (Masheb, Grilo & Brondolo, 1999; Frank, 1991). And the body is also the arena for change. Shame feelings may also be about not deserving and wanting to punish oneself, expressed through food restrictions and denial. Shame may also lead to self-degrading behaviour, as in bulimia, confirming low self esteem.

*Consequence.* Many patients are ashamed of having an eating disorder. The feelings of shame accompanying the eating disorder pathology may be linked to body shame, to bingeing and purging behaviour, as well as to the fact that one is shameful about not being able to eat in a natural way. At the basis is loss of control. The person with an eating disorder experiences and expresses lack of self control. Self control is a highly admired psychological quality in modern culture. Burney and Irwin showed that shame associated with eating behaviour was the strongest predictor of the severity of eating-disorder symptomatology (2000).

*Shame as mediator.* Andrews (1997) proposes that bodily shame plays a mediating role between childhood physical and sexual abuse and bulimia.

## ON E-COMMUNICATION

Electronic communication is forming relationships in "a world that is both everywhere and nowhere, but is not where the body lives" (Barlow, 1996). I am particularly interested in the effects of not being visible. I remind you that shame is linked to disclosure, real or imagined, a "disorder of the eye".

When dealing with shame in therapy, it is of the greatest importance to remind ourselves that therapy is a potential shame-situation. The patient-therapist relation is ambiguous. It may be a relation for healing, for plucking up the courage to reveal disgraceful qualities and then to experience acceptance. But it may also be a relation for re-traumatisation, for more shame. In therapy the client is expected to reveal himself/herself, to turn his/her innermost problems inside out.. Nobody expects the therapist to be equally open. It is a very unequal relation in terms of power, and in order to create a safe enough atmosphere the therapist must maintain high standards as regard both ethics and technique.

In online relations one can conceal oneself – and not least the body – behind pseudonyms and heteronyms. Fat or thin, it doesn't show. Or there is only partial concealment. One may operate with one's full name and identity, and have met the person(s) one communicates with (Bailey, Yager & Jenson, 2002). But in these interactions, the face, mimicry, gestures, body bearing, all that we name non-verbal communication, are not available. Accordingly, digital communication takes precedence over analogue communication (Wilden, 1972). Therefore, we must expect that these are media which may give protection and reduce negative shame.

How personal can relations become in the virtual rooms? Our concepts of "person" and "personal" originate from the Latin *personae*, which was the name of the mask worn by the actors. The mask helped the actor to better express the personality of the character. In his classic sociological work, *The fall of public man* (1977), Richard Sennett provokingly claims

that a romantic movement in favour of removing social masks and meeting face-to-face, being “genuine” and “natural”, runs the risk of reducing feelings of safety and trust in relations and inhibiting communication.

Both in the popular and the academic understanding of the development in net-relations, two positions are very soon to be established. One is that encounters in e-media are pseudo-relations, impersonal and unreal. The other position argues for authenticity and intensity, precisely because of the protection proposed by Sennett. Let me try to develop further the possible advantages and disadvantages based on the results from different empirical studies.

### Pros

There is ample documentation for how anonymity contributes to higher levels of self-disclosure and openness (Joinson, 1998; Kiesler, Sieglar & McGuire, 1984; King & Moreggi, 1998; Utz, 2000). The mask is back in place, and more dare to act faster. One quickly gets private and personal by pushing the keys on the keyboard. Low thresholds for disclosure can be useful for persons struggling with shame, secrets and isolation. E-media may be a therapeutic possibility for clients who because of their personality or their problems do not seek traditional therapy. Descriptions from online-therapies with gay men, lesbians and sexual abuse survivors (Struve) can serve as an example.

In computer-mediated communication the users have possibilities of selective self-presentation. They have the time to consider how to present themselves, and to emphasize their positive traits. The same goes for the recipient. This may be experienced as social support (Kummervold et al., 2002). Walther has in an attempt to explain that e-communication is more friendly and more social than face-to-face communication, developed the term “the hyperpersonal model of computer-mediated communication” (1966).

One may experience a high level of intimacy because idealisations are not corrected through physical confrontations. A classic situation of falling in love implies idealisation of the other, and in this way the e-media may promote falling in love (Baker, 1998; Chenault, 1998; Lea & Spears, 1995).

In such a context one can make interesting comparisons with classical psychoanalysis, as developed and interpreted by Sigmund Freud. One phenomenon is that he treated some of his patients solely via text. A more fundamental feature is that his technique was designed to foster dis-inhibition. A way to help the analysand with “free associations” was the fact that the analyst could not be seen, as he was sitting behind the analysand, who was lying on the couch. The similarities between the classic therapeutic situation and online-therapies are obvious and striking. The absence of the analyst’s face and body is a technical frame to promote the analysand’s projections. E-media can lead to strong projections and fantasies about the other. The screen is literally and metaphorically a screen for projections. In psychoanalytic terminology this may mean intense interactions of transference and counter-transference. To my knowledge, the possibilities of controlled and constructive work with transference in computer-mediated communication has been very little investigated and discussed.

### Cons

This text operates with a distinction between good and bad shame. To what extent can the anonymity online reduce positive shame? Can it promote shamelessness?

An example of this is the so-called "flaming", negative and aggressive behaviour. Lea and Spears claim that the phenomenon is relatively limited, less than five percent of the communication in these media (1995). Anonymity is absence of social control, and opens up for non-responsible behaviour. It is similar to the immoral acting-out by the apparently decent person, when a tourist in remote regions. When we look into other areas of the Internet, like sex and pornography, we can also find examples of brutality and primitive behaviour; or what in psychoanalytic terminology is called regression (Holland; Zizek, 1997).

The protection in e-media may also contribute to therapists' acting out.

Another disadvantage of the anonymity may be that the freedom to hide, change or distort one's identity and characteristics, leads to lack of trust among the participants. And there is also a risk of misunderstanding, due to the relative absence of non-verbal signs (King & Moreggi, 1998). The written language may be experienced as too rigid and in-flexible.

### The relational body

It is appropriate to modify the understanding of e-communication as an absence of non-verbal mediation. Texts are also bodily. Internet may be considered as an extension of our bodies, as "prostheses", and may hence contribute to changes in our experiences of ourselves. Even though there is mostly an abstracted bodily presence in the cyber-room, there is a gradual development of the e-language. These are developments in linguistic strategies to express emotions and mood. So-called *emoticons* (emotion + icon, like a smiling face) and *action words* are small signs replacing the expressive face (Gotved, 2000).

This of course does not mean that these forms of communication can contain the many rich nuances we have in face-to-face interactions, especially the more unconscious signals (Lønsted & Schramm, 2001). Even though bodily expressions mediated through emoticons and action words to some extent compensate for non-verbal communication, one has to remind oneself that these are expressions that are deliberately chosen.

Becoming more aware of the nuances in written language poses a great challenge to e-therapists.. Texts have accents, ambiguities and individual styles. This is not so much about learning new languages, as about plumbing the depths of the read and written language we already have.

## **CHALLENGES**

Let me sum up some of the central possibilities and challenges for future work with online therapy and consultation.

Accessibility. The new technology opens up for more equal and democratic access to limited therapeutic resources. This is both about time and space. Long distances are not hindrances, and the possibilities of a-synchronous communication mean more effective use of time. But it may also mean new inequalities, dividing those *online* from those *offline*, and the technologically competent from the non-competent. Increased accessibility must be discussed with re-

gard to possible negative side effects, as an increased tendency to seek medical and psychological solutions to the challenges of everyday life.

Getting help earlier. The experience of protection in the e-media may stimulate more people with eating disorders to seek help sooner. Getting help earlier is often, but not always, linked to better prognosis.

Recruiting for therapy. To dare initiating the very first interactions about shameful themes, such as bingeing and purging, may be a motivation for seeking more traditional forms of therapy. In such a context net-psychology and net-psychiatry is not an alternative to traditional therapy, but therapy-initiating.

Improvement of therapies. Therapy is a very wide concept, and not necessarily precise. With that in mind, let me state that e-therapy can improve the theory and practice of therapy.

- Certain forms of therapy may work better in the e-media. In such cases the face-to-face contact, and the physical presence of a problematic body, would have represented unwanted disturbances. An obvious hypothesis is that this goes for simpler forms of consulting and giving advice. And in the future it will be interesting to compare the efficacy of online therapies with traditional forms, in respect to traditions like psycho-educative and cognitive work, solution- focused therapies and using written texts from the clients.
- What works for whom? Comparative studies of online therapies versus traditional forms will give us increased knowledge about what is beneficial for whom, in terms of diagnostic groups, history of illness, personal histories, personality traits etc.
- Useful differentiation in the therapeutic field. Increased understandings of what works in the new media, will probably also tell us what does not work so well. I am particularly thinking of therapeutic traditions where the main emphasis is on the therapeutic relationship itself, i.e. psychoanalysis, long term psychodynamic therapy and some traditions within body oriented therapy. Hopefully this will lead to a differentiation, and a further development of the specific qualities within the different traditions and technological contexts.
- Useful integration in the therapeutic field. A very imminent future scenario, already existing, is the combination of virtual and physical encounters. With reference to shame: The therapeutic sessions, face-to-face, may work better when difficult themes have been introduced, or are followed up, via e-mail. (Skårderud, 1998; Yager, 2001).

Optimal anonymity. The possibility of being anonymous is the strength and weakness of telepresence. There are different strategies to promote positive and to reduce negative aspects. Or in the terminological context of this article: How to reduce negative shame and promote positive shame? And how to prevent shameless acting-out? What is the optimum of protection?

- In clinical chat-groups, anonymity is often a basic, and inevitable, premise. This is sometimes problematic. From my own experience I know that the role of the clinician,

in addition to function as an expert, should be to watch over, reduce and prevent unwanted behaviour like “flaming”<sup>3</sup>.

- Serious and controlled work as online therapists should require that the clients’ anonymity should be reduced. Depending on the therapeutic context, there are different alternatives:
  - A positive confirmation of identity.
  - An introductory meeting face-to-face – which of course undermines the great geographical advances of e-media.
  - Repeated meetings in RL (“real life”), not only in VR (“virtual reality”).
- E-therapists should not be anonymous. This might stimulate insecurity among the clients. But not least, it may promote unethical behaviour by the therapists. If the protection in e-media can further regression among clients, it can also further regression among therapists.

“Nethics” and e-competence. There is an obvious need to develop competence, procedures, ethical and practical rules for therapeutic behaviour in computer-based communication. Here are some central topics:

- An understanding of the advantages and disadvantages of relationships in these media; cyberspace as a room for good and bad projections, idealisation and devaluation.
- The therapist’s knowledge about the risks of misunderstanding in e-media, and the dangers of silence – for both parts.
- Knowledge about net-addiction, and the risks of regression, like “flaming”.
- Scientific knowledge. What are the main updated findings in qualitative and quantitative research?
- Guidelines and written contracts for online dialogues; agreements about frequency of contact, time-limits for response etc.
- Procedures in case of crisis.
- Information to clients about legal and technical matters and data security.
- Clear economical arrangements.
- The Internet is a tempting world for quacks and charlatans. Should therapists have “net-certificates”, with compulsory participation in educational programmes or documentation of skills?

## CONCLUSION

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<sup>3</sup> The author of this article is the editor of psychiatric themes in one of the major Norwegian web-portals – [www.lommelegen.no](http://www.lommelegen.no) – on health. The website is used by one hundred thousand Norwegians every month, from a population of nearly five million inhabitants. The information on eating disorders is made completely by the author: [www.lommelegen.no/spiseforstyrrelser](http://www.lommelegen.no/spiseforstyrrelser) (in Norwegian). The role of the editor, in addition to produce informative texts on psychiatry, is the daily surveillance of the chat group on eating disorders.

The computer-based technologies open new possibilities of therapeutic work. These media may be particularly beneficial for “shame-based syndromes”, like eating disorders. And they may be particularly beneficial for eating disorders, due to the relative absence in telepresence of the problematic and shameful body. These are central issues for future research. Today, we are only at the very beginning of developing useful concepts and empirical knowledge about the nature of clinical encounters in these media.

The necessity for competence, procedures, ethical and practical rules should be obvious through this simple and dramatic scenario:

What does the e-therapist do after the e-client, with unknown address and identity and not satisfactorily assessed, in a rage – maybe caused by a misunderstanding or by the silence of the inexperienced e-therapist – threatens with suicide. And then logs out?

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