

It is the weakness of the human being that makes us sociable; it is our common miseries that turn our hearts to humanity; we would owe humanity nothing if we were not human. Every attachment is a sign of insufficiency. If each of us had no need of others, he would hardly think of uniting himself with them. Thus from our weakness our fragile happiness is born.

Rousseau, *Emile*, Book IV

Although shame has been neglected in clinical education and in psychoanalytic training and literature, it has become increasingly evident that it is at least as important for clinicians as guilt. For me, it is even more so since it begins at birth, in its toxic forms is often the cause of treatment failures, is essential in our understanding of psychic pain, and affords us extraordinary resources in strengthening human bonds and in providing us with essential ways of keeping ourselves alive as clinicians.

Definitions of the Roughest Kind

Let me begin with a very provisional definition of shame. Shame can be associated with an urge to hide, a feeling of failure, a terror of being seen as one who is different from the way one needs to appear. Shame makes one feel unfit for human company, condemned to be isolated until the end of time, and intolerable to oneself. Such feelings are at once unbearable and judgments of what one is experiencing. The judgmental functions of shame are themselves feelings, which is why shame is so pervasive and so very difficult to define. There is no anxiety state that does not call up shame dynamics. For me, it is impossible to understand anxiety without an understanding of shame (Kilborne, 2006).

Shame and Guilt

In order to clarify further what shame is, let me very briefly attempt to characterize the difference between shame and guilt. Guilt tends to be paired with expected punishment and a sense that some act is strongly disapproved of. In this sense, we understand the legal notion of guilt as responsibility defined, and the definition associated with third parties. By contrast, shame is about one's relation to oneself; one's image or ideal of oneself, together with all the conflicts between and among ideals; shame is being caught with one's pants down in one's own eyes. Guilt can be associated with aggression towards someone else, some act of violence or injury caused to someone else for which one can be held responsible. Shame is more a blanket condemnation of one's own being, an inner condemnation from which there is no escape and no possibility of pardon or forgiveness.¹

Why then would Freud and others have focused on guilt at the expense of shame? The short answer is because guilt holds out the possibility of greater clarity. Guilt is easier to view in terms of the requirements for scientific objectivity; it comes packaged with implications of power and can be associated with blame and aggression, whereas shame is associated with fragmentation, dependency, helplessness, confusion, and feelings that are less tolerable. Shame therefore affects identity and identity confusions in ways that guilt does not. Also, whereas guilt can be determined from the outside (e.g., a judge can rule a defendant guilty), shame is always felt from within.

Recognizing shame can, however, be difficult. A central dynamic in virtually all diagnostic categories, shame is a feeling that wants to hide, and that we as therapists want to hide from. There is no experienced mental illness that does not produce shame: shame for being defective, shame over feeling different from others, shame over not being able to live up to one's ideals, shame over disappointing others whose connection depends upon what one cannot provide. Patients can be ashamed of not being able to love, of not being lovable, of not knowing who they are, of not living up to what they imagine we, as therapists, want them to be. Patients can also feel ashamed of their tendencies to manipulate or lie, ashamed of their feelings of doubleness.² When we are confronted by patients with severe identity confusions, shame is always at play. By definition, the experience

that one does not know who one is produces massive shame, and this shame can, in turn, be threatening to us as clinicians.

Patients can also be ashamed of their bodies, as in anorexia and various forms of distorted body image. Also, shame works in couples and in groups, often triggering toxic cycles of rage, recrimination, and assumed superiority and intolerance. In all these instances, we as analysts and therapists are likely not to see the shame unless we are aware of it and are looking for it. A partial explanation is that the very recognition of shame generates anxiety, and the anxiety triggers shame reactions, both in our patients and in ourselves.³

Shame and Guilt in Hawthorne

Hawthorne's *The Scarlet Letter* suggests why it is so difficult to define shame. The plot revolves around a bit of cloth with a scarlet letter found by the narrator. This letter A (for adultery) turns out to be one embroidered by Hester Prynne who is forced to wear such a letter because her child Pearl is born out of wedlock. Whereas Hester's shame is displayed in a scarlet letter, at once a stigma and an expression of defiance on her part, that of the Reverend Dimmesdale, the father of her child, who throughout the book must remain a shadowy figure, cannot be described, so horrifying and unbearable is his shame. In the finale of the book, Hawthorne draws back from any kind of omniscient narrator stance. Various onlookers report what they think they saw: some saw an "A" burned into his flesh, others saw different signs of his suffering; all witnessed his death, but none could say for certain what he died of.

Hawthorne contrasts the judgment of guilt brought to bear upon Hester Prynne and the internalized shame of the Reverend Dimmesdale. "What Dimmesdale cannot express, evoke, reveal, or represent (whatever produces the wound in the shape of the letter 'A') can, in the mind of the reader, be thought to kill him by being burned into his flesh. This is not to say that Dimmesdale does not realize that he is ashamed and is suffering. Rather, Dimmesdale's conviction that his suffering is doomed to be borne in solitude bleeds the reality from his life, drains it from the inside, and leaves him helpless to express who he is. This implies that his only reality is the one shown at the end of the book: a man dying of a wound he cannot but hide, a man whose feelings so overshadow what he can possibly put into words or symbols that the external world shrinks into unreality and his feelings acquire a sort of unimaginable hyperreality, a situation that condemns him to unutterable isolation and pain" (Kilborne, 2005, pp. 480-81).

In the plays of Sophocles in general and in the Oedipus trilogy and the Philoctetes in particular, Sophocles links the pain of toxic shame with murderous rage, defiance, and isolation. Imagine the opening of the Philoctetes. There is the hero Philoctetes isolated on an island, spurned and avoided by all because of his fetid, putrid sores oozing the most disgusting fluids. Yet he is mistrustful, defying anyone to come near him. With his pain and humiliation, he rages. I think it is impossible to emphasize too strongly the link between the pain of shame and humiliation, defiance, and murderous rage.

Like the Philoctetes and the Oedipus of Sophocles, Dimmesdale suffers from mortal wounds; all are tragic. With Philoctetes, the wound is what defines the hero right from the beginning of the play. With Oedipus, the act of blinding himself symbolizes and inflicts at the same time unimaginable wounds. With Dimmesdale, the ending of the novel intimates how vast and beyond comprehension is his mortal wound. With all three, toxic shame plays a major role in the nature and function of the wound and points to the inexorable link between shame and human tragedy.⁴

Shame is difficult to describe and identify when it is linked to an experience of human tragedy that runs counter to those representations of happiness, humor, and cheerfulness so prevalent in the media. Such culturally supported values become part of our defenses. Toxic shame, however, becomes more toxic if not recognized and can be associated with shame/rage cycles prominent in eating disorders, family violence, substance abuse and addiction, as well as in sado-masochistic pathologies. It also wreaks havoc in identity disturbances and sexual confusions because identity formation is so dependent upon an ability to work through shame dynamics.

What makes shame difficult to bear, and when it is unbearable, why is its unbearability so destructive? The meanings of the verb “to bear” can, according to the *Oxford English Dictionary*, be grouped into five categories. The first: to carry, hold or possess (the right to bear arms, designating something other than a short sleeve shirt); the second, to support, sustain or endure; the third means both to withstand and to bear a child (child-bearing); the fourth, to move onward by pressure, force or drive, and the fifth, carried or transported by (e.g., airborne). To these can be added “to bare,” meaning to uncover, expose, make manifest, reveal. In this sense, “bearing” can be the very opposite of secrecy and deceit. And being bare is the state of Adam and Eve in, for example, the Massacio painting. When Adam and Eve feel exposed, what is exposed is at once their bodies and their wishes. Prior to the temptation by the snake, they had no wishes since all their needs were gratified. And they had no consciousness of needing to hide anything at all about their bodies.

The bearing of shame in all these senses (to give birth, to tolerate, to drive, to be carried by, to expose, etc.) are hallmarks of what we can term promising, humanizing shame as opposed to toxic shame. To clarify this distinction it is useful to consider shame side by side with the concepts of trauma, of soul murder, and of body image. An oversimplified yet useful characterization of trauma is that it is composed of three parts: the traumatic event, the traumatic experience, and the response by another person to the traumatic experience. If a trauma has not been responded to and has led to an experience of soul murder, then the fear is that there is no living soul within one’s self, a fear that causes great shame. Under such circumstances, it is natural for shame to be hidden. One expects that a recognition of one’s shame will result in fragmentation and a dissolution of the self, or worse, the discovery that there is no soul, no self, within at all. This leads to a need to deceive, which itself calls for analytic scrutiny and great kindness and tact. Such patients speak of the horrifying fear that someone will see how isolated they feel, or how hollow are their desires and how empty their grandiosity at pretending what cannot be.

The trauma and shame of non-responsiveness triggers fears of isolation, neglect, and abandonment that cannot be spoken or even thought, and therefore must be thrust beyond recognition. This is toxic shame. Toxic shame is a first cousin to disgust and the objectification of others, either out of paranoid fears or narcissistic grandiosity.

Humanizing shame, by contrast, can be associated with beauty and awe; it encourages flexibility in responding to anxiety and feelings of helplessness and limitation. Humanizing shame fosters creative and sustaining object relations, contributes to consideration and sensitivity, and through a confidence in one’s own responsiveness, serves as a source of life and joie de vivre. Furthermore, humanizing shame comes with an acceptance, an awareness, and a sensitivity to one’s own body; by contrast, toxic shame comes with a negation of one’s body (i.e., disgust).⁶

Shame, Attunement, Trauma, and Development

Developmentally, shame begins at birth. Shame dynamics, like many inter- and intra-psychic dynamics, are inscribed in time; mother and infant acquire a context of experiences – experiences of past, present and future, together with what these designations mean. And these interactions will naturally be experienced differently by mother and by infant. For each, there will be individual sensations and cross-sensory perceptions and experiences. If the infant comes to be afraid of his sensations, either because he reads alarm in his mother or because he judges these feelings to be unacceptable and fears he will be unacceptable if he feels them, then experiences of such “black” feelings will themselves be laced with shame and judgment.

Moreover, relationships between mother and infant are constantly shifting,⁷ like sands in the desert, and include shame dynamics that can be either more or less bearable, depending on the interplay of fantasies and reactions both conscious and unconscious. What psychoanalysts, family therapists, and child therapists assume to be the function of sensory integration cannot be understood adequately without taking into account how shaming is the neglect or non-responsiveness of the parent, and how profound are the effects of non-responsiveness on body image; how devastating the effects of neglect on sensory integration and how shameful such devastation can be.

The trauma of neglect and non-responsiveness (as well as the trauma of physical abuse) have effects on both sensory and psychic organization, on body image and psychic structure. Over the past dozen years or so I have been forcefully reminded of the prevalence of undiagnosed postpartum depressions. When a mother is unable to respond to her newborn and withdraws into a state of depression and helplessness, an infant will tend to go into chameleon/helper mode, and thereby misrepresent his own needs to himself. Furthermore, he will come to be frightened of his own anxiety inasmuch as it reminds him of his mother's non-responsiveness. If we wonder why postpartum depressions have not been (and are not being) diagnosed, high on the list of possible causes is the shame of the mother for her own inadequacy, which is then protected by the infant and internalized as shame over unacceptable feelings. Practitioners often assume that motherly love is strong enough to conquer whatever difficulties the mother might be having with her newborn, and that in any case the infant will not be likely to suffer even if there is a depression in the mother. Here is another example of how the shame of depressed mothers can trigger fears of shame in practitioners, which then expresses itself as non-recognition of traumatic experiences.

Non-responsiveness becomes increasingly traumatic if protracted and repeated. And when such traumas (i.e., of non-responsiveness to experiences of trauma) themselves are not responded to, the result is often horrifyingly toxic shame and shame over the shame, and still more shame over the fears of isolation that continually run up against non-recognition, a form of soul murder. Also, in parents for whom toxic shame is prominent, the ability to empathize with their children is seriously impaired, leading often to narcissistic preoccupations with one's own feelings to the exclusion of one's children's. In this way, toxic shame can be passed from generation to generation, deriving from childhood experiences of negation, isolation, and soul murder. These dynamics can be seen in a wide range of pathologies from addictions to phobias and perversions.

When the infant looks into the mother's eyes, what is the mother responding or not responding to? What is she feeling? As soon as the infant can look in the direction of his mother, she fantasizes what he sees, who he is, and who he will become. The infant responds to his mother's fantasies of how she appears to him by making his response to her fantasies a part of his world with respect to which he must get his bearings. Correspondingly, the infant's struggles are picked up consciously and unconsciously by his mother, shaping the mother's fantasies about her infant and about herself as a mother.⁸

By the time the infant is four or five months old, the mother already has a history of her fantasies about how she is being looked at by her child; she already has a history of her attempts to control the ways she is being seen so as to control her own feelings toward her child and toward herself. And by this time the infant has a stake in helping his mother feel as she wants to feel in relation to him. This is the infant's way of trying to make the world a safe place.

Fortunate children come to acquire that sense of orientation and confidence in their own identity which serves to promote that humanizing shame which makes them more sensitive to those around them, more curious about the world, more sensitive to their bodies and to their physical limitations, and less fearful of their own destructive impulses.

With many, however, adolescence brings with it a determination to negate a childhood felt as impossibly weak and humiliating, and thereby to turn a traumatizing deaf ear to one's own childhood experiences. As Eliot writes in *The Mill on the Floss*, Maggie came to react to humiliation with anger and, because she is no longer a child, she can hide her tears. "There is no hopelessness so sad as that of early youth, when the soul is made up of wants, and has no long memories, no superadded life in the life of others; though we who look on think lightly of such premature despair, as if our vision of the future lightened the blind sufferer's present." But such discrepancies only add to the pain of shame in the child and to the anxieties over being unrecognizable and abandoned.

Eliot continues, "We have all of us sobbed so piteously, standing with tiny bare legs above our little socks, when we lost sight of our mother or nurse in some strange place; but we can no longer recall the poignancy of that moment and weep over it, as we do over the remembered sufferings of five or ten years ago. Every one of those keen moments has left its trace, and lives in us still, but such traces have blent themselves irrevocably with the firmer texture of our youth and manhood;

and so it comes that we can look on at the troubles of our children with a smiling disbelief in the reality of their pain" (Eliot, 1860, p. 66).

When toxic shame is unseen and neglected by analysts and therapists, such neglect can unconsciously awaken in the therapist unacknowledged shame as a response. When this happens, we as clinicians are likely to reach for an omnipotent stance as a way of keeping our own shame reactions at bay. However, such a response on our part inevitably renders the shame, anxiety, and hopelessness of our patients that much more intolerable because it was neglected – a neglect that further traumatizes patients whose shame is already toxic and destructive. This confirms the conviction of patients that they are inherently damaged and hopeless, since they have once again turned for help to those who cannot recognize their despair and shame. In this way therapists and analysts can be felt to look on the suffering of others "with smiling disbelief in the reality of their pain."

Hubris, Shame, and Trauma

Let me now comment on several features of shame and trauma. For one thing, being traumatized is by definition shameful. There is a human tendency not to want to believe one has been as deeply damaged as one has been. In fact, the ability to assess damage for what it is – neither minimizing it nor blowing it out of proportion – requires a tolerance of shame that characterizes psychic equanimity. It also requires humility.

This leads me to a second consideration: the role of omnipotence in traumatic responses and in the handling of shame dynamics. The ancient Greek term *hubris* comes to mind as fundamentally associated with grandiosity, arrogance, vanity, and shamelessness. In fact, *hubris* might be defined as a shameful disbelief in powers greater than oneself, and, consequently, as an expression of narcissistic vulnerability masquerading as power. Additionally, *hubris* can be seen as a basic obstacle to social consciousness, ethical behavior, and empathy or fellow feeling, as Adam Smith called it. These ideas are center stage in Aristotle. The greater the *hubris*, the less the capacity for empathy (for oneself as well as others) and the greater the disregard for human frailty and limitation. Such disregard is powered by shame and omnipotence in diabolical combinations.

Third, then, the greater the *hubris* the more severe is the potential for trauma. And the greater the shame over trauma. In such a case of toxic shame, shame and rage responses to fundamental challenges to omnipotence can then lead to the most destructive and murderous of shame-rage spirals, as Greek tragedies so well express.

The two forms of shame I have described, humanizing shame and toxic shame, may be related to the various dimensions of trauma: first, the traumatic event; second, the traumatic experience together with the shame of the traumatic experience; third, the response to the traumatic experience by another human being. Such shame as the response of another person to the traumatic experience (who thereby empathizes with the traumatized person) tends to detoxify shame reactions and provide resources for human connection. This is one way of characterizing the power of Greek tragedy: it portrays toxic shame so as to elicit those responses that detoxify it through the humanizing processes in the viewer of shame, vulnerability, and human limitation.

When shame is toxic, the feelings of worthlessness and helplessness can be so painful that one's inability to respond, together with one's expectation that there is nobody else who can respond to these feelings, can lead to defensive self-centeredness; there being nobody else from whom to get one's bearings, one becomes reduced to no more than oneself, like Narcissus. Consequently, narcissistic grandiosity and the impenetrable quality of narcissistic preoccupations – so often the source of intractable clinical difficulties – can be seen as defensive reactions to experiences of the most excruciating isolation and fears of abandonment. When we as analysts feel narcissistically wounded by the truculent neglect or indifference of our patients, when we feel shut out, diminished, and discounted, it is useful to bear in mind the possibility that toxic shame is at work, and that beneath the surface are patients suffering in ways they cannot begin to imagine.

Concluding Remarks

What then stands out about shame? It has been seriously neglected as an emotion and as a set of judgments about emotions, although it is essentially important in all clinical situations. As a set of shame dynamics, shame pervades all treatments and is often the unacknowledged cause of anxiety. In its toxic forms, it leads to serious distress and despair both in patients and in therapists; it can be passed down from generation to generation in the form of narcissistic preoccupations that negate the feelings of connection in children; it can be related to trauma not responded to and to intolerable feelings of rage, mistrust, and isolation. By contrast, in its humanizing forms, shame can be one of the most powerful therapeutic resources we have; it can be used as an essential antidote to sado-masochistic self-condemnations, panic and anxiety states, and paranoid fears. Humanizing shame can provide vast wellsprings of humility, gratitude, joie de vivre and an ability to bear human tragedy as an expression of identity and of essential satisfactions in human bonds.

References

- Eliot, G. (1860, 1996). *The mill on the floss*. Oxford: Oxford University Press.
Hawthorne, N. (1850, 1953). *The scarlet letter*. Oxford: Oxford University Press.
Kilborne, B. (2002). *Disappearing persons: Shame and appearance*. Albany, NY: SUNY Press.
— (2004). Superego dilemmas. *Psychoanalytic Dialogues*, 24(2).
— (2005). Shame conflicts and tragedy in *The Scarlet Letter*. *Journal of the American Psychoanalytic Association*.
— (2006). La honte et l'angoisse. *Le Coq-Heron*. No. 184.
— Tragic doubleness (manuscript).
Nussbaum, M. (2004). *Hiding from humanity: Shame, disgust and the law*. Princeton, NJ: Princeton University Press, 2004.
Wurmser, L. (2000). *The power of the inner judge*. Northvale, NJ: Aronson, 2000



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Footnotes

1. One of the distinctions between shame and guilt has to do with the threat to internal orientation. Shame poses a far greater threat to orientation than does guilt, which can actually serve to orient. With guilt, there is a sense of who is doing what to whom; one feels guilty for having done something to someone. By contrast, shame draws more directly on the wellspring of human helplessness; consequently, shame is characterized by an inability to locate "the enemy" except as a sense of defectiveness of the self or in the form of splitting (Kilborne, 2004, p. 179).
2. On the subject of doubleness and its pertinence for an understanding of the links between shame and identity confusion, see Kilborne, Tragic Doubleness (manuscript).
3. The less conscious we are of the shame dynamics in ourselves, the less stable will be our sense of identity and the more we will tend to rely on omnipotent defenses and superego smugness.
4. It is ironic that Freud's "talking cure" left out shame dynamics because they are so very difficult to verbalize, thereby making what is more easily verbalized the readier subject of psychoanalytic investigations and attention.
5. The subject of shame and trauma has also been seriously neglected. Recent issues of the major psychoanalytic journals [e.g., JAPA 51(2), 2003; IJP 88(2), 2007] contain no discussion of shame. Kathleen Kilborne and I are at work on a book on the subject.