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Image and Trauma

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Argument

In 1980, when the diagnosis of Posttraumatic Stress Disorder (PTSD) was introduced into the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), survivor guilt – a symptom long associated with trauma of the Holocaust and other extreme experiences – was included in the list of symptom criteria. But in the revised edition of the manual of 1987 (DSM-IIIR), survivor guilt was demoted to the status of merely an "associated feature" of the condition. Now that survivor guilt has disappeared from the official lexicon of trauma, shame has come to take its place as the emotion that most defines the traumatic state. This paper examines the rationale for the shift from survivor guilt to shame in the context of the American Psychiatric Association's revisions. It argues that the shift can be understood as yet another manifestation of the oscillation between mimetic and antimimetic theories of trauma that, I have argued in my book *Trauma: A Genealogy* (2000), has structured the understanding of trauma from the start.

In 1985, American physicians Elizabeth Brett and Robert Ostroff published a paper on the centrality of the image to the conceptualization of posttraumatic stress disorder, or PTSD. Their article had a polemical intent. They claimed that researchers had failed to appreciate properly the significance of imagery in the diagnosis and treatment of PTSD. Indeed, they contended that what they characterized as the diagnostic and clinical confusion marring the field of posttraumatic stress could only be remedied by reconceptualizing the official criteria for PTSD in terms of the image (Brett and Ostroff 1985). They were not alone in emphasizing the role of the image in trauma. Starting in the 1980s, in books and articles by Cathy Caruth, Bessel van der Kolk, and others, the notion of the traumatic image, conceived as an "iconic" memory that haunts the victim in the form of flashbacks, dreams, and other intrusive repetitions, has come to dominate American (and to some extent also, European) discussions of trauma (Leys 2000).

What is at stake in the recent emphasis on the traumatic image? In 1980, largely as a result of agitation by the anti-Vietnam war movement, PTSD was introduced into the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the official classification manual of the American Psychiatric Association. The

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new diagnostic category was welcomed by many in the field of trauma studies because it gave official recognition to signs and symptoms of disorder that had long been observed in victims of trauma. DSM-III represented a fundamental shift away from the Freudian tradition that had previously dominated American psychiatry to a more ostensibly "objective" approach to mental illness (Young 1995). In its initial formulation PTSD was defined as an anxiety disorder with four diagnostic criteria: A) The traumatic event; B) Reexperiences of the event; C) Numbing phenomena; and D) Miscellaneous symptoms. The traumatic event itself was defined as an event that involved a "recognizable stressor that would evoke significant symptoms of distress in almost everyone" (DSM-III 1980, 236, 238). There were several ambiguities in those criteria and definitions. The invention of PTSD had been propelled by the widespread desire to obtain formal acknowledgment of the idea that severely traumatic events could have prolonged psychological consequences in anyone, regardless of the individual's prior history or personality. In this regard, the PTSD diagnosis necessitated a shift away from the previous approach to trauma, which concentrated on the ways in which stressful life events were mediated by the subjective interpretation of the victim. As Brett and her colleagues noted, the PTSD "revolution" meant that investigators now had to identify the relevant environmental stressors "regardless of the coping styles or resources of the individuals exposed to the events" (Laufer, Brett, and Gallop 1984, 61). This meant that the previous, largely psychoanalytic emphasis on the role played in the traumatic reaction by the subject's earlier experiences, especially his or her early libidinal history, was replaced by a focus on the role of the external environment. The fact that PTSD was one of the few disorders in DSM-III to focus on etiology also strengthened the new tendency of researchers to highlight the causal role of the external traumatic event, since the symptoms associated with trauma without the presence of the highly stressful event were not held to constitute the disorder (Green, Lindy, and Grace 1985, 407).

Yet from the start what was lacking was a clear definition of what constituted a recognizable stressor, as well as methods to operationalize and objectify the traumatic event. In this context, the aim of Brett and Ostroff's paper was to reformulate PTSD in terms of the image so that the task of operationalizing and objectifying the disorder could proceed more effectively. The authors began by defining the image: "Images are mental contents that possess sensory qualities. They are distinguished from mental activity that is purely verbal or abstract. While images can have qualities associated with any of the sensory modalities, visual imagery is believed to be the most common" (Brett and Ostroff 1985, 417). The definition came from Mardi Jay Horowitz, who for many years had been simulating stress responses in the laboratory by studying the impact of stressful films on experimental subjects (Horowitz 1970, 4). Images, as internal psychic representations, were said by Horowitz to be different from perceptions in that, unlike the latter, they were not simple replicas of an external stimulus, but complex amalgams of memory fragments, reconstructions, and fantasies whose formation could be influenced at any time by the subject's emotional states, proneness to experimental

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compliance, suggestibility, and other factors (ibid.). Nevertheless, there was a tendency, inherent in Horowitz's information-processing approach to cognition, as well as in his experimental protocols, to collapse the image into perception, itself defined as a simple copy of the traumatic stimulus. One consequence was his readiness to treat images as if they were faithful replicas of the external world. This is a crucial issue, because what was lost in Horowitz's collapse of the image into perception was his own psychodynamic understanding of the potentially identificatory-mimetic or fantasmatic nature of the mental image. As a result, not only was the mental image abstracted from the human relationships that from a "mimetic" point of view might be considered to produce it and give it meaning, it also came to be understood "antimimetically" in indexical terms as if it were the causal outcome or literal imprint of the external trauma.

Throughout my paper I shall be using the terms "mimesis" and "antimimesis" as these terms were deployed in my book *Trauma: A Genealogy* (Leys 2000). In that book I argued that from the moment of its invention in the late nineteenth century, the concept of trauma has been fundamentally unstable, balancing uneasily, or veering uncontrollably, between two antithetical ideas or theories. The first, or mimetic theory, holds that trauma, or the experience of the traumatized subject, can be understood as involving a kind of hypnotic imitation of or regressive identification with the original traumatogenic person, scene, or event, with the result that the subject is fated to act it out or in other ways imitate it. Trauma is understood as an experience that immerses the victim in the scene so profoundly that it precludes the kind of specular distance necessary for cognitive knowledge of what has happened. The mimetic theory explains the tendency of traumatized people to compulsively repeat their violent experiences in nightmares or by repetitive forms of acting out, by comparing the traumatic repetition to hypnotic imitation. Trauma is thus interpreted as an experience of hypnotic imitation and identification that disables the victim's perceptual and cognitive apparatus to such an extent that the experience never becomes part of the ordinary memory system. This means that the amnesia held to be typical of psychical shock is explained as a kind of post-hypnotic forgetting.

An aspect of the mimetic theory that should be stressed is that mimesis leads to doubts about the veracity of the subject's testimony because the identificatory process is thought to take place outside of, or dissociated from, ordinary awareness. Since the victim or detainee is imagined as thrust into a state of hypnotic-imitation, the mimetic theory cannot help worrying about confabulation, or the problem of testimonial authenticity. Finally, since the mimetic theory posits a moment of terrorized identification with the aggressor, victims are imagined as incorporating and therefore complicitously sharing the hostility directed towards themselves. The concept of survivor guilt finds its explanation in the mimetic theory by assuming that the identification is always ambivalent because it is structured by hate and love and hence is inherently rivalrous and guilty.

The second, or antimimetic theory, also tends to make imitative identification basic to the traumatic experience, but it understands imitation differently. The mimetic

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notion that victims of trauma are completely caught up or blindly immersed in the scene of shock is repudiated in favor of the opposite idea that the subject remains aloof from the traumatic experience, in the sense that he remains a spectator of the scene, which he can therefore see and represent to himself. The result is a tendency to relegate the problem of mimesis to a secondary position in order to establish a strict dichotomy between the autonomous subject and the external event. The antimimetic theory is compatible with, and often gives way to, the idea that trauma is a purely external event that befalls a fully constituted if passive subject. Whatever damage there may be to the victim's psychical integrity, there is in principle no problem about his eventually recovering from the trauma, though the process of bringing this about may be long and arduous. And in contrast to the mimetic theory's assumption of an unconscious identification with the aggressor, the antimimetic theory depicts violence as simply an assault from without. This has the advantage of portraying the victim of terror as in no way mimetically collusive with the violence directed against him, even as the absence of hypnotic complication regarding the reliability of his testimony shores up the notion of the unproblematic actuality of the traumatic event. The antimimetic theory also lends itself to various positivistic interpretations epitomized by the various neurobiological theories of trauma that have won widespread acceptance today.

To return to the question of the traumatic image: In an interesting discussion of the many problems left unresolved by the new diagnosis of PTSD, the author Bonnie Green and colleagues observed in 1985 that although the exact form of the intrusive images or experiences thought to define PTSD was not specified in DSM-III, the manual implied that those images and experiences were a direct recapitulation of the event. Green and her group objected to that assumption, on the grounds that dreams as well as waking images often represented the trauma in disguised or distorted ways (Green, Lindy, and Grace 1985, 409). Nevertheless, as they acknowledged, it was an assumption that was already becoming normative in the field. In short, Brett and Ostroff's paper on imagery exemplified the antimimetic tendency in American psychiatry to treat the traumatic image as an externally imposed mental content uncontaminated by any mimetic, fantasmatic, or suggestive dimension.

Against this background, one of the striking things about Brett and Ostroff's paper was its claim to originality – its contention that, five years after the invention of PTSD, the fundamental importance of imagery had yet to be fully acknowledged. They stated that, with two important exceptions, all the major figures who had worked on trauma had failed to maintain a focus on imagery or to conceptualize its role in PTSD. According to Brett and Ostroff, these failures meant that the image had to be extracted from the previous literature if it was to be given the kind of prominence they sought for it. They were helped in their project especially by the work of Horowitz who had focused on the relationship between imagery and stress disorders through more than two decades of experimental-theoretical-therapeutic inquiry. As Brett and Ostroff acknowledged, their proposals for the reorganization of PTSD in terms of the image represented a simplification and application of Horowitz's theories. According

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to their summary of Horowitz's views, the traumatic event was considered stressful because it lay outside the realm of the individual's experience. The victim was unable to process the meaning of the traumatic information because it could not be assimilated into existing cognitive schemas. Instead, "untamed" images of the trauma remained stuck in a hypothetical image storage system, from which they repeatedly pressed for revisualization and assimilation in the form of peremptory flashbacks and imagistic intrusions. Horowitz posited that the amnesia, constriction of thought processes, and emotional deadening or numbing held to be characteristic of the trauma victim were forms of denial by which the subject attempted to defend against the intrusive images and reduce the anxiety associated with them. He believed that the intrusion and denial states alternated according to various intrapsychic trends and gradually decreased in severity and frequency as a new equilibrium was achieved (Horowitz 1976).

Horowitz's significance for Brett and Ostroff was not just that he had studied the formal properties of the image in experimental settings, or had developed interview protocols designed to assess objectively the role of imagery in actual patients. It was also that he had decisively expanded the role of the image in the stress disorders by arguing that images regularly occurred not only in dreams, to which earlier workers had tended to restrict them, but also in the awake state, where they had not been generally or systematically noticed. On the basis of Horowitz's approach, Brett and Ostroff proposed organizing the symptoms of stress around two "dimensions." The first dimension involved repeating or reexperiencing the trauma in the form of unbidden and intrusive images, images that were accompanied by affective states and actions. The second dimension involved defensive efforts to deny the trauma, including emotional numbing, amnesia, and other attempts to suppress or avoid the trauma. They went on to argue that all the theorists whose work they had briefly reviewed could now be placed in one of two distinct groups, depending on whether or not the author's ideas conformed to the proposed two-dimensional framework. Thus Freud's suggestion that the ego was overwhelmed in trauma because of an extensive breach in the mind's protective shield against stimuli, with a consequent unleashing of the repetition compulsion and tendency of the victim to reexperience the trauma in nightmares, was held to be comparable to Horowitz's assumptions that the trauma victim was liable to experience unbidden recurrent images. The only discrepancy between the two thinkers from this point of view was that Freud had failed to appreciate the importance of waking imagery. Freud's ideas about the patient's defensive efforts to control the repetition were assimilated into the denial or numbing phase of the two-dimensional model.

From a "genealogical" perspective, Brett and Ostroff's groupings of previous workers on trauma appear artificial and contrived. But they served the purpose of demonstrating how the ideas of certain major theorists of trauma, notably Freud, could be viewed as essentially conforming to the two-dimensional framework they were advocating, thereby reinforcing its seeming validity and plausibility. The elegance and economy of the new model lay in part in its self-vindicating character. In fact, as Allan Young has cogently argued, it was irrefutable (Young 1995, 140). Either traumatized subjects

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experienced intrusive images or they did not. If they did, the images were held to be an expression of the repetition compulsion, as the unassimilated traumatic experience repeatedly pressed for expression and processing in the form of daytime flashbacks, sleeping nightmares, and other images. If the victims did not experience such images, the explanation was that they were in the denial or numbing phase of the traumatic syndrome. The absence of reported images did not mean that such images did not exist. In short, Brett and Ostroff made the case for the centrality of intrusive imagery in the stress disorders by arguing that traumatic images only appeared to be absent owing to the patient's defensive efforts to suppress them, and by recasting other symptoms not previously associated with images as signs of intrusive visual contents and experiences.

Among the many consequences that flowed from the new emphasis on the image in trauma, the one that I want to pursue here concerns the status of the concept of survivor guilt. From the perspective of Brett and Ostroff's new model of PTSD, the original diagnostic criteria proposed for the disorder contained considerable redundancy, or overlap. In particular, the fourth or "miscellaneous symptoms" category contained a heterogeneous group of symptoms most of which could now be incorporated without difficulty into the two dimensions of reexperiencing or numbing. For example, the symptoms of hyperalertness or exaggerated startle response, sleep disturbances, and the intensification of symptoms by exposure to events that symbolized or resembled the traumatic event – all originally listed in the "miscellaneous symptoms" category – could now be regarded as forms of reexperiencing, and their relocation to that dimension could be seen as a conceptual clarification. Just so, the memory impairment and avoidance symptoms, also originally listed in the "miscellaneous symptoms" category, could now be reclassified as aspects of denial or numbing, yielding a similar conceptual advance.

That left one item in the "miscellaneous symptoms" category unaccounted for, namely, survivor guilt – a symptom that, since the earliest postwar discussions of the Holocaust survivor had been widely regarded as one of the most characteristic signs of posttraumatic stress. In their article on imagery, Brett and Ostroff expressed some uncertainty as to where to place survivor guilt in their revised model of PTSD. At first they suggested that it belonged to the dimension of reexperiencing. But that solution was only temporary. When in 1987 the diagnostic criteria for PTSD were revised according to Brett and Ostroff's two-dimensional model, survivor guilt suffered a demotion. In fact, it was dropped as a diagnostic criterion and reduced instead to a merely "associated" feature of the disorder.

The change did not occur without debate. "There was controversy over whether to include the survivor guilt item from DSM-III . . . as an aspect of reexperiencing," Brett, Spitzer, and Williams wrote in their capacity as members of the subcommittee charged with the responsibility for the revisions,

> but it was finally eliminated because it was not clear that survivor guilt is present in all cases of PTSD. It was agreed that survivor guilt is a prominent symptom of certain kinds

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> of PTSD and it was listed as an associated feature of the disorder. The diagnostic criteria are intended to be parsimonious, and the subcommittee believed that the removal of the guilt item from the criteria would not result in false negative diagnoses. (Brett, Spitzer, and Williams 1988, 1233)

In short, according to Brett and her colleagues, the dimensions of intrusion or denial were capable of capturing PTSD so adequately that the omission of survivor guilt did not matter diagnostically. Thereafter, survivor guilt could be safely omitted from the checklists and other instruments used to assess the nature and incidence of posttraumatic stress.

We can measure the effect of dispensing with survivor guilt as one of the diagnostic criteria for PTSD by noting that in a subsequent collection of papers that arose from the revision process for the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (1994), only one article referred to the topic. There, in a discussion of natural disasters and PTSD, Bonnie Green observed that survivor guilt "does seem infrequent and its removal from the DSM-III-R criteria does seem justified." She reported that even in the case of the Buffalo Creek flood, a famous disaster in which many people had died, more recent follow-up studies that attempted to operationalize the concept of survivor guilt found that it was a rare symptom – if ranked, it would have tied for last place (Green 1993, 79, 82). To assess guilt, victims were asked on the "Disaster Interview Schedule" whether the horrifying events they had experienced make them feel "ashamed of being alive" (ibid., 79), so that the operative term was in fact shame, not guilt. Green's reference to the flood in Buffalo Creek is an interesting marker of the shift in attitude towards the centrality of the experience of guilt to the survivor experience. For at the time of its occurrence, the Buffalo Creek disaster had been the topic of a well-known paper by psychiatrist Robert J. Lifton, in which the guilt of the survivor had been a prominent theme. Equally striking is the fact that in Lifton's study the question of survivor guilt was inextricable from that of the traumatic image. A brief examination of his paper will allow me to start raising some critical questions about the status of the image in PTSD.

In their paper on imagery, Brett and Ostroff praised Lifton as one of the few researchers, along with Horowitz, who had managed to sustain a focus on imagery in their work on trauma. Lifton had begun one of his books with the sentence, "We live on images" (Lifton 1983, 3), and in his studies of survivors of Hiroshima and the Vietnam veteran he had repeatedly emphasized the importance of death images in the traumatic response. Nevertheless, there were aspects of his thought that did not fit easily into Brett and Ostroff's framework. In particular, there was the awkward issue of the part played by identification in the production of the traumatic image. In Brett and Ostroff's post-psychoanalytic approach, the traumatic experience, as manifested in the intrusive image, was a formal entity that ought to be assessed independently of the question of unconscious-symbolic or subjective meaning. To the objection that they thereby isolated the image from the individual doing the imaging and hence from what

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the image meant to the victim (Haas and Hendlin 1986, 124–25), Brett and Ostroff replied: "We do not agree that the form of the stress response is essentially a function of what the traumatic event meant. Psychodynamic understandings of meaning do not explain the form of the symptoms. . . . The psychodynamic understanding of meaning is a secondary step" (Brett and Ostroff 1986, 124–25). Their emphasis on the form of the traumatic response allowed them to consider the role of imagery in PTSD without regard to the patient's relations to others, the role of expectation, suggestion, or other identificatory-mimetic factors. By contrast, for Lifton the image was the product of the survivor's highly charged, fantasmatic identifications with those who had died. His concept of survivor guilt also depended on the idea that the survivor of trauma identifies with the dead. In short, Lifton's ideas about the traumatic image could only be squared with Brett and Ostroff's by downplaying the identificatory aspects of his thought.

The Buffalo Creek disaster had occurred in 1972 when coal waste, negligently dumped into a mountain stream by the Buffalo Mining Company in West Virginia, created an artificial dam that then gave way, causing a massive "tide" of coal-waste water to flood and devastate the mining hamlets in the valley. One hundred and twenty-five people had been killed, and nearly five thousand made homeless. Lifton and a junior colleague, Eric Olson, had been hired as consultants to assess the psychic impairment of the survivors by the lawyers for the claimants in a lawsuit against the mining company. In summarizing their findings, Lifton and Olson had described three fundamental survivor symptoms, each of which was connected to the other and to the theme of the traumatic image. The first symptom was the death imprint, consisting of "memories and images of the disaster." These images, still "indelible" thirty months afterwards, often appeared in terrifying, recurrent dreams. Here is Lifton and Olson's report of one survivor's account of such a dream:

> I've never been to no funerals except the ones right after the flood. . . . In the dream there is a big crowd at the funeral – the whole family is watching. I'm being buried. I'm scared to death. I'm trying to tell them I'm alive but they don't pay no attention. They act like I'm completely dead but I'm trying to holler to them that I'm alive. They cover me up and lower me down, but I can see the dirt on me. I'm panicked and scared. I become violent trying to push my way through the dirt. . . . I think I'll suffocate if I don't fight my way out. I feel like I'm trying to shout that I'm alive. (Lifton and Olson 1976, 3)

Lifton and Olson had observed that the dream reflected the state of being "as if dead," a state they held to be characteristic of the most severe kinds of survivor experience. In other words, the dream images were identificatory or mimetic in nature, as in the dream the survivor imagined that he had suffered the same fate as his dead relatives and had put himself in their place. Or perhaps it would be more accurate to say that the dream images were at once mimetic and antimimetic in character, as the survivor mimetically merged with the dead and antimimetically distanced himself from the

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scene of death, by describing himself as someone who could see and represent the scene of entombment to himself and hence could register his protest at the dirt being thrown over his corpse.

The second symptom of trauma Lifton and Olson had mentioned was survivor guilt, the survivor's feeling of remorse at his survival, and his belief that he had somehow survived at the expense of those who had perished. Lifton's discussion of survivor guilt was indebted to Freud's account of the origin of guilt in the child's unconscious identification with, or incorporation of, the father or aggressor, which is to say that guilt was defined as an inherently mimetic phenomenon (Freud 1930, 123–33). In their paper, Lifton and Olson had stated that survivor guilt was found especially in recurrent dreams, in which a single image exemplified the entire disaster experience with its combination of fear, pity, and guilt. They wrote:

> People who have gone through this kind of experience are never quite able to forgive themselves for having survived. Another side of them, however, experiences relief and gratitude that it was they who had the good fortune to survive in contrast to the fate of those who died – a universal and all-too-human survivor reaction that in turn intensifies their guilt. Since the emotion is so painful, the sense of guilt may be suppressed and covered over by other emotions or patterns, such as rage or apathy. But whether or not suppressed, that guilt continues to create in Buffalo Creek survivors a sense of a burden that will not lift. They feel themselves still bound to the dead, living a half-life devoid of pleasure and with limited vitality. (Lifton and Olson 1976, 5)

It was precisely the feeling of limited vitality, depression, or psychic numbing that Lifton and Olson had characterized as the third major symptom of trauma. Calling numbing the essence of the "disaster syndrome," they had described it as simultaneously a product of a melancholic, ambivalent, and hence guilty identification with the dead, and as a defense against that same identification:

> Numbing . . . is an aspect of persistent grief; of the 'half life' defined by loss, guilt, and close at times to an almost literal identification with the dead. As one of the plaintiffs put it 'I feel dead now. I have no energy. I sit down and feel numb.'. . . Numbing is closely related to the psychological defense of denial. . . . [The survivor] is thus left psychologically imprisoned in death- and guilt-related conflicts that can neither be dealt with nor eliminated. (Ibid., 506)

Lifton's language of the "literal" (or "almost literal") here to characterize the survivor's fantasmatic identification with the dead, might make it seem as if he adhered to the kind of literalism found in the work of trauma theorists Caruth and van der Kolk, where the traumatic image or "icon" is theorized as a literal replay of the traumatic event that is considered to be aporetically severed from all knowledge and representation. In a recent interview with Lifton, Caruth can be seen trying to push him in that literalizing direction, and there are moments when he seems to accede to her formulations. For

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example, when speaking in an interview of the "new knowledge of death and therefore knowledge of life" that the survivor brings back from his immersion in death, Lifton says that the survivor has in that sense "lived out the mythology of the hero, but not quite."

Caruth picks up on that "not quite" aspect of the survivor's experience, in order to suggest that the survivor doesn't bring back simply a mastered knowledge of death but something else: a confrontation with death that has "that anticipatory quality of being not fully assimilated or known but projected into a future." "That's right," Lifton replies, seemingly accepting Caruth's ideas about the "deathlike break," interruption of representation, and the literal that she associates with the traumatic experience (Caruth 1995, 135–36).

But in seeming to agree with Caruth here, Lifton ignores or occludes the mimetico-identificatory dimension of the image inherent in his own descriptions of the death encounter. For if, according to Lifton and Olson's report of the Buffalo Creek disaster, the survivor's unconscious identification with the dead is so great that it is as if the survivor himself is dead, by the same token the traumatic image or memory cannot be a literal replay of the scene. This is because in the survivor's report of his dream, as cited above, the dreamer does not represent the traumatic scene literally, as a scene of the death of others, but fantasmatically as a scene of identification in which he himself occupies the place of the dead.

Moreover, it is not clear that the concept of survivor guilt can be retained, once the image has been purged of its mimetic dimension in the ways Brett and Ostroff wish. Rather, a history of the concept of survivor guilt shows that the latter has been inseparable from the notion of identification. A mimetic concept of the traumatic experience and the concept of survivor guilt have gone hand in hand. Conversely, an antimimetic concept of the traumatic image, defined by Brett and Ostroff and numerous others as faithful replicas of the external event stripped of any mimetic dynamic, and the repudiation of the notion of survivor guilt, have likewise gone together. So it is not at all surprising that recent definitions of PTSD simultaneously thematize the idea of the purely external traumatic image and eliminate the notion of survivor guilt.

This does not mean that survivor guilt has simply disappeared from the official lexicon of trauma. It continues to have currency – for example, it has frequently been mentioned as one of the after-effects of September 11. But in the official world of trauma studies it has lost its position of importance as well as its theoretical rationale. Moreover, it would not be difficult to show that a similar repudiation of survivor guilt has occurred in many other contexts and areas of inquiry. I mention only among numerous texts the work of literary critic Lawrence Langer and the Italian philosopher Giorgio Agamben, both of whom have recently described survivor guilt as a concept inadequate to the task of characterizing the moral legacy of Auschwitz – defined as the central trauma of our time (Langer 1998, 36; Agamben 1999, 87–99). And what in their work, and in that of numerous other recent commentators, including leading psychiatrists, takes the place of survivor guilt? The answer is shame, with the result that

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today shame (or shamelessness) has displaced guilt as a dominant emotional reference in the West.

The at times almost somnambulistic certainty with which so many theorists of trauma now emphasize the importance of shame is a striking recent development. Thus shame is now widely considered the emotion that most defines the post-traumatic state (Stone 1992; Andrews, Brewin, Rose, and Kirk 2000; Lee and Scragg 2001; Leskela, Diepernik, and Thuras 2002). I believe that this development can partly be explained by the antimimetic tendencies I have been describing in this paper. We have seen that the concept of survivor guilt has been inseparable from the notion of the subject's unconscious identification with the other. Conversely, my claim is that today's shame theory conforms to the antimimetic tendencies of contemporary thought in that it shifts attention from the guilty subject's blind or unconscious yielding to the other to the shamed subject's consciousness of being seen. That is, shame theory downplays the mimetic-immersive, interpersonal dynamic central to the formulation of guilt, in order to depict shame as an experience of consciousness of the self when the individual becomes aware of being exposed to the diminishing gaze of another.[1]

To bring this article to a close, I will point to some contemporary scenes that epitomize these developments. I refer to the scenes of abuse from Abu Ghraib prison. Nothing illustrates the shift from a discourse of guilt to that of shame more decisively than those images. In a recent publication, Mark Danner has shown that the methods used to soften up and interrogate detainees by American military personnel can be traced back to techniques compiled by the CIA as far back as the 1960s, techniques whose stated purpose was to induce a guilty and anxious regression by disorienting the prisoner and breaking down resistance. "All coercive techniques are designed to induce regression," a 1963 CIA manual states. "The subject's resistance is seriously impaired. He experiences a kind of psychological shock. . .Frequently, the subject will experience a feeling of guilt. If the questioner can intensify these guilt feelings, it will increase the subject's anxiety and his urge to cooperate as a means of escape" (*KUBARK Counterintelligence Interrogation of Resistant Sources* 1963). Viewed in this light, Danner remarks, the garish scenes of humiliation documented in the photographs and depositions from Abu Ghraib "begin to be comprehensible; they are in fact staged operas of fabricated shame, intended to 'intensify' the prisoner's 'guilt feelings, increase his anxiety, and his urge to cooperate'" (Danner 2004, 18).

The terms of Danner's analysis imply that there has existed a single logic of torture extending uninterruptedly from the 1960s to the occupation of Iraq, according to which any distinction between the emotions of guilt and shame is simply elided. Yet if we focus on the details of the manuals and protocols to which Danner has drawn our attention, certain differences become apparent. The CIA's early approach to interrogation was based on watered-down Freudianism that emphasized the psychic

[1] I have just completed a book, provisionally entitled *From Guilt to Shame: Auschwitz to Abu Ghraib*, in which the recent shift from survivor guilt to shame is examined in detail.

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relationship between the prisoner and interrogator, especially the tendency of the latter to assume the role of a parental figure with whom the prisoner might unconsciously identify in an ambivalent and guilty manner, thereby making compliance and confession more likely. We might describe that logic of torture as an identificatory logic of guilt. One telling detail from a revised version of the 1963 manual is the counsel that if audio or video recording devices are to be used, the subject should not be aware that he is being recorded – as if the psychic dynamic between prisoner and interrogator conducive to successful interrogation can only develop when the captive is oblivious of being heard or seen by anyone other than the investigator-aggressor (*Human Resources Exploitation Training Manual* 1983). Contrast this with the logic of torture at Abu Ghraib. All the techniques that have been described in the current scandal are designed to publicly humiliate and shame the prisoner and to do so by exposing him or her to the spectatorial gaze of the outsider. The abuse of prisoners at Abu Ghraib almost seems to demand what was counter-indicated in the earlier CIA manuals, the open use of the camera, because shame depends on the subject's consciousness of exposure. As Danner again notes:

> All of this was made to take place in full view not only of foreigners, men and women, but also of that ultimate third party: the ubiquitous digital camera with its inescapable flash, there to let the detainee know that the humiliation would not stop when the act itself did but would be preserved into the future in a way that the detainee would not be able to control. (Danner 2004, 19)

As a "shame multiplier," the camera epitomizes the logic of torture at Abu Ghraib, which can be described as a spectatorial logic of shame.

No doubt the techniques of abuse used in Iraq are designed to exploit the particular sensitivities of Arab culture to public embarrassment, especially in sexual matters. But it is also the case that the shift from a logic of torture based on guilt to one based on shame reflects the more general shift from a mimetic to an antimimetic, spectatorial approach to trauma. The images of humiliated prisoners of Abu Ghraib dramatically register that shift.

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