TRANSFORMING SHAME: TAMING THE INTOLERABLE

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Abstract

Shame is a social emotion that plays an important role in how we learn to function in groups. In traumatic doses, however, it can become a toxic introject that disrupts going-on-being and damages self-esteem. While often triggered by a social faux pas, the subjective experience of shame is the felt sense of exposure of the defectiveness of one's self and thus is associated with rejection for being unworthy of love. Shame can be debilitating, and because of the fierce avoidant defenses that develop to protect against future occurrences of shame, it is difficult to transform the prominent role it can play in one's psyche. This paper explores the nature of shame, including what activates it and the unconscious dangers associated with it. Also addressed are the relational factors that are necessary to help "tame" one's shame, thereby lessening the need for defenses that inhibit vulnerability, restrict degrees of freedom and diminish one's vitality.

Shame: A Personal Story

I am the son of a holocaust survivor. My mother's fear of death and loss drove her consuming preoccupation with health and security, and her fear of shame and judgment fueled her near phobic avoidance of exposure. She was a loving and devoted parent, but her fears led her to regularly and unselfconsciously interrupt my **going-on-being**, to use Donald Winnicott's term. Her fears not only obscured her view of me but made it

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nearly impossible for her to moderate her relentless, intrusive behavior. Francis Broucek described early interruptions of going-on-being as the precursor to later experiences of shame, the negative emotion of the self (Broucek,1991). Sylvan Tomkins wrote about shame as the deflation that occurs when excitement/positive affect is suddenly interrupted (Tomkins,1963).

A memorable shame experience of this kind that was emblematic of so many others in my childhood occurred after I had placed first in the running broad jump at a track meet between my elementary school and that of a nearby school. I hurried home, excited to show my mother the blue ribbon I had won, but my excitement was suddenly shut down when I was blindsided by her angry reaction: “You’re late for your piano lesson.” Her curtness was a reaction to her own shame about keeping the piano teacher waiting and her need to expel that intolerable feeling via her scorn.

Also memorable was the all-too-frequent childhood experience I had of being “noodged” by my mother imploring me to “put on an undershirt,” “put on a coat” or some other similarly panicked lifesaving demand. The fact that her pleading in front of my friends might have been problematic for me apparently never occurred to her as that possibility was obscured by her desperate need to protect me from the dangers of not wearing an undershirt.

When something is amiss in a child’s life, they tend to feel responsible in that it feels like the problem stems from something about **who they are**. This, of course, triggers shame. I have come to see how this process played out in my own childhood. By the

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time I was a teen, much of that shame had largely gone underground. My typical reaction to this relentless impingement was anger as I tried in vain to fend off my mother — although that anger, as well as the pain underneath it, was largely hidden from the rest of the world. My sensitivity to impingement, though no longer as salient an issue as it had been while I was growing up, still lingers today. In retrospect, it is not surprising that by high school I had developed what was then diagnosed as ulcerative colitis, requiring a lengthy hospital stay during my senior year — a problem that my mother was convinced was the result of my poor eating habits. It is of note that when I left home to go away to college, despite my significantly less healthy, typical college student diet, my gastrointestinal problems largely abated.

And yet I never doubted her devotion to me. When my internist said that I needed to be hospitalized, my mother brought me to the University of Chicago Hospital because she had learned that one of the leading specialists in the country was at that hospital. She had only recently learned to drive and was petrified of driving on highways, but she did the two-hour round-trip journey of mostly highway driving to visit me every day of my six-week hospitalization. How could I reconcile her effect on my health, and the frustration and emotional pain that she engendered, with the profound level of love and devotion that I knew was there?

The short answer to that dilemma was that part of me understood that, as far as she was concerned, this was a matter of life and death, and she was just trying to save me. Her fears, when activated, were so consuming that they obscured her view of other things, and so just about everything else became noise — including the inner worlds of

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her children. My mother's anxiety about loss and her inability to tolerate her shame overrode everything else and kept her from being able to really see me. I was essentially a body moving in space — a fragile and extremely precious body — but still just a body. I was frustrated beyond words as I was powerless to stop her. When facing life-and-death issues, there is little room for luxuries like empathy and emotional attunement. And in a concentration camp, anything but life-and-death issues was a luxury. When her fears were in the background, she was a different person, but her inability to see me when her shame or her fears were activated left me feeling quite alone. Impinged upon, but alone. As a young adult, I used to describe myself as having grown up an emotional orphan. The lack of mirroring, understanding or involvement in things that I cared about produced a residue of shame that is likely not only the reason that I've written this paper, but why I became a psychologist in the first place. And so**,** this paper is about shame: what it is, what triggers it, the unconscious dangers associated with it, how it's managed and how it can be defanged.

Why We Experience Shame

Many problems that human beings struggle with stem from experiences of shame that have been insufficiently metabolized. Proneness to shame has been shown to be associated with suicide, anxiety, addictions and family violence. It has also been linked to self-esteem problems, an impaired capacity for empathy, the propensity to blame others and the tendency to hold on to resentments. The connection between proneness to shame and difficulty engaging with the world in empathic, playful and vulnerable ways is not hard to see. For many, it can be debilitating. No wonder shame has come

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to be seen as not just undesirable but as a pathological emotion.

But as painful as it can sometimes be, shame is a normal part of human experience. In fact, the capacity to experience shame has actually had adaptive value. Human beings evolved to experience this social emotion because shame pushes us to behave in ways that are acceptable to others. It thus serves the function of maintaining the caring involvement of important attachment figures, like our parents, as well as acceptance by members of the tribe we are part of. Those ancestors of ours who didn't have the "shame chip" that makes us susceptible to this sort of social pain weren't subject to that form of social control. Consequently, they were more likely to behave in ways that resulted in their being rejected by the group, and so were less likely to have the advantages of full tribal membership — namely, access to group supplies and protection from external dangers. The consequences of this were that such "shame-challenged" individuals were more likely to die young and thus be less likely to contribute their genes to the gene pool. Most human beings today are the "beneficiaries" of this natural selection process and so have the capacity, in varying degrees, to feel shame.

Normal vs. Toxic Shame

There is a difference, however, between periodically experiencing manageable doses of shame in reaction to a failure or a social faux pas, on the one hand, and suffering from toxic shame, on the other. Toxic shame involves being shame-ridden in such a way that it interferes with functioning. For some people, their self-esteem is not only painfully, debilitatingly low, but it is unamenable to new information that could alter how they see

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themselves; they live a life oppressed by the shame that is nearly always present. For others, the need to defend against shame becomes the dominant organizing force in their life. Shame, according to Andrew Morrison, is “the underside of narcissism” (Morrison, 1989). Narcissistic Personality Disordered individuals have tremendous difficulty tolerating shame, and so, employ reality-distorting defenses to protect themselves from even knowing about their shame. An obvious example of this would be Donald Trump, whose grandiosity is on full display for the world to see, as he seems to be strikingly incapable of tolerating any form of shame, or as Franz Alexander (1938) referred to it, the feeling of inferiority. As a result, he appears to have developed a personality that is essentially one giant reaction formation to protect him from reexperiencing what surely must have been early traumatic experiences of shame — or more precisely, a childhood characterized by shame-inducing, traumatic relational experiences. Some things that have been written about his relationship with his father would seem to bear this out.

The opportunity to have manageable experiences of shame during development helps to develop the capacity to tolerate shame as a normal, albeit unpleasant, part of life. The capacity to feel shame is part of being fully human. But experiences of shame that are either overwhelming or occur too frequently and are experienced without the presence of an affirming “other” to help process those experiences, can lead to an impaired capacity to manage even small shame experiences. Shame, or more accurately, the need to defend against shame, can then take control of their life.

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But not all experiences of shame are traumatic — unpleasant, for sure, but not necessarily traumatic. Two experiences of shame in my own life illustrate this point. As a 12-year-old in my fifth year of piano lessons, I would periodically perform in recitals. As I was getting ready for an upcoming recital, my piano teacher informed me that I would be playing a particular piece by heart, something that I knew I was not yet ready to do. Despite my vigorous protests, she insisted that I was ready, and that was the end of the discussion. When my time came, I began playing, but halfway through the piece, I lost my place. Absent my sheet music, I simply could not find my way back to the place where I got lost and had to walk off the stage of the rather large ballroom, filled with people, humiliated. I never forgot what that mortifying experience felt like and haven't played piano in front of an audience since. This was obviously a traumatic shame experience that I simply did not have the emotional tools to manage, and the shame was potentiated by the absence of meaningful parental support to help me metabolize it.

Years later, I had the following altogether different experience of shame. As a young graduate student at Michigan State, I was asked to teach an undergraduate statistics class. A somewhat shy 24-year-old, I nevertheless jumped on the opportunity before really thinking about just what I was getting myself into. I prepared like crazy, got to the classroom early on the first day, wrote my name on the blackboard, and then quickly walked out of the room to take some deep breaths and get centered. When the class began, I started with the easy stuff: going over the syllabus, talking about measures of central tendency, etc. I recall saying to myself about 15 minutes into the class, "This

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isn't too bad. I think I got this." But a few minutes later, someone in the front row pointed to me and mouthed, "Your fly is open." I think I just didn't have the "luxury" of succumbing to the shame, and hiding from it wasn't really an option, so instead I was able to take comedic ownership of the embarrassing incident. I turned around to face away from the class, did an exaggerated, tiptoed pulling up of my zipper, and after joining the class in the chuckle, continued with my lecture. I felt embarrassment, a form of shame, but when your fly is open in front of a group of strangers, you're supposed to feel embarrassed. As this incident shows, that sort of exposure (so to speak) doesn't have to feel traumatic, debilitating or overwhelming, or lead to the activation of more pathological defenses. You feel it, it's unpleasant, you manage it — sometimes via the use of humor — and then you move on.

What is Shame?

Nearly everyone is familiar with the pain of shame. It is the experience of feeling inferior, dirty, defective, inadequate, undeserving or repulsive. Brene Brown describes it as the experience of feeling "flawed and therefore unworthy of love and belonging" (Brown, 2015). It is the felt sense of having one's defectiveness or worthlessness exposed and is generally accompanied by the urge to hide. It can also trigger a quick correction of a shame-inducing social faux pas. According to Franz Alexander, the deepest source of inferiority feelings (basically, shame) is the conflict between the wish to grow up and the regressive pull to passive dependency.

I recall an incident more than 20 years ago, when my oldest son was home playing with a friend. During those early years, when I would come home from work, he would run to

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greet me with open arms and an enthusiastic hug. That evening, when he heard me walk into our house, he ran toward me, arms open to hug me as he exclaimed, “Daddy!” But suddenly, he remembered that his friend was there, and so he quickly dropped his arms down to his side, looking mortified by what he had just displayed in front of his friend. His going-on-being had been interrupted by his own awareness of a social norm that he was in the process of internalizing. It was a sad, bittersweet moment for me as I was witnessing another step in the gradual loss of innocence that growing up entails, understanding that he was moving away from being my little boy in the unselfconscious way that he had been, and that his friends were in the process of being “promoted” to being his primary social reference group.

What triggers this painful emotion? Shame can be better understood when contrasted with guilt. Whereas guilt is the feeling of having done (or thought about doing) something that feels morally “bad” — typically something that is harmful to another person — shame is the felt sense of having one’s inferiority or defectiveness exposed. In other words, guilt is the response to immoral or bad **behavior**, whereas shame is the felt sense of **being** defective. Thus, shame feels like the deserved loss of a loving connection to one’s parents, and later, the loss of the love of a disappointed **internalized** parent. In both of these cases, the loss of love is ultimately associated with the threat of annihilation because of **who one is**. While often it is a specific behavior that triggers shame, it is because, in that moment, the individual feels as though the inadequacy or defectiveness that makes them unlovable is being exposed via their social faux pas or failure.

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Managing Shame

Because, at its core, shame is about who one is and not just something that one has done, it is difficult to free oneself of that burden. There are, of course, different levels of shame. At its most extreme are individuals who are functioning in a Paranoid-Schizoid mode of being, an early stage of development described by Melanie Klein (1946), that can also be a state that one temporarily regresses to. This is a mode of being that relies on primitive defenses like dissociation, projection and projective identification. Because while in that mode of being the individual is unable to "hold" or tolerate the feeling of shame, they are generally faced with two options: 1) be overwhelmed by that terrifying experience, often resulting in dissociation or numbness, and a kind of psychic paralysis referred to by trauma therapists as "tonic immobility," or 2) they can expel the shame onto someone else in an effort to just get rid of it.

The latter approach is illustrated in the first example I gave about my mother and my piano lesson. She was embarrassed by my tardiness and so, in a panic-driven state of tunnel vision, desperately expelled that intolerable feeling via her scorn. If she had been functioning in a more mature mode of being at that time — what Klein referred to as the Depressive Position — she would likely have had a different relationship to her own shame. The ability to better tolerate her shame might have enabled her to maintain her parental perspective in the face of this unpleasant feeling. She might then have been able to say something like, "Congratulations on your ribbon, but you're late for your piano lesson. We can talk about your track meet after the lesson, but you're late, so hurry on in there." After the piano lesson, she could have let me know that she was

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upset with me, suggested that we try to figure out how to avoid my being late in the future, and then asked me about my track meet, which, by the way, I had been very excited about.

While **shame-escape defenses** address shame that is being felt in the moment, **shame-avoidant defenses** develop to protect the individual from future suffering. Shame- avoidant defenses can sometimes coalesce to form an enduring coping style that expands to cover many areas of one's life and become part of that person's character. Although initially adaptive, shame-avoidant defenses can eventually come to interfere with the individual's relationship to the world and with themself. In effect, this avoidant coping style becomes part of a phobia of sorts: a shame phobia. The individual learns to protect themself from even small doses of shame, depriving themself of the experiences necessary to develop the ability to tolerate and manage this inherently unpleasant (but soon-to-become highly dangerous) emotion. The tentacles of these defenses against what has come to be experienced as intolerable shame continue to expand into more areas of the individual's life, interfering with relationships, the ability to take risks, to be open, to be flexible, to be vulnerable and to relate in genuine ways. The essence of this avoidance is about the habitual hiding of one's vulnerability via the disavowal of needs or "weakness." Among the vulnerable feelings that need to be defended against are sadness, hurt and disappointment. Shame-avoidant coping strategies include perfectionism, insatiable ambition, the need to regularly prove oneself superior to others, and the avoidance of activities that might risk embarrassment (like performing, public speaking or just trying new things).

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Changing One's Relationship to Shame

The role that shame plays in many emotional problems has been underappreciated since therapy began as a serious form of treatment over a century ago. Fifty years ago, Helen Block Lewis (Lewis, 1971) pointed out that Freud's emphasis on guilt had dominated psychoanalytic thinking, squeezing out shame as an area of focus. She wrote that, for Freud, the threat of loss of parental love (the source of shame) took a back seat to the threat of castration by the father (the source of guilt). Lewis saw this as a consequence of the disparate emphases placed on the two mechanisms of identification involved in the development of shame and guilt: anaclitic identification and identification with the aggressor, respectively. Harry Guntrip wrote that we prefer to see people as bad but strong, rather than as weak and afraid (Guntrip, 1973). Shame had been neglected, he said, because we prefer to focus on guilt-producing conflicts about the powerful forces within us, rather than on the shame-producing conflicts that stem from a fragile, needy self, plagued with self-doubt and the fear of rejection and abandonment.

The work done in the past few decades in the treatment of trauma has helped to bring shame more in focus and heighten our awareness of the role that it plays not only in PTSD but in a host of other problems as well, including anxiety, addictions, poor self-esteem and relational problems, among others.

I would suggest that another driver of this greater emphasis on shame has been the larger role that women have come to play in our field in the last half century or so, as

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well as the cultural changes that have made it more acceptable for men to be sensitive, involved with their children and relationally oriented. The resulting shift in emphasis toward attachment and loss, as well as relational needs and injuries, and the de-pathologizing of vulnerability as an integral part of healthy human functioning, have helped to usher in a “kinder and gentler” psychotherapy that has opened the door for the exploration of shame. To borrow a line from the old Cadillac commercial, “It’s not your father’s psychotherapy.”

I am also suggesting that, regardless of a patient’s presenting symptom picture, it is important to be sensitive to the shame, as well as the defenses against it, that might be underlying those symptoms — particularly the avoidant defenses that can come to take on a characterological quality. The more you know about shame, the easier it is to see how ubiquitous a role it plays in bringing people into therapy for a wide array of problems, including many problems that aren’t typically thought of as shame related (and, for that matter, the role it plays in keeping others out of therapy — in other words, resisting taking a risk that they intuitively sense might bring them closer to their shame).

My own struggles, experienced at different times in my life as alienation, anxiety, awkwardness in my interactions with girls during adolescence, grandiose ambitiousness, difficulty being vulnerable and my long-held secret sense of being superior to others, all stemmed from my issues with insufficiently metabolized shame. I have had a number of therapy experiences, and it has taught me a good deal about myself, particularly regarding my shame burden and my shame-avoidant defenses. But it has also taught me a lot about the therapy process and how essential it is that the

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therapist be cognizant of the shame in the room — both the patient's *a priori* shame and the shame dynamics that play out in the interactions between the therapist and the patient.

An enlightening, albeit unpleasant, experience occurred in my second analysis roughly 30 years ago. My analyst, who was fairly well-known and had made sure to let me know that he had been a patient and colleague of Heinz Kohut's, was often significantly late to my sessions. Particularly disturbing to me was the fact that he never apologized or even made mention of the fact that he was late. When I commented on this, he immediately went into neutral, "blank screen" mode, focusing exclusively on the fact that I was upset by this. It was an impersonal and, I would argue, dismissive reaction that basically left me holding the bag. Had he simply apologized and expressed some recognition of the fact that my reaction was, at least in part, an understandable reaction to his tardiness (and had then invited me to explore whether there was something familiar to me in the experience, or whether there was anything in my reaction that was worthy of exploration), I think I would have had an altogether different reaction. His selective allegiance to protecting the purity of the transference situation seemed to me to be self-serving, and I believe that what was being served was his need to shield himself from the unpleasant feelings that ownership would have engendered in him. Instead, he needed me to carry that burden for him. This may have been a familiar experience in my life, but as the saying goes, just because you're paranoid doesn't mean they're not following you.

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It is important in analysis, or any kind of relational therapy, for that matter, that the patient be helped to develop the capacity to take greater ownership of their role in their relationships, as well as in their subjective experience of those relationships. But the patient's immediate owning of full responsibility should not be an uncompromising expectation of the therapist. To require that a patient take full responsibility for their experience in the interactions between the therapist and the patient, and for the therapist to refuse to own enough of it to lighten that burden and make it manageable for the patient, is akin to a cardiologist requiring that their patient not have high blood pressure, or a dentist requiring that their patient not have any cavities. That is the reason that they are there: to lower their blood pressure, to have their cavity filled, and to develop the capacity to take responsibility for their role in how their interactions with others play out.

An image that I find helpful is that of a heavy ball of shame-filled responsibility that must be lifted and held. It is the job of the analyst to be assessing not only how heavy that ball is, but also how much of that burden the patient can manage at that time. The patient has the capacity to lift and hold some amount of that weight, but the therapist needs to "titrate the dose of responsibility" by holding as much of that ball as is necessary to make the patient's burden one that they are capable of handling.

This issue also plays out with couples who are constantly trying to lessen their own shame by getting their partner to lift more of that shame ball. Another metaphor that might be helpful here is the game of hot potato. The point of that game is to get someone other than you to be holding the potato when the music stops, but you can't

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just throw the potato at the person next to you — they have to take ownership of it in order for you to be free of it. Similarly, just projecting onto your partner is generally not enough to provide the sought-after relief from that shame; the partner has to take some ownership of it in order to lessen the burden.

A patient I worked with some years ago had been stuck in a reenactment with her husband in which both needed the other to change their behavior in order to lessen their own excruciating shame burdens. Each kept trying to rid themself of their own shame by pushing the other to take responsibility for their relational problems, essentially trying to expel it onto the other person, which of course intensified the other's desperate attempts to push it back. The more the other refused to take it in, the more primitive, desperate and rageful the expulsions became. This process was exemplified by my patient's response to her husband relaying to her his therapist's suggestion that they get into couples therapy. "This is not an 'us' problem," she shouted repeatedly in our session. "This is a Steve problem!"

So, how does shame change? The short answer is that it doesn't go away, and that shouldn't be the goal. The goal should be some version of Freud's goal for any psychoanalysis, namely "to convert neurotic misery into common unhappiness." This statement summarizes an important aspect of existential philosophy, as well as both Hinduism and Buddhism: Life has pain and suffering. If you chase the illusion that you can insulate yourself from it, then you will create more pain. *Samsara*, or enlightenment, comes from the acceptance of this truth. Of course, if there is insufficiently metabolized

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trauma, then that kind of acceptance will be nearly impossible, thus the importance of working through one's traumas. The road to that nearly always travels through shame.

But changing one's relationship to their own shame is one of the steepest hills to climb in therapy, if only because the defenses against it are so fierce. The power of such shame-avoiding adaptations can be diminished by getting to know one's shame, but the resistance to getting closer to that shame is fierce because of the unconscious terror of annihilation that underlies the felt sense of rejection that is so bound up with the experience of shame.

For that reason, the therapist needs to be able to provide a holding environment that, through their behavior, regularly reminds the patient that the therapist will not impose on them levels of shame that are more than they can manage. And most importantly, when the therapist has a lapse in empathy, they need to own it, rather than expelling it or leaving the patient alone in their shame with no interpersonal anchor. The therapist will need to know their own protective shame-repelling buttons so that they don't re-injure their patient. But even then, they will still periodically have injurious lapses in empathy, and at those times it will be important for the therapist to recognize this and repair the injury to the patient by acknowledging their lapse. It is not unusual for these sorts of repairs to be the most healing interactions in one's therapy.

The power of shame-avoidant defenses to disrupt one's life speaks to the importance of taming the beast of shame, and so, lessening the need for (and thus the intensity of) these defenses. But doing so requires that the patient become better able to tolerate the

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experience of shame, along with the associated sense of rejection for being unlovable. Such “dangerous” vulnerability points to the crucial role that the level of trust in the therapist plays in enabling the patient to begin to face the intolerable. The development of just such an attachment, however, runs into the patient’s resistance to being vulnerable; feeling needy or dependent, in itself, risks shame and rejection. The importance of a trusting relationship with one’s therapist is Psychotherapy 101, but this is particularly true when dealing with shame.

So, here I stand, a 67-year-old man who has been working on these issues for decades. I learned early in my life that it was not safe to be vulnerable and that the “best” insurance policy against that was my ambitious, competitive striving to be superior in order to protect myself from Alexander’s “feeling of inferiority.” I have learned a great deal about myself, about my relationships and about the therapy process itself. I’m no longer as controlled by shame, or by my defenses against shame, as I was years ago. I have come a long way, but I still struggle to overcome old patterns of shame-driven defensiveness. I am a better person and a better therapist than I used to be, but there are things that still interfere in my most intimate relationships, and being vulnerable will, no doubt, always be a challenge for me. Of this, the world keeps reminding me, and so I would like to conclude by sharing one of those reminders I had while eating dinner with my family roughly ten years ago. I had been behaving in a relatively emotionally guarded manner, and my then college-aged younger son looked at me and said, “Dad, you have to ‘man up’ and be more vulnerable.” I felt a pang of shame for having been

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busted, and a great sense of pride about his ability to recognize and call me on it. But he was right: Being vulnerable takes courage.

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