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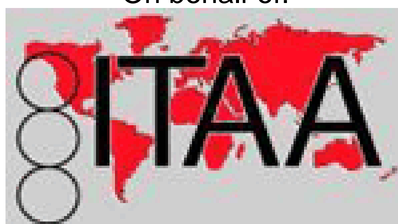

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What is This?

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Section II

Shame and Social Control Revisited

Fanita English

Abstract

The author elaborates on her 1975 article by showing the evolutionary value of shame in maintaining social structures by enforcing values. Specific shame-related *survival conclusions*, taken into the organism at various stages of development, operate in the same manner as instinct does in lower animals to enforce *survival strategies* and corresponding behaviors throughout life. Vulnerability to shame is necessary to maintain standards, but it can also lead to dysfunctional reactions in adults because of harmful shaming in childhood. *Antidote treatment* for such experiences is described, and the technique is illustrated with case examples. Emphasis is placed on how shame and guilt must be distinguished from one another in clinical treatment. At their origin, shame reactions are nonverbal and require "translation" into language, whereas guilt reactions are formed at later stages when the child possesses linguistic ability.

The Literature on Shame

For a long time there was little interest in the therapeutic community about the subject of shame as distinguished from guilt. However, in recent years this was reversed with a veritable flood of both popular and scholarly publications on the subject.

In 1973, at a psychosomatic conference in Mexico, I presented a paper on "Shame and Social Control" in which I underlined the fact that because the propensity to shame appears early in a child's development and is connected to organic components, certain methods of social control depend on human susceptibility to shame. A version of this paper was published in this journal (English, 1975).

Later, when I wrote about my concept of survival conclusions (English, 1988, pp. 295-296) in relation to scripts, I showed that many such conclusions are integrated within the growing child because of his or her particular vulnerability to shaming. I suggested a simple technique for treating particular issues of shame called the "antidote treatment for shame," and illustrated it with a case example (English, 1977, pp. 298-301). Since then, a number of trainees in the United States and Europe have used this treatment technique with what they have reported to be considerable success.

Description

Almost everyone has experienced shame. To feel ashamed, or the equivalent—humiliated, ridiculous, or even embarrassed (which is a lesser form of shame)—can be pervasive, or it can occur suddenly. Such feelings may be triggered by some event or by other people who provoke shame either unsuspectingly or deliberately by means of ridicule, sarcasm, or criticism. Or it may arise in specific situations that stimulate particular survival conclusions. It is often accompanied by bodily symptoms such as blushing, sweating, shortness of breath, increased heartbeat, stomach pangs, temporary confusion, and/or inhibition of speech. Such bodily reactions may be overcome relatively quickly, but there may remain lasting emotional discomfort, painful memories, and increased sensitivity to feeling ashamed again in similar circumstances.

Sometimes feelings of shame are more vague and pervasive: They attack the person's sense of honor, pride, self-esteem, and the ability to take effective action. Such feelings can range from a general sense of unworthiness to a feeling of being totally "beyond the pale," with no chance of escape. Attempts to deny such feelings may lead to excessive defensiveness,

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compensatory rackets as substitutes, or the use of addictions to bolster self-confidence artificially. Needless to say, these attempts lead to additional problems.

Propensity to Shame as an Evolutionary Phenomenon

Before focusing on a clinical view and the negative or inhibitory aspects of shame, it is important to note that the human ability to feel shame represents a particular evolutionary development which has an important role in maintaining standards in human societies. Darwin (1872) was the first to realize that the ability to feel shame is a uniquely human psychosomatic phenomenon, as exemplified by blushing when feeling ashamed. Other animals seem incapable of shame.

Freud also concerned himself briefly with the evolutionary aspects of shame in humans. In a footnote in *Civilization and its Discontents* (1930/1961) he speculated on the origin of shame in humans: "Man's raising himself from the ground . . . his assumption of an upright gait, made his genitals, which were previously concealed, visible and in need of protection, and so provoked feelings of shame in him" (pp. 46-47). By implication, Freud associated the origin of the human capacity for shame with attempts at self-preservation; survival is dependent on the sense that exposure of a vulnerable part of one's self can be dangerous. As described by Freud, the parts to be hidden have sexual functions, but the essential point is that feelings of shame correspond to the wish to hide parts of the self from others for fear of destruction. With or without a sexual connotation, even nowadays, both blushing and the wish to hide, which are manifestations of shame, correspond to feeling dangerously exposed. Indeed, in most languages people use expressions such as, "I wanted to sink under the floor . . . I wanted to disappear," to convey having felt ashamed. Even children may "hang their heads" or avert their eyes when feeling ashamed.

Shame as Internalized Disgust or Loathing of the Self

In earlier writings, in which Freud elaborated on the tendency of young children to "sexual exhibitionism and voyeurism" (parentally loaded words for children's spontaneous free enjoyment of nudity), he defined shame as a parentally engendered reaction-formation against such behavior, causing "tension, like loathing and disgust" (Freud, 1905/1942, p. 50). Thus, in Freud's view, shame represented the internalization of a particular negative view of the self by powerful others: originally the parents, then society by extension. In this instance, shame about nudity and/or sexual curiosity served to curb such allegedly unsocial behavior. Freud also added that he saw the ability to feel shame as "organically determined" (p. 46).

Indeed, it would be impossible to instill shame in a child if there were not an organic receptor for such a feeling. However, it is what is poured into a child's organic receptor for shame, in the course of development, that determines what the grown person will respond to in terms of shame and how she or he will deal with those feelings.

Shame, Social Control, and Issues of Power

Given that our aptitude for shame represents an evolutionary development, does it still have value today? The answer must be "yes," because human beings are interdependent and require standards and rules of behavior to hold their societies together. Prior to the development of actual laws, numerous unwritten norms or codes are determined in a society in accordance with the values it develops about what is deemed honorable, respectable, proper, or right. The more traditional the society, the more strictly are its members raised from childhood to adhere to its unwritten prescriptions. People may be stigmatized severely if they fail to function in accordance with a particular culture's unwritten codes. Even more important, having been raised in accordance with such norms, they will have internalized them in their Child and Parent to the point that they will feel profoundly ashamed if they transgress them, regardless of the intrinsic merit—or demerit—of a given norm. Because the effect of shame on individuals and groups can be devastating, social rules are often enforced thereby more drastically than are laws by courts.

For instance, unwritten codes in the Tamil and Kannada cultures of South India regulate family relations and responsibilities in great detail. Woe to the person who disregards them, for disgrace and shame await and will punish the individual more severely than would legal

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sanctions (Ramanujan, 1989; personal communication, June 30, 1993). Thus does the propensity to shame in individuals promote their adaptation to the standards of their society, both on macro and micro levels, regardless of individual preferences.

Although many such social codes were originally developed for protective purposes (e.g., to ensure the support of wives and children lest fathers abscond), over time, as new legal systems develop, unwritten codes often serve only to perpetuate irrelevant minutiae. They become uselessly oppressive to individuals, yet internalized reactions of shame whenever such codes are disregarded effectively maintain even those that are clearly unsound and anachronistic.

Thus, vulnerability to shame results all too frequently in the exploitation and abuse of individuals or groups by others who thereby establish power over them. For example, in Europe shaming was used effectively by the upper class (those born to aristocracy or privilege) to control the lower class and to make them feel inferior. Standards of appearance, behavior, and mores were said to be hereditary, and thus unattainable, even by those who sought to identify with the upper class. Then the upper class could look down on people who were different based on some arbitrary standard, thereby undermining the identity of these people in order to control them. This was a major technique of the British Empire; shaming took place whenever servants and colonials "failed to keep their place." Such servants, in turn, transmitted such attitudes to their children, who also became vulnerable to such shame as it was transmitted from one generation to the next. The caste system in India worked in the same way.

This process can occur on a much smaller scale as well—in business organizations or in families in which one member may humiliate and thereby dominate one or more others. For instance, in many cases of father-daughter incest the wife/mother has knowledge of what is occurring. If the mother is humiliated by her alleged sexual inadequacy, she may be too ashamed to protest or to notify the appropriate authorities.

As I shall discuss in more detail later, each of us may be vulnerable to shame around certain issues, whereas we are far less vulnerable—even invulnerable—in relation to other issues, for better or worse. Even when social standards are strict, there are powerful or ruthless individuals or groups who benefit from a double standard that tends to develop in societies. They are exempt from disgrace for behavior that is stigmatized in others. For instance, cheating and lying are shameful—but perhaps not for large corporations promoting their businesses!

Sometimes stigma that would normally go to one person or group is transferred to others who become scapegoats because they are vulnerable to taking on the disgrace. A "hot potato" gets passed on (English, 1969), whereby those who pass it on remain honorable and free of stigma. For instance, middle-class Victorian society maintained its standards of respectability by viewing the poor with disgust, and the poor, in turn, often felt ashamed of being in such circumstances. Similarly, the pretense of monogamy was maintained by emphasizing that respectable women did not have sexual feelings (they were shamed when they admitted to such feelings), and therefore men had to turn to "loose women" or prostitutes who were disgraced for being "shameless hussies" (and, therefore, were themselves often ashamed of their condition). However, the citizens who frequented these prostitutes were respectable in that they appeared to maintain the monogamous mores of their society. Still, they were vulnerable to blackmail, because exposure would have dishonored them.

We may have moved beyond these mores in the marital sphere, but not in relation to poverty. Witness how we in the United States humiliate homeless people. For example, rather than provide for homeless people, Mayor Jordan of San Francisco has instituted what is called a Matrix Program, in which police chase and hound the homeless into hiding lest tourists see them and be repelled by their deplorable condition!

Social Control of Sexual Behavior and of Women through Shame

Often particularly strict unwritten standards apply to the sexual behavior of certain members of a society. Until recently homosexuals had to "hide in the closet" for fear of discrimination. Women were often shamed or humiliated publicly in order to curb attempts at divergent behavior. Nathaniel Hawthorne's *The Scarlet Letter* comes to mind, but even that was not as

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bad as the stonings or executions of women for adultery that took place until recently in Saudi Arabia.

Shame has been and still is a major force in "keeping women in their place" in accordance with the mores of whatever society they are in. More effective than the use of the chastity belt of the Middle Ages has been the repeated social emphasis on modesty and humility for women, both in general and in the sexual sphere. Women have been made to feel ashamed, not only of their own sexuality, but also of being sexual objects, and they, in turn, have internalized this view of themselves. In most cultures women who are raped are so ashamed that they keep it secret. It is only this year that Korean women who were kidnapped and held captive as "comfort women" for Japanese soldiers during World War II have dared to talk about their sexual slavery (Goodman, 1993, p. A-17). Even in our own so-called open culture, only a small proportion of rapes are reported by their victims, and many grown women and men who were abused in childhood do not dare reveal it, even to friends.

A recent tragic example of the abuse of shaming for social control is the public rape of Muslim women by Serbs (who know that Muslims insist on sexual purity in women) as part of their systematic "ethnic cleansing." This is a horribly effective way to damage whatever Muslim population is not killed: The women and their men become even more incapacitated by their shame about these public rapes than by their violence.

Restrictive sexual standards in social groups may exist because the sexual yearnings of individuals are so powerful that they can promote nonconformity to the static imperatives of a society. Yet in many instances, these standards are internalized even by the divergent individuals themselves. For instance, a person who is sexually promiscuous may feel ashamed of his or her behavior or fantasies even in a permissive society.

Many languages still convey the message that women are shameful sexual objects. The German word for female genitalia is *scham* (shame). In Spanish a woman who is pregnant is said to *embarasada* (embarrassed). I am no fan of Madonna, the performer, but I must admit she has made an important contribution with her recent book, in which she unashamedly flaunts various sexual fantasies. Still, perhaps I should add that in the United States, at least, the pendulum of social expectations about women's sexuality may have swung to the other extreme; although they are no longer stigmatized for having sexual feelings, some women secretly feel ashamed for the reverse, that is, if they are nonorgasmic.

Social Standards Change with Time

Societies do gradually modify their standards, albeit slowly and often prodded by subgroups or individuals who refuse to be controlled by certain social stigma. In the United States, thanks to the women's movement, I am no longer likely to be criticized for being assertive, whereas, until recently, when I expressed myself forcefully I was often accused of being unfeminine and too aggressive. Even when I knew such an accusation to be unfair, because I am vulnerable to shame in this respect as a result of my upbringing, it was often possible to silence me when it might have been more effective for me to stand my ground. For instance, this caused me to be far less effective as an ITAA board member than I could have been when I served years ago.

It is heartening to note that the gay liberation movement is helping to relieve many from shame about their homosexuality by encouraging overt expression of sexual preference. Similarly, African-Americans themselves took on the label of "black" with pride rather than allowing themselves to be shamed for their skin color. Nevertheless, there is always a lag between what is accepted and what was stigmatized, be it by society or by the individual's Parent. For instance, individual reactions to being seen nude vary from utter shame to indifference, according to whatever social mores were internalized. In contrast to a Bantu woman, an Islamic woman will feel disgraced if seen nude. In the West, attitudes about nudity range all the way from prudishness to pride at being pictured in *Playboy*'s centerfold. Nudity in coed saunas is standard in Scandinavia, but embarrassing for Americans. We also have a range of standards for proper dress according to the social occasion, and one person might feel embarrassed if dressed inappropriately, whereas another would not care.

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Pride and Shame as Complementary Opposites

Good consciousness of self—that is, self-esteem—can foster appropriate pride in overcoming personal difficulties or embarrassing situations. This is in contrast to the helpless self-consciousness engendered by excessive vulnerability to shame, or the arrogance of those who use their Parent to shame those who do not meet their standards. For instance, some smokers feel terribly self-conscious about their evident lack of control over their addiction, whereas others are highly defensive about it. Still others take appropriate pride if they stop, whereas others transform prior feelings of shame about smoking into inordinate vanity about having stopped, to the point of mercilessly trying to humiliate those who have not stopped.

In contrast to defensive pride that is competitive and flaunted, or to shame that is inhibitory of self-esteem, both pride and shame can be useful adjuncts to self-respect and may generate ethical behavior. For instance, Winston Churchill described in his memoirs how he felt ashamed as an Englishman by Neville Chamberlain's policy of appeasing Hitler (Lewis, 1993). In this situation, pride—and identification with his society's professed standards of honor and justice—brought on Churchill's apt feeling of shame when these standards were not upheld. This contributed to his determination to offset such shame by positive action. Similarly, it has become shameful for people to wear coats made from the fur of rare animals, whereas previously to own such an expensive coat was a source of pride.

Sometimes it is disappointing when others are impervious to shame with regard to a particular standard we hold dear. For instance, when U.S. President Clinton was trying to break the impasse over his job's bill he gave a speech to union delegates in which he said, rhetorically, of the Republicans who were blocking the bill: "Have they no shame?" (Devroy & Pianin, 1993, p. A-2). As a personal example, I remember how, on trying to board a taxi after arrival at a railroad station, I was rudely pushed aside by some young punks who preempted it. "Shame on you!" I yelled. However, this did not embarrass them into relinquishing my taxi, for they were invulnerable to the social standard about consideration for elderly ladies such as myself.

Thus, as discussed earlier, individuals only feel ashamed about issues for which they are receptive, either because of prior programming or identification with a particular norm. The question remains: What is each one of us likely to feel ashamed about? In itself, the ability to feel shame can contribute to both our participation in society and its improvement in that we are able to recognize some responsibility toward other human beings rather than looking out only for ourselves. To reject our ability to feel shame, as some modern "gurus" would have us do, can only harden us to the kind of anarchy of which shameless "ethnic cleansing" is one extreme example or make us indifferent about the fact that people in our rich society must sleep on city streets for lack of adequate shelter and mental health facilities.

Ultimately, each one of us may have to distinguish, in each particular instance, what it is specifically that we feel ashamed about. We can evaluate with our Adult whether in each circumstance the feeling of shame is a call for self-improvement or social action that might uplift us if we respond or whether it invites an archaic response that undermines our self-respect or effectiveness. It is only in those situations in which shame is truly dysfunctional that I recommend the use of the "antidote" (English, 1977) approach I will describe later in this article. Before I can do so, however, it is necessary to describe my own general approach, which has emerged from TA and other theories.

Existential Pattern Therapy

As indicated in previous articles (English, 1987, 1988, 1992), existential pattern therapy (EPT) is based on the concept that our lives are affected by three distinct unconscious drives. Their attributes stimulate us to learn and practice whatever we humans need to do in order to grow to independent maturity, to develop the ability for social interaction, and to contribute to the improvement of our species. The manner in which we can use the attributes of our drives is not preprogrammed; instead, we have more flexibility for learning than is possible with the kind of preset, instinctive behavioral programs of more primitive creatures.

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The three drives and their goals are: the *survival drive*, which seeks to promote individual survival; the *expressive (creative) drive*, which promotes the survival of the species; and the *quiescence drive*, which promotes our connection to the planet or the universe. Each drive has different evolutionary goals and functions. Some of these goals, functions, and attributes conflict inside us at certain times, although they also combine effectively at other times.

For the purpose of this article, I will focus primarily on the survival drive and the survival conclusions it generates, because the human ability to experience shame and guilt are important attributes of this drive. Note, however, that attributes of the survival drive often conflict with those of the expressive drive, which stimulates sexuality, curiosity, self-expression, and risk taking. These attributes are essential for our species, for they lead to invention and discovery, without which we might have become extinct. Note, also, that it is thanks to the fact that our drives have divergent attributes that there is so much diversity among humans, in contrast to other creatures, even our nearest relatives, the monkeys.

Survival Conclusions and Strategies

I described previously how a child integrates survival conclusions into his or her organism in sequential layers (English, 1977). This occurs under the influence of the survival drive; eventually there is a build up within us of hundreds—probably thousands—of conclusions established at different stages of development. For instance, unlike other mammals, young children do not instinctively recoil from fire or deep water. A young child will blithely step into a swimming pool and drown if unsupervised. The child must internalize survival conclusions about such dangers. As is well known in TA, such conclusions are established in conjunction with strokes. However, the aptitude for shame also operates to set certain conclusions within the human organism. These take on determining power for potential behaviors or reactions the way inborn, preprogrammed instincts operate in other creatures. As indicated earlier, this aptitude has evolved in humans to socialize us beyond the confines of the immediate family. In effect, those survival conclusions that are connected to shame occur as a result of whatever contents were poured, during childhood, into the organic receptors for shame referred to earlier in this article. These conclusions then enforce parentally and socially transmitted dictates by threatening disgrace "worse than death" if transgressed.

As we grow, we devise an increasing array of behavioral strategies to cope with our environment in accordance with early conclusions. We continue adding other conclusions and strategies, also by identification with those around us. This is how children learn toilet training, table manners, cleanliness, politeness, limits to destructiveness, a sense of fair play, and many other cultural norms. Conclusions and strategies connected to shame are particularly forceful and rigid because most of them are set in the organism at an early stage of development (the two-year to four-year age period).

In my previous article on shame (English, 1975), I gave an example from the Eskimo culture of how such conclusions can be established as well as their effect. In order for tribes to cross frozen lakes with young children in tow and without danger, as soon as a toddler gets its feet wet on thin ice, members of the tribe surround the child and ridicule him or her for wet feet by pointing at them and laughing loudly. As a result of this traditional ritual, by the time children are three years old they can distinguish what spots of ice are too thin to hold them, just as though they had an inborn, animal instinct about gauging the thickness of frozen surfaces. Many native tribes routinely used comparable ritual methods of shaming young children to establish taboos against incest or to enforce other religious edicts.

Although modern, so-called rational societies no longer use traditional rituals in this manner, in the course of our upbringing, all of us are conditioned to varying degrees by similar processes. Of course, a conclusion such as "caution about deep water" is protective and leads to progressively useful strategies about deep water for the individual as he or she grows. However, if taken on by shaming rather than by strokes, such a conclusion can lead to exaggerated fears, including phobias. We may also take on useless, but damaging conclusions by the same process. Many conclusions are reinforced over time through parental or other influences, and they may thus combine with one another and become particularly powerful in

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generating ineffective or, worse, inhibitory strategies. The earlier a conclusion is set into an organism in the course of development, the more significant is its integration as a part of the person's "second nature," just as though it were an inborn instinct. For instance, probably as a result of excessive shaming against bed-wetting in childhood, there are certain hospital patients who simply cannot urinate horizontally in a bedpan, even when this is prescribed during an illness. At the Methodist Medical Center in Dallas, staff found that they can avoid using a catheter with such patients by helping them sit up to use a bedpan.

Educational Considerations about Shaming Children

Many persons in parental roles—and older siblings—intuitively recognize the susceptibility of children to shame and frequently use ridicule and teasing (equivalents to shaming) as ways to control a child's behavior from the time he or she is two, when bodily reactions to shame such as blushing or cringing are recognizable. This is all the more true because children become mobile and very active at that stage under the influence of the expressive drive; their exploratory contacts with the environment are often taxing to grown-ups, who therefore want to set limits by inhibiting them. I shudder when I hear parents boast of being able to control their children's behavior "just by looking a certain way." Usually this means that they used shaming as their primary educational technique. Some grade-school teachers do this also; unfortunately, it is a highly effective technique.

Shaming is also how "hot potatoes" may be passed on to children. A damaging episcript may result from a combination of such hot potatoes (English, 1969). This operates particularly in conjunction with nebulous issues of shame in a family, when one or more family members may themselves feel ashamed for reasons that are not clear to the child—for instance, for belonging to a particular ethnic group, for poverty, for a parent's alcoholism or mental problems, for a retarded sibling, for suicide of a grandparent, or whatever. Such shame can have a ripple effect in that its manifestations may differ and be transformed by each member of a family. This has many implications with regard to episcripting. In contrast, there are children who first take on feelings of shame about the family, the home, or the self and then transform these with defensive strategies and identify with outsiders, thus becoming severely critical of anything reminiscent of their disgraceful family.

The effect of shaming children is also destructive when the personal prejudices or whims or needs of parental figures are promoted; all kinds of attitudes and prohibitions may be set up in the child, be it about masturbation, curiosity, or friendship with children of other races. These are particularly damaging when they relate to factors or labels that are outside a child's control, such as being too dark-skinned, or too clumsy, or "too much like crazy Aunt Martha," or even "too assertive for a girl," as was the case with me. Such conclusions maintain lifelong dysfunctional vulnerability for the individual. He or she may respond with excessive shame any time criticism is leveled at this particularly sensitive area, even when this occurs incidentally by strangers who are not aware of hurting the person.

Even with socially desirable goals, such as toilet training, safety, consideration for others, or limits to destructiveness, I caution parents against shaming, ridicule, or mockery as a means of training or controlling, because this can cause severe damage to the child's self-confidence. In fact, it is important to be aware that young children are also sensitive to unintended shaming. They can be hurt even by good-natured laughter about something "cute" they say or do. In such instances—which are easily noticeable by the child's bodily reactions—it is important to reassure the child as warmly as possible, so the memory of the experience is not a memory of disgrace.

Antidote Treatment for Archaic Conclusions Related to Shame

This simple but highly effective technique can well be incorporated into other treatment. The prerequisite is a therapist who has established good rapport with the client and who has good diagnostic skills with which to evaluate whether unrecognized dysfunctional shame appears to be the principal cause for the client's current problem. (Alternately, the client realizes this and says so, but knows that he or she is "stuck" with the symptoms.) Either way,

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under the surface, the client feels that it is deathly dangerous to expose—or to risk the exposure of—something having to do with the self or the childhood family.

It is this "something"—the content of a dysfunctional survival conclusion based on shame—that is the poison which requires an antidote. However, as with chemical poison in which the choice of antidote depends on information about the nature of the poison, in order for the psychological antidote to be effective, the "something" must be brought to consciousness and defined clearly. Therein lies the paradox: On the one hand, the client wants relief from his or her related symptoms, such as anxiety, inhibitions, or pervasive feelings of discomfort; on the other hand, the very conclusions set by shame in childhood which cause the problem motivate clients not to reveal to the therapist, or, sometimes, even to their own conscious mind, exactly what the "something" is about. Also, because specific conclusions set by shame frequently occur as early as during the two- to three-year-old age period, it is almost impossible for clients to remember under what circumstances they were established or to formulate them in communicable language. Thus new shame or anxiety may be added in the here-and-now because the client feels incapable of being specific about the issue and fears being seen as resisting treatment.

However, usually conclusions that are powerful enough to cause major problems are reinforced by episodes at later stages of development, and these are often recalled more specifically. Both therapist and client must assume that eventually the issue can be formulated, even if it requires some reconstruction of past events.

Because clients cannot identify immediately what the disturbing archaic conclusion was, or the early situation within which it was set, I find it useful to ask for minute details about one or more recent episodes that triggered the feelings of humiliation, embarrassment, or discomfort that led them to seek help. It is such details from the here-and-now or recent past that can offer clues about early dysfunctional conclusions, even when clients block significant connections.

In a previous article I described the case of Nancy (English, 1977, pp. 298-301). I will refer to this case now to describe the process of antidote treatment.

Case Example: Nancy's Shame at Failing

At first Nancy believed that her disturbing symptoms were due to a negative evaluation by a student. However, this did not seem sufficient to cause her problems, because she was a successful teacher and had never had trouble in the past about an occasional disgruntled student. It was only after I pressed her with more questions about the exact circumstances that preceded her insomnia, which she believed was because of this evaluation, that it became clear that the actual trigger for her discomfort was not the evaluation itself, but the fact that a male colleague to whom she was secretly attracted had seen it on her desk (without seeing all the excellent ones underneath it) and had teased her for her "poor performance." This teasing had stimulated a flashback in her preconscious memory to a humiliating episode when she was two years old: Nancy's father and some of his colleagues had laughed at Nancy and her mother when Nancy "failed" to recite a poem that her mother had bragged Nancy knew.

Nancy's conclusion, based on shame at that time, was that from then on she would never be safe from disgrace for failing. As a result she developed strategies whereby she was always particularly well-prepared, so she would never be "caught" failing. In some respects these strategies served her well; she was successful in her studies and subsequently took pride in being acknowledged as an excellent teacher. Yet on the one occasion when a colleague had happened to "catch" her allegedly inadequate performance and teased her for having "failed"—even though it was with a student who was a problem for the other teachers as well, and regardless of Nancy's Adult knowledge that she had done very well with her other students—her secret vulnerability to shame for nonperformance was touched off so dramatically that she was distraught for nights and days on end, without quite knowing why.

In Nancy's case we had good rapport because of prior work we had done on other issues, so Nancy had less unconscious need to hide from me her feelings of humiliation about the recent incident. However, originally she had "covered up" even to herself the actual issue about which she felt shame. This is why I cannot underscore enough how important it is to learn in great detail about the situation that precedes the problem or symptom for which the client is seeking

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help, because it is those details that will finally indicate what the "poison" is for which an antidote may be necessary.

Clues that the client is hiding a current issue related to shame even from herself, or, at least from the therapist, lie in fleeting changes in the client's facial and bodily expressions during a session, particularly if these differ from the person's usual demeanor or are exaggerated. Such clues include blushing, avoiding eye contact, hanging the head, wriggling in the chair, slight stuttering or lisps, halting speech, and inappropriate giggling. By noting when such signals occur, the therapist can insist on more clarification about what is being said at the moment and thus obtain a here-and-now impression about the underlying problem. In Nancy's case it was particularly significant that after she told me that she was upset about the evaluation (the cover-up reason) I noted some bodily signals and asked her to tell me more about what she did with the evaluation and its content. She then reluctantly told of her colleague seeing it and how bad she had felt when he teased her. From then on, the way was clear to our finding the early conclusion and devising an antidote.

With Nancy, once she understood what we were looking for, and she had overcome her discomfort at telling me about her colleague's reaction, she connected it to the story her mother had told her about her failure to recite the poem. With other clients it might not be as easy to reconstruct an actual early episode which establishes a conclusion with shame that would cause later feelings of disgrace in comparable situations. Nevertheless, usually early conclusions based on shame are reinforced by subsequent experiences of horrible embarrassment which can be remembered after some prodding (or minor hot seat Gestalt work). They can then serve as a basis for devising one or more antidote exercises to counteract the conclusion—if not permanently, then at least sufficiently so that the next occurrences are less painful and the next doses of antidote more effective and can even be administered by the client herself or himself.

Once we had identified the problem conclusion, the "de-shaming antidote" I offered was to ask Nancy to bring up the subject of the negative evaluation in the teachers's lounge when the male colleague was present, brag about it, and be willing to risk being teased further about it. Nancy's first reaction was, "I'd rather die!," which confirmed that I had found the right antidote and that it might later even have the value of a vaccine. Eventually, Nancy's expressive drive stimulated her to accept the challenge, especially because both of our Adults established in advance that there was no realistic danger to her job or her status if she dared do it.

In summary, the steps to antidote treatment are as follows:

1. Clarify in great detail the recent situation that triggered a shame reaction (or fear of being overly embarrassed). If necessary, get additional examples until it is clear what the common denominator is in situations that are particularly humiliating for the client. Be aware of facial and bodily changes.

2. Determine with the client whether this is an appropriate cause for shame in terms of the client's current value system, so you can decide jointly whether an antidote is necessary or whether the feelings of shame are a call for appropriate action (as in the earlier example of Winston Churchill).

3. If an antidote is required, help the client to formulate clearly what the current feeling of shame is about and/or the fantasies about disgrace and its consequences. (The client's willingness to struggle honestly with this depends on your good rapport.)

4. Reconstruct with the client, as best you can, what early episodes set shame in his or her organic receptor for situations similar to the current one. This can be based on how the client now evaluates the situation and the personality of caretakers during the two-year to four-year age period or on anecdotes told about that period, as in Nancy's case. It is important not to lose track of the original goal, that is, the relief of the current problem. An alternative to identifying the early episode is to use educated guesses about the original cause.

5. Help the client put into his or her own words what the early conclusion may have been and its ensuing strategies. Thus the whole issue becomes conscious and manageable for the Adult of the client, even though the problem is still not resolved on the emotional level. However, once the dangerous "something" that constitutes the poisonous content of a conclusion set by humiliation is clearly defined in the client's own mind, the way is clear for the

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antidote treatment. The analogy is that if food rendered indigestible because of poison is still in the body, it must be flushed out and, in the process, the poison itself may be progressively flushed out as well.

6. Now for the curative part, which is simple, except that it will meet with resistance. (Who wants to swallow bitter medicine that might cause stomach pangs?) Figure out one or more exercises by which the client exposes herself or himself to criticism and ridicule, as in Nancy's case. Specific exercises that accurately counter the client's dysfunctional survival conclusion in the here-and-now must be creatively devised. These may be discussed with the client, perhaps hypothetically or even humorously at first: "What if you were to ___________? What might happen?" Groups are wonderful for this purpose.

7. The rest is up to the client. He or she has to perform the exercise outside the safety of therapy to learn that after exposing himself or herself to ridicule over precisely the thing about which he or she tended to be so ashamed, that he or she survives and discovers that nothing terrible happened after all. Of course, sufficient Adult safeguards must be discussed in advance for the realistic protection of the client. Then trust the client's expressive drive to motivate him or her to go ahead, in spite of resistance from the survival drive, because the expressive drive always has a stake in promoting the blossoming of the individual's full potential.

The following example illustrates a more complex process as well as how, even when nebulous shame and guilt are carried by the same person, conclusions based on shame must be distinguished from those based on guilt.

Case Example: Robert's Secret Shame

Robert was born out of wedlock. His mother was a music-hall artist and his father a French aristocrat who was married at the time and had a son, Etienne, about a year older than Robert. When Robert was about two years old, his father's wife died and his father married his mother. She dropped her career and moved with Robert to her husband's town, where she sought to be respectable in accordance with the tenets of her husband's social class in France. Robert and Etienne were raised as brothers, and the fact that Robert's birth was illegitimate was kept secret. Yet the boys must have remembered some differences about their very early childhood and must also have overheard some gossip about it, although questions about background were taboo. Robert developed a nebulous sense of shame about his origin and his mother's past, without knowing what it was about.

When Robert was eleven years old, Etienne died in a car accident. Robert's father then told him that he would acknowledge him formally as his son, and that the legal work would be done discreetly to maintain the secret of his birth—about which Robert already had vague feelings of shame. No one—not even Robert—recognized that this information reinforced his early feelings of worthlessness. To the contrary, Robert forced himself to believe in the family's assumption that he should be pleased by the special recognition he now received from his father, and they all grieved about Etienne's death. However, Robert started to do poorly in school, and even though therapy was itself a reason for embarrassment for the family, they arranged for him to see a therapist. Robert's difficulties were diagnosed as stemming from survivor's guilt over Etienne's death. After some time his school performance returned to normal, but a few years later he became moody and depressed again, with no reason that either he or his parents could fathom.

On a trip to England with his high school class, Robert became violently ill when the class attended a play. He returned precipitously home to France and the following evening made a failed suicide attempt. His previous therapist was not available, so I substituted temporarily. He was severely withdrawn when he came in and, on questioning, ascribed his attempted suicide to dating problems. However, he showed symptoms of profound shame in response to innocuous questions, without admitting any such feelings, although he indicated that his previous therapy had helped him to resolve his grief and guilt about fantasies that he had caused his brother's death.

Rather than continue with the subject of Etienne's death, in accordance with my usual style of getting detailed data about the onset of a current crisis, I persisted in asking about the trip to England and the circumstances surrounding his visit to the theater. The play was *Richard II*, and suddenly, as though a dam had broken, he was flooded with all that was

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connected to the shame he had repressed since childhood. "It was about a bastard king," he said, "like me." Feelings about his birth, his mother, his father, and the various ways in which he had secretly felt ashamed came gushing forth. Now we had the connection about why he had felt he "could not face the world." It was for fear of exposure of his dreadful secret.

The gnawing conclusions of worthlessness because of shame about being a bastard son had been dormant and covered over by the subsequent survivor's guilt he had felt at Etienne's death. Although his previous therapy had helped him deal with the guilt feelings, his basic conclusions of shame about his origin and his mother's past had remained untouched. The connection with the underlying cause of many of his symptoms of anxiety and depression had remained hidden even from himself until he saw a play about a bastard king. Thus do family secrets often establish and maintain excessive unconscious shame, with potentially severe problems for the person's life (Crespelle, 1992; Schutzenberger, 1993).

In Robert's case it was not possible to follow the process of antidote treatment as outlined in this article because of considerations he owed his mother and stepfather in the society in which they lived. Still, when we were able to establish clear connections with the nebulous feelings of shame he felt, and he was able to deal internally with the fact that the secret of his origin was not terrible and did not reflect on his intrinsic quality, he gained more self-confidence than he had ever had. He saw that, for himself, he could choose when and where to mention the fact of his birth—for instance, to his own friends, including girlfriends—even if he did not discuss it with his family.

Distinction Between Shame and Guilt

Robert's case illustrates how important it is to distinguish between shame and guilt, even when the latter also requires therapeutic attention. Etienne's death did indeed cause survivor's guilt in Robert for whatever angry fantasies or jealousy he may have felt while Etienne was alive. Treatment of these feelings did offer relief of associated symptoms. However, by focusing only on repressed guilt, the therapist overlooked Robert's gnawing conclusions of worthlessness because of shame about his birth and his mother's past, from which suicide seemed the only escape.

As indicated earlier, survival conclusions are set in the organism in a sequential manner in accordance with the emergence of different aptitudes at different stages of development. Erikson (1950/1963) charted the sequence of human development and showed that the aptitude for shame emerges approximately at the two- to three-year-old stage of development, whereas the ability for guilt only appears several years later, when the child can distinguish right and wrong, however inaccurately. Also, at this later stage of development, the child will have acquired fairly good language proficiency to support his or her perceptions. By contrast, two-year-old mental processes are primarily nonverbal. Accordingly, survival conclusions established with shame are inchoate, confused, and felt in the organism rather than articulated mentally, because language to aid understanding was not available when they were formed.

Thus, even later in life a person will have difficulty formulating the content of such conclusions in order to recognize their meaning and effect. Even memories of traumatic events from that age are jumbled because the child's perception of events and experiences was jumbled in the first place. This is particularly true for vague impressions such as Robert's that there was something wrong and shameful about his birth and parentage that was dangerous to expose.

The distinction between survival conclusions deriving from shame and those deriving from guilt corresponds to the difference between how a two-year-old might communicate pain and how a five-year-old might. If a two-year-old child falls and gets hurt, the child might cry for help, but he or she would be unable to name accurately what body part hurts. The best he or she can do is show the spot nonverbally (perhaps by rubbing it), but it would require someone else to *name* it. In contrast, a five-year-old hurt in the same manner might call out, but if asked, the child could also say where he or she had been hurt and even indicate the degree of pain, because he or she already had the verbal skill to specify and distinguish.

Thus, survival conclusions established with shame are far more primitive, organic, inchoate, and nonverbal than those established

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with guilt, which can be formulated and are therefore in a different treatment category. Problems resulting from guilt are amenable to psychoanalysis, whereas those derived from shame are not. However, paradoxically, for the person to understand feelings engendered by conclusions derived from shame, the therapist must help to translate conclusions into words. If such translation is done respectfully but accurately, treatment need not even be as complicated as therapy about issues derived from guilt. Therapists must determine which symptoms and/or behaviors are caused by which kinds of conclusions or stimuli in order to offer the appropriate interventions. Such distinctions are particularly important in cases of child abuse and in the treatment of adults who were abused as young children.

Nowadays, perhaps as an overreaction to the fact that early psychoanalysts neglected issues of shame and lumped them together with guilt, there is a tendency both in popular culture and the professional world to overlook issues of guilt and to ascribe more problems to shame than is warranted. The current trend is to combine guilt with shame by suggesting that shame is ubiquitous and by relating all addictions and many other problems to shame or childhood abuse, when only some of them are. I hope that new work in the therapeutic community will clarify the distinction between shame and guilt in personal and social areas, in addition to highlighting the reciprocal effect of one on the other.

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