An Exploration of the Formation of Shame and its Treatment in the Therapeutic Space

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Abstract

This dissertation set out with two primary aims. Firstly, to outline a theoretical understanding of the development of shame in the individual. The second aim was to develop an understanding of how a shamed client may present for therapy and how best to treat them. The findings of this dissertation were that shame develops in the individual as the conscience begins to form; the result of repression of desires and the incompatible idea. Shame also can manifest through the relationship with the primary caregiver. Finally shame can be the result of societal interaction, whereby the individual feels of lesser worth compared to societal expectations. Clients suffering from shame are far less likely to disclose their feelings to the therapist, thus the therapist must remain vigilant of shame dynamics and regressive behaviour on the part of the client. Empathy, genuineness and understanding seem to be key attributes for the therapist hoping to build a secure attachment with the shamed client.

Chapter 1 - Introduction

It could be argued that shame is an elusive emotion to succinctly describe, given the inherent similarities in its presentation to guilt or disgust. Throughout the last century or more several psychoanalysts have made contributions to the understanding of shame. This is in relation to internal development: in terms of the ego; external causal factors: relationship with the other; and interaction in society as a whole.

Over the course of Chapter Two, with reference to Breuer and Freud's (1895) studies on shame in its relation to repression and hysteria; Melanie Klein (1933) and her theories on shame in early childhood attachment; Erikson and the role of shame in his stages of sexual development, as well as the later work of Mollon (2002), Gou (2019), Rosenberger (2005), Scheff (2000), and Lansky (2003), Chapter Two focuses on providing a psychoanalytic understanding of the formation of shame in the individual.

With reference to Friel's (2016) study on the treatment of toxic shame in the integrative therapeutic relationship, referring to Mollon's (2002, 2005) work focused on demonstrating empathy towards the shamed client, Lewis' (1971) studies of the complexities of shame in the therapeutic space, and the work of Macdonald and Morley (2001), Chapter Three focuses on the presentation of the shamed client, the effect of shame on the therapeutic relationship and how best to accommodate the client presenting with toxic shame.

The aim of this dissertation is to provide an understanding of the emotion we call shame from a psychoanalytic perspective relating to its formation, and from both the psychoanalytic and integrative point of view in relation to its treatment in the therapy room.

Chapter Two – Shame, Self and the Other

Shame and the Self

In his early work the psychoanalyst, along with then colleague Joseph Breuer, Sigmund Freud made reference to shame in relation to the psychopathology of hysteria. In their work, *Studies on Hysteria* (1895, pp.313), they stated that shame can arise in an individual who unconsciously represses ideas that they found to be of a distressing nature in an attempt to avoid the "affects of shame", including the fears of being harmed, experiencing psychical pain and feelings of self-reproach.

Scheff (2000) argued that while feelings of self-reproach can be linked to shame, the fear of being harmed is a more general experience and the phrases psychical pain, hurt and emotional arousal can practically be applied to any emotion, not making them solely applicable to shame. Freud and Breuer at the time named shame as the emotion that leads to repression in the unconscious.

Scheff (2000) believed had Freud and Breuer remained focused on their work on shame, continuing their investigation into its causation in repression. Their investigation may have led them to attribute shame as being the causal factor of all mental illness, not just in terms of its psychopathology in hysteria. In later years Freud would neglect shame, replacing it with a focus on anxiety and guilt, which he believed to be "the appropriate emotions for responsible adults, especially male adults…", branding shame as a "regressive emotion, seen only in children, women and savages." (Scheff, 2000) Research by Gou (2019) echoed the above statements of Scheff. The former explained that although Freud tended to favour a focus on

guilt over shame, in relation to the psychodynamic, Freud's focus on the phenomenology of guilt "actually confirms the same forces that make shame such a central modern phenomenon."

In Freud's later work, the psychoanalyst referenced guilt formation in the individual as the result of an internal conflict between the ego and the superego, in response to negating acting upon desires. Freud explained that when the individual attempts "to render his desire for aggression innocuous", this is transformed and introjected, whereby the individual takes aim at part of its own self; "it is directed towards his own ego." (1930, pp.123-24) The repressed aggression related to the person's desire remaining unfulfilled is transformed, and directed inward.

Once internalised within the super ego, this sensation is focused on the individual's own ego, "in the form of conscience", and the same aggressive response that would have been externalised and focused on extraneous individuals erupts in a tension "between the harsh super ego and the ego". This leads to a sense of guilt arising in the individual or in an attempt to avoid the experience through the application of shame dynamics, as discussed below by Lansky. In a somewhat self-flagellating style, the super ego acts as authoritarian over the ego as the sense of guilt "expresses itself as a need for punishment." (Freud, SE 2 1 : 6 4 -1 4 5 [1 9 3 0]), SE 2 1 : 1 3 4 .)

Subsequently, Freud pointed out that the guilt arising from the judgemental super ego and the fragile ego acts as a barrier between the individual and the fulfilment of their desire. Instinctual urges are negated in an effort to avoid feelings of guilt, or if one is to refer to Freud and Breuer's earlier vessel of repression, shame. In relation to the societal implications for the individual attempting to overcome baser urges of desire, Freud explained that society triumphs over "the

individual's dangerous desire for aggression", by internally shaping the super ego in the vain of social norms. This is achieved when the super ego's standards reflect those of the civilisation within which the individual resides (Freud, 1930). In essence, the individual is shamed into adherence to social norms.

Carl Jung (2009) addressed his own ego directly in an excerpt taken from *Scrutinies* in *The Red Book*. Jung accused his ego of lacking a proper sense of self-esteem, modesty or piety, made reference to his ego focusing on pursuits of pleasure, lamenting its wickedness as he said, "What is concealed in you I will drag out into the light, shameless one!", in an attempt to curtail the ego's harsh criticism. Having found the words to challenge this generally oppressive internal force, Jung exclaimed, "after I had spoken these and many more angry words to my I, I noticed that I began to bear being alone with myself". There is a hint at a sense of empathy overcoming the analyst in the aftermath of his tirade.

Lansky (2003) elaborated on points made by Freud and Breuer relating to incompatible ideas, how one may repress them from memory as their mention will evoke a feeling of shame or guilt in the patient. When these ideas approached the individual's ego, should the ego find them to be incompatible in some way or thoughts to "arouse the effects of shame" the super ego would come into play. Freud described this as "a repelling force of which the purpose was defence against this incompatible idea" (Freud & Breuer, 1895, pp.268-269). In instances where the individual were to recall a memory of some sexual desire, one which is in some way "incompatible with personal morals and standards", it is repressed by the conscience to the unconscious, as a means of avoiding the experience of these moral emotions, shame and guilt. The memory is forced out of sight of one's moral standards. The model outlined by Freud and Breuer is one where "the patient is not only the audience, as it were, but also an actor and, more

often than realised, the author of the scenario": editing the lines and role in accordance with societal expectations, according to Lansky (2003). The patient's conscience playing a vital role in this act of self-shaming and attempted avoidance thereof.

Both Lewis (2003) and Lansky (2003, pp.1181) mentioned the vital role of conscience in the formation of these feelings of shame and guilt, the former referred to shame as one of the "self-conscious emotions." Having not met the standards one has set for oneself, judgement is passed on the act or behaviour in the aftermath and the individual feels shamed for their actions.

Lewis (2003, p.1182) also pointed out that there is a concern on behalf of the individual relating to how they or their actions are perceived by others, explaining that certain events are more likely than others to produce a shame-state in the individual, depending on the likelihood of said event to "lead to shame producing thoughts". It seems there is a dual possibility for the experience of shame, one arising internally through judgement of one's own standards or desires, and the second whereby one is shamed via judgement from the other.

Referring to Darwin's experiments with blushing, Lewis (2003, pp.1182) explained the complexities of shame in relation to the individual and consciousness. In the instance where the individual is driven to become embarrassed, or shamed, the awareness that there is another in observation of this uncomfortable experience adds to the negative feeling associated with the event. As Lewis explained, "shame arises from how others see us", another example of the duality of the experience of shame for the individual. The shame in being seen by the other.

Freud's explanation that a sense of guilt arose as a result of repressed aggression relates to the developing relationship between child and caregiver, as the first authority figure the individual

forms a relationship with is the primary caregiver. The child, who is fearful of the implication of disobeying the authority figure attempts to circumvent experiencing this sense of guilt by "avoiding the activities censured by the authority, since the evil consequence (loss of love) will follow only if his action is discovered." (Hazard, 1969, pp.245)

Shame and the Other

Now that there is a grounding in the formation of shame internally, in relation to the conscience, the super ego and the ego, one wishes to outline possible causation of shame in relation to the other. Complimentary to the theories of Lewis, Rosenberger (2005) stated it is generally accepted among analysts that there is a "visual function" tied to shame, whereby one who is feeling ashamed wishes to hide away from the judgemental gaze of the other. There are also two ancillary feelings that arise for the shamed person, embarrassment and humiliation, akin to that mentioned by Darwin in his study of blushing.

In reference to Kleinian object-relations, Rosenberger (2005) commented upon the frustration and gratification seen in infants in early life "as they lusted for and raged against their mothers' breasts", pointing to the experience of envy in the child "to his or her frustration in seeking gratification from the unavailable mother." (Rosenberg, 2005). In not receiving gratification from the desired object, the baby is not met in their needs by the other, leading to feelings of shame, embarrassment or humiliation as a result. Not receiving the mother's milk becomes, for the child, "an interpersonal event, in which the denying breast became an object the infant, in envy, wanted to attack, to destroy". This aggressive response from the infant bears similarities in the aggressive reaction described by Freud and Breuer (1895), which related to the

individual's desires not being met. Lewis (2003) noted the experience of envy ("conscious or unconscious comparison with another who is seen as more complete or loveable than oneself") is actually triggered by shame, functioning as a defensive element to avoid the experience of shame, commenting on Klein's omission of this from her theories on conscience and the pre-oedipal super ego, and the role it plays in the formation of the conscience of the individual. (Klein, 1933)

For Mollon (2005), sexuality played a role in the experience of shame, as the very frightening nature of sexuality to humans, in terms of their desire and their formation as individuals is threatened by sexual desires. There is also a fear of judgement should those desires be verbalised to another, and become part of the social discourse. The individual who may be conscious of the "object of shame" in an internal discourse will withhold from discussing this with another, for fear of shame or embarrassment. In relation to the Freudian stages of sexual development, Erikson (1950) noted the battle for the child with "shame and autonomy with the anal stage of Freud's psycho-sexual scheme", another causal factor in shaming the individual.

The still faced experiments conducted by Tronick *et al* (1978) first showed signs of a shameful reaction in the child who was not met in their needs of receiving a loving gaze from their primary caregiver. This is similar to Freud's views on the manifestation of guilt in relation to the repression of aggressive desires, through the interference of an external force, namely a parent preventing a child from seeking some internal gratification through their actions, the child seeking a loving gaze from the parent is met with no change in facial expression. The result of this send the children into a mode akin to panic, whereby the child attempts to evoke a loving gaze from the parent and upon failure, generally culminates in tears and tantrums, or simply aggression, as Freud stated. In the experience of not receiving a loving gaze, the child

internalises a feeling that they are a bad or in some way shameful being. These studies lead Tronick *et al* (1978) to believe this is where feeling of shame originates in the formative years of the individual.

Earlier work conducted by Winnicott (1947, p.201) compliments the experiments conducted by Tronick *et al*, as the former stated "the baby is not her own (mental) conception"; having to depend on an external figure, in this case the parent, for understanding and the restoration or maintenance of the child's mental equilibrium. According to Winnicott's statement, the child is enslaved emotionally to the (m)other, seeking the loving gaze of the primary caregiver for comfort. Rignell (2013) elaborated upon this further, explaining that infants are constantly looking for some sign that they are good and if this is not done consistently by the parent, then their internal world becomes one of self-hatred and self-reproach over time. Mollon (2003, pp.5) also referenced shame as being a 'narcissistic affect' observable in the child who is not met in their desired response from the primary caregiver.

There is a sense that the early work of Freud and Breuer, ascribing shame to be a causal factor in repression of an incompatible idea, that in being missed in the gaze of the parent, thereby feeling shamed by the act (experience is incompatible with desire), the child internalises these feelings of shame and directs them towards the self. Nathanson (1992, p.334) explains that this leads to a point where the child experiences a state where it is "good to feel bad". This can lead to a cyclical occurrence where shame if a self-perpetuating entity, essentially feeding off itself.

Chapter Three – Shame in the Therapeutic Space

The previous chapter discussed the formation of shame in the individual, primarily through internal conflict between the ego and super ego, as the conscience comes in to play, and secondarily through the relationships formed with the primary caregiver,, This was elucidated using Klein's (1933) theories on object relations with the mother's good and bad breast, and the internal struggle for the child as a result of the desire and envy that can erupt in this exchange. Both self and society play a role in shaming the individual, akin to a living theatre play in which the script is being constantly rewritten to reflect societal expectations placed upon the individual at the time. Rignell (2013) work on the presentation of shame in the client; Mollon's (2002, 2005) theories relates to utilising empathy in the therapeutic space; Cattaneo *et al.* (2013) on their work relating to the psychopathology and treatment of shame, a study on disclosure of shame and guilt by Macdonald and Morley (2001), and finally, Lewis'(1971) and Friel's (2016) respective studies of the presentation and detoxification of shame in the therapeutic relationship, this thesis will demonstrate an understanding of the presentation of shame in the client and the methodology in the treatment of the shamed client.

How Shame Presents in the Client

Rignell (2013) explained that shame is often masked by loathing or a hatred of others. It is incompatible for certain individuals to demonstrate vulnerability, in the form of divulging a shameful experience, so the feeling may be titrated into a more acceptable emotion, thus the client can act in an aggressive manner. This aggression bears similar traits to those theorised by Freud and Breuer (1895) in their work relating to aggression, the incompatible idea, and the

repression of desire. In a paper focused on male sexual shame, Gordon (2019) explained that "shame may be associated with traditional masculinity - suggesting that men with this gender ideology may be particularly vulnerable" to experiencing shame over those who do not adhere to the traditional masculine gender ideology.

Rignell (2013, pp.79-80) stated that he cannot recall a client, upon commencement of their therapy, seeking treatment for shame outrightly, yet in due course it came to light that these clients, finding it "easier to admit difficulties with anger or guilt" were actually suffering at the hands of the emotion known as shame. Complimentary to Rignell's statement, Helen Lewis (1971), noted the disparity between the number of shame markers arising in the transcripts compared to their discussion in said sessions. The client can, in a sense, become ashamed of their shame, noted by Lewis as "feeling traps", neglecting to share it with the therapist.

Rignell (2013, pp.80-81), in line with a statement made by Michael Lewis (2003, pp.1182) noted that "shame arises from how others see us", continuing that shame and guilt are often confused, but the former emotion is conjured up in relation to the other. Shame is birthed in the gaze of the other, externally speaking. Generally, it is believed that guilt arises in the individual in relation to something they have done, whereas feelings of shame relate to the self. As noted by Freud (1930) in relation to the internal battle between authoritative super ego and subservient ego.

How to Hold the Shamed Client

Friel (2016) investigated the treatment of toxic shame in the integrative psychotherapeutic space, finding that recognising shame is the first step in treating it. The study focused on the isolating aspects of the experience of shame for the client and the approach that should be taken by the therapist in the treatment of toxic shame.

Friel (2016, pp.532) referenced the correlation between early childhood development and relationship with the child's caregiver, in clients presenting with toxic shame. The theorists work focused on the role of the therapist "in detoxifying shame through recognising, understanding and working to normalise it", highlighting the importance of shame sensitivity on the part of the therapist, in their attempt to form a secure attachment within the therapeutic relationship with the client. The client presenting with toxic shame is suffering from the view that their "whole self is a mistake and of being defective at the core" (*Ibid.*, pp.533). In building a secure attachment, these feelings can be addressed over time.

In a controlled study of five participants, Friel (2016, pp.538) found that all participants presenting with toxic shame disclosed feelings of worthlessness in relation to the perceived expectation placed upon them when discussing their shame experiences. Feelings of isolation and splitting, whereby the participants mentioned "a tendency to split off aspects of the experience" in an attempt to block it out of consciousness, repressing it from conscious memory, were also disclosed by all participants. Finally, the concepts of abandonment or rejection were expressed by each participant in relation to their experience in sharing their shaming experience.

In terms of the relationship with the other, the participants noted the quality of their relationships suffered at the time of their experience; Friel (2016, pp.539) noted the necessity of a secure attachment in the wake of a shameful experience, as there is a tendency for the shamed individual to become avoidant, angry or feel anxious. There were notable transference phenomena disclosed within the study, as the therapist takes on the role of the mother, the lover, the shame-provoker in the relevant situation. Lansky (2003) noted the challenge in highlighting shame dynamics within the therapeutic relationship, commenting on the "powerful countertransference resistances" at play in the process of working with a client presenting with shame. In attempting to build a secure relationship with the therapist, the client can overcome their experience through a trusting relationship with the therapist as a ""responsive other". Another vital element of the building of the therapeutic relationship is one in which the client feels validated and "affirmed by the significant other during the detoxification process." (*Ibid.*, pp.539) Empathy and genuineness on the part of the therapist two necessary components of the secure attachment.

The final theme of the study, which focused on the reparative relationship between client and therapist, found that all participants sought a quality relationship whereby the therapist is attuned to the client's needs and emphatic in their understanding and commitment to the client in their processing of the shame experience. It was shown that all participants required a holding relationship with the therapist built upon "trust and safety". In summary, the study found that "there can be no shame without regression", leading to a break or split in the therapeutic relationship which needs to be addressed in rebuilding of a stable and reparative relationship post-event (Friel, 2016, pp.540-41). The link between early childhood relationships and shame is evident in the study, which found that two necessary requirements for the detoxification of shame are the "security of attachment and the reparative relationship"

(*Ibid.*, pp.544). An awareness on behalf of the therapist of regressive behaviour on the part of the client will aid the sustaining of the secure therapeutic bond.

Psychoanalyst Helen Lewis (1971), in a psychological analysis of therapy sessions noted that shame was the prevalent emotion – "shame markers were frequent in all sessions" (Scheff, 2005) – accounting for more markers than all other combined emotions disclosed by participants. In the sessions analysed, the manifestation of shame was not mentioned by client or therapist, noting the lack of awareness of these shame markers by both parties, and noting that this seemed to occur when there was a sense, on the part of the client, that the therapist had somehow rejected, criticised or exposed them in their session. The data reflected a tendency in clients to attempt to "bypass shame", whereby the client would seemingly demonstrate that they were in pain through "obsessional speech on topics that seemed somewhat removed from the dialogue", which Lewis noted needed to be held and named by the therapist in order to manage and understand the client's shame, similar to Friel's (2016). Findings relating to naming the regressive behaviour by the therapist.

Lewis discovered a link between shame and anger, as well as instances where shame cycles seemed to last for extended periods of time. In what the analyst described as "feeling traps", the client has an emotional response to an emotion spoken about in-session, or somehow misinterprets the therapist's response as hostile or dismissive, thereby causing them to feel embarrassed or ashamed. In these episodes, the client would respond in kind with an aggressive or angry response; "each emotion in the sequence is brief, but the loop can go on and on" (Scheff, 2005), leading to a repetitive and unstable experience for the client.

In line with Mollon's theories relating to empathy in working with the shamed client, Lewis found that shame occurs as a "response to the threat of disconnection with the other". (Scheff, 2005). Concurrently to the findings aforementioned, Lewis suggested that shame can also manifest "in response to actions in the "inner theatre", in the interior monologue in which we see ourselves from the point of view of others" (*Ibid.*, 2005). Complimentary to the study conducted by Friel (2016), through the formation of a secure attachment in relationship with the therapist, the shamed individual can begin to overcome their experience.

A study by Macdonald and Morley (2001) found that a vast number of participants who were referred for psychotherapy neglected to disclose their emotional responses to others. Some 68% of participants neglected to disclose their experiences of shame, hatred or guilt to another person. A further marker of the sense of difficulty in disclosure relating to shaming incidents is the disparity between the discussion of everyday incidents to other people in comparison to that of shame or guilt. Participants were 58% more likely to discuss everyday emotions with others than they were to discuss feelings of guilt or shame. The pair deemed this reluctance to disclose the experiences by the primary group was related to the possibility of experiencing negative responses from others, as well as self-critical factors such as shame or disgust. In some cases (33%) of the participants stated that they were concerned with apparent positive responses of people when attempting to relate to their issue. Insight or concern for someone held in a shame-cycle can be deemed critical as this forces them to remember their past experiences of not being met in their emotional needs. Participants stated that the preventative factors from disclosing their experience were related to a negative sense of self and concern over the possibility of a negative response from the other.

Cattaneo *et al.* (2019, pp.107), in a study of the psychopathology of shame, noted several techniques that can be employed by the therapist treating a shamed client. Similar to the "feeling traps" described by Lewis, the therapist can teach the client to overcome these repetitive emotional states that by "teaching patients more adaptive emotion regulation strategies in different contexts", thereby aiding the alleviation of the symptoms of the client. A second strategy for the therapist to utilise is to discuss their experiences "as if they were not ashamed" (*Ibid.*, pp.107) which helps the client to avoid relying on avoidant behaviours relating to the disclosure of their feelings. Thirdly, through the therapist encouraging the client to "do certain 'shameful' things", the client is enabled to challenge long held "underlying dysfunctional/irrational beliefs" (*Ibid.*, pp.108).

The study conducted by Cattaneo *et al.* found that by expressing the importance of an awareness on the part of the therapist of the causal and active factors in their shame interventions in order to optimise the strategy undertaken in treating the shamed client, noting that by "tackling shame-proneness and maladaptive shame regulation strategies we may reduce the negative impact of this emotion on therapeutic alliance and symptomatology" Cattaneo *et al.* (2019, pp.109).

For Mollon (2002, pp.26), the work in facilitating the shamed client begins with an understanding that there may have been instances in the past where the client may not be " able to evoke an emphatic response in the other". Mollon (2002, pp.142) noted that the shamed individual experiences life as though there is a vast gulf in the relationship with the other, on which there is a sensed lack of acceptance and attunement. This experience feeds into the internal belief that the shamed individual is not good enough or in some way lacking. Mollon's work lead him to focus on the healing power of empathy within the therapeutic relationship,

stating: “the cure for shame is the empathy provided by the other” (*Ibid.*, pp.142). In a research paper noting the link between shame and sexuality, Mollon (2005) referenced the failure of language to encapsulate the full essence of sensory experience and its link in provoking shame, which “is associated with whatever is outside the discourse, whatever cannot be spoken of”, a nod to Lacan’s theories on the failure of the symbolic order in the representation of human experience *in totum*. Through the use of empathy in the relationship with the client, the analyst attempts to alleviate the experience of shame for the client “by drawing more and more of the analysand's self into the spoken symbolic realm” (Mollon, 2005).

In terms of a hopeful outcome for someone experiencing deep shame in a therapeutic space, Nathanson (2007, xv) offered this: “Wherever you see shame (no matter how vigorously defended against) someone is hoping for reconnection”. This statement is a demonstration that the shamed individual wishes to form a safe and functional attachment with the therapist, in spite of their affliction, as it were. As Nathanson (2007) says above related to the hope for reconnection, perhaps shame can be bested through the vehicle of the psychotherapeutic relationship whereby the therapist is attuned to the client’s needs, willing to name regressive behaviour and can hold the client through a secure, emphatic bond that empowers the shamed client to overcome their situation.

Chapter Four - Conclusion

The aim of the previous chapters was to lay out the groundwork for an understanding of the psychoanalytic formation of shame in the individual, and also a framework for how best to treat the shamed client as a therapist.

The self-conscious emotion we refer to as shame, developing from the interplay of the ego and super ego as the conscience begins to form an understanding of the world and the societal expectations placed upon the individual, and via the relationship with the primary caregiver in early childhood plays a role in human behaviour, both socially and internally, through the inner dialogue of consciousness. If unaddressed, this can become a repetitive loop whereby the shamed individual, feeling less than in comparison to the other, is repeatedly shamed by their own perceived lack.

A client presenting with the symptomology of shame can demonstrate a numerous array of defensive behaviours while addressing their experience. The therapist would do best to remain vigilant of regressive behaviours from the client, to develop the relationship with the shamed client whereby they demonstrate empathy, understanding and are willing to name directly, the display or evocation of shame in-session. As noted in the study of Cattaneo *et al.* (2019), equipping the client with new cognitive approaches to dealing with their shame and acting out these shame-impulses to challenge long held beliefs can help to dissipate shame for the client. For Mollon (2002), the demonstration of genuine empathy was key in the treatment of shame. Finally Lewis (1971) and Friel (2016), in a similar manner, noted the importance of building a secure, reparative relationship is key in the detoxification of shame. The shamed client can, in time, overcome their experience with the support of a therapist who is equipped with the

aforementioned abilities. To note Nathanson's (2007, xv) words again, the shamed client is someone hoping for reconnection.

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Appendix I – Quotes on Shame

“Soul, if you want to learn secrets,
your heart must forget about
shame and dignity.
You are God's lover,
yet you worry
what people
are saying.”
– Rumi

“Beauty shames the ugly.
Strength shames the weak.
Death shames the living –
and the Ideal shames us all.”
– Jordan B. Peterson

"What do you consider the most humane? –
To spare someone shame.
What is the seal of liberation? –
To no longer be ashamed in front of oneself."
– Nietzsche

“I never wonder to see men wicked,
but I often wonder to see them not ashamed.”
- Jonathan Swift