Beyond the Pale: Shame and the Shameless Object.


Introduction

The Kite Runner is the story of a boy’s failure to live up to the ideal of manliness set by his father. Unable to bear the shame of failure to save his friend (and, it turns out, brother) from violent rape he arranges for the boy to be banished, ridding himself of the sight of the object whose presence shames him. (Of course there is also the element of his unconscious guilt at wishing this on his rival).

Reservoirs of unmanageable shame and its agent provocateur, humiliation drive people to dangerously irrationality. In his recent book Max Hastings describes how General McArthur, having been shamefully defeated in the Philippines, wasted valuable resources and lives in his determination to re-invade the islands despite the fact that by 1994 Japanese occupation of the islands was not a serious strategic threat. McArthur’s forceful and omnipotently bombastic nature stopped him thinking clearly while he tried to abolish his sense of shame.

Over 400 years ago Robert Burton wrote his extraordinary study of depression, The Anatomy of Melancholy.

Shame and disgrace cause most violent passions and bitter pangs.... Generous minds are often moved with shame, to despair for some public disgrace. And he...that subjects himself to fear, grief, ambition, shame, is not happy, but altogether miserable, tortured with continual labour, care, and misery. It is as forcible a batterer as any of the rest: Many men neglect the tumults of the world, and care not for glory, and yet they are afraid of infamy, repulse, disgrace............ they are quite battered and broken, with reproach and obloquy.........and are so dejected many times for some public injury, disgrace, as a box on the ear by their inferior, to be overcome of their adversary, foiled in the field, to be out in a speech, some foul fact committed or disclosed, &c. that they dare not come abroad all their lives after, but melancholise in corners, and keep in holes.”

Shame-driven depression

Miss R was 23 years old, hardly able to work, chronically depressed with bouts of hospitalization. I saw her for a consultation. She arrived looking depressed, flat and passive. She announced that she wanted to be dead, but that would be ‘difficult for her family’. She told me her story in a flat, affect-less way. I felt bored and irritated. I found myself unable to think of anything useful to say, - ashamed of my growing sense of incompetence and guilty over my aggressive irritation. I wondered about the shadow of shame and guilt she was projecting into me. She assured me of her perfectly ordinary childhood. I said it depended on what one regarded as ordinary. She opened up a bit and began to intersperse her story with assertions that she felt ‘wrong’. She asserted ‘I must be wrong’; ‘I am wrong’; ‘I’m in the wrong place’; ‘I have no business being here with you’; ‘It’s not my place to say anything’; ‘I have always thought there’s something wrong with me’; ‘I have a genetic flaw’. I began to think that each time she thought of something authentic to say about herself she seemed to face shaming disapproval and defensive hostility which she could direct nowhere but at herself.
She had put herself beyond the pale of ordinary humanity. Others had the right to seek help but not her. She said that ‘born wrong’ she had managed to keep this idea at bay by hard studying. She had been very successful as a student but later was overtaken by the idea that she had no place. I thought of her as wandering, exiled and homeless. The only place she had felt ‘right’ or ‘at home’ was in hospital where she had felt cared for. She added, disapprovingly, that she shouldn’t have been in hospital as there was nothing wrong with her, she was just attention seeking. I thought of her as needing care and attention but cruelly regarding this as utterly shameful. Oddly, she described her father as ‘honourable’, - a respected pillar of the community.

I challenged her bland version of her childhood and she became aggressive but this at least was lively. She said she hated her father during her early adolescence because he had been so passive. He had not helped her deal with her mum who was quite disturbed, always shrieking in a loud voice or worrying about everything. She said she had always hidden her emotions because she thought mum could not cope. She added that she was ‘wrong to think all this’. In her early teens her GP had wanted a psychiatric assessment but mum would not allow it. I suggested a fear of something being exposed. At fifteen she had become dangerously anorexic and been hospitalised. Mum did not want anyone to know she was ill and told her to keep quiet about it, including not telling grandparents. Her parents visited her once but did not mention the fact that she was in hospital.

I suggested that she and the family seemed plagued by shame. She talked about her parents’ spectacular rows and her mother’s extra-marital affairs, the longest being with the vicar, which had been an open, shameful secret, never to be spoken about. She told me she was bisexual. Her shame about her body, her sexuality and confused sexual identity seemed to have been reinforced by her mother’s lack of containment and intrusive denigration of sexuality. I said that I wondered if feelings of shame had led to her feeling she was a ‘wrongun’. She said there was something, but she could not tell me what it was. I suggested another shameful secret and she said she could not tell me ‘because you would have to tell the authorities’. She soon told me her mother had sexually abused her for as long as she could remember until her early teens (in fact when her periods started). She then immediately defended her mother as ‘not knowing what she was doing’, saying that she was ‘wrong to talk about it’... that it was ‘nothing’. She had told no-one of this before, in spite of several encounters with psychiatric services. I thought of how chronic shame and guilt intertwined inside her mind to act as a double-dose of persecution. I think the idea of the ‘authorities’ was to do with her fearing bringing unbearable shame down on herself and an ‘honourable’ family. She was protecting an idealised ‘right’ family by thinking of herself as ‘wrong’.

**Shame and Guilt differentiated**

Shame and guilt are found together, but are different experiences. Mostly we live in our minds, and our body is in the background. Acute shame is a primitive neuro-biological response that catapults us back into our body. If the ego is first a body-ego, we are shot right back into it. We lose our minds. Only when we recover from the shock does fantasy and thinking re-emerge. Shame arises out of a sense that we are no longer seen as we would like to be seen by
the other. It results from the failure to live up to an ego-ideal and induces self-
reflection, an expectation of shunning and a wish to disappear. Guilt is a more
developed mental affair and arises out of a sense that we have attacked and
damaged the other, whose retribution we may expect and fear. It results from a
transgression of a superego limit and induces reparation, an expectation of
punishment or an urge to deny.

**Traumatic and Pathological Shame**

Extreme shame creates a shocked state of mind in which the internalised,
approving other has left the scene making one absolutely alone and utterly
helpless. Acute shame emerges out of a sudden confrontation with reality: We
are who we actually are and not who we would like to be. The wish to hide from
the searing gaze of the other indicates an unconscious wish to annihilate the
seeing, shaming other, which paradoxically re-enforces a sense of abandonment.
A solution is to conjure up an idealised unconditionally approving object. A total,
melancholic identification with the shunning object may lead to suicide.

One person’s embarrassment is another person’s catastrophic, shame,
depending on how each has internalized either a reasonably facilitating positive
environment or its negative opposite. One person may find an exposing situation
painful and will soon recover from disconcerting embarrassment, the capacity to
think is only temporarily suspended. If a negative observation is valid the shame
may be an impetus for development. Another more fragile person may feel this as
too shameful and will struggle to make use of the experience. Someone burdened
by a reservoir of unmanageable shame-affect will experience any slight or
disappointment as a trauma because it will activate unconscious layers of other
past traumas. Some individuals are in a permanent state of shame so chronic that
their ability to think is severely and permanently restricted.

Shame, and its malignant derivative, pathological shame, has been almost
ignored by psychoanalysis and it still goes missing. For example, the recent,
admirable psychoanalytic book ‘Murder’, does not mention shame as a
precipitating cause.

Judeo-Christian culture emphasizes guilt, particularly the inherited guilt of
Adam’s sin of defiance of God in eating of the tree of knowledge and the collective
guilt for the crucifixion of Christ. Perhaps the classical analytic method of patient
on couch means that the usual bodily signals of shame go unnoticed. Self-analysis
as practised by Freud was unlikely to be conducive to the discovery of unconscious
shame because it is induced by the presence of the seeing other. Also, the
immediate post-Freudian inheritance established superego guilt and its vicissitudes
as the predominant dogma of psychoanalysis.

An aspect of the Genesis story is that eating of the tree of knowledge
means self-consciousness and inevitable shame:

7: And the eyes of them both were opened, and they knew that they were naked; and they
sewed fig leaves together, and made themselves aprons. 8: And they heard the voice of
the LORD God walking in the garden in the cool of the day: and Adam and his wife hid
themselves from the presence of the LORD God amongst the trees of the garden.

Hidden within the story Oedipus and his guilt there is a tale of pathological
shame. The guilt of Oedipus, as Steiner says, (1985) is glaring. But, Oedipus is ill-
equipped, because of a reservoir of tyrannical shame, to manage the threat to his narcissism at the crossroads. The wound of his abandonment is re-opened. The shame of his smallness, failure and rejection provokes murderous rage so that he annihilates the shaming object. He bypasses the complex to which Freud allotted his name. The shame of Oedipus, as depicted in the Theban trilogy is present in the text. The stories the Greeks told were concerned with pride and the pitfalls of excessive pride, hubris, shameful excess - the assumption of God-like behaviour. The punishable crime of Oedipus’ father Laius was the abduction and rape of his friend’s son. The homosexuality was not the crime but only a god might abduct and rape. Recent translations of Sophocles have returned to the original Greek and away from the earlier Christian/guilt based view of the myth. There are many references, direct and indirect to shame and far fewer to guilt in the original Greek. For example, Tiresius says to Oedipus

I say that with those you love best you live in foulest shame unconsciously.

Oedipus is pursued by the shameful fraudulence of his claim to his father’s throne. When blind Tiresius ‘sees’ that Oedipus should look to himself, Oedipus threatens to kill him. Oedipus’ self-blinding (and eventual third exile) represents the infantile fantasy of ‘if I cover my eyes then I cannot be seen and my shame will be invisible’. In the final part of the trilogy of plays Oedipus, as (John Steiner says), omnipotently evades the truth. God-like he disappears into the ground. This is a shame-defence made actual: ‘I wish I could sink into the earth’. Merging with the primal mother earth wipes out all shame. Oedipus avoids exposure of his shameful self-knowledge and his Oedipal guilt. From this viewpoint Oedipus is not neurotic, - but subject to chronic shame, lying and murderous road rage, he has a personality disorder.

**Freud and Shame**

What does Freud say about shame? Well, actually a surprising amount. References to it are dotted around his writing but he made no systematic study of it. He has two differing attitudes to it. The familiar one is the idea of shame as a defence against sexual exhibitionism,

a dam against sexual excess (1905, p. 191).

There are many instances where Freud refers indirectly or directly to shame as a driver of defences and repression. Early on, in a letter to letter to Fleiss Freud explained the symptoms of a ‘25-year-old fellow who can scarcely walk’ as driven by shame. Also, Freud talked of shame driving repression and intriguingly (to my mind) links shame with trauma:

In traumatic neuroses the operative cause of the illness is not the trifling physical injury but the affect of fright—the psychical trauma. In an analogous manner, our investigations reveal, for many, if not for most, hysterical symptoms, precipitating causes which can only be described as psychical traumas. Any experience which calls up distressing affects—such as those of fright, anxiety, shame or physical pain—may operate as a trauma of this kind; (1893: 6).

Later Freud returned to this idea of traumatic neurosis with idea of symptoms that
were ‘beyond the pleasure principal’ in that aspects of the personality might be organised to deal with unmanageable psychic impingement. He sometimes refers to shame as being connected with feelings of inferiority, particularly in his (heavily criticised), idea of shame as a particularly feminine characteristic; a defence against ‘genital deficiency’. Freud's describes the Wolf Man's aggressive fantasies as an active compensation for his unconscious feeling of passive helplessness. Here shame is being dealt with as if it were an affective state, (rather than a defence), connected with an awareness of trauma, vulnerability and helplessness, in which the self-image of the subject is threatened. Primary shame due to inferiority gives rise to secondary, defensive, object-directed aggression which causes an overlay of guilt. Freud discusses the two mental states of inferiority and guilt. He says

Little attention has been given in psycho-analysis to the question of the delimitation of the two concepts” (In his lecture 'Dissection of the Personality' (1933 [1932]) p.66).

Feelings of inferiority and shame go together. Freud connects the sense of inferiority with a perceived lack of love, and is thinking of feelings of inferiority as being an emotional response rather than a defence:

A child feels inferior if he notices that he is not loved, and so does an adult (1933[1932] p.65).

Withdrawal of approval provokes a sense of failure and inferiority and narcissistic tension. The positive ego-ideal is the internalised version of the aspirational goal held up by the admiring, loving parent. It is the agency against which the individual evaluates his achievements and replaces the grandiose self-love of infancy and is essential for forward development. The parent keeps an eye on the child and the child internalises that watching eye. The child looks out for the approving or disapproving gaze of that watching eye.

**Shame in Development**

In 1950 Erikson incorporated shame into the Structural theory as being, like guilt, a part of conscience. Conscience had been regarded as arising, like guilt, at the oedipal stage when the child attempts to master the sense of helplessness caused by castration anxiety, by identifying with an internalised parental aggressor. Erikson separates shame from guilt by proposing that shame arises before the classical Oedipus complex, out of the conflicts of the stage of 'Shame versus Doubt and Autonomy' in which the child attempts to master feelings of helplessness. So, in ordering itself about, for example, the pre-oedipal child masters passivity by identifying with the 'aggressor' parental figure. This internalised relationship later merging with, and affecting the developing superego. Erikson's thinking on shame seems to have had little influence on orthodox psychoanalytic thinking.

Around the time that Erikson was writing ‘Childhood and Society’, Sartre wrote 'Being and Nothingness'. He elaborates the idea that shame is what makes us aware of the existence of the other, is essential for our self-awareness and makes us human. We inevitably hide our nature from ourselves and will inevitably feel shame when we feel ourselves to be observed.
It is shame or pride which reveals to me the Other’s look and myself at the end of that look. It is the shame or pride which makes me live, not know the situation of being looked at.

Lacan famously elaborated Sartre’s image of the voyeur at the keyhole with his thoughts on the ‘mirror stage’ of self-consciousness. Sartre and Lacan understood that to be is to be ashamed.

The entire phenomenology of shame, of modesty, of prestige, of the specific fear engendered by the gaze, is quite admirably described there…it is essential reading for an analyst’ (Lacan, [1954] 1998: 215).

For Lacan shame is a signal anxiety that arises in the mirror stage when the infant’s narcissistic equilibrium is disturbed by the recognition of his own image as ‘other’. This contributes to the formation of the ego-ideal and marks the beginning of inevitable alienation. The mirror-stage begins a dialectic between a subjective self prone to the double gaze of the other and the objectified self. For about 30 years after Erikson and Sartre very little was said about shame in the psycho-analytic literature. While it was discussed regularly by sociologists, anthropologists and counsellors it wandered about homeless on the fringes of psychoanalysis.

**Recent Psychoanalytic Ideas**

In the 1980’s Kinston published a trio of papers on narcissism including one about shame which laid out the idea of pathological shame as a problem of disturbed narcissism. Kinston and Chasseguet-Smirgel describe shame reactions and consequent defences as passive-into-active repetition of trauma caused by the impingement of narcissistically disturbed parenting upon the relatively helpless and immature infant psyche. Placating and the formation of a temporary or permanent false-self structure are an ‘identification with the aggressor’: The negatively regarding parent becomes embedded in the child’s psyche. Shame indicates the activation of an unconscious negative self-image. In certain patients shame is so chronic and disturbing that they must move from a state of painful scrutiny into a merged state. The observer and the shame are thereby abolished but at the cost of loss of autonomy. A move to merge with the analyst may indicate the threat of unconscious shame. A permanent move into a merged state allows the patient to be shameless. Feelings of shame (or more accurately the too painful unconscious fantasies associated with it) are refused conscious access. The patient then feels ‘in control’ of his potentially shaming analyst but at the cost of loss of meaningful relations, leading to despair and emptiness. This defensive state is unstable because split-off, negative self-images permanently threaten the patient’s equilibrium. I find it useful to think of this as part of the core-complex. It is as if the patient is saying ‘if you see me as I truly am you would reject me, therefore I must merge with you but then I lose my autonomy and so must flee, but then I am abandoned’. This casts light on the difficult behaviour of personality and borderline disorders. Defensive manoeuvres against unmanageable shame are aimed at the removal of the self from the presence of the shaming object, - in extremis via suicide or murder. Manoeuvres
may be temporary or may lead to character pathology. They serve the purpose of subverting, replacing or annihilating the presence of the seeing other and include deadness, idealization, hiding, camouflage, trance-like states, lying, perversion, seduction and false-self character formation.

Individuals with problems caused by the presence of shame-ridden negative self-images feel a continual sense of helplessness and will experience the analyst’s interpretations as diminishing 'attacks'. This can cause shame-guilt cycles in which the patient tries to move from a passive, helpless, state of 'being done to', in which ongoing narcissistic equilibrium is disturbed, into an active, aggressive state of 'doing'. The classical view of these cycles is that they arise from an instinctual aggressive impulse, which creates guilt, inferiority, acting out and further guilt. If primary shame is seen as a driver of defensive aggression, secondary guilt is then the result of the seeing object being attacked. Paranoid anxiety leads to further helplessness and negativity, leading to more shame and so-on leading to paralysing guilt/shame cycles. A shame-guilt cycle may be perpetuated in a repetition-compulsion in the transference and counter-transference. Shame remains unmanageable and guilt unreachable. As Mollon says:

A therapeutic stance that is oblivious to the pervasive role of shame in narcissistically disturbed patients may tend to provoke a sado-masochistic relationship and therapeutic stalemate in which the patient is constantly struggling to master narcissistic injuries unknowingly inflicted by the therapist. (1984, p.213)

**Fairbairn, the ‘Moral Defence’ and the Good/Bad split**

Fairbairn’s explanation for depressive guilt (as distinct from ordinary guilt) is that it is a survival technique: The child identifies with bad objects but represses them leaving him at the mercy of a band of internal fifth columnists or persecutors, against which defences have to be, first hastily erected, and later laboriously consolidated.

This system is unstable. If the 5th columnists re-emerge the child strikes a contract, the Moral Defence by saying: 'OK, so as to maintain approval by the good object I conditionally agree to regard myself as bad'

It is that it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil.

This concerns the ‘good/bad’ dichotomy of guilt in which the good hides the bad and the bad hides the good.

**The Right/Wrong Split**

I think that without the idea of a right/wrong split an understanding of our patients is seriously impeded. Shame is part of a right/wrong dichotomy. Constant or repetitive negative regard by a caretaker imparts an ever-increasing sense of failure, inadequacy and shame which is internalised by the infant. If
neurotic defences against the resulting persecution fail, a contract parallel to the one described by Fairbairn is struck: “So as to maintain your rightness I agree to the condition that I regard myself as wrong’. Klein’s idea of splitting suggests that when the unstable ‘moral defence’ breaks down, the underlying situation of ‘I am absolutely, shamelessly right’ and ‘You are absolutely, shamefully wrong’ breaks out and hopeless fundamentalism rules. During analysis this may be projected into the analyst who will doubt his confidence and even at times doubt the idea of psychoanalysis. The patient will then accuse the analyst of being a fraud.

**Neuroscience**

Work in neuroscience and infant observation suggests that the somatic response underlying psychic shame is there from birth as part of a repertoire of innate responses. (see Tomkins, 1963, Demos and Tomkins 1995, Nathanson 1992, and Schore 1999). Very young infants will turn their head down and away from stimuli. This ‘proto-shame’ reaction may serve the survival aim of switching off attention so that the infant does not become stuck on a stimulus, inhibiting its development and ultimately its survival. The idea (not analytic but remarkably like the pleasure/un-pleasure principle) says that a certain level of stimulation switches on the aversion reaction. This proto-shame is at first an entirely automatic neurological thing without emotional or symbolic content. As the brain develops, this automatic response accrues emotional content as do all other innate responses. Any failure provokes this aversion response and of course failures are inevitable and this becomes the location for shame affect.

Awareness of failure and success is built into the brain. The primitive brain monitors the activity of the higher part. When a baby randomly throws its arms about or moves its eyes around (evolution has told it to do so) it will alight on an object, touching or focussing. The primitive part of the brain registers success and ‘remembers’ the synaptic chain of command. Unsuccessful synaptic pathways fall out of use. Again this is rather like the pleasure/unpleasure principal. This basic system extends to mental focussing as thinking develops. The infant reaches out for milk, soothing touches and soft words and registers its ability to find these as success. If these efforts are repeatedly thwarted or negated then the child registers persistent failure and turns away from the experience accumulating a reservoir of latent, persecutory shame.

**The Shameless Object**

I want to use material from the analysis of a patient to illustrate the presence in the unconscious of the ‘shameless object.’ The patient had internalized this object as a result of relentless negativity from a shameless parental object that the patient felt powerless to change. The patient projected that object into me, regarding me as that object. This object is a fundamentalist object, absolutely free of any shameful doubt about itself.

Mrs Y came to analysis because she ‘felt like shit’. Her difficult and relentlessly aggressive mistrust made the analytic work gruelling. She was the kind of patient who would attract the label of borderline personality disorder. She was uncomfortable in her own skin. She described a severely hypochondriachal,
un-containing, self-centred mother who had always countered Ms Y’s childhood needs with an expression of her own neediness. The patient’s relentless contempt for her parents and her husband struck me from the start as rather shameless. The families on both sides were from backgrounds dominated by the shame of intergenerational poverty, alcoholism and physical and sexual abuse. Sexuality was shameful and sex, according to the patient’s mother, was a dirty, unpleasant duty. The patient grew up in an atmosphere that she experienced as extremely negative. Worse than uncontained, she felt as a child, and now as an adult, relentlessly projected into by both parents. She felt constantly undermined and criticized by a father whom she described as if he were besieged by envy. He rubbished everything and everyone, including any of the patient’s interests and potential childhood friends. He would tell her ‘what’s the point in taking an interest in that shit’. He wanted her to go to Oxford university not a ‘shit’ one. Mrs Y said that absolutely the worst thing was the way that her mother, while dramatically wallowing in self-blame, took no real responsibility for anything.

Her sexual development went awry making it very difficult for her to manage the oedipal situation. She hated men because ‘they can get away with anything’. Perhaps in identification with her mother she recalled no sexual feelings until well after her late teens. Her first period, for which she was unprepared, was traumatic as she was shocked by the reality that she was female.

Underneath her harsh, exterior there seemed to be a little girl who longed to be cherished. She had kept this true self safe by saying ‘OK, I am wrong and bad’. She was persecuted by a view of herself as wrong, born wrong, useless, hopeless, filthy and deadly. She imagined that I thought of her in this way. She told me in our fist meeting that she saw herself as deadly. Just as with her mother, guilt caused by her defensive hostility could only be counterfeited in a placatory way. A negative ego-ideal, domineering shame, defensive destructive rage and consequent potential guilt had contributed to a terrible superego.

In the early stages of the analysis the patient relentlessly complained about her situation and the lack of understanding shown her. Suddenly she would apologise. I would be relieved but nothing changed. I began to think of this as the same as her mother’s pseudo-guilt, designed to ward off rejection and shame about her dramatic moaning, (which at times had an excited, sado-masochistic quality). The patient created a counter-transference trap. She would relentlessly rubbish me, inviting me to retaliate, switch off or avoid trouble by being nice to her. All this would make me feel incompetent and ashamed. I then had a choice: I could either deal with my shame by trying to make myself more like the analyst I thought I ought to be, or repress the shame. Or, I might temporarily succumb to cruel, critical impulses in order to relocate this shame in her. This would make me feel further shame and the guilt that was utterly beyond her reach.

An analytic session:

Mrs Y berated me relentlessly for about twenty minutes, telling me in an increasingly excited way: ‘You are useless, I don’t, and can’t trust you, you have not said anything useful for months, when you do speak all you tell me is that I am rubbish and shit. You pay no attention to how difficult my life is. When you do say something it is based on some stupid analytic theory. I may as well end the analysis.’
She fell silent and I thought she was waiting to see what I would do. I asked what did she now imagine I might feel or think? She replied ‘I don’t think you feel anything, I think you are thinking you want to get rid of me’. I asked her why I would want to do this and she replied ‘because I am useless, I can’t do this.. I am a failure’. She began again to launched herself into her complaint. This time it lacked the force of the previous attack. She began to sound doubtful in contrast to her previous doubt-free, fundamentalist position. She ran out of steam and I asked her why if I wanted to get rid of her, I wouldn’t tell her so, but would instead carry on putting up with her. She replied ‘because I don’t think you work that way. You would continue to make things so awful for me that I would eventually just go’. She began to work herself up again but seemed to realize that she might go too far. Perhaps needing to reassure me, she said that if she were discussing herself as a case with someone else, then that person might say to her ‘don’t worry, she is just being difficult, awful and foul, you’ve just got to wait’. I chuckled at this and she laughed in response. The she reprimanded me by saying ‘I don’t know why you are laughing. You don’t ever seem to think I think about anything’. I said that I thought she knew that my chuckle had been affectionate and that I thought that this was more frightening for her than the usual complaint. She patient said ‘Well, it means I can’t be as angry as I was which is a relief, really’. She began to sob. Then she said ‘but it doesn’t sort anything out’. I told her that I thought she was right, that it did not sort out what went on when she got herself into a state of mind where she rubbished both herself and me in a relentless way. She took this up by saying ‘Well, I hear that as you saying to me that it’s never your fault, it’s never down to anything to do with you’, and as you telling me that it’s all due to my internal state — or some such theoretical crap. I’m just not a suitable patient for this kind of work. I can’t see any way forward’.

I said ‘um’. The patient said ‘saying “um” is cheating. It is like you are saying “come on, you can’t carry on being that horrible.”’ She was now was much calmer than she had been. She continued: ‘I always end up feeling in the wrong and then I can’t think. I just feel you think everything is my fault all the time’. I said: ‘I think you are seeing me as utterly self-righteous, as never admitting that anything is ever my fault’. The patient then said, thoughtfully, ‘Like my mother not taking responsibility for anything’, I said ‘Yes, “mea-culpa” but shameless, no real responsibility’. The patient took this up by saying ‘Yes, and I get furious and then I flip and become just like her. Not responsible for anything, utterly self-righteous. It’s not so easy to just leave now. I do wonder why I am so furious when the things you said that made me furious were about two years ago and you might actually change your mind. When I get furious I forget that I think you might be able to change your mind’.

Mrs. Y was determined to see me as the utterly shameless, fundamentalist object. When we chuckled together she rightly pointed out that this in no way let me off the hook. As a shameless object, if I did not accept my shame then I could not change. It was no good me just cheering us both up! From the patient’s point of view, if I could accept my shame then I could become a better analyst.
Manic Depression

For patients who are prone to shame and doubt the trigger, the agent provocateur of unmanageable shame is humiliation. This may be caused by a chance remark made by another, self-doubt sparked off by something heard or read, a compliment expected but not paid, a physical illness or injury - anything that casts doubt upon the state of shameless omnipotence. A slight that others would ignore or accommodate creates catastrophic trauma due to the eruption of doubt and shame, overwhelming a structure based on fragile omnipotence. Once the defensive wall is breached doubt and shame pour in as self-esteem collapses. The only way out is for the subject to flee, which creates unbearable loneliness, or to attack the shaming object, which creates potential guilt. Both are too painful and so the person reconstructs, out of the fragments of the disaster, a collage or picture of the self as perfect, approved of by a corresponding picture of an ideal maternal object. The reservoir of self-esteem is artificially re-filled again. Shame is once again abolished but the subject knows that the reconstructed version is only a picture, a fraud, and so doubt nags away. Eventually the defensive wall is once more breached and unbearable shame doubt threatens. These are the dynamics of manic-depression. (I have detailed elsewhere the way that manic defences against shame may be employed by a patient - Archer 2002).

Melanie Klein

There is no mention of shame in Klein’s works. In 2006 John Steiner addressed the issue of the neglect of shame in the Kleinian oevre when he said:

Guilt has been given much attention in relation to Klein's formulations around the depressive position (Klein, 1935, 1940; Steiner, 1992, 1993), but the role of shame in relation to the observing object has not been widely noted.

Because shame plays a neglected part in the analysis of hostile, difficult patients it is useful to revisit a well-known paper. In her paper ‘A Contribution to the Psychogenesis of Manic-depressive States’ ([1935] 1975) Klein comments on a sense of doubt linked to feelings of unworthiness (p. 270). Due to splitting there is, within the infant’s mind, alongside the attacked and damaged maternal object, a compensatory ‘beautiful picture’ (p. 270) of the mother. The child knows this is only a picture. The actual mother is experienced as dangerous, damaged or damaging. The infant doubts his capacity to repair and restore the object damaged by his attacks. Anxieties created by this doubt are defended against by means of manic omnipotence which assures control and mastery of the dangerous doubt and dangerous objects. By using the beautiful picture of the idealized, intact mother as a replacement for the anxiety-inducing, attacked and damaged object, the infant becomes at one with the beautiful object. For some patients trauma is the sudden collapse of this beautiful, shameless object which disappears and is replaced by an intense, shaming helplessness.

I think there are references to shame in the Kleinian tradition. I think of Klein’s idea of early, persecutory guilt as being constitutional/biological shame. Just as in everyday speech shame and guilt are confused, the same thing may happen in psychoanalysis. Mrs Y was, like the patients described by Riviere,
hypersensitive to any hint of criticism, which would make her feel both triumphant and frightened. If she imagined that I had given into sadistic impulses she could imagine she had levelled the playing field. If she could project her shame into me, she would no longer have to envy what she perceived as my relative freedom from shame. Riviere's (1936) paper links ‘Negative Therapeutic Reaction’ with the failure to resolve deep, unconscious persecutory guilt. Riviere refers to Freud’s *The Ego and the Id* in which he says that

‘certain people cannot endure any praise or appreciation of progress in the treatment’ (Freud, 1923: 49).

Praise activates shame because the subject experiences a discrepancy between the praise and the shameful, hidden belief that he or she is unworthy. Riviere says the

‘carefully selected and arranged material, calculated to deceive the analyst as to its “free” quality’ (p. 306)

is designed by such patients, only to show ‘nothing but good of themselves’. Shame-persecuted patients do not see the scrutinizing gaze of the therapist as positive or even neutral. Plagued by hidden, doubting mistrust of the self and the object, the patient has constructed a counterfeit, alternative self. The idea of the presence of shame helps make sense of this. The analyst is viewed with cynical suspicion because the patient creates, via the projection of this counterfeit system of thought, an untrustworthy, fake, counterfeit analyst. Under the pressure of projective identification the analyst will feel angry, useless, incompetent and ashamed.

Riviere points to the idea of the mask of omnipotence which, when removed, reveals the true underlying state of the patient. She attributes this state to unresolved persecutory guilt and the associated manic defences against it. Riviere says these patients are highly sensitive to

any admission of failings in themselves’ (p. 309) and to the faintest breath of criticism (p. 314)

But the mask may be concealing shameful, as much as guilt-ridden aspects of the self. Hiding, omnipotent control and acute sensitivity are always an indication of the presence of unbearable shame. The manic defences and the mask are used to control the analyst who is seen as threatening. Riviere says that such patients are

Highly sensitive and easily mortified’

But, mortification is a state of mind that is, par-excellence, associated with shame. In fact the word is defined as *a feeling of shame, humiliation, or wounded pride*. Wisely Riviere advised against going head-on at the aggression of such patients. This avoids the creation of shame-guilt cycles.

Patients not driven by unconscious, pathological shame understand that while they may wish to be liked, they come for analysis in order to be understood. Shame driven patients come to analysis demanding the blissful glow of
unconditional approval by an idealized object whose existence, paradoxically, they profoundly doubt. For these patients to be scrutinised is to be stripped naked, seen and shunned.

It has been my experience that shame, and defences against, it are the primary driver of personality disorders with guilt, due to defensive attacks upon a threatening object (distorted by projection) as secondary. The shame needs to be recognised and understood before the guilt can be worked through.

**Group Phenomena**

In society, group phenomena make chronic defences against shame, such as self-righteous fundamentalism very dangerous. In my home city of York there occurred in 1611 one of the most horrific anti-Semitic incidents in English history. At Cliffords Tower some 150 Jews, fleeing from a mob were burned to death. In 1942 Hitler projected all his own unmanageable shame into the Jews and other groups. While he raged to avert his own chronic shame he was able to mobilise the shame-driven violence of the mob. History has concentrated on ‘German Guilt’ but paid scarce attention to the insidious shame of one utterly failed individual who was able to mobilise the latent shame of a population, leading to the most terrible atrocities the world has ever seen. Auschwitz did not begin ‘out there’. Such things begin at home within a matrix of paranoid-schizoid family functioning in which children are treated with hostile and sometimes sadistic negativity which may be concealed behind a mask of pseudo-decency. This is brilliantly portrayed in Michael Haneke’s 2009 film about pre-Nazi Germany, ‘The White Ribbon’.

To be human is to be ashamed. Ordinary shame is essential to our sense of humanity and our ability to empathise with others. Within the family unmanageable shame may hide behind a mask of decency and respectability while it is secretly and relentlessly projected outward into the world and into one generation after another.

Societies and nations habitually project shame into each other while maintaining a sense of the absolute rightness of their position. Shame makes us susceptible to gratifying, sadistic superiority and contempt. This can be so subtle so that it may go unnoticed in a turn of phrase. The Psychoanalysis is not immune. We need to continually attend to the way we deal with our internal ‘ethnic’ groups and categories and to our relations with the rest of the psychotherapy world if we are to avoid justifying charges of superiority and infantilising. We are no different from any other group in that it is human to be susceptible to the pressure to project our own shame outwards.

That which we put beyond the pale is always an aspect of ourselves.


Freud S (1918) *From the History of an Infantile Neurosis*. S.E.17.


