MASSACHUSETTS SCHOOL OF PROFESSIONAL PSYCHOLOGY

SELF-IN-RELATION, SHAME-IN-RELATION:
WORKING WITH SHAME AS A RELATIONAL CONSTRUCT

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It turns out that the process of writing a doctoral thesis has some things in common with the process of psychotherapy. Both require that one sit down with a rich but substantial volume of material in the hope of finding narrative threads that will help deepen understanding or clarify meaning. For each, it also becomes clear from early on that the real work lies underneath the content—tolerating the confusion and anxiety, sitting with the unknown, and shaping and reshaping the material until a path that is quite different from the original vision begins to show you what you’re ready to learn. Like psychotherapy, this kind of writing is a process infused with vulnerability. I am genuinely grateful that I had the right supports along the way.

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Abstract

This theoretical exploration of shame develops the thesis that while shame is intimately tied to one’s sense of self, it is most deeply understood in the context of relationships. Just as relational models of psychotherapy envision the development of self as a self-in-relation, this project suggests that the development of shame is best understood as shame-in-relation. A review of the traditional psychoanalytic literature offers an examination of the intrapsychic dimensions of shame as an emotion that is tied to experiences of annihilation anxiety, fear of fragmentation, and “basic badness” (Balint, 1968). Relational models of psychotherapy, however, understand emotions, in part, to be constructed within an intersubjective field. In the context of therapy this
implies that both members of the relational dyad have a role in maintaining or recovering from shame experiences that arise in session.

Working from an intersubjective premise, shame occurs in those moments of relational engagement that lack regulation and authentic recognition. The application of Grand's (1997) work on dissociated affect to shame dynamics reveals that recovery from shame necessitates the movement of the patient-therapist dyad from a position of co-constructed defense to a position of authentic recognition. In other words, recovery from shame requires that each member of the dyad transcend objectified relational dynamics in order to appreciate the full subjectivity of self and other. In this project, Trevarthen's (1998) developmental model of intersubjectivity is used both to explore the relational construction of shame and to forward potential interventions for working with shame. The therapist's ability to recognize shame and to develop a stance in which she can tolerate shame is perhaps the most difficult, and most crucial, aspect of therapeutic work.
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Emotions, in my experience, aren't covered by single words. I don't believe in 'sadness,' 'joy,' or 'regret.' Maybe the best proof that the language is patriarchal is that it oversimplifies feeling. I'd like to have at my disposal complicated hybrid emotions, Germanic train-car constructions like, say, 'the happiness that attends disaster.' Or: 'the disappointment of sleeping with one's fantasy.' I'd like to show how 'intimations of mortality brought on by aging family members' connects with 'the hatred of mirrors that begins in middle age.' I'd like to have a word for 'the sadness inspired by failing restaurants' as well as for 'the excitement of getting a room with a minibar.'

Jeffrey Eugenides

*Middlesex*, p. 217
Psychodynamic psychotherapy is an endeavor marked by ambivalence. Regardless of what brings a person to therapy—a desire for deeper understanding of self, alleviation of symptoms, or help responding to a conflict—the wish to change is coincident with a wish to remain the same. Furthermore, the willingness to participate in the intimacy of a therapeutic relationship lives alongside a worry that it is not safe to be known. The tension that lies between a craving for intimacy and a desire to remain safe (i.e., unknown) is a deeply human experience. In the crevices of this ambivalence lies the potential for shame.

Certainly we have each worried about the potential for shame, more or less, at some point in our lives and it is easy to consider the weight of such a dilemma. To confide in another, for example, opens the possibility for judgment. To change any aspect of our physical or psychological being is also a decision to be different and therefore to “stick out” for others to notice and potentially ridicule. Even to acknowledge that we need help means showing others that we have deficits as we stumble toward making a decision or building competence. In the public arena we may ignore uncomfortable feelings in an effort to align with society’s expectation that one present a consistent, strong, and competent self to the world. Stripped of this “public,”
however, the process of therapy draws attention to one’s interiority, as well as to the intricacies of being in relationship. Therapy, in other words, is often a very vulnerable place to be.

At its best, shame acts as a healthy social regulator by coaxing one to adhere to social boundaries and cultural mores. However, as the intensity of a shame experience grows beyond a useful purpose (i.e., becomes toxic shame) it can become an obstacle to deeply knowing another, to speaking honestly, and to listening fully. The presence of shame creates distortions in what one expects and limits one’s ability to move freely in the relational world. Shame strains one’s ability to feel compassion for others, fuels rage, and is often shown to feed on itself—as if instantiating an insatiable hunger for badness. Perhaps most worrisome, shame disrupts the trust that relationships can be safe and therefore may preclude a desire for intimacy.

While it might be useful to explore any number of emotions in depth, shame is unique because in its most raw form it motivates one to disengage, often through withdrawal, and to become silent (Schore, 1998). This unique tendency toward disengagement cannot be emphasized enough, for most emotions help us to facilitate social regulation (Damasio, 2003) in a manner that ultimately promotes staying in connection with others. Indeed, the intolerability of disconnection helps to explain why shame so often becomes buried under other, safer, emotions. Even anger, for example, is a kind of pushing back (against the other) in an attempt to clarify a boundary. The person experiencing anger may be distressed or disoriented but she remains engaged.
The feeling state that abides shame is often associated with an acute sense of narcissistic injury (Kohut, 1966) or a pervasive feeling of “basic badness” (Balint, 1968). In other words, shame engenders the feeling that something is terribly wrong with the very core of one’s being. The complications of shame are compounded when unexamined shame leads to a “feeling trap”—shame about having feelings (H.B. Lewis, 1971).

Indeed, Helen Block Lewis (1971) suggests that the invisibility of shame is often responsible for premature terminations of therapy. Shame, and its counterpart contempt, has the potential to insidiously corrupt relationships (Gottman, 1999). Nevertheless, examining shame is a difficult and painful process. H.B. Lewis refers to shame as excruciating and contagious. She (1987) states, “the witness to it [shame] ordinarily looks the other way. Contemporary psychoanalysts are no exception to this tendency” (p. 4). The impulse to turn away is reminiscent of the reaction one has when witnessing a traumatic event. It will be demonstrated that shame might best be understood as a trauma to the self.

In sitting with another’s shame we too often rush to change the channel, so to speak, in an effort to “fix it” or to distract attention. When shame is noted in another person, the witness often quickly defends against the discomfort. The witness may attempt a stance of compassionate neutrality while internally wondering if the person “deserves” the shame. This default to a power-up position allows the witness to avoid participating in the shame experience. Alternatively, one might try to convince the
shame-ridden person that their circumstance does not warrant a shame response—another attempt to ward off shame. To tolerate shame is decidedly different because it requires that one participate in the shame experience in some manner. It is difficult not to rush in to try to avert the experience.

Basic Assumptions

Before turning to the literature, it is important to outline three basic assumptions that will be made in this project regarding the relevance of shame to psychotherapy and psychological health. To start, an assumption will be made that fostering a more integrated understanding of shame will inform clinical practice. Secondly, it will be presumed that everyone, at some point, struggles with shame. Finally, this project will work from the position that human beings have inherent value and that a felt sense of this value is necessary for psychological health. Thus when we talk about the influence of shame on the self, the understanding is that this inherent value is under attack.

The first assumption in this project is that deepening one’s understanding of shame will inform clinical practice. As the clinical zeitgeist continues to trend toward positive psychology, this assumption may seem countercurrent and possibly outdated. In fact, from the vantage of positive psychology, shame may seem a less clinically illuminating exploration than that of more self-promoting emotions like pride, love, or satisfaction. However, the good intentions of positive psychology may backfire if
strength-based perspectives are so rigidly held that negative or difficult emotions become unwelcome—or are perceived by the patient as being unwelcome—in the therapeutic relationship. This is not to imply that these theories advocate that clinicians disregard negative emotions, but rather that some clinicians erroneously apply these theories in a manner that is more akin to coaching and that focuses exclusively on building on the positive. In these instances, not only are negative emotions experienced in isolation, but an individual may also feel shame about having these negative emotions in the first place.

I experienced this in the fall of 2007 after my father, who had distanced himself from the family long ago, tragically committed suicide. What I find interesting to share about this event in the context of this project has to do with how I experienced people’s responses to me following his death. Everyone around me was trying to be generous, careful and kind. Many close, wonderful colleagues, friends, and family members reached out and offered incredible support that included inquiry into the hardest of the hard emotions.

Other equally close and wonderful people offered incredible encouragement and continuous feedback about “how well I was handling things.” I often left these ostensibly encouraging exchanges feeling unsettled and, at times, lonely. I talked about this with some friends and learned that they were trying to “protect my dignity” by focusing on what was going well. Here, we might pause to remember how often we try to protect our patient’s dignity in a therapeutic hour. The irony is that the urge to
protect someone's dignity may include an intrinsic message that their dignity needs to be protected from the stain of some shame.

Even when we choose to work from a strengths-based perspective, then, we must be careful not to disregard more painful emotional dynamics. For the isolation that results from not having a difficult life experience acknowledged may, ironically and inadvertently, exacerbate a notion that the negative emotion is bigger, more frightening, or more intolerable than it actually is. Furthermore, when certain aspects of experience are defended against, the attendant emotions become unspoken entities in a therapeutic relationship. As a result, shame may be unintentionally fostered. Thus, clinical work is deepened through understanding, acknowledging, and processing shame. This type of work offers a more authentic possibility for exploring the whole range of emotions in therapy. In this way, positive emotions like pride, love, and satisfaction become authentic states and not prescriptive “fronts” to bring to the world.

The second assumption in this project is that shame is a universal emotion (Ekman, 1999) that every human being (and some argue certain animals, as well) has had to contend with. The literature on trauma, perhaps more than any other domain of study, has consistently addressed the experience of shame. While this makes clinical sense, one might wonder if shame isn’t more comfortably tolerated in the trauma literature as this circumscribed location creates a defensive (and false) notion that only some people experience shame. This project will certainly draw from this rich body of literature, but the intention here is to focus on the universal experience of shame—
underscoring the assumption that everyone, in therapy and not, patient and therapist alike, contends with shame at some level.

The third assumption to be forwarded is that shame involves a threat to one’s inherent human value. Shame is a fundamental moderating influence on psychological health and well being. In his writings on aesthetics, Kant (1764) argues that the perception of beauty is disinterested from desire (as cited in Burnham, 2006). Kant states that we take pleasure in something simply because we identify it, with an immediacy that is unmediated by cognition, as beautiful rather than judging something as beautiful because we have cognitively decided that it will serve the function of bringing us pleasure (Burnham, 2006). Given that something in our most basic selves responds to beauty, Kant equates this with something that is “final without end.” This concept is sometimes translated as “purposive without purpose” and perhaps most simply thought of as having inherent value simply for being itself. It just does.

A foundational assumption of this project is that humans have inherent value; and therefore, according to Kant’s model, there is something beautiful about the essence of humanity. Throughout this project, it will be assumed that optimal psychological health is associated with a personal understanding of one’s own inherent value. As will be explored later, this understanding is not demonstrated by a narcissistic aggrandizement but rather a deeply held knowledge of self-worth.
Brief Comments on Terminology

There is a large body of literature on emotions ranging across disciplines. However, this work is riddled with an inconsistent recognition and endorsement of what constitutes a concept like emotion. This leaves one to consider, amongst other things, whether an emotion is rational or irrational; universal or socially constructed; and a basic entity unto itself or comprised of subcomponents. The term “emotion” is derived from the Middle French *emouvoir*: to stir up. The use of the term dates back to 1579 (OED) and its misuse may be equally historic. For while the notion that an emotion acts to stir something within one’s interiority may resonate with many people, the academic use of terms like emotion, feeling, mood, and affect has been convoluted and contradictory throughout time.

As a theoretical endeavor, the intention of this project is to deepen the understanding of shame as a relational construct. While many disciplines will be drawn from, this study will not attempt to parse the nuanced distinctions between how terms are used across disciplines but instead will offer broader conceptual definitions. Some detail might be lost in such generalization, but this approach will allow the focus to remain centered on the psychological experience of shame. Some brief comments on how this study will utilize the concepts *shame*, *object*, and *self* are warranted before continuing on to the next chapter.
Shame

By the early 1960s it was widely agreed by most psychologists that emotion has both a cognitive and affective component. This understanding continues today and many theories conceptualize emotion to be the thread that allows thoughts and experiences to be integrated into coherent, meaning-filled narratives. Niedenthal & Halberstadt (2000) refer to emotion as “a glue that binds experiences in memory and action” (p. 169), and are careful to recognize that the thoughts and events that become associated by emotion “are likely as idiosyncratic as people’s learning histories” (p. 171). Shame is similarly evoked by conditions that are idiosyncratic to the individual; however, a universal aspect of shame is that it centrally involves an awareness of self. Lansky (2003), states:

Shame then, is the affect that signals danger to the self—its preservation, its integrity, its standing and its security within the social bond—the bond to the subject that makes the self a self. The problem with shame is that it is inextricably tied to the problem of what one needs an object for (p. 433).

Throughout this text it will become important to explore the interrelationship among self, shame, and object usage.

There is some debate as to whether shame is a family of emotions or a unique emotion unto itself. Hibbard (1994), for example, identifies shame as a category of emotion that includes other self-critical affects like humiliation, shyness, mortification, and embarrassment. Wurmser and Nathanson similarly support the idea of a shame family (Miller, 1996) that is comprised of self experiences of inadequacy or disarray.
Miller (1996) suggests that “disarray” is added as a qualifier in order to capture embarrassment—the state in which individuals feel so disorganized that they don’t experience themselves as presentable to others. On the other hand, other theorists embrace a more restricted version of shame as distinct from other self-critical emotions. These theorists (e.g., Broucek, 1991; W. Miller, 1993) argue that shame should be isolated because it is uniquely associated with a felt experience of self dissolusion or self destruction.

As will be discussed, one interesting consequence of this latter description is that the felt experience of self destruction is associated with the loss of perspective taking (e.g., from a classical perspective, the loss of observing ego). As a result, shame is experienced as something that has been inflicted upon the self by another person. In more traditional models of psychotherapy, the infliction of shame is understood to result from experiences of being judged. In more contemporary models, shame is understood to result from the failure of important others to meet basic needs of regulation and recognition—i.e., the failure of others to adequately engage in a necessary relationship—when attachment needs are foremost. It will be shown that the felt experience of shame coming from “out there” will be implicated in distinguishing shame from other self-conscious emotions, like guilt, which are perceived to come from “within.”

Finally, it should be noted that there is some debate in the field as to whether shame is only indicative of experiences of narcissistic distress or if it can also be
understood as a defense. Following Miller's thinking (1996), this project will assume that “shame is not fundamentally a defense but is an expression of narcissistic distress that can be used defensively” (p. 1). Miller reminds her readers that there may be times when “feeling small or weak or in need of rescue” (p. 35) offers something to an individual. As with any early experience, emotions can be reproduced later in life in order to try to manage relationships or inner life. The adaptive and defensive functions of shame will be explicated in Chapter Four.

Object and Self

Along with the psychoanalytic notion of an object, the understanding of self has been a continually evolving concept throughout the history of psychoanalysis. Notably, each theorist may intend to capture markedly different ideas when utilizing these terms. This conundrum of language is easily evidenced in a brief comparison between classical and object relations theory. For each of these models an object is consistently understood to be a person. Freud, however, initially reasoned that objects were the repository of indiscriminately directed drive discharge, whereas object relation theorists placed emphasis on the value that unique objects come to have for individuals. The function that is implied when speaking of the role an object plays in shame experiences, then, widely varies. While it is impossible to avoid these shifting definitions, it is important to keep this natural evolution of ideas in mind so that concepts do not get “lost in translation.”
The term self is equally varied but arguably far murkier. Notably, it wasn’t even until the mid-19th century that Western societies moved away from a pre-modern, theological understanding of self that was defined by observable roles and actions and toward a psychological articulation of self that focused on internal, and therefore not directly observable, experiences (Jackson, 1985). Since this time, self conceptualizations have ranged from rigid, intrapsychic models to constantly shifting and socially constructed interpersonal models. Modell (1985) captures this range when reflecting on the difference between one- and two-person psychologies: “The experience of a self persisting through time [one-person] is both conceptually and phenomenologically disjunctive with the comparatively rapid alterations in the sense of self that occurs in many individuals in response to the affective communications experienced in a dependent relationship [two-person]” (p. 72).

As shame and self are intertwined, changing conceptualizations of self have had consequent implications for conceptualizations of shame. Rather than understanding these changes as linear, with models progressively eclipsing one another, the assumption in this project is that shame can be most deeply understood when drawing from a breadth of models. Modell (1985) appreciates that even though self-conceptualizations may be disjunctive across models, both one-person and two-person psychologies are necessary and complementary. He states, “In addition to our customary structural and developmental understanding of narcissistic disorders it is necessary to add another dimension that is conceptually disjunctive with structural ego
psychology. That is the dimension of a two-person psychology” (p. 71). Lansky (2006) similarly cautions his readers not to blithely replace “one language for another” but to integrate the two when able, for, he states, “otherwise we are stuck in the concreteness of the dyad without a language of explanation of clinical phenomena and the tools for exploring treatment impasses and failures” (p. 4).

Method for Approaching This Project

In this spirit, the focus now turns to theoretical conceptualizations of shame, first from a traditional perspective and then from the vantage point of contemporary relational theory. It is beyond the scope of this project to offer a comprehensive discussion of the many nuanced conceptualizations of shame that have been forwarded throughout the history of psychoanalysis. Rather, Chapters Two and Three will serve as review of the literature in which landmark theorists in the study of shame will be highlighted. Then in Chapters Four and Five attention will turn toward working with shame in psychotherapy.

In Chapter Two shame will be considered from a traditional psychoanalytic perspective. Intrapsychic aspects of shame will be considered from Freudian, ego and self psychology frameworks. Looking at Kohut’s (1971) work, for example, offers an opportunity to explore how key features of self-psychology—including the notions of narcissistic injury and self-cohesion—relate to shame. Chapter Three will go on to examine shame from contemporary relational perspectives. Drawing on the work of
attachment and infant researchers, the impact of understanding how shame is constructed within relationships will be considered.

In the second half of this project, attention will turn more directly to clinical work. Chapter Four will consider manifestations of shame in therapy. Lansky (2003) acknowledges the challenges of identifying shame in the therapeutic encounter. He (2003) states, “Shame dynamics are difficult to pull into focus clinically because the clinical presentation of such dynamics does not usually involve the affect per se and because the handling of shame dynamics pose powerful countertransference resistances” (p. 366). Therefore, in addition to a focus on physiological expressions of shame, language, and body posture, a look at relational paradigms that are frequently enacted in moments of shame and the subsequent defensive processes will also be reviewed. Finally, Chapter Five will explore the implications of shame theory for clinical practice. Trevarthen’s (1998) model of intersubjectivity will be used as a framework for the discussion of working with shame in therapy.

As previously mentioned, this material will be presented with a particular eye toward understanding the interrelationship between self, object usage, and shame experiences. What constitutes self, what happens to the self when shame occurs, and how objects participate in these experiences are all important considerations. This is particularly true because Lansky’s (2003) suggestion that “shame is intimately tied to what one needs an object for” (p. 433) is integral to how the psychotherapist envisions her role and positions herself in the therapeutic relationship. Self conceptualization, on
the other hand, shapes how we understand the impact and function of shame on the patient’s experience.

At base, this is a project about how shame enters into and is processed within the therapeutic relationship. Why shame? It might be argued that in some fashion every therapeutic technique, from building an alliance and maintaining a frame to facilitating a safe termination, is partially done in an attempt to manage shame. What is less often elaborated upon, however, is the manner in which shame might be articulated and processed, when appropriate, in therapy. The affective experience of shame is an exquisitely private state, but to be shamed is a social transaction. Shame happens within relationships and the work of psychotherapy is, amongst other things, a negotiation of shame at both the level of the individual and the relationship. It is the nuanced therapeutic negotiation of this twofold experience that will be explored in the remaining chapters.
CHAPTER TWO

TRADITIONAL CONCEPTUALIZATIONS OF SHAME

This chapter will highlight the structural and developmental aspects of shame that align strictly with one-person psychologies, as well as those psychologies that act as a bridge between one-person and two-person models. Gill (1994) distinguishes one-person psychologies, which emphasize "intrapsychic structure—with its varying proportion of innate and internalized experiences—as a closed system" (p. 33), from two-person psychologies, or those models that emphasize "the interaction between the intrapsychic and the interpersonal" (p. 33). From Freud’s implication of a harsh superego to Kohut’s focus on narcissistic injury, interest in shame dynamics expanded as the field of psychoanalysis matured. Exploring the trajectory of traditional conceptualizations of shame will facilitate deeper understanding of this emotion as the focus shifts to two-person models in subsequent chapters.

In this chapter, psychoanalytic formulations of shame will be reviewed from classical, ego, and self psychology perspectives. As mentioned, shame gained increasing attention as the field evolved and, as will be discussed, the reason for this is multifold. Perhaps most notably, Freud himself acknowledged that his theoretical models did not incorporate a comprehensive theory for understanding emotion (Rapaport, 1953). This oversight left ample room for Bowlby’s (1969) work on attachment theory, the newly
established affect theory (e.g., Izard, 1977; Tomkins, 1963), and the growing interest in sociological and anthropological findings to inform the manner in which shame would be integrated into the rapidly developing branches of neo-Freudian theory.

Developmental considerations that are pertinent to understanding shame from traditional psychoanalytic perspectives will also be reviewed in this chapter. The burgeoning presence of developmental models in the 1960s and 1970s encouraged many psychoanalytic theorists to more fully consider the impact of the socio-cultural surround on the maturing child. In a manner that seems to anticipate the interpersonal aspects of two-person models, for example, Helen Block Lewis (1971) and Erik Erikson (1968) both underscore the social aspects of a shame experience. Nevertheless, their theories continue to fall under the rubric of one-person or one-and-a-half person models (Stark, 1999) because in their work, shame continues to represent an experience whose impact is primarily intrapsychic.

**Freudian Conceptualizations of Shame**

In accordance with the long-held interest that shame received in the fields of philosophy and theology, Freud's earliest writings privileged shame as a central organizer of human experience. As Freud's psychoanalytic theory unfolded, however, the study of shame was given increasingly limited attention. Ego psychologists (e.g., H.B. Lewis, 1971; Rapaport, 1953) argue that Freud's study of shame was limited by his
growing tendency to focus on Oedipal guilt, as well as his failure to develop a well-articulated and consistent definition of self. Other theorists (e.g., Damasio, 1999; H.B. Lewis, 1980) understand the gap to be a more general consequence of Freud’s wish to create a scientific understanding of the human mind. From this scientific stance, Freud conceptualized emotions as Darwinian remnants (Damasio, 1999) in need of mastery lest the individual fall prey to psychic disorganization. Rapaport (1953) suggests that Freud, as a consequence of this sentiment, adopted a negative view of most emotions “as similar to ‘inherited hysterical attacks’ in that they express or discharge unconscious ideas in bodily form” (p. 182). Freud’s changing thoughts on shame are reflected in three of his benchmark concepts that will next be discussed: the incompatible idea, the ego ideal, and the structural model of self.

The Incompatible Idea (1895)

Freud’s earliest works assert that shame is a central response to conflict and an essential organizer of behavior. In Studies on Hysteria (1895/2004) Freud writes:

I have had to overcome a psychical force in the patients which was opposed to the pathogenic ideas becoming conscious. From these I recognized the universal characteristic of such ideas. They were all of a distressing nature, calculated to arouse the affects of shame, of self-reproach, and a kind of psychical pain and the feeling of being harmed (p. 268) [emphasis added].

The incompatible idea was introduced as a basic conflict between self and conscience that results in experiences of shame and other psychic pain. At this stage in his writing,
Freud equates shame with threat to one’s basic being, or what contemporary theorists might refer to as narcissistic mortification (Lansky, 1994). Moreover, Freud (1895/2004) identifies shame as both a motivation for defense as well as a kind of defensive structure, or anticipatory signal, which guides an individual away from socially inappropriate behaviors that might lead to psychic pain. Shortly into his career Freud began to identify intrapsychic fantasy as a primary tenet of his theory and with this shift, shame was abandoned as a central consideration.

Fred’s Narcissism: The Ego Ideal (1914)

Fred’s attention to shame was revitalized in his landmark volume On Narcissism: An Introduction (1914/2004). Fred uses this volume to acknowledge that self-preservation instincts are distinct from sexual instincts and this delineation renewed Fred’s interest in his earlier conceptualization of shame as a threat to one’s basic being (1895/2004). However, in this model Fred specifies that self-preservation is not an impulse for preservation of one’s physical self but rather for preservation of an idealized self—i.e., the impulse to protect self-image or self-respect.

Fred conceptualizes the ego ideal as a quintessential version of one’s moral self and suggests that the ego ideal develops early in life as a response to the ongoing tension between self and object instincts. As the maturing infant begins to contend with reality and the subsequent need to be in relation with others, Fred (1914/2004) reasons that the infant’s primary narcissism—libidinal energy directed toward the ego
as a means of fostering a felt sense of omnipotence—will no longer be sufficient for sustaining literal or psychic survival. As a result, primary narcissism is redirected toward the developing infant’s internalized, often moral, ideals. This narcissistically infused structure comprises the ego ideal and its presence frees the infant to shift attention between self and object libido rather than to remain narcissistically absorbed in a manner that promotes pathology.

As an intrapsychic agency, the ego ideal works to monitor what Lansky (2006) refers to as self-worth and lovability and further determines one’s felt sense of self-regard (Spruiell, 1979). In this model, to love another means to “lose” narcissism and this depletion elicits negative self-regard (i.e., shame). It is only by receiving love in return, and thereby “possessing” the loved object, that self regard can be maintained.

As previously alluded to in Chapter One, a central component of studying shame was forwarded by Lansky (1994), who reasons that “shame is inextricably tied to the problem of what one needs an object for” (p. 433). For each theorist the problem of what that need is will be different, but here in this economic model shame is understood to result from a net loss of libido. In other words, shame results from an object’s unwillingness, or failure, to return libidinal energy in the form of love.

Moore (1975) clarifies that by “possessing” the idealized object (i.e., receiving love in return), one’s libidinal energy merges with narcissistic remnants residing in the ego ideal. This merger resonates with the archaic sense of an omnipotent self and
subsequently fosters positive self regard. In this situation the ego and ego ideal are experienced as being in alignment with one another. On the other hand, when the narcissistic remnants of the ego ideal are not in alignment with the experience of the ego, shame ensues.

The comparative function of the ego ideal is a forerunner to the notion of self-appraisal—a concept that will be returned to repeatedly in the study of shame. As a result of this function, emotions, like shame, allow the ego ideal to shape one’s interactions with external objects (1914/2004). In other words, Lansky (1994) states that the “ego ideal presages danger to meaningful attachments because of the comparison with ideals that make a person lovable, acceptable, or worthy of bonding” (p. 436). Given that the principal anxieties of childhood, according to Freud, include things like loss of object or loss of the object’s love (Brenner, 1995), it is clear that shame remains at the heart of Freud’s model at this time.

*The Structural Model of Self and the Centrality of Guilt (1933)*

After 1914, Freud moved away from narcissism and the ego ideal in a steady effort that was geared toward creating a structural, conflict-defense model. This shift included a new theoretical framework that focused on repetitive reenactments of core unconscious conflicts and fantasies, object internalization, and defensive adaptations (Messer & Wolitzky, 1997). Within Freud’s (1930/1961) structural model, guilt became the predominant affect as he more fully articulated his long labored over Oedipal
complex and the related superego. Unfortunately, this emphasis on the Oedipal complex foreclosed shame’s role as a central player in Freudian theory.

In *Civilization and Its Discontents* (1930/1961) Freud takes an in-depth look at the manner in which children learn to negotiate social mores. He suggests that humans are born into a natural dilemma in which a biologically driven antisocial impulse conflicts with a need to belong in society in order to survive (Johnston, 1999). The internalization of the father, or cultural authority figure, in the form of the superego is a central feature of psychic life and acts as the conscience which guides the child away from “taboos” (Freud, 1933/1964) and toward a necessary place in society. Without much explanation for this shift, Freud determined that the superego functions largely through the use of guilt, not shame. As a result guilt, and not shame, became implicated in Freud’s core intrapsychic processes and pathologies.

In fact, in Freud’s book *New Introductory Lectures on Psychoanalysis* (1933/1964), he describes the ego ideal as a minor and subordinate function of the superego. Although the ego ideal was nearly abandoned, shame did not entirely disappear from Freud’s thinking at this time. It was, however, relegated to a much less central position. At this point, Freud’s mention of shame was largely associated with impulses that were argued to require restriction. For example, shame was seen as a reaction formation against sexually exhibitionistic impulses or as a response to matters related to anality (Tangney & Dearing, 2002).
This distinction seemed to confuse, not clarify, the difference between shame and guilt for future theorists and clinicians. Lansky (1994) reasons that shame was not demoted but unnecessarily obscured by its association with anal issues:

Those concepts, although they certainly have some clinical usefulness, tend to assume without proof that a wide variety of, for example, so called “anal issues” are in fact derivatives of conflicts involving anal eroticism per se rather than as manifesting dangers of loss of control (e.g. of rage) of dirtiness or inner unlovability or emptiness or struggles with powerful persons for approval or autonomy (p. 434).

Building on this argument, Lansky (1994, 2004, 2006) has invested a great deal of effort toward demonstrating that central psychoanalytic concepts have far more to do with shame than Freud’s writings during this period explicitly acknowledge. For example, he argues that castration anxiety is best captured by the dynamics of sexual humiliation and therefore center around shame, not guilt. Additionally, Lansky (1994) looks at shame as comparable to Freudian conceptualizations of envy, stating that they are both “self-conscious comparative emotions having to do with seeing one’s self as deficient as compared with the other. I see envy as a more visible concomitant of shame” (p. 438).

While very interesting, Lansky’s retroactive reframing of Freudian theory is not without its own problems. Most pointedly, a number of theorists (e.g., H.B. Lewis, 1971; Morrison, 1989) have suggested that the structural model is inadequate for the exploration of shame simply because Freud fails to clearly distinguish the concept of self from ego. Many ego psychologists (e.g., H.B. Lewis, 1971; Hartmann, 1960), in
particular, have suggested that without a clear model of self as separate from ego it is impossible to differentiate whether the critical evaluation that results from certain conflicts is directed toward the ego, for failing to comply with the superego’s demands, or directed toward the self, for failing to live up to an ideal. Without this distinction, it is impossible to parse guilt from shame.

Ego Psychology Renews Interest in Shame

Major contributions of ego psychology to the study of shame include an elaboration of Freud’s structural theory, including a detailed understanding of the ego ideal, and a repositioning of narcissism as a libidinal cathexis of the self and not the ego (Morrison, 1989). This section will give a brief overview of some key contributions that ego psychology made to the understanding of shame. Closer attention will then turn to two theorists who technically are identified as ego psychologists but whose works represent strong examples of early integrative theory, which acts as a natural bridge to the contemporary models that will be addressed in the next chapter. Helen Block Lewis (1971) and Erik Erikson (1959) both wrote extensively on shame. In some fashion their conceptualizations of shame represent one-and-a-half person psychologies (Stark, 1999), as they take a microsocial stance (Prilleltensky, 1995) in which the individual is understood not only to be motivated by intrapsychic drives but also to be deeply affected by the social system.
In an effort to understand shame more fully, ego psychologists began to excavate and reinterpret Freud’s notions of narcissism, ego ideal, and self regard (Tangney & Dearing, 2002). As a result, guilt was decentralized and clearly differentiated from shame. This shift is well reflected in a landmark publication by Piers and Singer (1953) which outlines a more fully elaborated understanding of the role of the ego ideal in psychic life. Not unlike Freud, Piers and Singer (1953) identify the ego ideal as both conscious and unconscious in nature. In further agreement with Freud, Piers and Singer emphasize that guilt is a reaction to clashes between the ego and the superego while shame is a reaction to clashes between the ego and the ego ideal. Importantly, however, they suggest that the ego ideal plays a central role in psychic development and therefore shame is no longer relegated only to peripheral matters like anal exhibitionism. Rather, Piers and Singer (1953) reason that guilt is associated with transgression and the related implicit fear of punishment (more specifically, castration), whereas shame is associated with feelings of inferiority and the related implicit fear of abandonment. The work of Piers and Singer (1953) inspired a number of theorists to continue investigating the role of the ego ideal in psychological life. Over time, these elaborations began to emphasize the central link between shame and self.
Self Is Differentiated from Ego

As previously mentioned, Freud’s work frequently refers to the ego and self interchangeably (Sandler, Holder, & Meers, 1963), and many ego psychologists (e.g., Hartmann, 1960; H.B. Lewis, 1971) reason that this shifting terminology led to a great deal of confusion in differentiating the roles of guilt and shame in psychic life. One of the major contributions that ego psychologists made to the study of shame, and to psychology more generally, was the clear distinction between the self and the ego.

In general, ego psychologists believe that the self is born from the ego and represents a felt experience of contiguous identity, while the ego pertains to overarching processes that are necessary for existence. H.B. Lewis (1971) describes the ego as “the holder of the defenses, tester of reality, and the organizer of perceptions” (p. 4) which she contrasts with the self, or “that sense of our own identity which each of us experiences, at times consciously and more often unconsciously. The self may also be thought of as the unifying tendency in the activities of the organism” (p. 5). Jacobson (1954) goes on to suggest that internalized self and object representations are fundamental in shaping what she calls an experiencing self, an identity that is greater than the sum of its intrapsychic parts.

Shame is Linked to the Self

In differentiating the self from the ego, a clarification regarding the intrapsychic impact of shame became necessary, and the self, not the ego, was soon intimately tied
to shame experiences. In early works, Jacobson (1954) returned the field's attention to the notion that the ego ideal was implicated in self regard, not ego regard. She suggests that the ego ideal is comprised of self and object representations that recreate the longed for merger between loved self and loved object (Morrison, 1994). As an extension of this thinking, while it was generally maintained that the ego ideal serves a function of appraisal, this appraisal was reconceptualized to indicate a comparison made of the self against an ideal self and not of the ego against an ego ideal, as previously understood (Kaufman, 1996).

The term ideal self was reclaimed by many ego psychologists (e.g., Jacobson, 1954; Schafer, 1960) from Freud's earliest writings, but it came to represent a more experience-near and fluid fantasy of self. Unlike the ego ideal, ego psychologists suggest that the ideal self represents a shifting image of what an individual desires of herself in any moment and not a static moral ideal (S.B. Miller, 1996). Thus the ideal self that is conjured when one is making a public presentation may differ significantly from the ideal self that one imagines in a romantic encounter. At any given point, whether the ideal self is positive or negative, rage-filled or giving, it generally takes a form that minimizes inwardly turned aggression while simultaneously maximizing narcissistic gratification (Sandler et al., 1963).

As previously mentioned, Hartmann (1960) argues that narcissism represents a libidinal cathexis of the self and not, as Freud suggested (1914), the ego.
narcissistic gratification was newly understood to be gratification of the self. This
association deepened the appreciation for the role of shame in self development. From
this model it is reasoned that if the self fails to adequately approximate the ideal self,
narcissistic gratification will not occur. This failure becomes the trigger for shame.

It should be noted that ego psychologists recognize that a perceived gap
between the self and the ideal self is not always indicative of shame. It is commonly
thought that individuals rarely fulfill their idealized images of self and that this failure is
often weathered without evoking shame (Sandler et al., 1963). In fact, achieving some
approximation of the ideal self generally results in a degree of narcissistic satisfaction
that is experienced as quite positive. It is only those experiences in which the gap
between the ideal self and the experiencing self feels intolerable, and not the presence
or relative size of the gap, which trigger shame. Conversely, some contemporary studies
(e.g., Lindsay-Hartz, 1984) have shown that shame is most likely the result of a negative
ideal—in other words, the evocation of a negative, self-deprecatory introject or “the
recognition that we are who we do not want to be” (Tangney & Dearing, 2002, p. 13)—
and not, as originally suggested by ego psychologists, the comparative result of realizing
that we did not achieve an ideal vision of self.

Regardless of how ego psychologists have conceptualized the role of the ideal
self, they succeeded in linking shame more securely to the self and not the ego. In this
way, ego psychologists facilitated a deeper appreciation of the implications of shame for
general psychological well being. Their writings helped shame to gain recognition as an emotion related to self worth, thereby freeing it from the circumscribed and peripheral role to which Freud had limited it in his structural model. Erikson (1959) used this resurgent interest to forward a model that featured shame as a primary force in development. H.B. Lewis (1971) worked to distinguish shame from guilt and to understand the impact of shame on therapeutic relationships. Interestingly, H.B. Lewis and Erikson (1959) both began to emphasize interaction with the cultural surround as a primary factor in psychological development.

*Erik Erikson*

An exploration of traditional conceptualizations of shame would not be complete without a discussion of Erikson’s (1959) second psychosocial stage of development: Autonomy versus Shame and Doubt. Erikson identified himself as both a developmentalist and an ego psychologist; he associates shame with the ego-ideal, but his writings focus more keenly on developmental and cultural considerations than on the intrapsychic dimensions of shame. When Erikson (1959) reinterpreted Freud’s psychosexual stages to emphasize the importance of culture on ego development, he drew attention to the fit between the individual and society as a possible definition of psychological health (Cloninger, 2000). This orientation toward the social self was a welcome venue for the study of shame.
Autonomy versus Shame and Doubt

Erikson reasons that the ego is driven to struggle against entropic forces and toward a sense of unity, or self-integration, at each stage of a child’s development (Friedman, 2000). For Erikson, a stable identity has been achieved when one’s internal sense of self matches the way she is viewed by others in the community. While self-integration is not fully established until adolescence and continues to unfold across the lifespan, Erikson (1959) argues that a child has a sense of self by the age of two years and that it is this incipient sense of self that makes shame possible.

Around the age of two, according to Erikson (1959), the child is faced with the task of establishing autonomy, a process that is complicated by the potential for shame and doubt. Eriksonian doubt “has to do with the unknown ‘behind’ that the child cannot see yet must try to control” (P.H. Miller, 2001, p. 152). In other words, doubt is related to a child’s unwillingness to take risks in trying new things for fear of being “surprised” by a negative parental response. At its most basic, Eriksonian shame is defined as premature exposure (Cloninger, 2000; P.H. Miller, 2001). As will be discussed in Chapter Three, these concepts might be conceptualized from a contemporary relational perspective as an impingement, or dysregulating response, from an important other. Erikson’s (1959) qualitative descriptions poignantly capture his understanding of shame. He states:

Shame is an infantile emotion insufficiently studied. Shame supposes that one is completely exposed and conscious of being
looked at—in a word, self-conscious. One is visible and not ready to be visible; that is why we dream of shame as a situation in which we are stared at in a condition of incomplete dress, in night attire, “with one’s pants down.” Shame is early expressed in an impulse to bury one’s face, or to sink, right then and there, into the ground (p. 71).

Key to his focus on developmental considerations, Erikson goes on to state, “Shaming exploits an increasing sense of being small, which paradoxically develops as the child stands up and as his awareness permits him to note the relative measures of size and power” (p. 71). The child’s growing awareness of how she “fits in,” or compares to others is an important feature of shame and Erikson underscores that shame develops within a social context.

Shame Develops in Social Interactions

Erikson, along with H.B. Lewis (1971), is one of the first psychodynamic theorists to locate shame in relationships. He reasons that in the second psychosocial stage of development, children begin to explore their relationship with the law (an important criteria for establishing a “fit” with society), symbolically, via their relationships with parents and other authority figures. Erikson (1959) points to the law as the cultural institution responsible for both developing boundaries within which an individual can exert her autonomy and also providing punishments, frequently associated with shame, when those boundaries are violated. According to Erikson, when this symbolic negotiation is smooth, the child develops autonomy and, with this, the capacity for
healthy will power (P.H. Miller, 2001). When this negotiation does not go smoothly, however, the child struggles with a sense of shame and doubt.

The child’s burgeoning curiosity about authority and rules is understood to be a natural consequence of physiological changes that occur around the age of two (Erikson, 1959). Muscle maturation at this age facilitates accomplishments such as toilet-training and language development. This stage of development is often associated with Freud’s anal stage, which is symbolically described by the “psychosocial tasks of holding on (anal retention) and letting go (anal expulsion)” (Erikson, p. 178). Ambivalence over whether to hold on or let go pervades the child’s behaviors and attitudes. P.H. Miller (2001), for example, cites toddlers who zealously hoard toys at one moment but then casually give them away in the next moment. Importantly, this ambivalence becomes fraught with strain when applied to relationships. A conflict is established between the child’s excitement regarding new opportunities to interact with the world in increasingly complex ways (i.e., autonomy) and the child’s anxiety regarding separation and the potential consequences of either losing control or losing connection (i.e., shame and doubt).

In the face of this ambivalence, Erikson predicts that a “clash of wills” between the child and her parent is inevitable. He goes on to suggest that if the parent’s attempts to control the child’s behavior are either too rigid or too diffuse, the child will
likely resort to rebelling against her environment. In these moments the individual and culture do not “fit” (Cloninger, 2000). P.H. Miller (2001) explains,

Shame and doubt about one’s self-control and independence may come if basic trust was insufficiently developed or was lost, if bowel training is too early or too harsh, or if the child’s “will” is “broken” by an overcontrolling parent (p. 152).

Reminiscent of Winnicott’s (1958) “The Capacity to be Alone,” Erikson posits that the child needs the support of the parent in achieving a sense of autonomy. He encourages parents (i.e., objects) to help the child feel “a sense of control without the loss of self-esteem” (P.H. Miller, p. 149). Doing so facilitates what Erikson sees as the main theme in life—quest for identity—without the debilitative experiences of shame and doubt.

Erikson understood shame, in moderation, to be a healthy factor in the quest for establishing identity. His thinking aligns with the work of evolutionary psychologists (Cosmides & Tooby, 1992) who view shame to be a necessary part of socialization in human development. Beyond that, Erikson argues that shame fosters poor self-esteem and, at times, psychopathology. In fact, Erikson identifies shame as destructive to hope (Friedman, 2000), a concept he cites as necessary to sustain life.

Shame and Psychopathology

Erikson (1959) is one of the earlier theorists to make direct links between shame and psychopathology. More importantly, he underscores the potential impact of early childhood shame experiences on lifelong well being. According to Erikson, unsuccessful negotiation of the second psychosocial stage of development leaves a lasting
impression. He reasons that issues of shame and doubt will resurface for such an individual throughout the course of her life. In adolescence, for example, he argues that identity certainty, which asks the individual to stand on her own and be acknowledged as a unique individual, will more likely be thwarted by self-consciousness. The act of "standing on one's own," Erikson reasons, will evoke the shame that in earlier years was associated with unsuccessful attempts to establish a sense of self-control and independence.

As an example of the lifelong impact that shame may have on the development of psychopathology, Erikson (1959) describes a child who has not successfully negotiated the second stage of development as vulnerable to developing an obsessional compulsion in adulthood. He states:

A child [who has not successfully resolved the crisis] will develop a precocious conscience...and instead of taking possession of things in order to test them by repetitive play, he will become obsessed by his own repetitiveness, he will want to have everything "just so" and only in a given sequence and tempo. By such infantile obsessiveness, by dawdling, for example, or by becoming a stickler for certain rituals, the child then learns to gain power over his parents and nurses in areas where he could not find large-scale mutual regulation with them. Such hollow victory, then, is the infantile model for a compulsion neurosis (p. 252).

Erikson goes on to reason that these patterns of relating became habitualized and without intervention the adult will struggle with having a "shallow" sense of control in society. In Chapter Four, the role of shame in obsessional dynamics will be further explored.
Erikson’s contributions to the understanding of shame were plentiful, including his identification of shame as an enforcer and possible destroyer of identity development and his appreciation for the fit between self and culture as a consideration in the development of shame and pathology. The attention toward culture and the supposition that shame was a central force in development and psychopathology was similarly held by Helen Block Lewis.

_Helen Block Lewis: The Roots of Shame Are in Social Attachments_

Helen Block Lewis has been called the “midwife of shame” (Zarem, 2006) and her clinical and experimental efforts can be traced to her belief that shame is at the core of therapeutic failures. Technically, Lewis is classified as an ego psychologist, but throughout her career Lewis’s greatest allegiance was clearly directed toward deepening her understanding of shame. Lewis heartily embraces the work of Bowlby (1951) and affect theorists (e.g., Izard, 1977; Tomkins, 1963) who argue that emotions are born from the social matrix. Indeed, she puts forth a definition of shame as an experience that is a necessary part of human life, occurs within the context of relationships, and is deeply affected by an individual’s perceptual style (Witkin, Lewis, Hertzman, Machover, Meissner, & Wapner, 1954). She further reasons that shame and guilt are both different modes of effecting reparation in relationships. Shame communicates deference, while guilt propels the action of repair.
H.B. Lewis "came to recognize that proneness to shame and guilt was based on a host of developmental factors and would lead to predictable variations in neurotic symptomatology" (Nathanson, 1987, p. 93). In fact, Lewis claimed that self-psychology was an unnecessary offshoot of Freudian theory and argued that narcissistic disorders would be better defined as unrealized shame in the transference. She forwarded a two-tier model of self development and was one of the first theorists to claim that some aspect of shame is possible from the first days of life.

Shame and the Developing Self

While H.B. Lewis (1971) agrees that shame is "directly about the self" (p. 30), she claims that it is impossible to isolate self as a construct from the environmental surround. She understands her cross-disciplinary considerations as an attempt to privilege the social nature of human existence. This assumption markedly shifts the conceptualization of shame away from an individual’s "...‘partial instinct’ of exhibitionism or ‘narcissism’" and toward a "means by which people try to preserve their loving relationships to others (H.B. Lewis, 1987a, p. 2)." Thus, shame serves a communicative function in relationships, in addition to evoking a physiological and psychological response. At base, in other words, Lewis places the roots of shame in social attachments, not instinct. That said, Meisels and Shapiro (1990) argue that "because of her detailed study of the intrapsychic consequences of the interpersonal sequences" (p. 13-14) her theories remain fundamentally psychoanalytic.
H.B. Lewis (1958) reasons that a felt experience of self is present from birth and this core me is reasoned capable of experiencing forerunners of shame, such as separation anxiety and stranger anxiety (Erikson, 1968). Lewis (1958) distinguishes that these forerunners of shame are affective but not cognitive in nature. As will be seen in the next chapter, Lewis’s suggestion that there is a developmental unfolding of emotion, and not a certain age at which the emotion “turns on” (e.g., Erikson, 1968) aligns with the works of contemporary infant researchers who suggest that emotions develop from a crucible of physical and physiological regulatory gestures between caretaker and infant.

H.B. Lewis’s (1958) second tier of self development unfolds between the ages of 1 and 3, as the child begins to understand not only that she is a separate entity but that she is also located in space. This orientation brings attention to the notions of “inside” and “outside.” The child’s growing understanding of the relationship between self and the external world, Lewis stipulates, acts as the catalyst for the development of self boundaries, as well as the burgeoning experience of an agency driven “I” (p. 5).

Interestingly, H.B. Lewis suggests that the development of self boundaries is impacted by emotional experiences and that self boundaries, in turn, shape how emotion is tolerated over the course of life. Lewis (1958) states:

We have said that the self segregates itself out of a field of body and distance experiences. This field also includes the affective experiences of the organism, its libidinal and aggressive strivings and relationships to other people and things. The segregation of
the self, its organization, thus reflects the vicissitudes of instinctual development and conflict. It follows that many different factors or forces may influence the organization of the self (p. 14-15).

The organization of the self, then, partially represents an individual's intrapsychic response to managing overwhelming affects. Over- and under-differentiation of self boundaries is directly related to the quality of the relationship with the primary caregivers (Lewis, 1958, 1984). Lewis reasons that the infant looks to the objects in her environment to help her with boundary regulation; if the objects are not able to respond to this need, then the infant is made vulnerable to shame. Over-differentiation may occur when the primary caregiver is unavailable or absent. In this case the infant experiences herself as "alone in the field" and therefore must rely solely on self. As a result, self boundaries are rigid. On the other hand, under-differentiation of self boundaries might occur when the child has an overprotective caretaker who is "always present" and thus the child does not have opportunity to experience herself as an independent being.

*Shame is associated with a threat to self boundaries.*

Self boundaries that are either too rigid or too loose are implicated in compromised self image, shame, and psychopathology (H.B. Lewis, 1959). More specifically, H.B. Lewis (1959) posits that shame indicates some threat to self boundaries and, in turn, this threat triggers ego-defenses in an attempt to protect these boundaries. Implicating the social, Lewis further claims that the threat to self boundaries is born in a
relationship between self and a real, or internalized, object “in whose eyes one is ashamed.” Understanding the infant as a social being, Lewis (1958) states:

With this hypothesis, socialization proceeds not only from affectionate caretaking by the infant’s “objects,” but on the basis of biological “givens” which equip the infant to participate in these earliest affectionate exchanges. The infant is seen as not only helpless and dependent physically, but as powerful socially (p. 16).

Thus the infant depends on objects in her world to help regulate boundaries. However, the infant is also considered a powerful social being—a clear extension of object relations theory which, she (1958) reasons, “has conceptualized the infant’s behavior as symbiotic, thus denoting that the infant is [only] dependent” (p. 16). Building from attachment and object-relations theory, Lewis (1981) claims that internalization that occurs in the earliest days of life is not a taking in of the other as good or bad, but rather “is itself a social process derived from an interaction between the infant’s ‘given’ social ego and the mother’s more fully developed social ego” (p. 241).

The quality of the relational interaction, then, impacts the relative health of the individual’s self boundaries. The shame that is associated with the breach of self boundaries may occur when the infant is rejected by or impinged upon by the other. Again, as will be shown in Chapter Three, these ideas seem to anticipate the work of more contemporary infant researchers (e.g., Beebe & Lachmann, 1998).

In applying this theory to relationships, H.B. Lewis (1958) reasons that children who receive consistently negative feedback about their personality traits tend to
develop an attributional style in which “failure is attributed to these traits and success is attributed externally” (p. 19). In this situation, when attention is directed toward self, it is experienced as an impingement and the child is susceptible to shame. Lewis goes on to suggest that this child may defend against that shame by “turning away from the threatening inner self experiences and increasing concentration of attention upon the relations between the self and the external world, in other words, upon the self boundary” (p. 20). A rigid self-boundary must be developed to defensively ward against the possibility of shame. Under-differentiation of self boundaries may also be associated with shame. In this situation, an individual often has difficulty establishing where self begins and ends. She is unable to listen to her own internal cues (i.e., to mount defenses when necessary) and therefore painfully sensitive to any hint of shaming statements that come from her external surround.

**Shame-proneness and Perceptual Style**

Related to self-boundaries, Witkin & Lewis et al. (1954) demonstrated that shame-proneness was correlated with perceptual style. They associate field dependence/independence with the figure/ground metaphor captured by Gestalt therapists. An individual who is field dependent is described as one who relies on cues from the environmental surround—most notably from relationships with people (i.e., objects) in the environment—to ascertain her sense of self in the world. Conversely, an individual who is field independent is described as one who relies on internal cues to
determine their sense of self. In a series of studies with Witkin (1954), in which transcripts of psychotherapy sessions were analyzed, H.B. Lewis was able to determine that persons who have a field dependent style are more prone to shame experiences.

This relationship may seem counterintuitive at first. H.B. Lewis (1987b) explains, “Because the self is involved in imagery of itself in relation to others, it can appear as if shame originates ‘out there,’” whereas guilt appears to originate ‘within’” (p. 108-109). Just as shame is associated with a field dependent style, guilt is associated with a field independent style. Shame is a rejection of the self by both self and other, whereas guilt is a rejection of one’s own behaviors. Importantly, one’s basic sense of self is preserved in the midst of feelings of guilt. Lewis states, “Shame is an ‘implosion’ or a momentary ‘destruction’ of the self in acute self-denigration” (p. 95). Alternatively, R. Mills (2005) reflects on Lewis’s distinction of these emotions as follows: “Shame is often perceived as a global and uncontrollable rejection of the self. Whereas guilt is concerned with rejection due to undesirable behavior, shame is concerned with rejection due to personal undesirability” (p. 48). Witkin & Lewis et al. (1954) suggest that understanding a patient’s perceptual style might help a psychotherapist to parse whether guilt or shame underlie core conflicts.

Helen Block Lewis made a number of significant contributions to the understanding of shame across her lifetime of study. The most significant contribution may have been her understanding of how shame manifests itself in psychotherapy and
other intimate relationships. This work will be detailed in Chapter Four. Presently, the role of self psychology in deepening the understanding of shame will be reviewed.

Self Psychology: Kohut's Contributions to Shame

While ego psychology secured the link between self and shame, self psychology reconfigured the psychoanalytic understanding of self development. As a result, the role of shame became a more central consideration in clinical work, and the role of objects—in both triggering and defending against shame—was given further consideration. Within the field of psychology, Heinz Kohut's name is synonymous with self psychology and the related narcissistic disorders (McWilliams, 1999; Summers, 1994). Over the course of his professional career, Kohut created a developmental model of self differentiation, ultimately described pathology as an arrest in self development, and brought attention to shame as a primary affect associated with disintegration anxiety—a felt experience of losing the self or having an experience of self that is fragmented or not coherent (Summers, 1994).

Self psychology, as first conceptualized by Kohut, was developed in response to a seeming gap in the classic analytic literature in understanding pathologies that were captured by neither psychoses nor structural neurosis (Greenberg & Mitchell, 1983). Eventually, Kohut created an entirely new theoretical framework in which he conceptualized all pathology as pathology of the self. Kohut's new therapeutic
framework underscored empathy and introspection, not observation and interpretation. Kohut (1959) states, “Free association is replaced with empathic immersion into another’s psychology as the primary investigative tool” (p. 303). These shifts entailed significant conceptual change, which Kohut did not always explicitly acknowledge nor define (Summers, 1994). For this reason, Kohut’s writings are sometimes confusing and, despite the volume of writing he produced, can feel somewhat incomplete. For example, it has been noted that Kohut’s direct discussion of shame was ironically sparse (S.B. Miller, 1996). His definition of shame has further been scrutinized as vague, and as will be demonstrated in Chapter Four, his delineation of the defenses against shame was far more specific than his attempts to describe the experience of shame itself.

Nevertheless, some time will be spent reviewing the basics of Kohut’s work because many clinicians still view the self psychology model, and its related narcissistic disorders and defenses, as hallmark indicators of shame. Using Kohut’s model offers a way to understand how self psychology developed in response to Freudian theory, and therefore offers a kind of “primary source” for understanding the basic tenets of self psychology as they relate to shame.

Shame, Psychopathology and the Self

Kohut (1971) forwards a nuclear, or inborn, program of self which claims that within the context of an empathic environment, a child will naturally move toward her full potential and will develop a sense of self that is coherent and positive. Kohut argues
that previous conceptualizations of psychological disorder should be reconceptualized as an individual's attempt to negotiate the frustration of not being able to achieve the "next step" in the nuclear program. Kohut believes that a developmental arrest during self formation (between the Freudian stages of primary narcissism and the Oedipal period) leaves an individual with an enfeebled self, or a self that is vulnerable to disintegration anxiety and, therefore, is vulnerable to shame.

Kohut's Model of Healthy Self Development

For Kohut, empathy is the origin of psychic life (Greenberg & Mitchell, 1983; Summers, 1994). The importance of this statement cannot be emphasized enough, for Kohut is suggesting that the empathic or unempathic responses that a developing infant receives from her primary caregivers are fundamentally responsible for the infant's development of a self. From this vantage point, "what one needs an object for" (Lansky, 1994, p. 433) is the fundamental development of self. Kohut believes that a child is born with innate potentials and, in the best case scenario, appropriate empathic attunement from the primary caregiver helps mobilize these potentials (Greenberg & Mitchell, 1983).

The form that empathic attunement takes changes with the developing child's needs. Throughout development, the child responds to the caretaker as a selfobject—or extension of self whose primary function is to sustain self cohesion—and not a separate, subjective being. When the caretaker's response is successful the child's sense of self
remains intact and a narcissistic need is said to have been met. When not successful, a narcissistic injury is said to have occurred in which the child is vulnerable to disintegration anxiety and, thus, shame.

Summers (1994) states that in the earliest days of life the infant is fully dependent, and because of this the primary caretaker must attend to the infant's most basic needs. Included in these needs is the furnishing of what Kohut (1971) called a virtual self. It is the caretaker’s mirroring of the infant’s experiences that comprise the virtual self. In other words, the infant, who lacks the capacity for self awareness, relies on her caretakers to literally offer self reflection.

The ability of the caretaker to effectively mirror the infant’s grandiose-exhibitionism distinguishes between the development of healthy self and shameful self regard. Kohut (1971) suggests that a grandiose-exhibitionistic libidinal drive is both present at birth and similar in function to Freud’s primary narcissism. According to Kohut, an empathic response from the caretaker necessitates that this grandiosity is mirrored back to the developing child. Kohut goes on to say that in health, some element of this exuberant, grandiose self remains into adulthood and is the repository for creativity and other forms of play. However, the majority of this exhibitionistic libido is transformed into a more mature, positive self regard that is associated with healthy narcissism and the sense of self as a valued and valuable being.
The transition from exhibitionism to healthy self regard is part of the nuclear program that is triggered when the child's grandiosity is no longer sustainable. This is an outcome of the child's physiological and cognitive development, as well as the parent's inevitable failure to satisfy all needs. When these failures (i.e., narcissistic injuries) are appropriately responded to, they represent an optimal frustration to the developing child that facilitates development from the virtual self to a nuclear self as the child learns that she can survive in a world that does not meet her every need and can delight in her newfound capabilities. Because the nuclear self is less dependent on selfobjects in the environment, she strikes a healthy balance between autonomy and dependency.

Kohut's Shame

Kohut (1971) reasons that if the child’s earliest grandiosity is not sufficiently mirrored, it becomes split off. The archaic grandiosity remains walled off from the self in what Kohut referred to as a vertical split. Throughout life this archaic grandiosity both requires constant mirroring, like the youngest of infants, to sustain itself but also results in depleted self regard. Instead of realistic ambitions, the individual contends with archaic grandiosity; instead of healthy self regard, the individual remains dependent on idealized figures. The individual further becomes vulnerable to any narcissistic slights.
For Kohut (1971), shame is the reaction experienced by an individual when a narcissistic need is not met and a threat to the self is not quickly repaired. This conceptualization is significantly different than that of earlier theories in that Kohut’s shame does not represent a response to an intrapsychic comparison (e.g., self to ideal self). Rather, Kohut defines shame as the experience of the ego becoming flooded by archaic grandiose-exhibitionistic libido. The flooding of the ego by the core grandiose-exhibitionistic libido, according to Kohut, results in the ego “freezing” and a physical experience of flushing, shrinking, and gaze aversion. Kohut states that this response is automatic and intimately tied to disturbances in the self structure. He regards this experience to be intolerable and often refers to it as nameless mortification.

For Kohut, the presence of shame always reflects some arrest in development that thwarted the individual’s ability to transform her grandiosity into healthy self esteem. Kohut (1971) identifies three levels at which self development might become arrested. If developmental arrest occurs at the earliest stages of development, the individual experiences selfobjects as part of her own psyche. An arrest at this stage of development would be consistent with a diagnosis of psychotic disorder. If the developmental arrest occurs further in maturation, the individual experiences selfobjects as like the self, but not part of the self. Finally, an arrest that occurs closer to the Oedipal stage of development results in the experience of selfobjects as separate and significant, but only insofar as they fulfill narcissistic needs.
Kohut (1971) reasons that shame is evoked with arrested development at any stage. It is the last stage of development, however, he reasons, that shame is most relevant to therapeutic work. His work on narcissistic defenses, which will be reviewed in Chapter Four, was conceptualized as an individual’s attempt to ward off shame at this stage.

Kohut’s reconceptualization of self development was drawn on by infant researchers, as will be explored in the next chapter, and has had profound implications for the understanding of shame. Before turning to contemporary relational theories, however, it is important to mention contemporary approaches to understanding shame from a traditional psychoanalytic perspective.

Contemporary Psychoanalytic Conceptualizations of Shame

A number of theorists continue to conceptualize and work with shame from a traditional, psychoanalytic perspective. Some of these theorists take a stance that is less metapsychological and more phenomenological in nature (S.B. Miller, 1996). Others (e.g., Wurmser, 1981) carefully attempt to reconstruct a psychoanalytic model to better fit their understanding of shame dynamics. This project will not adequately address this body of work. In an effort to honor the important contributions, however, a small sampling of these contemporary and integrative theorists will be briefly reviewed. S.B. Miller (1996) encourages a synthetic appreciation of all models that have
been advanced throughout the history of psychoanalysis and goes on to say that what is problematic about adhering to only one model is that:

Some look at only those aspects of shame they are interested in—Kohut, for example, who was interested in infantile exhibitionism and its relationship to narcissism, looked at the form of shame that occurs when the grandiosity of the narcissistic adult is stimulated (p. 7).

Contributions of Lansky, Morrison, and Wurmser will be touched upon as examples of some of modern psychoanalytic contributions to the study of shame.

Lansky

Melvin Lansky (1987; 2003) has worked to advance the work of Piers and Singer (1953) and writes widely on the interrelationship between shame and guilt. Lansky locates shame in systems and has worked to articulate the role of shame in dysfunctional families—with a particular interest in domestic violence and fatherhood. Lansky (1992) privileges the development of the conscience, and the superego, in understanding both guilt and shame. As mentioned in the beginning of this chapter, he argues that Freud’s theories are more shame-centric than originally thought and he continues to see the superego as central to the experience of shame reactions.

Lansky identifies shame as a regulatory affect (2007) that helps an individual stay in connection with important objects. Lansky argues that suicide can be understood as a result of shame flooding—an experience in which the individual is unable to access feelings of connection to any important others. Lansky underscores the need to
appreciate the patient’s defensive maneuvers to avoid shame in developing effective interventions.

**Morrison**

Andrew Morrison (1989) has written widely on shame. He criticizes Kohut’s theory of shame in narcissistic disorders as too narrowly focused and his writings have attempted to identify shame as indicative of tension between the ego and ego-ideal. That said, “Morrison translates Piers’s structural terms into the language of self psychology, resulting in the restatement that shame reflects severe tension or strain between the self and the ideal self” (Broucek, p. 16). Importantly, Morrison has integrated the relationship between individuals and society in understanding shame. Though his work will not be explored in greater detail in this project, the relationship between self and culture, as it relates to shame, will be addressed in Chapter Four when considering variables that contribute to shame-proneness.

**Wurmser**

Leon Wurmser (1981), in an attempt to preserve Freudian theory, eloquently writes about shame as related to partial drives of voyeurism and exhibitionism. He forwards a *theatophilic drive*, associated with the desire to observe as a means of mastering experience, which is contrasted with a *delophilic drive*, encompassing the drive for self expression and the desire to gain the attention of others. In an attempt to align with Freud’s erogenous zones, Wurmser suggests that the theatophilic drive...
originates in the perceptual zone of the eye and that the delophilic drive originates in the perceptual zone of the face. According to Wurmser, when the aims of these drives are thwarted, shame ensues. As will be seen in the next chapter, Wurmser's association of shame with acts of seeing and being seen have some similarity to the role of authentic recognition in contemporary relational theory. Wurmser believes that early shame experiences can have catastrophic effects leading to long-term psychopathology. Central to his proposed drives, Wurmser identifies the archaic fear in shame as that of being unlovable. He forwards that this fear creates complex conflicts around the behaviors of looking and showing—behaviors that, according to Wurmser, are associated with our core ability to sustain relationships.

Summary Remarks

The primary objective of this chapter was to offer an overview of psychoanalytic conceptualizations of shame that reflect one-person psychologies, as well as those psychologies that act as a bridge between one-person and two-person models. Review of conceptualizations by Freud, Erikson, Lewis, and Kohut offer a framework for understanding how self, object usage, and shame experiences are interrelated in classical, ego, and self psychology models. A brief introduction of more contemporary theorists further demonstrates the centrality that shame has in psychopathology and
intrapsychic conflict. S.B. Miller (1996) appreciates the contribution that a focused investigation of emotion may bring:

Frequently in considering psychological dynamics, we refer to the patient's circumstances in broad terms, saying, for example, that his self esteem is deficient or that she behaves narcissistically. Emotions may be implied but they are not stated. The study of shame or any specified emotion is an attempt to consider actual moments of experience, which we characterize as precisely as possible (p. 3).

However, she also cautions her readers that studying shame out of context may distort understanding. The next chapter will begin to contextualize shame by turning attention to the role of shame in two-person psychologies—or those psychologies that seek to understand how affect is articulated within the context of a relationship.
CHAPTER THREE

SHAME FROM A CONTEMPORARY RELATIONAL PERSPECTIVE

To understand shame from a two-person, relational perspective does not necessitate a reconfiguration of theory, but rather a shifting of focus. As demonstrated in the previous chapter, self psychology and other one-person models associate shame with disintegration anxiety or loss of self-coherence. This perspective offers the field a clear formulation of the intrapsychic aspects of shame. As Morrison (1989) suggests, shame is a deficit of the self—not the result of doing, but of being. Core to relational theory, however, is the concept of self not as an isolated entity, but as a self-in-relation. In response to this, relational theorists build on one-person perspectives by broadening the focus to include the social milieu in which the shameful self develops. Relational models, in other words, offer a more nuanced understanding of the interpsychic roots of shame.

In the past several decades, relational models of psychoanalytic thinking have emerged at the forefront of the field and have changed the way we think about human experience. In reflecting on works by relational theorists, Spezzano (2005) notices that many relational models understand affect "not as a noun, representing an internal state, but rather a verb (to affect), describing a field process of co-construction constituted by the interplay between analyst and analysand" (p. 1). Though relational
models of psychotherapy vary widely, they share certain conceptual foundations. Mitchell (1988) states, "In this [relational] vision the basic unit of study is not the individual as a separate entity whose desires clash with an external reality, but an interactional field within which the individual arises and struggles to make contact and to articulate himself" (p. 3). In further comparison to more traditional models of psychotherapy, J. Mills (2005) notices that relational models "emphasize the phenomenology of lived conscious experience, dyadic attachments, affective attunement, social construction, and mutual recognition over the role of insight and interpretation" (p. 155). Shame, as part of the emotional matrix in which the dyad exists, is impacted by all of these aspects but, as will be the focus of this chapter, perhaps most prominently by failures in affective attunement (an integral feature of dyadic regulation) and mutual recognition.

The aforementioned failures align with and build upon Kohut’s notion that nameless mortification, or shame, is triggered by a caregiver’s failure to mirror (akin to failures in regulation) or idealize (akin to failures in recognition) a child when necessary and appropriate (Swartz, 2008). Importantly, Kohut (1971) imagined selfobject failures to be unidirectional, whereas contemporary relational theorists speak of interactive dyadic exchanges in which both members of the dyad are influenced. While recognition fosters a robust sense of self that aligns with Winnicott’s notion of a true self, it is the
regulatory concatenation of the dyad that is internalized and serves as the crucible from which the earliest sense of self develops.

It is important to note that shame is understood within the context of the attachment system—a system that identifies attachment as a basic need for survival. When motivation for attachment is foremost (i.e., the individual is aware of her need for being in connection with another as more pressing than her need, for example, to satisfy hunger), failures in regulation and recognition become associated with shame. Shame is certainly not the only emotion that is associated with dysregulation. Furthermore, the failure to be recognized is not always indicative of shame. Rather, the following discussion will work from the premise that when these failures arise in the context of attachment exchanges—i.e., when failures in regulation and recognition become associated with the potential loss of a relationship that is necessary for sustaining a sense of self—that shame may occur.

Shame Is Associated with Failures in Regulation

From a relational perspective shame is associated with failures in self and mutual regulation—processes that interface at a number of verbal and nonverbal levels across the lifespan. The annihilation anxiety that defines shame in the classical analytic literature is reconceptualized as significant dysregulation of self, secondary to breaches in regulatory patterns of the attachment dyad, in contemporary relational theory.
Relational theory embraces a systems theory of intersubjectivity in which an individual is impacted, or regulated, by her own behaviors as well as by the behaviors of the other. Inherent in a discussion of intersubjectivity then, is a discussion of regulation. In describing regulation, Beebe and Lachmann (1998) offer that the interior and exterior worlds of the developing child are reciprocally co-constructed. They go on to say that while these worlds are referred to separately, their reciprocal nature implies that the quality of dyadic regulation shapes the quality of self regulation and vice versa.

Trevarthen (1998) forwards a stage-model of intersubjectivity within which self regulation and mutual regulation develop. In this chapter this three-tier model will be used as a framework to explore the developmental arc of shame experiences (Tangney & Dearing, 2002). In each stage, the interrelationship between the burgeoning self, breaches in regulation, and shame will be discussed. Then, in Chapter Five, Trevarthen’s (1998) model will be returned to as a means of framing developmentally appropriate interventions for working with shame in the therapeutic encounter.

*Trevarthen’s Primary Intersubjectivity (0-9 months): Nascent Shame*

During the stage of primary intersubjectivity (0-9 months) Trevarthen (1979, 1998) forwards that regulation occurs at a presymbolic and preverbal level which is defined by rhythmic coordination of aspects of vocal, facial, eye gaze, and physical expressions. Stern (2004) states that from the first days of life the infant is an *embodied mind* and suggests that nascent emotions are largely body-based and associated with
patterns of physical position, tonus, and arousal. Stern likens these experiences to 
*background feelings*—events that inform the infant’s experience, eventual meaning 
making, and development of self. Thus, in the earliest stages of life, nascent shame 
experiences are associated with dysregulation that occurs at a nonverbal, body-based 
level.

*Nascent Shame Is a Nonverbal, Body-Based Experience*

When considering shame, Tronick (2007) states that the infant has a deeply 
visceral experience that is akin to the sentiment “This is threatening, I must try to hold 
myself together” (p. 303). This sentiment is to be taken quite literally. In other words 
the infant has a reaction akin to the sentiment “This is threatening”—i.e., to my psychic 
survival—“I must try to hold myself together”—i.e., literally hold my *self*, my essential 
being (comprised of body-based feelings and processes), together.

Badenoch (2008) reasons that the preverbal infant encodes consistent 
experiences of mutual regulation—whether positive or distressing—along with the 
accompanying relational representations in amygdala-centered, implicit-only memory. 
This aligns with Damasio’s (1999) concept of a neural self. Damasio forwards that there 
are three forms of self, with the most rudimentary reflecting “deep structures in the 
brain that represent sensory information from the outside world (perceptions) and from 
the body (via the somatosensory system)” (Siegel, 2003, p. 35). Experiences that shape 
the neural self literally shape the brain and create what Damasio (1999) calls a neural
map. While this map is malleable to some degree, it influences the infant’s developing sense of self in the world. The early neural self experiences are the materials from which meaning is established about the trustworthiness of relationships, as well as the experience of self-in-relation.

Thus, one way to understand the link between dysregulation at this stage of development and nascent shame is to consider that an infant who consistently endures dysregulation will, over time, make a direct link between her dysregulated background feelings and her implicit sense of self-in-relation (Badenoch, 2008). At the earliest stages of development the self that is threatened is comprised of visceral, body-based feelings that will become encoded in memory and will influence future behaviors, cognitions and self regard (Stern, 2005; Trevarthen, 1998).

The caretaker’s role in the earliest regulatory exchanges is initially more elaborated than the infant’s (Beebe et al., 2005), as the caretaker has a broader capacity to match the infant’s vocal, gestural, and other offerings. For this reason the caretaker has a greater responsibility to protect the infant from breaches in regulation and the accompanying nascent shame experiences. That said, the infant is identified as a social agent, capable of participating in the regulation of both self and other. Drawing on works by Korner and Grobstein (1976), Beebe and Lachmann (1998) state:

Infant self regulation refers to the regulation of arousal, the maintenance of alertness, the capacity to dampen arousal in the face of overstimulation, the capacity to inhibit behavioral expression, and the capacity to develop predictable behavioral
cycles. It includes variations in the readiness to respond and the clarity of cues (p. 485).

That said, while a child participates in the regulatory dynamics of a relationship from the first days of life, her cognitive ability to make meaning of these regulatory states markedly changes as she matures (Tangney & Dearing, 2002). Because of this, Beebe and Lachmann (1998) clarify that the terms mutual, bi-directional, and co-constructed
do not imply 'mutuality'; instead, they refer to the contribution that each partner makes to the regulation exchange” (p. 484). In other words, while each member of the dyad is influenced by the other, they do so in varying degrees.

The Process of Regulation: Matching and Difference Responses

The earliest forms of intersubjective regulation describe a kind of protoconversation (Trevarthen, 1979, 1998) in which imitation and conversational musicality offers the preverbal infant a sense of optimal stimulation and the opportunity to gain the skills of mutual mirroring and turn-taking. Beebe et al. (2005) suggest that the translation of concrete behavioral dimensions of the mother-infant dyad (e.g., timing, form, and intensity) into emotion is a developmental benchmark that aligns with the capacity for symbolic thought in the earliest months of life. Elliott (2002) states, “The mother, as mirror, shows the infant that she understands emotional states of jubilation and distress, and that she accepts these feelings. This acceptance, in turn,

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1 Following the lead of Beebe these terms will be used interchangeably in this text.
permits the incipient self to begin symbolization of inner feelings and to make emotional
corrections with other people” (p. 73). These emotional states are then folded into the
overall process of mutual regulation in what Stern refers to as affect attunement
(Fonagy, 1999). Stern (2004) posits that affect attunement is not a direct mirroring, or
perfect and consistent imitation of the infant’s expressive gestures but rather a
regulatory “form of selective and cross-modal imitation as a path to sharing inner
feeling states” (p. 84).

At any micro-moment, the caretaker who is attempting to regulate her infant’s
affective response—whether consciously or unconsciously—may offer a matching or
difference response to the infant’s display (Stern, 1985). These terms can be taken at
face value with a matching response indicating a similar, though not exact, expressive
gesture and a difference response indicating a significantly altered expressive gesture.

It is important to note that matching and difference responses are not inherently
facilitative or disruptive to regulation. Instead, it is the context of the relationship and
intensity of the affective exchanges that impact regulation. For example, matching a
positive affective display may contribute to a sense of “expansiveness,” whereas
offering a difference response to a positive affective display may, at other moments,
offer a much desired gesture of down-regulation (Stern, 1985). Moreover, matching a
negative affective display may feel empathic whereas offering a difference response to a
negative affective display may be experienced as rejecting. Furthermore, the affective
tone (i.e., positive or negative) that is present in the relationship does not directly
dictate the quality of regulation; regulation is possible in the presence of positive or
negative affect. These distinctions will be discussed in greater detail in the section on
Trevarthen’s (1998) tertiary intersubjectivity. These notions will become important in
Chapter Five when thinking about the therapist’s response to negative affects like
shame.

As noted, shame is associated with dysregulation. Dysregulation may occur
when the caretaker matches the infant’s distress in a manner that becomes
overarousing. On these occasions the infant is left alone to attempt to regulate herself
but, as previously mentioned, she has not yet developed the capacity to do this
effectively. Likewise dysregulation may also occur when the caretaker offers a
difference response of an intensity or frequency that leaves the infant feeling
disconnected from the dyad. In this situation the caretaker effectively gives the infant
the message that her self presentation is somehow intolerable or “unacceptable.” It is
suggested that when these types of dysregulations are repeatedly endured by the
attachment dyad, the infant has a stronger likelihood of developing a shameful self.

The infant’s first response to disruptions in regulation typically involves attempts
to evoke bids for a different kind of engagement (Tronick, 2005). If the caretaker
responds to these bids, regulation is restored. From a psychodynamic perspective, this
experience might be likened to Winnicott’s (1971) notion that the infant does not
differentiate the *autistic world* of fantasy and impulse from the real, external world. When "good enough" (Winnicott, 1971), the mother's regulation of the young infant gives an illusion that external reality corresponds to the infant's needs in a manner that is tolerable and safe.

On the other hand, if the mother continues to present a response that sustains the disruption, as evidenced in Tronick's (2005) well-known "still-face" experiments, the infant becomes dysregulated and is prematurely given the message that she is alone and must tend to her own internal world. Dysregulation triggers a distress reaction that may include frowning, fussing, crying, loss of tonus, *going dead* (i.e., going limp and utterly still in an attempt to stop the overstimulation) and withdrawal (Beebe et al., 2005). The more extreme responses such as going dead and withdrawal may help the infant to survive the dysregulation in the moment, but without intervention these behaviors also leave the infant vulnerable to the development of lifelong defenses, like dissociation, that may challenge healthy adult engagement.

*Shame or Fear?*

One might wonder how the aforementioned dysregulation becomes associated with nascent shame and not unadulterated fear. This confusion is confounded in a number of ways. Fear, for example, is consistently labeled a basic emotion (Ekman, 1999), whereas the primacy of shame as an emotion is debatable. Furthermore, the young infant's state of dysregulation evokes a fight-or-flight response (Cannon, 1915),
an immediate activation of the sympathetic branch of the autonomic nervous system that indicates acute stress.

Some clarification of the shame/fear dilemma can be found in Badenoch’s (2008) work on interpersonal neurobiology. Her work highlights the early formation of internal working models of regulatory relationships as a key consideration in delineating shame from fear. She suggests that fear may be part of the “mix” in these early states—a statement that aligns with Schore’s (2003b) comment that shame “perhaps more than any emotion is intimately tied to the physiological expression of a stress response” (p. 154)—but underscores that it is the relational aspects of the dysregulation that distinguishes the experience as shame. Thus it is the eventual association between dysregulation and threat to the attachment system that the developing child comes to identify as shame (Badenoch, 2008). While Beebe et al. (2005) pointedly choose not to label these physiological states as emotion specific, other theorists (e.g., Schore, 2003a, 2003b) understand an unrepaired state of dysregulation to represent nascent shame.

As the infant is dependent on the attachment system, dysregulation further indicates a threat to self. In these moments, an attempt to reestablish regulation as a means toward reestablishing the attachment bond becomes the infant’s primary aim. Such efforts to avoid or repair dysregulation often necessitate that the developing child adapt her behavior, and consequently shape her very sense of self, based on what the parent can tolerate. Whether dysregulation in the earliest months of life can be labeled
It is clear that the early experience of dysregulation is implicated in self development, as well as the health of the attachment system, and that these associations have primary significance for self-conscious emotions, like shame, over the course of development.

**Shame and the Attachment System**

Importantly, Beebe et al. (2005) clarify that regulatory processes are indicative of the character, not the content, of the relational interaction. Nevertheless, the character, or attachment style, of these regulatory processes often comes to comprise the very matter from which preoedipal, psychodynamic issues (i.e., content) are formed.

Beebe and Lachmann (1998) state:

> Organizing principles of regulation describe self- and interactive process, not dynamic content. They can apply to the verbal as well as nonverbal levels, and they impact on the more familiar psychoanalytic dynamic issues such as, for example, safety, efficacy, self esteem, separation and reunion, boundaries, self definition, intimacy, aloneness in the presence of the partner, and mutual recognition (p. 21).

If regulation facilitates self esteem and self definition, it follows that dysregulation is implicated in negative self regard and an incoherent sense of self—both factors that have been demonstrated to be relevant to shame. It should be noted that the overall quality of the relationship’s regulatory patterns and the child’s present stage of self development will each influence the extent to which regulatory breaches are
experienced as shameful (Karen, 1994). Secure attachment, while not infallible, is relatively more protective against toxic shame experiences (Karen, 1994).

Intersubjectivity, according to Daniel Stern (2004), is a human drive and he reasons that from the first moments of life “infants are born with minds that are especially attuned to other minds as manifested through their behavior” (p. 85). Schore (2003b) reasons that these behavioral manifestations are regulatory processes that act as precursors to psychological attachment. The attachment system, according to Lichtenberg, Lachmann & Fosshage (1992), is one of five motivational systems\(^2\) that are responsible for the development of one’s innate potential and sense of self. When the attachment is to a caregiver who is not able to adequately regulate the full array of affective experience, the child is vulnerable to shame. Karen (1994) shares,

> A secure child can cry, shout, or fall silent and know that he will be responded to in a meaningful way [i.e., successful regulation]. His negative emotions are thus an effective part of his repertoire and do not become ugly to him and have to be disavowed. He can say, “I hate you,” or “You don’t love me,” or “You’re mean,” ...with confidence that he will not be met with an icy stare, the silent treatment, a slap, an order to go to the room...[i.e., dysregulation] (pp. 240-241).

Regulatory patterns that begin at birth will eventually comprise the dyad’s attachment style, become internalized by the developing child as a template for self regulation, and

\(^2\) Lichtenberg, Lachmann, and Fosshage (1992) forward 5 motivational systems: the physiological regulation system, the attachment motivational system, the aversive motivational system, the exploratory motivational system, and the sensual motivational system.
remain intimately tied to the child’s burgeoning sense of self (Beebe, 2000; Lichtenberg, Lachmann, and Fosshage, 1992; Trevarthen, 1998).

**Secondary Intersubjectivity (9-18 months): Shame and the Experiencing Self**

Between the ages of nine and eighteen months, cognitive capacities are developing that inform the infant’s sense of self as a separate being. The incipient realization that self and other are separate objects has a significant impact on shame experiences. Because regulation becomes increasingly complex with development, shame is no longer associated only with body-based experiences. Now it involves the negotiation of shared attention toward an external object or event. Trevarthen’s (1998) secondary intersubjective attunement maps onto this stage and is defined by subject-subject-object triangles in which the child and caretaker jointly turn attention toward something.

Amongst other things, this newfound way of relating introduces a more cognitive aspect to intersubjective regulation. In this stage of development, Gallagher (2007) states, “Things and situations provide scaffolds for understanding the actions of others—and in those pragmatic contexts, we see and come to learn and imitate what they do” (p. 11). Cooper (2006) suggests that shared attention toward an external object allows the child to practice “passing through the other to reach the object,” an early manifestation of empathy and a criteria for mentalization. Bråten (2007) reasons that within trusting relationships, the infant uses pride and shame to display her
knowledge and skill regarding shared social intentions. The association of pride and shame with knowledge and skill is reminiscent of Kohut’s (1971) theory of infantile grandiosity.

In addition to this focus on shared experience, Trevarthen’s (1998) secondary intersubjectivity also includes goal-directed intentions, as well as what Damasio (1999) distinguishes as the “feeling of an emotion,” as compared to the mere experience of emotion as pure action (Trevarthen, 1998). In other words, shame as an emotion begins to take on the affective-cognitive structure forwarded by Izard and Ackerman (2000), who share that this structure represents “an association or bond between the emotion feeling [body-based] and cognition. It is the most common type of mental structure, the fundamental building block of mind and memory” (p. 256). It might also be added that these mental structures are fundamental to the continuing development of self.

At this stage, higher brain regions develop an experiencing self (Damasio, 1999) which facilitates the capacity for comparison of the neural self before and after an interaction with the world, body, or another person. Siegel (2003) explains that the infant can now begin to connect neural self-states with ongoing perceptions. In other words, the experiencing self is the self that starts to integrate the body-based feelings of dysregulation with the associated object relationship.

The experiencing self is the second of three self forms that Damasio (1999) forwards. It comprises what he refers to as core consciousness. Siegel (2003) states,
“Core consciousness is a ‘here-and-now’ experience of focused attention that is fundamentally a measure of how the neural self is changed by interaction with an ‘object’ in the internal or external world” (p. 35). Stern (2004) reasons that it is the experiencing self that must survive the obliteration that occurs in the dysregulation of shame. Moreover, the experiencing self associates this obliteration with a particular object, or other, in the environment. Thus while shame does not fully emerge during this developmental phase, the experiencing self sets the stage for shame proper. Indeed, Panksepp (1998) reasons that shame may arise as a derivative process of social learning in which earlier feeling states (e.g., separation distress) are integrated into the infant’s more complex understanding of the relational world.

_Tertiary Intersubjectivity (18-24 months): Shame Emerges in Full_

Trevarthen’s more mature, tertiary intersubjectivity (18-24 months) entails a second-order symbolization of self and other which includes the potential for perspective-taking, empathy, mentalization, and emotional absorption (Bråten, 2007). These capacities facilitate the capacity for self-consciousness, and the attendant social emotions like shame. Furthermore, the capacity for being in relation in these ways informs and coincides with the developing child’s readiness for socialization. Badenoch (2008) shares,

At just about the time a little one learns to walk, with great excitement, in his new-found freedom, his brain begins to function at a level of complexity that allows the experience of shame to emerge. The necessary ingredients include a developing
parasympathetic branch of the autonomic nervous system, functioning as the arousal brakes, and a maturing orbitofrontal cortex in the prefrontal region, which allows this boy to represent himself in his mind. Both a braking system and a capacity for self-consciousness are necessary for shame (p. 107).

As will be discussed shortly, the toddler’s developing brain is fully ready for shame in toddlerhood. Shame reactions continue to occur in the context of attachment relationships that have become dysregulated, but the toddler begins to “own” more directly the shame as related to her “own” self (a self that is now experienced as different from the others).

The affect attunement that is primary in the first year and a half of life provides a “thread of feeling connectedness” (Beebe et al., 2005, p. 48) which sustains the “shared mind,” or dyadic state of consciousness, (Meltzoff, 2004; Stern, 1985; Trevarthen, 2005) within which life begins. Fonagy, H. Steele, Moran, M. Steele, and Higgitt (1991) purport that around eighteen months of age a “reflective self” emerges that is capable of taking one’s own mind and the mind of others into account. The tasks of toddlerhood, thus, pull for a number of new developmental feats that include the recognition of self and other as separate, though relational, beings. This recognition accompanies the developing toddler’s attempts to separate from her parent.

Shame Is a Healthy Part of Development

Schore (2003b) posits that in small doses shame plays a necessary (i.e., healthy) role in regulation by facilitating the process of positive social development. For
example, Schore (2003b) notes that shame assists the developing child's successful negotiation of the separation-individuation phase (Mahler, Pine, & Bergman, 1975). When regulatory breaches are experienced too frequently, however, Schore (2002) reasons that shame becomes toxic and the child's capacity for adequately recovering from the associated state of dysregulation becomes compromised.

In understanding healthy shame, Schore (2003b) applies his conceptualization of shame as an attachment emotion to Mahler's (1975) model of separation-individuation. Mahler (1975) forwards a model of development that focuses on the growing child's process of separation-individuation from her parents. In this model, Mahler describes a practicing period in which the young toddler experiences a mood of narcissistic intoxication, the grandiose feeling that is associated with the mastery of new experiences in the world. As the young toddler moves away from the "omnipotent (m)other" and toward exploring the world, she is able to become absorbed in the narcissistic pleasures associated with this exploration, so much so that the toddler becomes oblivious of the caretaker. Shortly into the process, the toddler becomes aware of her separateness and begins to long for renewed connection. At this point, the toddler returns for reunion. Mahler (1975) states, "Brief contact with the parent reassures, comforts, and provides the emotional energy needed for further daring missions" (p. 17).
Mahler’s (1975) reunion stage, labeled *rapprochement*, is infused with arousal. The young toddler is negotiating deep feelings of remembering and longing for the omnipotent other, while simultaneously fearing that the omnipotent other will not be available. Schore (2003b) suggests that in healthy development the omnipotent other welcomes the reunion of the toddler but does not match (Stern, 1989) the narcissistic intoxication in which the toddler revels. This lesser enthusiasm is a kind of *difference* response (Stern, 1989) and evokes a felt breach in the relationship. Schore suggests that the affect associated with this misattunement is shame, as the child is keenly aware of herself as disconnected and dysregulated. Under optimal conditions the caretaker quickly attempts to reestablish regulation. This repeated pattern of separation, incomplete reunion, and return to regulation serves to help the child downregulate her narcissistic reverie in exchange for developing a more mature sense of self as separate *and* in relation. The child comes to understand that dysregulation of self is tolerable, as it becomes predictably followed by a return to a more homeostatic equilibrium. In this way, shame serves as a healthy catalyst toward mature intersubjective exchanges.

*Toxic Shame*

On the other hand, Schore (2003a, 2003b) reasons that the prototypical object relation pattern for the emergence of toxic shame is found when the caretaker sustains the misattuned response to the returning toddler’s narcissistic reverie. In this pattern, the toddler returns to the mother in hopes of having the mother join in the narcissistic
reverie; however, the mother’s misattunement (often occurring at a visual-affective level) is not recovered from, thus triggering a sudden “shock-like” deflation of positive emotion. “The mother, at these moments, becomes a stranger to her infant” (Schore, p. 160). Reminiscent of Tronick’s (1995) work with the “still-faced” mothers, the toddler is intensely aware of being alone while simultaneously propelled into a state that she cannot yet self-regulate. In this scenario, the infant does not anticipate a return to equilibrium and thus does not learn that dysregulation is tolerable. Rather, a “dysregulated-self-in-relation-to-a-misattuned-other” selfobject representation is sustained and will eventually be internalized.

It is the sudden state shift, according to Schore (2003b), from a pre-existing state of elation (positive affect) to a negative state that defines shame. The correlation of exhibitionism and invisibility with the shame experience is readily drawn here. Schore (2003) states, “The shock of shame results from the violation of the infant’s expectation of affective attunement based on a memory of the last contact with the mother that was energizing, facilitating and rewarding for the grandiose self” (p. 160). The “deactivation” of the attachment system creates a shift from a stance of elation, curiosity, and positive hedonic tone to a stance of affective deflation, passively and internally focused, and negative hedonic tone. It is this very sense of what Tomkins (1963) calls interrupted joy upon which he developed his shame theory.
Interestingly, Schore (2003b) identifies the evocation of shame to be associated not with the inevitable separations that occur in relationships but with an unwelcome reunion—i.e., an inability to rejoin the dyadic regulatory system when needed. When these failures are quickly followed by repair, Schore argues that the caretaker is using difference responses to help the child downregulate and contain the intensity of affect, as well as to align her behaviors with social expectations. This thinking follows an evolutionary perspective (Cosmides & Tooby, 1992) that holds that the shame system acts as a reinforcer of social mores in the service of helping the individual gain a sense of belonging within the community. In the absence of such repair, however, the child contends with toxic shame.

**Interpersonal neurobiology and shame.**

The sudden state shift that is described by Schore (2003b) aligns with the toddler’s newly developing parasympathetic system, a process that begins at approximately 18 months old. Badenoch (2008) refers to the parasympathetic system as the “brakes” of the nervous system and the sympathetic nervous system as the “accelerator.” These systems are fundamental in regulation. Badenoch conjures the image of a toddler running toward a dangerous situation but then stopping in her tracks upon hearing her parent’s firm reprimand. Neurologically, the toddler’s parasympathetic system has “slammed on the brakes” in an effort toward self-preservation, as well as social conformity. If the parent then attempts to reinitiate
regulation, the child’s parasympathetic and sympathetic systems begin to regain balance and this recovery is the physiological underpinning of regulatory repair.

If the parent does not initiate regulatory gestures, however, the child is left to contend with the heightened stimulation of the parasympathetic system (i.e., the instantaneous deflation associated with slamming on the brakes) on her own. Following Schore (2003b), Badenoch (2008) reasons that the sudden onset of the parasympathetic system is consistent with a shame reaction and is responsible for a number of shame presentations, including: gaze aversion, inwardly turned attention, and deactivation of the attachment system. The association between the sudden activation of the parasympathetic system and shame is another way in which shame is differentiated from fear, a feeling that is associated purely with activation of the sympathetic nervous system.

Importantly the notion of repair is not a simple return to homeostasis for the child, but to regulation. In other words, without repair within the dyad, the integration of experience has not occurred. Thus, the child may defend against a dysregulated state in an attempt at returning to homeostasis or self-regulation. However, as will be discussed in the next chapter, without repair this often comes at the cost of dissociating certain states of self-in-relation from consciousness.

Badenoch (2008) further describes a particular type of toxic shame which develops when the caretaker’s attention to her own self regulation overshadows the
child’s regulatory needs. In a case like this, Badenoch reasons that parental reprimands are likely not pure attempts to keep the child safe but also attempts for the parent to meet her own regulatory needs. The child, who now has some cognitive ability to assess her own situation, receives the message that she (not the environmental situation or behavior) is unacceptable. Like the previous examples, the child’s parasympathetic system will “slam on the brakes” in response to the reprimand; however, in response to the parent’s angry rejection the sympathetic system is simultaneously triggered. Badenoch (2008) states,

> So now the parasympathetic system slams into action while the parents’ anger continue to accelerate the sympathetic system—a situation akin to pushing the accelerator and brakes to the floor at the same moment...the unmodulated parasympathetic system pulls the child into painful and isolating stillness as the parent turns away. This young one is simply left (p. 107).

This scene is complicated by the probability that a child who is in relation with a caretaker who privileges her own regulatory needs has likely lived through a great deal of dysregulation in the relationship. It might be argued that the child has been primed for shame in that her early neural and experiencing selves (Damasio, 1999) have experienced frequent states of dysregulation. This kind of relational history sets the stage for developing a shameful self, as will now be discussed and is more likely to be associated with the development of defenses like dissociation.

When reflecting on Lansky’s (1994) reminder to consider “what one needs an object for” (p. 433) it might be argued that one looks to the other (i.e., object) to engage
in a pattern of regulatory exchanges that directly shapes affective experiences. In turn, these affective experiences are a core component of the developing sense of self. As will be discussed, experiences of consistent dysregulation lead not only to experiences of shame but also to the development of a shameful self.

*The Construction of a Shameful Self*

Mitchell (1988) states, “The person is comprehensible only within this tapestry of relationships, past and present. Analytic inquiry entails a participation in, and an observation, uncovering, and transformation of, these relationships and their internal representations” (p. 3). In other words, relational theories abide a manifold concept of self development which is representative of multiple internalizations of self and object (i.e., intersubjective) relational experiences.

The regulatory patterns that develop in the earliest relationships impact the developing child “from nervous system to cortex” (Badenoch, 2008). At the most extreme, repeated shame experiences lend themselves to the development of a self that is conceived of as shameful at the core. Badenoch (2008) explains:

> Inwardly, the terrifying picture of an enraged and denigrating parent grows larger, while the shamed inner child cringes in the shadow. If this dynamic is repeated often enough, the synaptic strength of the neural nets comprising the state of shame increases to the point that it becomes a trait, an accepted part of the person’s self-perceived identity. These neural nets are also so strong and so isolated from integration with the rest of the brain (because the empathic interpersonal relationships needed to foster further integration have not been available) that this
person is a sitting duck for any perceived slight or criticism, literally at the mercy of engrained implicit mental models (p. 108).

Building on this notion, Schore (2003a, 2003b) reflects on the impact of internalizing relational configurations that have been imbued with shame. He speaks of the possibility of a self that is partially comprised of a “dysregulated-self-in-interaction-with-a-misattuning-other” representation (p. 27). Schore further argues that internal working models of early relationships “determine the individual’s characteristic approach to affect modulation for the rest of the lifespan” (p. 25).

In reflecting on the impact of early intersubjective experiences on self development, Stern (1989) suggests that these experiences not only shape one’s ability to have conscious access to certain emotions but also influence the competency with which one is able to tolerate and manage these emotions. Beebe et al. (2003) go on to say that those experiences that are not tolerably regulated in the dyad define what cannot be known about the self. Beebe et al. (2003) go on to say that this experience:

has a strong parallel in Winnicott’s (1965) concept of the “not-me” experiences. It is also paralleled in Stolorow and Atwood’s (1992) concept of “the unvalidated unconscious:” affects that were never validated by the caregiver become the source of vague, diffuse, unsettling feelings and sensations that do not become shareable and thus do not become integrated into the self (p. 848).

These “vague, diffuse, unsettling feelings” limit what is possible within intimate relationships and also have consequences for relative health of the self. Optimal development of self, then, continues to occur in a crucible of tolerably experienced
affect and is thought to be fostered when a fluid oscillation between self regulation and mutual regulation is possible. According to Beebe et al. (2005), such balance offers flexibility, "presumably facilitating disruption and repair processes, and yielding relatively optimal levels of infant attention, affect, and arousal" (p. 87).

Shame Is Associated with Failures in Recognition

Shame, in addition to failures in regulation, is also associated with failures in recognition, or those times when some aspect of an individual's self is not authentically acknowledged and appreciated. Within the context of an attachment system, a failure of recognition is equivalent to a failure to thrive, as the self is not fully welcomed into the relationship. When some aspect of an individual's self is not authentically recognized the message that is given is that this aspect of self is unacceptable. Moreover, because relational theory embraces the theory of self-in-relation, it will be shown that those aspects of self that are not welcomed into the relationship must somehow be dissociated or otherwise defended against.

It is in regulatory exchanges of relationships that we learn to feel, as well as to understand the bounds of what is acceptable to feel and how we might embody emotions. From the first days of life the infant's needs and very presence will evoke feelings in the parent. Long before the infant has any awareness, the caregiver's reaction to the child will have a privileged position in telling (verbally and nonverbally)
the child what is acceptable to feel and to be, what parts of the self should be brought to the forefront versus hidden, and what is comfortable for the caregiver to handle. Karen (1994) states,

Shame theorists believe that neglect and rejection, especially if early and extensive, generate a self-feeling in the child of ugliness and undesirability. Parental rejection can be global, it can be limited to specific aspects of the child that the parent dislikes, or it can be a subtle combination of the two. Is the child accepted and valued for what he is—slow, placid, squirmy, delicate, dark-skinned, plain? Is he allowed to be dirty, funny, needy, silly, proud, aggressive, weak, defiant, creative, uncertain? To the extent that such qualities arouse anxiety in the parent and are responded to with coldness, punishment, or ridicule, they will become sources of shame (p. 239).

and regulate, the infant will learn—first at a neurophysiological level and over the years at a more cognitive, narrative level—what aspects of the child’s self the parent is willing to acknowledge. Aspects of self that are not tolerable are not authentically acknowledged and become imbued with shame.

Relational theorists emphasize that optimal health is associated with a process of mutual recognition, in which members of a relational dyad interact with each other in an authentic manner that acknowledges each member’s full subjectivity (Spezzano, 1993). When mutual recognition is achieved, the relational interaction is not biased by transference and countertransference dynamics. Furthermore, a number of theorists (Benjamin, 1988; Ogden, 2006; Schore, 2003b) suggest that shame is not possible when authentic recognition has been achieved.
When a relationship is defined by failures in recognition, each member of the relational dyad is stripped of their full subjectivity and in exchange is forced to assume a “role”—i.e., to interact with the other in an objectified manner, or a manner constrained by transference/countertransference. Garfinkel’s (1957) work on degradation scenes and Benjamin’s (1988) work on the master-slave archetype will be used to demonstrate how shame becomes a currency of exchange in these constrained, or objectified, ways of relating. Moreover, as will be discussed in the next two chapters, it is only through reestablishing authentic ways of relating, which include mutual recognition, that shame dissolves.

Failures in Recognition Evoke Objectification

The natural oscillation between subjective (those relationships defined by mutual recognition) and objective (those relationships defined by failures in recognition) dyadic states has become a cornerstone of contemporary relational theory. Though objectification limits relational possibilities (Benjamin, 1988), Buber reasons that it is a natural part of relational exchanges. Buber (1923/1970) offers that “to man the world is twofold” (p. 19) and consists of an oscillating, interdependent transition between subjective and objective states that occur in relationships. He argues that a shift from an authentic to an objectified way of being in relationship would occur without prompt, as all humans struggle with competing claims for autonomy and intimacy. Buber (1923/1970) laments, “But this is the exalted melancholy of our fate, that every Thou
[an other who is authentically recognized] in our world must become an It [an other who is not authentically recognized]” (p. 30). However, when negative feelings like hate or shame enter the relationship, their presence triggers this shift automatically by rendering one “compelled to reject either the other or himself” (p. 30). Importantly, Buber further argues that such rejection necessitates objectification.

Jaine Darwin (personal communication, December 2007) states, “Ogden, building on Winnicott’s notion of potential space, reasons that the analytic third is a process by which the analyst and analysand co-create a subject of analysis that informs both participants about their unconscious interrelatedness.” Ogden (2006) reflects that the concept of an analytic third was originally born in writings on projective identification and goes on to state, “The analytic third is the notion that much of the time in the analytic setting it takes two people genuinely to think and to dream” (p. 421). When each of the members is able to authentically recognize the other, a shared state of mind is developed from which individuals can grow and feel most deeply appreciated and known. Benjamin (1988, 2004) suggests that the capacity for thirdness is a developmental achievement; others (e.g., Buber, 1923/1970) see this capacity as possible from birth.

From a relational perspective, Spezzano (1995) defines consciousness as the creation of minds in interaction. It is this mutual creation of consciousness, and not the Freudian impulses of sexuality and aggression, that are considered to drive human
behavior. Building on this idea, Spezzano (1995) reasons that a drive toward consciousness motivates an individual to make use of another’s mind in an attempt to facilitate the expression of self. The assumption is that the patient is always trying to communicate—whether consciously or unconsciously—something about her self. If this communication is not recognized, the individual becomes vulnerable to shame. On the other hand, when the other’s mind can be used in a manner that facilitates mutual recognition, the process is consistent with authentic intersubjectivity in which the third is present. Spezzano (1995) states:

> Holding in one’s own consciousness alone all of one’s affects and unconscious self and object representations would lead to disturbance, pain, and, eventually, madness and breakdown (p. 24).

The absence of the “third” in a relationship reflects a way of interacting that is constrained by objectification and likely to be imbued with shame.

Not unlike Winnicott’s notion that there “is no baby without a mother” (1958), Buber (1923/1970) reasons that the experience of self and other is mutually interdependent and that from birth onward it is in relationships that we come into being. A consequence of this is that one cannot fully experience self subjectively unless one is able to experience the other subjectively and vice versa. Reflecting on Buber’s work, Bender states (2006), “When I treat the other as an object, I become ‘objectivized’ as well. Not just epistemologically—but ontologically—as well—a thing—a functioning thing.” This constant transition is both normative and difficult to negotiate.
The reduction of self and other to object status, otherwise thought of as a failure in recognition, is a pivotal component of shame. When Lansky (1994) wonders “what one needs an object for” (p. 433), it might be argued that here the need is to be treated, and to treat another, subjectively. When the other objectifies, and by definition, becomes objectified, the relationship is vulnerable to shame. It is argued, then, that shame requires an objectified sense of self and other, as will now be discussed.

Shame Entails Objectification of the Self

There is long held agreement that shame is a self-conscious emotion. “Aristotle defines shame as a kind of fear of disrepute...it requires one to imagine the world as it appears to another and to judge oneself from that perspective” (Warne, 2006, p. 72). In other words, one is functioning as both the observer and the observed—or, more simply as the observer and the object of observation. From a more contemporary perspective this is echoed by Sartre (1943/2001) who proffers the following conceptual point: “Shame therefore realizes an intimate relationship of myself to myself (i.e., self-consciousness). Through shame I have discovered an aspect of my being” (p. 221).

Because self observation is a behavior that requires an ability to take witness of oneself as a separate object, Guney (1998) writes, “while I am engaged in the shameful act, I am the act” (p. 2). When one objectively observes and labels oneself to be shameful, the judgment and the object become one and the same. This is equivalent to
assuming shame as one’s basic identity and in this way the subjective experience of shame becomes reminiscent of Balint’s (1968) “basic badness.” This all consuming badness precludes connection to other aspects of self and helps to articulate why shame is associated with such excruciating discomfort. It is the phenomena of experiencing one’s self in an objectified manner that makes shame possible.

*Shame Necessitates that Relationships Function from a Stance of Objectification*

Relational dynamics that function from an objectified stance are constrained by certain roles, or ways of being together. This constraint fosters failures in recognition and this quality makes the relational dyad vulnerable to shame. Garfinkel’s (1957) paradigmatic degradation scene will demonstrate how shame is constructed in relationships. The construction of shame involves each member of the relationship and is decidedly not a process that occurs in isolation. If one feels shame it indicates that one has been judged, or held in contempt, by another. This relational exchange, as will be discussed, can happen between oneself and a real (e.g., therapist and patient) or internalized object. After reviewing Garfinkel’s paradigm, Jessica Benjamin’s work will be briefly reviewed as a means for understanding how objectification is developed and sustained in the relational dyad.

*The degradation scene.*

The increased likelihood of shame in relationships that are defined by objectification is well articulated in Garfinkel’s (1957) paradigmatic model for
“successful degradation.” Central to degradation is the notion that one person is made to feel shame by another person. From a more literal standpoint, according to Bergner (1987), degradation describes what happens when one is “de-graded or demoted in his or her community. That is, the individual is relocated to a new community position conveying drastically reduced eligibilities for participation in the social practices of that community” (p. 25). It follows that degradation in the context of a relationship implies that the individual is relocated to a position of lesser power in the relationship. This repositioning involves reduced eligibilities for participation, and therefore reduced access to the expression and experience of self. It is useful to understand degradation because it is representative of core inter- and intra-psychic features of shame dynamics. Furthermore, to understand degradation opens the possibility to understand “undoing degradation” (Bergner, 1987), a matter that will become the focus of Chapter Five.

Degradation scenes function from a stance of objectification. By virtue of “playing a role” each member of the scene is both objectifying self and other. In other words, each member is agreeing not to take into account each member’s full subjectivity, but rather interacts with a limited experience of all members involved. Garfinkel (1957) outlined five conditions for “successful degradation.” These are:

1) A community exists that shares certain basic values.
2) The community is represented by three distinct members: perpetrator, denouncer, and witness.
3) The denouncer and witness act as representatives of the community (i.e., not out of personal interest alone).
4) The denouncer describes the perpetrator to the witness as having committed a shameful act and,

5) The denouncer presents a case suggesting that the perpetrator’s act is a genuine expression of his character and not something to be excused by circumstances. “If the denouncer makes his case successfully, he demonstrates that the perpetrator is not now and never really was ‘one of us’” (Bergner, pp. 25-26).

In Garfinkel’s model, the perpetrator is the individual whose actions or qualities are deemed egregious by all members of the degradation scene. Shame is tied to how we think we ought to be. When the perpetrator participates in violations of the self that she thinks she ought to be presenting to others, the possibility of shame is evoked. Charles Horton Cooley (1902) captures the importance of this notion in his introduction of the “looking-glass self,” described below:

In imagination we perceive in another’s mind some thought of our appearance, manners, aims, and deeds...and are variously affected by it. A self-idea of this sort seems to have three principal elements: the imagination of our appearance to the other person; the imagination of his judgment of that appearance; and some sort of self-feeling, such as pride or mortification (p. 184).

The “looking-glass self” is described by Scheff (1990) as the foundational gird for social order. Scheff argues that we constantly monitor our self when in social situations. In the midst of this monitoring we feel pride when we obey and shame when we disobey. In this way, Kemper (2000) states, “Pride and shame ensure social control and order without need for external surveillance” (p. 50). This is reminiscent of Foucault’s
“invisible omniscience.” According to Foucault (1978) the architectural structure of a Panopticon—a prison model that was designed in such a way that an observer could observe all prisoners without the prisoners having any knowledge of whether or not they were being watched—led prisoners to cautiously assume that they were always being watched by guards. This fostered an internalized and anticipatory self-monitoring on the part of the prisoners, in which one’s self was constantly compared to the prison’s standards for behavior. Cooley’s “looking-glass self” describes a similar dynamic of self-monitoring against a more general social “norm.” In this instance, the invisible omniscience is captured by the “public eye.”

Ossorio’s (2006) work with degradation dynamics aptly demonstrates that shame is quintessentially relational. For the denouncer to be successful, the content of what he is denouncing must be considered shameful to all involved, including the perpetrator of the shameful act. If one truly doesn’t vest value in physical appearance, for example, then having one’s slovenliness called out will be met with a shrug of the shoulders and not a red face. In conjunction with the witness, the denouncer, then, is representative of upholding shared social mores and values. They form a mutual, though often not articulated, agreement about what is tolerable and acceptable in the given community.

As has been reviewed, many suggest that shame is experienced very early in the formation of self (e.g., Erikson, 1959; Kohut, 1971; H.B. Lewis, 1971). This is supported
by the idea that shame is frequently associated with the body proper (McWilliams, 1994). For example, early childhood “training” experiences—e.g., feeding and toileting—often are tied to notions of wrongdoing, and it has been suggested that the first degradation scenes in life are often experienced in the community we call family.

*Benjamin’s master-slave archetype.*

Jessica Benjamin (1988) proffers that a baby’s dependence on her mother is necessary but also, by definition, an objective interaction. This is both because Benjamin believes subjectivity is a developmental achievement that the young infant has not reached, but also because this objective way of being together temporarily “resolves” the infant’s conflicting unconscious desires for independence and dependence. This conflict is otherwise known as Hegel’s paradox (1807)—which states that one’s desire for utter independence clashes with a need for recognition (note that here, recognition is entwined with dependence). Hegel’s solution to his own paradox is a relationship that functions from a stance of objectivity. Benjamin (1988) likens this arrangement to an archetypal master-slave relationship, or what she describes as the roles of *doer* and *done-to*. In this arrangement, one member of the relationship dominates and the other is effectively dominated.

The unconscious master-slave bargain, allows each member to partially satisfy their respective and unconscious conflicting claims, however it also demands that perception of self and other be distorted to match the assumed roles. The pair becomes
ensnared in playing out a way of being together that is necessarily constricted—the master dominates and controls while the slave allows oneself to be dominated and controlled. The master-slave dynamic does not abide a basic assumption of this project that all humans have inherent value. By virtue of being treated as an object that is somehow dominated and thereby diminished in value, the individual who has assumed the role of slave is not authentically recognized. Relationships that are imbued with these kinds of status dynamics are vulnerable to traumatic affects like shame.

Hegel (1807) anticipated that objective interactions were the only solution to his paradox and therefore felt that a “structure of domination” (reminiscent of degradation), defined by failures in recognition, was an inevitable fate for relationships. Relational theorists, on the other hand, see mutual recognition as a means of shifting out of this paradox and the impact of this assumption on working with shame in therapy will be discussed in the next two chapters.

Internalization of shame.

It should be noted that as one matures and internalizes objects (D.W. Winnicott, C. Winnicott, & Sheperd, 1989) it is not necessary that the degradation scenes be fully observable, nor that the roles in the degradation scene be played by three, separate and real players. Rather, the perpetrator is capable of enacting all three roles internally. Schwartz (2008) states, “Garfinkel portrays a paradigm case of these ceremonies as a public performance...[however,] these actions can be, and commonly are, performed
silently or unconsciously, ambiguously, or even in a lonely act of self-recognition” (p. 57). Certainly one can feel shame alone or in the presence of others. Nevertheless, the emotional state is a response to a relational interaction whether the relationship be with an internalized object, an actual other, or a fantasized other. Cooley reminds us that self-consciousness is a capacity to “perceive in another’s mind” (1902) and it is this aspect that captures the relational features of shame.

Summary Remarks

Stern (1985) claims that affect attunement, a primarily implicit process, is the most prominent form of interaction that occurs during the first year of life. Stern’s reconceptualization of matching and difference responses is one of the caretaker “changing with” (p. 66) and this formulation is “fundamentally dyadic and moves the concept into a process model” (p. 66). This process, in conjunction with the natural unfolding of physical maturation, offers a context within which the infant can grow into a cognitive ability to represent self. Stern (1985) and Schore (2003b) both argue that affect states are central organizing features of autobiographical memory. This memory, in turn, is pivotal to the development of self. Thus, while a number of theorists (Erikson, 1959; H.B. Lewis, 1971; P.H. Miller, 2001) identify shame as a social emotion that is not fully experienced until around twelve to eighteen months of age, it is clear that “early primitive states are not of mind but of mind-body” (Schore, 2003b, p. 59) and that these
states minimally inform, and sometimes reflect one’s developing sense of self. Frequent misattunements inform a sense of self that is informed by shame-like experiences.

Additionally, when a relationship is riddled with failures in recognition, both parties are entrenched in ways of being that distort and constrict the perception of self and other (Audard & Grosz, 2000). These ways of relating are more likely to incur relational breaches that trigger self and mutual dysregulation (Schore, 2003a, 2003b). Benjamin (1988) suggests that a set of constricted emotional dynamics also tend to describe stances of objective relating. Dynamics of shaming and being shamed (e.g., the degradation scene) are included in such constricted ways of relating.

Relationships that are described by subjectivity do not map onto the master-slave trope, nor do they create distortions in how one perceives self and other. This healthier way of relating encompasses the dynamic mutual regulation that was described by Badenoch (2008), Schore (2003b), and Fonagy (2001). Mutual recognition allows one to simultaneously be authentically oneself (independent) but also to be recognized (dependent) by the other and vice versa.

Before exploring how relational dyads might work toward ways of being in relationship that support mutual regulation and recognition (the task of Chapter Five), it is first important to review how shame manifests itself in the therapeutic relationship. From physical posture to choice of language to dyadic construction of defenses, shame
is a frequent but sometimes insidious participant (H.B. Lewis, 1971). The next chapter will explore shame manifestations in the therapeutic dyad.
CHAPTER FOUR

SHAME IN THE THERAPEUTIC ENCOUNTER

For a psychotherapist to recognize that a patient is feeling shame is rarely ever as simple as listening for her to verbally articulate the emotion. For while the psychological literature states that shame is a frequently experienced emotion that may be elicited in both reactive as well as global ways (Tangney & Dearing, 2002), shame is also described as a hidden emotion that is not typically expressed directly (Lansky, 1994). Helen Block Lewis (1971) argues that unprocessed shame is the primary reason that therapies fail and therefore it can be argued that building an awareness of the many nuanced presentations of shame is pivotal to the success of ongoing therapeutic work. Adding to this complexity, it should be noted that the failure to recognize, and therefore process, shame is often the result of a patient or therapist defending against shame experiences.

This chapter will first explore some of the factors that make one prone to shame. Though shame is widely recognized as a universal emotion (Ekman, 2003), some individuals may be more apt to struggle with shame throughout their life or at certain developmental stages. As has been discussed, the attachment style that develops between parent and child contributes to shame vulnerability (Tangney & Dearing, 2002). Additionally, developmental and cultural considerations must be taken into account. Following this discussion, common manifestations of shame will be explored.

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on theoretical frameworks from Chapters Two and Three, a consideration of how shame is evidenced in both one- and two-person models will occur. Aspects of the shame reaction that reside with the patient—posture, language, physiological response, cognitive distortions, and psychological defenses—will be described. Additionally, the manner in which the therapeutic dyad experiences and manages shame, including the co-construction of defenses, will also be addressed.

Proneness to Shame

Proneness to shame is addressed in this chapter because a therapist who recognizes that a patient has a propensity toward shame will be more likely to recognize the signs of shame as they arise in session. It is generally agreed that proneness to shame develops early in life and is the result of an interaction between the developing child’s temperamental characteristics and shame-promotive experiences (R. Mills, 2005). Self-rumination, self-condemnation, difficulty thinking clearly and speaking aloud, as well as a general wish to disappear when in public, are some of the characterizations of shame-prone individuals (R. Mills, 2005). The term shame-prone often describes an individual whose daily existence is comprised of frequent emotional distress, secondary to feelings of worthlessness (Balint, 1968; M. Lewis, 1992), that interferes with the capacity for relating. For other individuals, shame-proneness is less deeply entrenched. In certain circumstances this individual may be able to act in a manner in which she experiences herself as competent and confident. However, her
threshold for maintaining this stance is easily disrupted if information that is schema-consistent with shame scenarios enters the relational exchange. This individual would have more difficulty preempting the shame experience or achieving self-soothing once triggered.

Much work remains to be done in understanding shame-proneness. To date, it has been typically studied through the use of checklist assessments in which a person is asked to imagine how they might react or feel in hypothetical scenarios, or to endorse a certain set of self-describing adjectives (Tangney & Dearing, 2002). Enduring chronic shame that has become an internalized part of one’s identity, for example, is measured through the Internalized Shame Scale (Cook, 1989) which is comprised of thirty-nine patient endorsed statements (e.g., “Compared to other people I feel like I somehow never measure up”). Studies done with these types of surveys have provided useful information, for example, about the correlation between shame and psychological disorder. However, the structure of the instruments may fail to capture individuals who are expressing more nuanced manifestations of shame, including those individuals who are defending against shame, or those individuals who are able to retain a more cohesive sense of self when imagining hypothetical reactions—which may or may not accurately reflect their response to actual situations.

Given such, it may be that observation of relational dynamics, whether live or via videotape, offers a more nuanced medium for identifying shame-prone individuals. Some interesting work using “failure paradigms” (Thomaes, Bushman, Stegge & Olthof,
2008), for example, has generated the opportunity to observe individuals negotiate being witnessed while thwarted in their ability to successfully complete a socially valued task. Another relevant body of work is Gottman’s (1999) investigation of the role of contempt (and its counterpart, shame) in longevity of marriage. Using a facial activation unit (FAU) coding system that allows for the observation of microexpressions of emotion, Gottman observed hundreds of couples discussing heated topics. Even when couples seemed to be openly engaged in a respectful conversation at first glance, those whose body language portrayed frequent experiences of contempt and shame had a strong correlation with marital dissolution. In alignment with attachment theorists, who associate shame with unrepaired breaches in relationships, Gottman describes shame and contempt to be a kind of rust that wears away relational connectedness.

*Developmental Considerations*

The neurophysiology that supports both an understanding of cultural norms and an objective understanding of self typically develops between 18-24 months of age (Schore, 2003a, 2003b). This age also represents the first time that children have the capacity for meta-memories (memory of memories) and meta-feelings (feelings about feelings), experiences that support the development of relational schema and therefore offer the capacity for evaluative comparison of self and experience (R. Mills, 2005). These developmental milestones support an increased capacity for socially evaluative emotions like shame.
Understanding the appearance of shame at this stage has been of great interest to a number of developmental researchers. As previously discussed, Schore (2001) argues that shame serves the evolutionary tasks of aiding in socialization, as well as facilitating the separation-individuation process. Bischof-Kohler (1991) has demonstrated that only those young toddlers who are able to recognize themselves in a mirror are able to demonstrate empathy and to experience self-comparative emotions. On the worrisome side, it has been established that children who have an early propensity for self-awareness are positively correlated with insecure attachment styles. In turn, insecure attachment is positively correlated with shame-proneness (Bischof-Kohler, 1991). Thus, while the capacity for self-awareness is a developmental milestone, premature acquisition of this capacity is implicated in the development of shame-proneness. This relationship seems an important future area of exploration for the field.

Interestingly, a general trend has been indicated in which the relative frequency of shame experiences is understood to increase with age well into adulthood. This is not only because of the neurophysiological changes that occur over time but also because the developing child continually gains a more nuanced conceptualization of self. Tangney & Dearing (2002) state, “Children move from a self defined by fairly concrete, often observable characteristics (e.g., “I am a girl,” “I am tall”) to a self defined by current activities and involvements (e.g., “I am a swimmer,” “I am a hockey player”), and then to a self constructed by more enduring patterns of behavior (e.g., “I am nice to
my friends,” “I do well at school”)” (p. 140). Later still, self is defined in more abstract and inchoate terms. Thus, over time there is a growing set of self qualities that are eligible for comparison and the possibility of shame increases.

The greater awareness of social mores and rules that is established with age also impacts shame-proneness. Adolescence, for example, is typically a shame sensitive stage of development. On the one hand, this vulnerability reflects the developmental tasks occurring at this age; understanding the social rules that facilitate “belonging to a group” is a privileged task for adolescents and any threat to this task (e.g., not belonging or not measuring up) lays the groundwork for shame. Furthermore, as Erikson argues (1968), adolescents don’t have plentiful life experience in negotiating these new tasks. Like the toddler, the adolescent is also experiencing a great number of physical changes and this new, and often unchosen, way of “sticking out” puts the adolescent in an objectified position of being on display in public. The social rules and expectations regarding what this newly sexualized body is, or is not, for is often more keenly understood from an idealized (Erikson, 1968) or an intellectual basis than an experientially known basis. And like the toddler, once again, the necessary “doing” that brings the knowledge of lived experience about is often a process that is publicly commented on or observed. These dynamics are rife for shame.

It is curious to wonder if a child’s shame-sensitive stages of development aren’t similarly sensitive times for parents. While no research exists on the topic, it is interesting to notice that by virtue of the relationship the parent is, in a kind of parallel
process, similarly drawn into a heightened awareness of social norms and may be unwittingly drawn into some aspect of shame dynamics with their child. For example, one thinks of the “battles” that are described between parents and children who are in the “terrible twos” or “rebellious teens” during which the roles of the parent and child become narrowly defined—not unlike Benjamin’s (1995) *doer* and *done-to*. This would certainly be further complicated if the parent was reminded of her own unresolved issues that attend the developmental stage in question—or if the parent experiences her child as a narcissistic appendage and thus feels her very self is on the line, along with her child’s, when shame sensitivity is heightened. These dynamics are pertinent to transference-countertransference patterns that may infuse the therapeutic relationship, a phenomenon that will be expounded on later in this chapter.

Other developmental stages in life have been shown to be shame-sensitive, as well. These generally include periods of life in which one’s sense of self is shifting. Interestingly, these periods often correspond with bodily changes that occur in a publicly noticeable manner (e.g., pregnancy, illness, and aging) and in which the psychological “catching up” is slower than the physical experience (Tangney & Dearing, 2002). Some argue (e.g., Harper & Hoopes, 1990) that the “failure” to achieve socially sanctioned milestones in life also create shame vulnerabilities (e.g., an Orthodox woman not marrying). This notion aligns with Erikson’s (1968) idea that one measure of psychological health is the capacity to adapt to a given set of societal rules and expectations. That said, it is crucial to understand that the aforementioned
developmental considerations are not, by definition, shameful but rather shame-vulnerable occasions. Additionally, remembering that much of what we deem shameful is culturally constructed offers the therapeutic dyad an opportunity to deconstruct and often decentralize the shame experience.

Cultural Considerations

An assumption is frequently made that shame is a central dynamic for individuals who identify with certain religious and ethnic cultures. Japanese and Maori cultures, for example, are widely described as “shame-based” societies. This distinction between collectivistic, shame-based societies and individualistic, guilt-based societies was popularized shortly after World War II by Ruth Benedict who, in 1946, published The Chrysanthemum and the Sword. This book was an attempt to understand the culture of the Japanese, with whom the United States had been in bitter rivalry. A number of sociologists and anthropologists have credited Benedict with accurately describing the Japanese culture—even though she had never set foot on Japan’s soil. However, it has been more recently suggested that despite Benedict’s accuracy, she fell into the trap of “Orientalism” (Vogel, 1989; Kent, 1999).

Said (1979) defines Orientalism as “a political vision of reality whose structure promoted the difference between the familiar (Europe, West, ‘us’) and the strange (the Orient, East, ‘them’)” that created a false dichotomy (p. 43). Scheff (2003) argues that Americans have such strict taboos about shame that, as a society, we pretend it doesn’t exist and find relief in associating shame with other cultures that are perceived as
different from our own. As will be discussed later in this chapter, Scheff goes on to suggest that in American culture shame is hidden under "code" words and through the process of denial. In an interesting affect-control study comparing Japanese and American culture, Smith (2004) demonstrate that differing norms in these societies shape emotional events and outcomes, but that the presence of shame is decidedly not circumscribed to the collectivistic culture. This finding seems to have some potential to be generalized. Tangney and Dearing (2002), for example, demonstrate that the degree of orthodoxy has more influence over shame-proneness than a particular religious affiliation. When considering "broad classes of religious identification" there is "virtually no difference in people's proneness to guilt (and no differences in shame either) as a function of religious background in the United States" (p. 152). They go on to suggest that this counters the cultural assumptions about "Catholic guilt" or the "guilt-inducing Jewish mother." Further research is warranted.

Building on the work of Elias (1939/1969), who identified shame as a driving force of modernity, Scheff (2003) asserts that shame is a "master emotion" in society that has become more, not less, prevalent over time. Thus, a patient's cultural background is an important consideration in understanding how, not if, shame pertains to the person's life. Finally, it is important to note that an individual interacts with culture on a variety of levels in her life. A great deal of work has recently occurred regarding the culture of family as it relates to shame. Lansky (1992), for example, forwards that family systems will go to great lengths to adapt, often at the expense of
the well-being of individuals, in order to protect a shame-prone parent. Lansky posits that we are quick to assume that these families are “other” in that they are filled with domestic violence or other extreme “dysfunction.” While shame may be pertinent to such families, Lansky (1992) suggests that therapists should recognize that shame dynamics can be equally destructive for a variety of families in far more frequent and subtle manners.

*Shame-proneness and Psychological Disorder*

The literature on clinical diagnosis and formulation frequently identifies individuals with psychological disorder as more shame-prone. Shapiro (1989) sees some level of impairment, of autonomy or sense of direction, as definitive of psychopathology and states that such impairment contributes to a diminished sense of self. He suggests that psychological disorder infers a set of defenses that support self-estrangement, a “reaction by the personality against itself leav[ing] the person who experiences it estranged, cut off, from himself in certain ways” (p. 3). Building on this notion, S.B. Miller (1996) suggests that anytime an individual takes the risk of exposing the estranged self, the potential for shame is significantly increased. She goes on to say that this is one way to understand how shame is intimately tied to psychological disorder.

The correlation between psychological disorder and shame has recently found some biological validation as well. Pallanti and Quercioli (2000) note that shame reactions have been associated with activation of the cortico-thalamic pathways. As will be discussed in the next section, this finding offers a concrete, neurophysiological
marker with which to identify whether certain psychological disorders are relatively more or less shame-prone. In a meta-analysis of related studies, Pallanti and Quercioli (2000) state that there is neuropsychological evidence that shame "...is fairly ubiquitous in psychopathology but is clinically much more structured in its abnormal expressions in anxiety disorders, particularly social phobia, obsessive-compulsive disorder, eating disorders, body dysmorphic disorder and even in bipolar mood disorder" (p. 28). Thus while an individual with any psychological disorder may be more prone to shame, it has been argued that some disorders are more shame-infused than others.

Adding to this discussion, a number of researchers have suggested that certain disorders, once conceptualized as guilt-laden, are more accurately described as shame-ridden. Harder and Lewis (1987), for example, have shown that shame is far more strongly correlated than guilt to Obsessive-Compulsive disorder and depression. Tangney and Dearing (2002) further identify a surprisingly low correlation between feelings of guilt and the self-blame that is descriptive of certain disorders. Rather, Tangney and Dearing (2002) suggest that guilt is more typically a reaction to legitimate transgressions, whereas shame and self-blame are often triggered by situations in which the individual has little responsibility for the triggering circumstances. If accurate, these findings would bolster the original laments of ego and self-psychologists that Freud’s theories too often confused shame with guilt. Whether shame holds a preemptive position in psychopathology or is better understood to be present alongside guilt is unclear and remains an interesting question for future investigation. What is clear,
however, is that shame is in the therapeutic encounter far more frequently than Freud’s later writings suggested. Attention will now turn to how shame manifests itself in the therapeutic encounter.

Individual Manifestations of Shame

Shame intensity and proneness are variable and must be understood within an individual’s life context. Still, the question of how shame manifests itself in the therapeutic encounter remains. This section will give a brief overview of shame manifestations that are centered within the individual. Some permutation of these manifestations is arguably present during any shame experience, whether conceptualized from a one- or two-person model. Moreover, it is important to acknowledge that shame is not circumscribed to the patient’s experience but may be brought into the therapeutic session by the therapist as well.

Physical Posture

While there is some controversy over whether shame is a basic emotion (i.e., present from birth), there is plentiful evidence to support Ekman’s suggestion that shame is a universal emotion with an innate and spontaneously generated biological expression (2008). Shame manifests itself with slumped shoulders, gaze aversion, drooped head, narrowed chest, downward mouth and a general posture of cringing or otherwise appearing submissive (Damasio, 1999). In fact, this presentation differs from other self-conscious emotions like embarrassment, which includes oscillating approach-
avoidant behaviors, including darting eye contact and hesitant smiling, that help
distinguish embarrassment as less destructive to the psychic self (Tracy & Matsumoto,
2008). In other words, the physical posture of embarrassment reflects that the self is
continuing to attempt to make relational contact and repair the relational bond,
whereas the physical posture of shame reflects a complete breach in the dyad—and if
anything the attempt at repair is found in the submissive posturing that communicates
deferece. There is some thought that shyness, which has many similarities in body
posture to shame, is likely to be biological (e.g., temperamental) and not psychological
(M. Lewis, 1995) in nature. Understanding whether and how shyness and shame are
correlated remains to be explored in greater depth.

In an interesting set of studies, Tracy & Matsumoto (2008) demonstrated that
shame expressions are universally witnessed across cultures and that it did not matter
whether the individuals under observation were congenitally blind or sighted. The latter
finding is important because it suggests that shame expressions are not observed and
learned behaviors but rather innate reactions to certain social antecedents and
appraisals.

Body signals are thought to have originated as an evolutionary attempt to
communicate important emotional information. It is suggested that these signals then
become ritualized across the human species as a way to exaggerate the information and
insure the greatest potential for conveyance (Tracy & Matsumoto, 2008). This
functionalist perspective sees shame as serving a socially mediating purpose to
“maintain others’ acceptance and preserve self-esteem by maintaining social standards and submitting to others” (R. Mills, 2005, p. 28). The action tendencies that are associated with these goals include distancing oneself from others in an effort to reduce exposure to evaluation, internally focusing attention on social mores, and communicating deference to others (R. Mills, 2005).

Blush

One of the most classic and yet to be mentioned signals of shame is the phenomenon of blushing. Nietzsche (1883/2007) defines man as the “animal with red cheeks” (p. 57). Blushing is also understood to have a functional, evolutionary explanation. Changizi, Zhang, & Shimogo (2006) argue that the development of color vision is best understood as a tool for discriminating emotional states and socio-sexual signals and not as a tool for identifying edible foods (e.g., berries) as previously argued. Unlike other non-primates, the spectral sensitivity of human eyesight is optimized to notice changes in skin pallor. Changizi et al. forward that animals that have color vision also have faces that are significantly barer (i.e., having less fur) and therefore changes in skin color can be used to represent threat, sexual, and emotional signals. Changes in skin coloration are noticed as differences from an individual’s baseline, and are affected by changes in blood flow regardless of one’s skin color. In other words, everyone blushes. Changizi et al. (2006) go on to report, “Color is sufficiently suggestive of emotion that even cartoons use color on the face to indicate emotional states” (p. 5).
This reminder leaves one to wonder how a therapist’s blush might impact the therapeutic exchange.

The term blush denotes an emotional reaction and it is this characteristic that distinguishes it from a more medically described flushing. Blushing serves as a bridge between one’s internal affective experience and social relationships; however it is important to note that the link between the physiology of blushing and the social significance of blushing are, in part, socially constructed. For example, in the 18th and early 19th centuries, blushing was desirable and understood to evoke Diogenes’s (412-323 BC) notion that “blushing is the color of virtue” (as cited in Walsh, 1908, p. 92). However, in other time periods, blushing is assumed to be a scarlet letter indicating one’s “true colors”—and something people go to great lengths to avoid. This was evidenced in a New Yorker article by Gawande (2001) which opens with the phrase “What is blushing? No one knows but it can ruin your life” (p. 1). This article features a television anchorwoman who elects to undergo a costly and invasive open-chest surgery called endoscopic thoracic sympathectomy (ETS), which severs the neural pathways that facilitate facial blushing. Another recipient of this surgery was quoted as saying “I would have gone through with it [ETS] even if they told me there was a fifty-percent chance of death” (p. 3).

Darwin (1872/1965) devotes an entire chapter in his book *The Expression of Emotions in Man and Animals* to self-conscious emotions, including shame, and in this chapter he speaks at length about blushing. Darwin cites that blushing can be
physiologically mimicked by the administration of amyl nitrate and researchers (e.g., Carlson, 2000) now know that this is a direct result of amyl nitrate activating the parasympathetic nervous system. This finding is explained by MacCurdy's (1930) work, which suggested that blushing reflects a shift from the sympathetic to the parasympathetic components of the autonomic nervous system. The implication of this transition will now be discussed.

*Physiological Response*

The social self preservation theory (SSPT) proposes that a social evaluation of threat evokes a coordinated psychobiological response (Rohleder, Chen, Wolf, & G.E. Miller, 2008) that culminates in the feeling of shame. There is a temperamental aspect to be considered, beyond the scope of this paper, which further associates shame-proneness with anxiety-proneness. MacCurdy (1930), who studied shell shock following World War I, suggests that shame is representative of a particular type of anxiety. Whether or not anxiety and shame are understood as related or separate traits, or chronic shame is understood to be experienced as a chronic stressor in and of itself, it has been established that the physiology of shame is closely aligned with the physiology of anxiety (Schore, 2003b).

A dysfunction in the Hypothalamic Pituitary Adrenal Axis (HPA-Axis), with a significant increase in the stress hormone cortisol, has been correlated with chronic shame responses. Moreover, the worrisome health risks—such as high blood pressure, high cholesterol, psychological burnout, fatigue, and decreased immunological
functioning—that are typically associated with chronic stress have similarly been associated with unmanaged shame states (Rohleder et al., 2008).

The in-the-moment physiology of shame also mimics stress reactions. The person who is feeling shame often experiences an increase in breathing rate, blood pressure, and heart rate. As will be discussed in the next section, the person may also experience a sense of cognitive confusion, or the colloquial feeling that one’s “head is swimming.” This feeling can be understood as a result of shame activating the cortico-thalamic pathways (Pallanti & Quercioli, 2000), or what LeDoux (1998) refers to as the “low road” (e.g., fight-or-flight) limbic response, which tend to be unfiltered by cognitive appraisal and therefore is unmediated in intensity. In fact, dysfunctional activation of the cortico-thalamic pathways has been implicated in dissociative episodes (Mirzaei et al., 2001). The role of dissociation in shame experiences will be discussed later in this chapter.

A number of other brain regions are implicated in shame. For example, the Preventricular System (PVS), associated with the submission aspects of the submission/dominance response system, and the anterior region of the hypothalamus, associated with the punishment aspects of the punishment/reward response system, both demonstrate increased activity during shame reactions (Saxe et al., 2004). Shame has also been associated with the activation of the Cingulate Cortex, a brain region that becomes activated during traumatic separations and the resultant separation distress cry (MacDonald & Leary, 2005). Similarly, a number of neurohormones, including
Monoamine Oxidase (MAO), which is associated with introversion and withdrawal, show increased activation during shame reactions (MacLean, 1993).

A number of researchers are using these findings to better understand the role that shame may have in psychological disorders. McMillan (2006), for example, reasons that shame may be the "psychological engine of compulsive addictive behavior" (p. 156). Meanwhile, van der Kolk (2006) and other researchers interested in Post-Traumatic Stress Disorder (PTSD) are investigating the impact of chronic shame on identity development.

Cognitive Implications

From a clinical perspective, understanding the physiology of shame offers the therapist a number of clues to watch for in the patient’s presentation. Minimally, there are some concrete changes like increased breath rate that may be observed alongside the postural changes that indicate shame. More notably, it is important to remember that the internal state of shame evokes a reaction akin to fight-or-flight. The association of shame with intense anxiety, cognitive confusion, and the potential for dissociation renders an individual unlikely to participate in a reflective dialogue. This is the internal state that accompanies complementary roles, and not the achievement of a third—concepts that were discussed in the previous chapter.

Michael Lewis (1992) suggests that shame evokes a cognition that is akin to the command "Stop! You are no good," which he differentiates from guilt’s command "Stop! What you are doing violates a rule, change your behavior."
The cognitions that evoke shame can result in attention that is hypervigilant for shame-triggering stimuli in the environmental surround, or internally directed and hyperfocused on the shameful self. As previously mentioned, cognitions may be muddy or confused, distorted toward seeing self as bad, or perseverative in nature as the individual continually replays the shameful event in her head. Likewise, acute shame may facilitate dissociative reactions (Bromberg, 2006).

Thus shame has an impact on cognitive process as well as content (Leeds, 2004). It is important to acknowledge that the antecedents and appraisals of shameful events may be unique to the individual. Therefore, while the loss of a necessary other that accompanies perceived disapproval is a universal trigger of shame, there is an indeterminate range of triggers specific to individuals.

Language

Closely tied to cognition is the use of language, for how we think about things impacts how we verbalize experiences. Kaufmann (1996) states, “Language plays a central role in the perception of inner states, and perception is always an active, constructive process” (p. 21). Scheff (2003), H.B. Lewis (1971) and others have suggested that individuals rarely endorse a direct feeling of shame (i.e., “I feel shame”), but rather talk about shame with code words. This can be particularly confusing because the feelings “guilty,” “embarrassed,” and “humiliated” are often concurrently experienced with shame but also used as global descriptors in an attempt to articulate shame. Miller (2004) similarly purports that “shame is often a central ingredient” in the
following experiences, and that the following experiences are conversely often used as code words to describe shame:

<table>
<thead>
<tr>
<th>Alienation</th>
<th>Inadequacy</th>
<th>Powerlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defenselessness</td>
<td>Weakness</td>
<td>Insecurity</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Shyness</td>
<td>Inefficacy</td>
</tr>
<tr>
<td>Inferiority</td>
<td>Flawed</td>
<td>Exposed</td>
</tr>
<tr>
<td>Unworthiness</td>
<td>Being Hurt</td>
<td>Intimidation</td>
</tr>
<tr>
<td>Defeat</td>
<td>Rejection</td>
<td>Being dumped</td>
</tr>
<tr>
<td>Rebuffed</td>
<td>Stupid</td>
<td>Bizarre</td>
</tr>
<tr>
<td>Odd</td>
<td>Peculiar</td>
<td>Different</td>
</tr>
</tbody>
</table>

This list is representative but not exhaustive, and Miller points out that the language above centers around experiences of being disconnected or made to feel different from the norm in some way. Becoming attuned to these themes offers the therapist a means for noticing potential shame experiences. Additionally, certain issues or words in and of themselves may evoke shame for some individuals. Sexuality and finances, for example, are frequently referenced as difficult topics for patients. It may be reasoned that because of contemporary social mores, shame is evoked for many people when discussing these aspects of their personal lives.

Interestingly, it should be noted that laughter is considered a language structure that is associated with shame. According to Provine (2001), laughter is used as punctuation in speech for hearing individuals and is frequently considered a transitional language phenomenon more than an emotional experience. Genuine laughter is an expression of release or affiliation; however, laughter can also be used to chide another individual. While research has not occurred on this topic directly, it has been suggested
(Scheff, 2003) that nervous laughter, directed toward the self, may be indicative of a shame reaction. In this scene the individual is both the subject and the object of the interchange ("laughing at oneself"). Interestingly, genuine laughter also serves a reparative function in shame. Being able to distinguish shared laughter from being the object of laughter is the key distinction here. The role of laughter in self-conscious emotions is an interesting area of study. The question of how laughter, and humor, might be used in therapy to both facilitate the alliance and deepen intimacy, without evoking shame, seems an important future area of investigation.

**Narcissistic Defenses**

In addition to the physical and physiological manifestations of shame, there are also psychodynamic manifestations that might enter the therapeutic encounter. One sentinel of shame that has been forwarded by self psychologists is the presence of narcissistic defenses. At the core, self psychologists agree that narcissistic defenses describe an individual's use of selfobjects as a means for averting disintegration anxiety and the attendant emotions, including shame (McWilliams, 1999). The core defenses used by persons with narcissistic struggles are idealization and devaluation of self and others (McWilliams, 1999). As will be seen, a secondary (though psychically expensive) gain of these defenses is a validated sense of self aggrandizement, which includes a false sense of total self-sufficiency (McCullough Vaillant, 1997).

Gabbard (2000) outlines an integrative model of narcissism and proposes a continuum scale that can be used to indicate and gauge how an individual defends
herself from narcissistic injury. In Gabbard’s model (2000), an oblivious style of narcissism marks one end of the continuum and describes an individual who boasts about personal and selfobject successes (a form of idealization) while insulating herself from negative responses from objects in her environment through self denial and devaluation. On the other end of the continuum, a hypervigilant style of narcissism describes an individual who avoids vulnerable situations by devaluing and discrediting objects in her environment but also intensively studying (and idealizing) others in an attempt to conform to expectations.

When narcissistic defenses are employed, an idealized or devalued aspect of the self, rather than a discrete object from one’s past is projected onto the therapist (Britton, 1998; McWilliams, 1999). In this way, the therapist is experienced as an extension of the patient’s self-esteem. As a result, the person struggling with narcissistic injury constructs a world of relative illusion that allows for a sense of total self-sufficiency, specialness, and grandeur. However, this world comes at a high cost. Waska (2005) states,

> The patients I am highlighting experience intimate relationships as an impossible task...[They] can align themselves with good objects but feel a looming loss or betrayal to be imminent...or [they] can deliberately detach from the experience...and feel in control, but lost and alone (p.88).

McWilliams (1999) goes on to say that “narcissistically structured people are aware at some level of their own frailty” (p. 177). Here we find a paradox. The narcissist is dependent on others to serve as selfobjects. However, recognition of fallibility or
dependence is simultaneously intolerable. Such recognition evokes a depleted or shame-ridden self-state (i.e., lack of self-cohesion). Because individuals struggling with narcissism fear fragmentation, and make efforts to avoid the shame associated with such devastation, they defend against experiences and feelings that remind them of their dependence on others or their potential for failure (Gabbard, 2000). Narcissistic defenses have unique implications for the therapeutic relationship. As persons with narcissistic defense structures have difficulty forming intimate relationships (Jacoby, 1981), therapy poses a challenge.

The Cocoon Transference

Modell (1993) builds on these dilemmas and forwards a unique therapeutic presentation that he calls the cocoon transference. Modell reasons that “it is the centering of affect within the self that leads to a sense of psychic aliveness” (p. 84). For those individuals who are more vulnerable to narcissistic injury, however, Modell (1993) reasons that a private self, whose role it is to defend against experiences of intrusion, is evoked. This private self is experienced as a cocoon that keeps the individual from authentic engagement in exchange for psychic safety. The cocoon transference, according to Modell, (1993) may be experienced as “a prison from which there is no escape, in accordance with the intrinsically paradoxical autonomous and dependent nature of the self” (p. 82). In therapy, this imprisonment may be experienced by both the patient and the therapist as authentic engagement is precluded.
In therapy, Modell (1993) claims that these patients may appear as if they are filling the sessions; however, upon closer inspection it becomes clear that “the affective charge has been removed [and] the analyst must feel lost in a sea of words. In the absence of authenticity, there can be no psychoanalytic dialogue; meaning cannot be communicated without some trace of genuine feeling” (p. 81). The cocoon transference protects the individual from expressing genuine feeling, which is experienced as an expression of need. Moreover, by avoiding such expression, the individual sustains a felt sense of self-sufficiency.

The therapeutic presentation of a person who employs a cocoon transference aligns closely with the self-psychological notions of how narcissism manifests itself in the therapeutic relationship. This presentation often results in the therapist feeling “stuck” (Stark, 1994). If the cocoon transference is challenged too quickly or too intensely, the patient may flee therapy, justifying this behavior through devaluing the therapist in an attempt to preserve self-cohesion (Leigner, 2003; McWilliams, 1999). On the other hand, because the therapist is not related to authentically nor recognized as a separate individual, countertransference responses can include boredom, loss of concentration, irritability, and a sense that “nothing is happening” in treatment.

The patient’s deficient self-structure is accompanied by “hypersensitivity to perceived criticism or lack of affirmation” (Ivey, 1995, p. 357). Moreover, the therapist’s feelings of boredom, if recognized by the patient, may become coupled to the patient’s fragile self-esteem. This therapist-patient combination makes for a tentative
relationship. As will be discussed in the next chapter, patience and empathy are tantamount to forming a therapeutic alliance in this instance. From a more traditional psychoanalytic perspective, the therapist must further be willing to serve the role of the “old” selfobjects in the hopes that over time the patient will replace archaic selfobjects with more mature and appropriate selfobjects (McWilliams, 1994).

The Defensive Use of Affects

In addition to narcissistic defenses, shame may be defended against through the evocation of other, ostensibly safer, emotions. H.B. Lewis (1971) reasons that just as shame is rarely endorsed directly with language, it is also infrequently felt as a raw emotion in a sustained way. Lewis suggests that shame is so threatening to the self that it is rarely felt, but more often serves as a signal to mount other defenses. When shame is felt, she reasons, the experience is often fleeting and often not accompanied by rational ideation. Similarly, Heller (2003) aligns with researchers (e.g., Cosmides & Tooby, 2000; Ekman, 2003) who endorse a functionalist view of emotion, in stating that elementary shame is “necessarily expressed” (p. 1020). In other words, shame is understood to be immediately expressed in the physical and physiological manners described above, without an individual’s ability to prevent such expression. If the individual begins to reflect on the experience then the reflexive shame, which is similar to the dysregulated experience of the young infant who has not yet developed a capacity for mentalization (Badenoch, 2008; Schore, 2003b), transforms into shame proper, a more sustained experience of shame that is consciously acknowledged. More
frequently, the reflexive shame expression is fleeting and often does not enter the awareness of the person who is experiencing the affect (or for that matter, the awareness of the witness—e.g., therapist—to the emotion). This is because shame can be diverted or suppressed almost immediately.

H.B. Lewis (1971) refers to this diversion as bypassed shame and suggests that “as soon as shame is felt, it begins to diminish or recede; it may be labeled as feeling ‘lousy,’ ‘tense,’ or ‘blank’” (p. 197). Indeed, there are several common manners in which shame becomes masked. Action tendencies including withdrawal and violence (Gilligan, 1996) are typical. Furthermore, Lewis offers a long list of emotions that may be secondary to shame—most prominently rage, sadness, and indifference. A brief exploration of these will now be offered.

**Shame Cycles: Rage and Sadness as Defensive Affects**

Bypassed shame, according to H.B. Lewis (1971), is frequently associated with humiliated fury, an expression that is best understood in the context of a shame-rage cycle. Lewis (1971) suggests that shame-rage cycles are complex emotional reactions that are both triggered by shame and help to defend against shame. Lewis reasons that shame is frequently associated with a perception (real or imagined) that the other person is feeling hostile toward oneself. She argues that the accompanying threat of potential rejection evokes hatred that manifests itself in rage. This rage is often felt as deeply justified by the person even if the recipient of the hatred experiences the reaction as unjust or confusing (Zarem, 2006).
H.B. Lewis (1971) goes on to say that the aggression that is implied in “hatred involves the threat of losing the affectional tie” (p. 152). This heightened threat to the relationship paradoxically intensifies longing for the cherished object, and a type of depressive reaction ensues. That said, such longing increases the potential damage that the feared rejection would incur, the knowledge of which unconsciously evokes shame, which then triggers more rage. And thus, the cycle continues. Within this cycle a capacity for tolerating ambivalence is low and affect feels definitive and often overwhelming.

A number of researchers have used the shame-rage cycle to try to understand dynamics that occur in romantic partnerships and other intimate dyads. As previously mentioned, for example, Gottman (1999) has identified the corrosive impact of contempt, which is closely related to humiliated fury, on long-term partnerships. Nevertheless, it is important to note that H.B. Lewis views humiliated fury, or rage, as an attempt (albeit a destructive one) to recover the self, as the individual is attempting to stay in relation with another. She contrasts shame-rage with shame-shame cycles—in which the individual is provoked into being shamed and then becomes more deeply shamed by the very presence of affect. This shame creates shame, and so on. According to Lewis, shame-shame cycles are far more difficult to recognize and work with in therapy when compared to the recursive shame-rage cycles which generate rage and depression, as they more likely represent a continually downward cycle and tend to
evoke isolation of the self. Thus, shame-shame cycles, according to Lewis, offer a far smaller possibility for breaking out of the cycle and recovering self.

*Indifference as a Defense Against Shame*

H.B. Lewis (1984) identifies indifference as a powerful affect that is defensively used to bypass shame. Because Lewis identifies emotions as born from a social matrix she posits that they are experienced by each person in the relationship. She suggests that there is both an individual state of arousal, as well as a communication to significant others, within any emotional experience.

From this perspective, H.B. Lewis (1981) argues that an emotional stance of indifference is often an unconscious attempt to communicate hostility and other derogatory, or degrading, affects. If the communicator conveys a message of "not caring" and the recipient is poised to receive this communication then Lewis (1981) states, "It succeeds in warding off feelings of humiliation in the self, and it can succeed in evoking them in the other" (p. 12). Lewis contrasts the indifference that is often born from bypassed shame with the indignation that is associated with guilt. She reasoned that "righteous indignation" mobilizes the individual who is feeling guilty to either make amends or to defend oneself as unjustly accused. Again, this defense is more clearly associated with the behavior and not the self. Understanding Lewis's conceptualization of indifference highlights another manner in which one might unconsciously use objects to maintain a stable sense of self. More importantly, it serves
as a good introduction to the relational aspects of defenses, the next topic of this chapter.

**Dyadic Manifestations of Shame**

Attention will now turn to dyadic manifestations of shame, with a particular focus on the co-construction of defenses. Stern (1989) suggests that the impact of early intersubjective experiences both shapes one’s ability to have conscious access to certain emotions and also influences the competency with which one is able to tolerate and manage these emotions. Optimal development of self and healthy psychological defenses, then, continues to occur in a crucible of tolerably experienced affect and is thought to be fostered when a fluid oscillation between self and mutual regulation is possible.

**Co-construction of Defenses**

Lyons-Ruth (2001) locates the ontogeny of defenses in an intersubjective field, stating that “defense formation occurs at the interface between individual fearful arousal and the responses of central attachment partners” (p. 11). From the earliest days, it is the interaction between an infant’s distress and the caregiver’s response to said distress that becomes the template from which defenses develop. Working models of relationships are unique to the dyad and uniquely constitute how the dyad tends to breaches in regulation. Despite this uniqueness, however, there are certain trends that align with the attachment style of the dyad.
Often referred to as the “psychological immune system” (Karen, 2000; Lyons-Ruth, Bronfman, & Gwendolyn, 1999), the attachment system works to modulate negative arousal. When the attachment style is secure, the developing child is able to play, learn, and explore her environment. In the absence of attachment security, however, the child’s need to obtain regulation takes precedence and supersedes her ability to fully explore her environment. In the latter category, the infant is left to adapt to the caregiver’s failure to provide the necessary soothing response. The defense is both generated within and unique to the dyad, but may also be internalized and evoked across the lifespan at times of relational distress. Karen (2000) poignantly states:

Children are constantly being defined by their parents’ emotional states. Living with a rageful, unforgiving parent continually emphasizes the child’s badness, makes him feel as if he is too bad to be embraced. He feels inadequate, ugly, unworthy, not good enough to be loved. There is a deep sense of shame, which may be largely unconscious. But unconscious does not mean inoperative. The child becomes susceptible to the belief that he deserves to be locked out, excommunicated, put into solitary confinement; that he must be stripped of his membership in the family and humanity. That is the proper fate of one who is so wicked, unworthy, or unlovable. In the future, when reprimanded or rejected by others or regretful about something he’s done, he will return to this terrible box and sink into depression. Or he will try desperately to stay by holding on to an irreproachable or grandiose image of himself or engaging in some kind of power struggle, like a blaming-match, the purpose of which is to put the other person in the box (pp. 87-88).

The aforementioned reactions may become defensive styles. As will be discussed in Chapter Five, the individual who develops a sense of self as deserving of excommunication may assume the defensive strategies of a masochistic stance, while
the individual who takes an irreproachable or grandiose stance may assume the
defensive strategies of narcissism. Defensive strategies are constructed in all
attachment dyads, but the capacity for timely mutual regulation and repair is predictive
of the relative level of fluidity and health of such defenses. As will now be discussed,
Lyons-Ruth (2001) suggests that traumatic affect, like shame, is more likely to occur in
caregiver-infant dyads that are described by a hostile/helpless relational pattern. It
follows that the hostile/helpless relational pattern offers a good paradigm for
understanding the development of defenses against shame.

*Lyons-Ruth’s Hostile/Helpless Relational Patterns*

As discussed in the last chapter, shame may be triggered by an unrepaired
breach in an attachment dyad that results from failures in regulation or recognition.
Certain relational styles (Lyons-Ruth, 2001; Solomon & George, 1999) are more apt to
generate shame experiences. For example, Lyons-Ruth’s hostile/helpless relational
model is notable both for the restricted range of permissible affect as well as for the
notion that one partner’s relational needs are markedly subjugated in the service of the
other partner. This imbalance in whose needs are attended to, mimics the *doer* and
raised in this type of relational pattern is more likely to grow into a narcissistic or
borderline stance, or to create a false-self in an effort to weather the caregiving
relationship. Each of these outcomes has a strong correlation with proneness to shame.
The hostile/helpless labels describe patterns of relating that the caregiver brings to the relationship. These patterns shape the possible range of responses available to the developing child. The hostile pattern represents a caregiver whose behaviors may be perceived of as frightening (e.g., yelling, negating children's emotions) to the infant and include *negative-intrusive* and role-confused behaviors (Lyons-Ruth, 2001). These caregivers tend to be self-referential and controlling. Lyons-Ruth (2001) states, “These caregivers may be attempting to master unbearable feelings of vulnerability by denying their own vulnerability” (p. 15). A helpless pattern, on the other hand, represents a caregiver whose behaviors may be perceived of as frightened (e.g., dissociating, withdrawing) to the infant and full of vulnerability. Lyons-Ruth (2001) states that caregivers in this category “appear to be fearful and are easily overwhelmed by the demands of others” (p. 15). This group of caregivers is more difficult to identify as “their more withdrawing and fearful but non-hostile behaviors are harder to discriminate from more confident and structuring parental behaviors…” (p. 14).

The understanding is that each of these styles is indicative of the caregiver's attempts to prevent becoming flooded or overwhelmed by her own affect. Because the caregiver is preoccupied with her own affect and not that of the infant, each of these styles is riddled with communication, or regulatory, errors. As a result, Lyons-Ruth, Melnick, Bronfman, Sherry, & Llanas (2004) argue that mixed affective signals are often forwarded by the caregiver, offering the example of a caregiver who laughs at an infant's distress while simultaneously picking her up. Such behaviors interfere with the
dyad’s capacity for repair and Lyons Ruth et al. (2004) state that according to Main and Hesse’s reasoning this create a fundamental bind for the infant:

If the parent herself arouses the infant’s fear, this will place the infant in an unresolvable paradox regarding whether to approach the parent for comfort. The parent becomes both the source of the infant’s fear and the haven of safety (p. 70).

The infant’s adaptation reflects the irresolvable paradox. The infant may vacillate between approach-avoidance, as well as freeze, dissociative, and other atypical behaviors (Lyons-Ruth, 2001). Such behaviors are commonly described as “disorganized” and this label is an apt reflection of the way fearful or negative emotion is being handled in the dyad. Without intervention, these adaptive strategies become consolidated into defenses.

According to Lyons-Ruth (2001), by the age of six role-specific stances have been organized that attempt to control the caregiving relationship. The child may attempt to control the relationship through punitive, hostile behaviors or, conversely, through solicitous, caregiving behaviors. While these strategies may have differing implications for the child’s experiences in her greater relational world, they serve the same strategy in the relationship with the caregiver. A caregiver can feel equally helpless with a child who is “larger than life,” that is, [a child who presents] as especially gifted or talented” or with a child who is “impossible to control or influence” (p. 15). In other words, Lyons-Ruth (2001) states, these defensive stances are different strategies for “core
representational and affective themes, namely a disruption in the regulatory function of the caregiving system that exposes the child to inadequately modulated fear” (p. 15).

Importantly, Solomon and George (1999) reason that for the caregiver’s frightened or frightening behavior to be disorganizing, it must be pervasive in nature or sufficiently traumatic if occurring in isolated incidents. Additionally, they reason it is the lack of repair, and not the frightened/frightening behavior itself, which becomes disorganizing. The infant is scrambling to adapt to the caregiver in a manner that reestablishes regulation.

Thus, the infant’s burgeoning defensive style is markedly shaped by the caregiver’s ability to regulate her own fearful arousal. A caregiver who struggles to modulate her own affective experiences is less likely to notice her infant’s dysregulation or to feel competence in responding to this state. Moreover, while it may be the caregiver’s own discomfort with affect that evokes the infant’s dysregulated state, in an attempt to decrease a sense of vulnerability the caregiver may perceive the infant as the sole source of the dysregulation. Whether consciously or not this assignment, or blame, has implications for the infant’s developing sense of self as bad or shameful. Moreover, when the parent’s regulatory needs take such precedence over the infant’s, a lack of balance in the roles that are possible occurs, as well as a diminishment in the lived experience of mutual regulation.

Internalization of Co-constructed Defenses

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Without a balance between self and mutual regulation the child is left with a dilemma, the resolution of which will imbue future relational patterns, and is therefore relevant to therapy. When a person has not experienced a balance between disruption and repair in early relational dyads, she may attempt to compensate by excessively tending to self regulation or mutual regulation. Excessively tending to self regulation may result in the defenses of isolation, dissociation, or inhibition. On the other hand, excessively tending to the regulation of the other in the context of the relationship may result in an "interactive vigilance" that constrains the patient's freedom to tolerably experience a broad range of affects. The resultant defenses include repression, denial, and projective identification. These descriptions are further reminiscent of narcissistic structures in which one turns to others only as selfobjects, or offers oneself to the other as a narcissistic appendage (Kohut, 1971), which potentially create a vulnerability to shame, particularly within intimate relationships (e.g., therapy).

Further relevant to psychotherapy is Schore's (2003b) notion that the internalization of self and object representations that are associated with affect regulation is akin to the development of the superego. He reasons, "The investigation and characterization of a unique affect [shame], emerging in a specific time" (p. 152) is descriptive of a unique developmental function. Citing works by Jacobson (1964), Kernberg (1984), and Pine (1980), Schore (2003b) establishes affect regulation as a primary function of the superego:
The hallmark of a developmentally and functionally evolved superego, which is often too narrowly defined in terms of cognitive and verbal aspects of conscience, is reflected in mood stability and a relatively rapid recovery from disruptive emotional distress states to positively toned emotional states (p. 183).

As previously described, Schore (2003b) hypothesizes that a successful negotiation of the separation-individuation phase utilizes shame in moderation. However, when the negotiation of this stage of development is overly imbued with shame, the individual develops regulatory strategies that are similarly imbued with shame and that are consistent with the notion of superego pathology. Drawing on works from the fields of psychoanalysis and infant mental health, Schore (2003b) states that unresolved separation-individuation issues often linger into adult life including difficulty negotiating physical and psychological boundaries, as well as difficulty regulating body comportment and gestures. Building on this, Schore (2003b) posits that “it is just these strategies of affect regulation and pathogenic schemas of dysregulation that must be recognized and addressed in the transference-countertransference matrix” (p. 28).

**Grand’s Theory of Mutual Dissociation**

In her work on understanding the dynamics of incestuous relationships, Grand (2002) purports that trauma occurs within a “dyadic system of mutual dissociation” (p. 63). Turning to the co-constructed nature of relationships, she suggests that it is only through shared states of mutual dissociation that the relationship can be sustained. Put another way, to become authentically aware of the traumatic exchange represents a
threat to a relationship that feels necessary for both parties involved. The less threatening solution, therefore, is often found in the dissociation of the self and object representations that were embodied during the traumatic encounter.

It is suggested here that shame, an emotion that is widely talked about as a traumatic interruption of self-cohesion (Kohut, 1971; H.B. Lewis, 1971; Schore, 2000), follows a similar relational dynamic. As discussed in Chapter Three, whether conceptualized in Garfinkel’s (1957) language of degradation (perpetrator, denouncer and witness) or Benjamin’s (1995) complementary roles of doer and done-to, shame occurs in relationships that are defined by objectification. Furthermore, when mutual recognition and regulation become disrupted but are not responded to with quick repair, each member of the dyad participates in co-constructing a defense against the generated shame. As a result of the defense, the shameful self lives without speech, memory, or consciousness (Bromberg, 2006). On the other hand, for the person who participated in triggering the shame experience, the defense results in a self that is experienced as justified and innocent.

Grand (1997) reasons that one important consequence of this dyadic system is that the recognition of a traumatic exchange is dependent upon both individuals in the relationship shifting from a state of dissociation toward a state of full acknowledgment. Grand’s theory of recognizing trauma can easily be applied to recognizing the traumatic affect of shame. While the recognition of shame that occurs with this shift is possible in any relationship, it is most likely to occur in a safe, therapeutic exchange where “the
perpetrator-within-the-analyst” (Grand, 2002, p. 64) can be acknowledged and worked through. As will be discussed later in Chapter Five, this idea is reminiscent of Davies’s and Frawley’s (1994) notion that survivors of trauma grapple with a dissociated world of (childhood) relational dynamics that are reenacted in the therapeutic encounter.

Summary Remarks

It is widely argued that emotions evolved as an adaptation to fundamental life tasks (Cosmides & Tooby, 2000). Oatley and Jenkins (1996) view emotions as regulating systems that help an organism become motivated, gather information, prioritize, make judgments, take action, and communicate. Damasio (2003) underscores the function of shame when stating, “Even the emotions proper—disgust, fear, happiness, sadness, and shame—aim directly at life regulation by staving off dangers or helping the organism take advantage of an opportunity, or indirectly by facilitating social relationships” (p. 39).

Despite the important role that shame plays in relationships it is often not directly acknowledged and, according to H.B. Lewis (1971), Gottman (1999) and others, this oversight can have a devastating impact on therapeutic and other intimate relationships. This chapter reviewed the manners in which shame might manifest itself—both overtly and defensively—in relationships. Manifestations of shame from
both individual and dyadic perspectives were reviewed. These manifestations were then placed in the context of the therapeutic encounter.

It has been suggested that when relationships are defined by Lyons-Ruth's (2001) helpless/hostile dynamics, internal working models of attachment regulatory patterns are not a fluid continuum but rather become rigidly defined by varying permutations of the subjugated or subjugator roles. This aligns with Benjamin's doer and done-to paradigm discussed in the previous chapter. From early infant-caregiver relationships, the developing child learns what is possible to feel, how to defend against intolerable feelings, and what "role" she can comfortably assume in relationships.

As discussed in the previous chapter, failure of recognition or loss of the third, facilitates a kind of relating that is described by objectification. This kind of relating creates complementary positions in which each individual, consciously or unconsciously, assumes a 'role.' These roles become the scaffolding from which defenses are developed and manifest themselves in unique patterns that are consistent with certain pathologies.

Fonagy, Gergely, Jurist, & Target (2004) suggest that the "ultimate form of affect regulation...mentalized affectivity...marks an adult capacity for affect regulation in which one is conscious of one's affects, while remaining in the affective state. Such affectivity denotes the capacity to fathom the meaning(s) of one's own affect states" (p. 96). They further suggest that this capacity is as meaningful as the capacity to act on one's emotion and constitute a large percentage of therapeutic work. Schore (2003b), citing
Kaufman (1985), underscores the import of “returning internalized shame to its interpersonal origin” (p. 151). The final chapter will explore the process of returning shame to its interpersonal origin in the context of the therapeutic relationship.
CHAPTER FIVE
WORKING WITH SHAME IN THERAPY

In most adult relationships, deepening intimacy is the result of a back-and-forth rhythm of self-disclosure and shared vulnerabilities. The process of psychotherapy, however, sets itself apart by facilitating a process of disclosure that is primarily unidirectional. It can be argued that the asymmetrical nature of the therapeutic relationship may contribute to the experience of shame for the patient and, in different ways, for the psychotherapist as well. In the case of the psychotherapist, Malcolm (1980) argues that shame may be evoked in those moments that the therapist struggles with knowing that she is not the ideal that the patient needs her to be, or, as Broucek (1991) suggests, when she is asked to negotiate the sense of “hiding” that an unbiased therapeutic stance may sometimes evoke. On the other hand, as has been discussed throughout this project, a host of factors can initiate shame reactions in the patient. At its most fundamental, shame in psychotherapy is about seeing and not being seen (Wurmser, 1981). From a traditional perspective, for example, shame may be evoked when the patient becomes aware, via interpretation, that the therapist knows things about her that she does not yet know about herself. Or from a more contemporary perspective, shame becomes relevant when the patient, who is asked to divulge her most intimate thoughts and feelings, is not met with a response that offers authentic recognition or necessary regulation.
The intention of this chapter is to explore how shame might be addressed when it makes itself known in a therapeutic encounter. James Strachey (1934/1999) reminds his reader that psychoanalysis originated as a therapeutic procedure. That said, while the procedure of psychotherapy has remained the most clinically consistent aspect of the analytic tradition over time, there is a relatively larger proportion of literature on theoretical formulations, as compared to therapeutic action, in regards to shame. As a result, this chapter will focus on clinical approaches to working with shame. It will further highlight questions that might reveal themselves as next steps for investigation and clarification about working with shame in psychotherapy.

As has been demonstrated, one of the unique dilemmas of shame, or any traumatic affect, is that it is experienced when individuals are relating to one another in a complementary, or objectified, manner (Benjamin, 1995; Garfinkel, 1957). In contrast, the processing of affect is most successful when interactions are described by a mutual recognition of subjectivity, or the capacity for the third (Ogden, 2006). Building on Grand’s (1997) model of mutual dissociation that was presented in Chapter Four, it is suggested here that working with shame necessitates a dyadic shift from a position of objective to subjective interaction in which each member of the dyad moves from dissociation and toward acknowledgment of the traumatic breach that has occurred within the relationship. Trevarthen’s (1998) developmental model of intersubjectivity will be used as a framework for proposing therapeutic interventions that may facilitate
this relational shift. Clinical examples, drawn from the works of S.B. Miller (1996) and others, will be used to demonstrate the concepts under consideration.

The impetus for working with shame in the therapeutic relationship is multiply informed. Helen Block Lewis (1971) suggests that when shame is acknowledged and actively processed, the therapeutic relationship is less likely to undergo premature termination. Furthermore, a contemporary relational perspective embraces the theory of multiple selves-in-relation, which understands health to involve “a relatively fluid access to these selves and a general sense of comfortable containment of them” (Grand, 1997, p. 475). From this perspective, shame decreases the ready accessibility one has to various self-states and therefore working with shame in therapy helps the patient reestablish or gain access to a fuller self (Bromberg, 2006). In Chapter One it was suggested that psychological health is associated with a deep understanding of one’s inherent worth. The process of gaining access to one’s fullest self is a fundamental component of appreciating self-worth.

Of equal importance, facilitating greater access to self-states has direct implications for risk assessment in clinical work. Grand (1997) states that in contemporary models the unconscious is no longer a receptacle for unacceptable affects like shame but rather a “fluid temporal medium of not-knowing” that is comprised of “whole selves...hoping to be heard and to be not-heard” (p. 475). From this perspective, shame is understood to provoke the dissociation of self-states. Bromberg (2006) shares that “pathological dissociation can be said to exist to the
degree that the patient cannot simultaneously access self-states that might modulate
the ‘truth’ being held by the self-state that is the ‘real me’ in the moment” (p. 72). Shame has been implicated in acts of violence toward others as well as toward the self (Gilligan, 1996). When considering risk assessment, Grand (1997) wonders, “Which self is engaged with our inquiry?...Can a speaking, depressive self know and give assurances on behalf of a wordless, presymbolic, ‘adhesive’ self?” (p. 476). Working with shame to facilitate greater access to self-states, therefore, markedly impacts the reliability of risk assessment.

Trevarthen’s Developmental Model of Intersubjectivity

Adapting Grand’s (1997) model to working with shame involves shifting the therapeutic dyad from a state of co-constructed defense to a state of mutual acknowledgment of self and object representations. This process is multiply informed and Trevarthen’s (1998) model of intersubjectivity offers a framework for working with shame over the course of this transition. It should be noted that Trevarthen (1998) forwards a developmental model that focuses on the burgeoning child’s capacity for intersubjectivity and not on the interactions of adult psychotherapy. That said, while infant and developmental researchers are not directly identified as relational theorists, the field of infant research has contributed greatly to the understanding of dyadic communication and the regulatory patterns that occur in all relationships. Beebe et al. (2005) see “a continuity between our work, their work [Lachmann & Jaffe], and that of
Stephen Mitchell and Lewis Aron, whose studies of an array of patient-analyst interactions have been seminal to the growth of a relational perspective” (p. xx). Thus, with the caution that working with adults in therapy is not a direct mirror of the developmental process of childhood, there is enough overlap to apply Trevarthen's model in this discussion.

It is also important to mention that the goal of moving from dissociation to acknowledgment is not always indicated. Some aspects of self remain unknown not because they are imbued with shame but rather because they represent a kind of private or core self (Bromberg, 2006). At other times, dissociation may serve to bolster resiliency, even if it is defensive in nature. While shame often goes unnoticed, the therapist must be careful not to assume the presence of shame. Additionally, she must weigh the impact before attempting to work directly with shame in psychotherapy.

Primary Intersubjectivity

In the here-and-now moments during which the therapeutic dyad becomes dysregulated by shame, Trevarthen’s (1998) primary intersubjectivity informs appropriate therapeutic interventions. As previously discussed, Trevarthen (1998) claims that a presymbolic, preverbal intersubjectivity—defined by rhythmic coordination of aspects of vocal, facial, eye gaze, and physical expressions—necessarily precedes verbal intersubjectivity. The earliest forms of intersubjective regulation, described as protoconversation (Trevarthen, 1998), are argued by Damasio (1999) to shape the experience of the neural self. As discussed in Chapter Three, Damasio (1999)
reasons that the neural self is the earliest form of self to develop and consists of patterned physiological responses that comprise background feelings. It is the neural self that experiences and encodes the most primitive, body-based forms of dysregulation and that emerges in the therapeutic encounter at times of dysregulation.

In the moment that shame is evoked, the immediate therapeutic goal is regulation. In these moments the therapist, like the caretaker of a young infant, has a more elaborated role and takes the majority of responsibility for establishing regulation (Beebe & Lachmann, 1998). The most important job of the therapist at this stage is to recognize the dysregulation and perhaps more difficultly to tolerate the affective experience of shame. In the absence of these conditions, the therapist is, wittingly or unwittingly, participating in a co-construction of defenses and, as has been discussed, the self and object representations will remain out of consciousness. Effective interventions at this stage maximize the aspects of self that can be brought to the therapeutic encounter and minimize the replication of toxic shame. Therapeutic actions at this stage include becoming keenly aware of nonverbal aspects of communication and distinguishing between regulation and homeostasis.

_Becoming Aware of the Nonverbal Cues of Shame_

In the previous chapter a review of the nonverbal manifestations of shame was offered. Most generally, the therapist is asked to observe the physical posture, physiological reactions, and other previously described shame cues as a means of identifying dysregulation in the therapeutic encounter. However becoming aware of the
nonverbal cues of shame requires discipline in observation, as the cues are often subtle and fleeting. One manner in which the therapist may become aware of these cues is by attending to the nonverbal regulatory gestures that comprise Trevarthen’s *conversational musicality*. This is an interchange of mutual mirroring and turn taking that offers the therapist a way to both observe the patient’s body, but also to physically experience the emotion as she matches the patient’s vocal, gestural, and other offerings. Building on this, the therapist is keen to also pay attention to countertransference reactions. As will be discussed in the next section, the therapist may notice internal responses that provide clues to the patient’s dissociated self-states. Thus, moments of dysregulation offer the therapist an opportunity to begin to collect data regarding the patient’s unique reactions to shame.

The common body-based colloquialisms like “saving face” and “being seen” further remind one that the face and eyes are frequently implicated in shame. Averting one’s eyes and turning one’s face away are core aspects of the physical expression of shame (Damasio, 1996). Cooper (2006) refers to eye contact as the window into intersubjectivity. As mentioned in Chapter Two, Wurmsen (1981) identifies the eye as an “erotic zone,” the libidinal aim of which is merger with an object. He goes on to suggest that when this aim is thwarted, shame ensues (Wurmsen, 1981). Kohut speaks of the developmental need for a child to be the “apple” of her parent’s eye (Bornstein, 1986). More basically it might be argued that shame is involved in all that is associated with being seen when one wishes to be invisible—we might think of the proverbial child
who is “caught” with their hand in the cookie jar—or being ignored when one is wishing
to be seen—the “invisible” child.

The therapist is wise to consider her use of looking as a therapeutic tool. If it is
determined that “being seen” is too exposing in a particular moment, the therapist may
be judicious in the intensity of her visual consideration of the patient by moving her
body to a less direct angle or averting her gaze periodically. In other words, reminiscent
of Haven’s (1989) notion that creating a safe place in therapy sometimes entails the
patient and therapist looking out at the world together, the therapist may soften the
centrality of the gaze in the therapeutic encounter. On the other hand, for those
moments that a patient needs to be visible, the therapist is asked to become practiced
in establishing a kind of concentration that is reminiscent of a new parent’s attention to
her infant. Reminiscent of Kohut’s (1971) mirroring, the therapist is asked to quiet her
body and let the patient know that she is seen and central, without any distractions
(e.g., drinking of water, fidgeting) that might indicate the intrusion of the therapist’s
own needs.

Transference Reactions Happen at an Affective-Configurational Level

It is further necessary for the therapist to recognize that at moments of utter
dysregulation, the patient is not in a position to reflect on self or experience. Instead, at
these moments, the majority of the communication is occurring at a nonverbal and
often unconscious level. Regina Pally (2005) states:
Consciousness and spoken language account for only a very small percentage of the brain activity involved in perception, behavior, emotion, memory, planning, decision making, learning, and interaction. [...] Psychoanalysts do recognize unconscious, nonverbal elements of analytic treatment but typically focus on their symbolic and communicative function (Jacobs, 1994) (p. 195).

As mentioned, it has been established that selfobject representations are encoded in the Orbital Frontal Cortex (Damasio, 1999). Representations at an affective-configurational level are imprinted and stored in the right hemisphere and at a lexical-semantic level within the left hemisphere (Schore, 2003b). Importantly, the right hemisphere is predominant in the first three years of life, thus the internalization of early selfobject dyads is affectively laden.

When a patient becomes overwhelmed, it is the right-brain, affective-configurational internalizations that will be powerfully evoked. The therapist must be prepared for this shift from verbal, left-brain discourse to one of affective-configurational, right-brain discourse. Transference reactions from the earliest relationships, in other words, are largely body-based. If the therapist is willing to enter this exchange, then she has the opportunity to experience the dysregulation from the inside-out, as well as to live through the patient's strategies for reestablishing regulation. If the therapist is unable to tolerate the dysregulated state and defends against this by minimizing, distracting, or otherwise being out of attunement, shame experiences are readily accessible and the "dysregulated-self-in-relationship-to-a-
misattuned-other” is reinforced as indicative of how the relational world works. Thus, nonverbal regulation is a key consideration in therapy. Beebe et al. (2005) state,

One of the most essential aspects of what was reparative in this treatment was Delores’ sense that she could affect me and that I could affect her. [...] The basic concept of the mutual regulation model, that each partner affects the other, is broader than the concept of matching. It indicates that each partner senses in herself an ongoing receptivity (or lack of receptivity) to the other, in adjusting, tracking and being “influenced”; as well as an ongoing impact (or failure of impact) on the other. This is the bedrock of the entire treatment, the foundation of all human communication (p. 137).

It is only when the therapist realizes that regulatory patterns that were developed in the there-and-then, inform the here-and-now that therapeutic change is possible.

Regulation versus Homeostasis

Returning to Stern’s (2004) notion of regulation as a process of “changing with,” it is important to underscore that the goal in the presence of shame is mutual regulation and not, necessarily, an immediate grounding or return to emotional homeostasis. Remembering Stern’s (2004) work on matching versus difference responses, the therapist must use her judgment in deciding how to respond to the patient’s dysregulation. The intention is to convey to the patient that even the most profound loss is survivable and not necessarily to rush toward grounding the patient, which may convey the message that “this is [i.e., you are] not tolerable to me.” Importantly, if it is appropriate to offer a matching response, the psychotherapist must be in a position to tolerate the experience of shame.
Empathic Stance

A willingness to take on shame, or any other traumatic affect, is not work that is done simply nor without impact and at this stage some of the therapist’s most difficult work is embracing an empathic stance that facilitates the tolerance of shame. Jack Kornfield (2008), a psychologist who trained as a Buddhist monk, talks of shame as an unhealthy mental state that can be addressed in therapy through mindfulness and self compassion. Pema Chödrön (1994), an American Buddhist nun, cautions, however, that there is a difference between rushing toward self-recovery and tolerating dysregulation:

This approach [tolerating dysregulation] is very different from practicing affirmations, which has been a popular thing to do in some circles. Affirmations are like screaming that you’re okay in order to overcome this whisper that you’re not. That’s a big contrast to actually uncovering the whisper, realizing that it’s a passing memory, and moving closer to all those fears and all those edgy feelings that maybe you’re not okay. Well, no big deal. None of us is okay and all of us are fine. It’s not just one way. We are walking, talking paradoxes (p. 19).

Mercy, a term that is most frequently addressed in the theological literature, will be briefly commented on here because it captures a kind of empathic stance that is argued to be necessary for authentically working with shame. This stance can be understood in the context of contemporary relational dynamics as easily as it can be understood from a theological perspective.

John Keenan (2000) defines mercy as a willingness to enter into the chaos of another. He goes on to state that mercy is a reciprocal relationship and that we are only truly acting from a place of mercy when we are deeply convinced that we are receiving
mercy from the same person to whom we are giving it. In other words, responding to a patient as what Said called the “other,” as if the patient’s pain is somehow definitive of her total experience and perceived of as “not me,” only serves to exaggerate the asymmetry in the therapeutic relationship. Even if the therapist intends to be of help, a stance of compassion that distinguishes the patient as “other” is problematic. Kennedy (2004) states, “The danger in a myopic view of mercy is that the person engaging in the action may never progress towards seriously analyzing the roots of the suffering one is working to alleviate” (p. 7).

Kennedy (2004) further states, “To look at the suffering and injustice of this world is an option for all people” (p. 8). It is an option to see the reality of suffering, just as it is an option to let oneself experience the suffering of another. Psychologists face the dilemma of where to place themselves in the therapeutic encounter. To believe that one must become deeply involved in suffering, and then to work together from this place of suffering in a manner that each member of the relationship is touched by the other, reflects an empathic stance that is infused with mercy. Aron (2006) poignantly captures that once a therapeutic dyad is involved in something together “the analyst may be said to need his patient’s recovery, because in a sense, his own is actually involved. It is not simply a matter of invested time and energy, instead, a real opportunity for personal growth and recovery is at stake” (p. 352).

Prescribing this therapeutic stance is certainly easier than detailing how one comes to achieve it. Joining in another’s suffering is a destabilizing process. Sobrino
(1994) describes a merciful person as “one who interiorizes, absorbs in her innards, the suffering of another—in such a way that this interiorized suffering becomes a part of her” (p. 17). This description might be thought of in psychology as countertransference, projective identification, or authentic relating. The important point is that even a therapist who intends to work empathically may become unconsciously pulled into a position where reality is more comfortable if shame is denied. Engel (1987), who coined the term *biopsychosocial*, reminds his reader “Where you think you stand determines what you think you see” (p. 21). In addition to making a general commitment to remain aware of her own feelings, the discipline of recognizing the unique impact that “joining in another’s chaos” might offer, may help the practicing clinician remain centered while becoming involved in the patient’s pain. Furthermore, the therapist can call on her own experiences in therapy, in which she was joined in her own traumatic affect, as a source of remembering the power that mercy holds.

**Clinical Example: Trauma**

Brothers (1997) opines that *self-trust* is a necessary component for achieving a felt sense of self-cohesion and that self-trust becomes severely disrupted in the face of trauma. Brothers (1997) defines self-trust as the “hope or wishful expectation of receiving or providing for others” (p. 248). Interestingly, she argues that self-trust serves a transitional role between the realm of selfobject fantasy (primary process) and subjective reality (secondary process). From a self-psychology perspective, self-trust, when intact, is similar to transmuting internalization—it facilitates self-organization.
based on the experience of relationships with others. Importantly, Brothers (1997) states that “only those who meet our self-trust criteria will be represented in selfobject fantasies” (p. 249), suggesting that all others are dissociated. Consequently, the cohesiveness and vitality of self experience depends on the trustworthiness of selfobject connections.

Furthermore, when self-trust is betrayed, a survivor may alter her experience of subjective reality in order to “protect the trustworthiness” (p. 250) of the perpetrator. This is especially true for children who have been victimized by people they are dependent on for survival, such as family members or other primary caregivers. While this alteration may quell disintegration anxiety, and the associated shame, it does so at the cost of distorting subjective reality. Dissociation of affect, meaning, or ways of being in relation may be necessary to protect the “trustworthiness” of a perpetrator. This results in what Brothers (1997) calls black holes of consciousness that prevent a survivor from developing a sense of self-cohesion.

For the adult survivor, these black holes become triggers for shame in psychotherapy and other intimate relationships as they represent moments of utter dysregulation, as well as aspects of the self that have never been recognized. Brothers (1997) suggests that the survivor seeks relationships with selfobjects that represent dissociated aspects of the self. These selfobjects are either uncomfortably similar to objects from the past (and thus more likely to literally reenact traumatic experiences) or are responded to, through transference, as if they are objects from the past.
In certain therapeutic moments the patient will unconsciously respond to the therapist as a traumatic selfobject. In these moments, the dysregulated right-brain responses that were originally associated with the old traumatic objects will be triggered. The patient may feel unsafe or uncertain without really understanding why and it is unlikely that she will verbalize, or even recognize, this discomfort—as the left-brain, semantic-lexical level processing is not involved in this reaction. If the therapist also feels uncertain in these moments then the dyad may unconsciously construct defenses. However, the goal in these moments is for the therapist to begin noticing the dysregulation that occurs at the nonverbal, body-based level. For the therapist, developing an awareness of when shame has entered the room and subsequently tolerating the affect allows for the initiation of regulatory exchanges. In this way, the features of primary intersubjectivity inform the immediate response to shame—verbally and nonverbally, consciously and unconsciously.

A brief example of some of these concepts in action is found in a clinical vignette. A young man with whom I worked for approximately three years arrived to therapy with a long history of complex, traumatic loss—a history that he rarely talked about with anyone in his life. During childhood he was given the message that he needed to “move on” and to “make the best of life” and he was frequently praised by all in his community for doing just that. His sense of self-sufficiency was fragile, though, and it was further complicated by a number of medical conditions that left him “unable to trust his body”
to take care of him. He protected his close relationships by adhering to their “good advice” and denying his need for more.

For many months our sessions deviated away from black holes and focused on how lucky he felt to have such a “good childhood” and to be such a “successful person.” We began to notice, however, that whenever these notions were challenged in even the slightest way—inside therapy or in his external world—that he would become quite dysregulated and I noticed that he would assume a posture that was shame. He would sink into silence, all the while slumping his shoulders, bowing his head to his chest and covering his eyes with his hands. Later, he described these experiences as feeling “almost dead inside” and like “the ‘me’ I know is gone.” While he did not name this feeling to be shame, he had a deeply felt sense that he could not trust others/objects to be with him in negative emotions that was compounded by a feeling of not “knowing himself” when negative affect arose. His early expectations were that I would expect the same rigid presentation. In other words that I might reject, or shame, any aspect of his self that was not “good” and “successful.”

His experiences of being recognized and regulated when feeling negative affect had been infrequent and this led him to associate negative emotions with the potential for relational loss which, in turn, became complicated by deep feelings of shame for being “needy” and “not happy enough.” For many months, during dysregulated exchanges, I would attempt to match my breathing rate and posture, all the while attempting to sit in a manner that was open but not overly focused. It was well over two years before we
talked about these exchanges explicitly; however, within those two years more and more affect was shared in the therapy room. It might be suggested that this reflects his burgeoning implicit, nonverbal understanding that this relationship would not be destroyed by negative affect and that a fuller sense of self was welcome.

*Secondary Intersubjectivity*

Trevarthen’s secondary intersubjectivity is associated with what Damasio (1999) refers to as the experiencing self, or that aspect of self that facilitates the comparison of the neural self before and after an interaction with an object. The experiencing self is the self that must survive the obliteration of shame. Early on, in an effort toward self protection, the child begins to cobble together an awareness of which object relationships are safe and which are not.

Trevarthen’s secondary intersubjectivity becomes relevant to shame in therapy when regulation is secure but the patient remains defended. Importantly, the assumption here is that the therapist has recognized the dysregulated shame state and is tolerating the affect, rather than unconsciously participating in the co-construction of defenses. Thus the therapeutic dyad is in a moment of transition where the shared experience of not-knowing is disrupted. The therapist agrees to know of the shame; the patient, on the other hand, remains in a state of not-knowing—though it will be shown that the patient may be unconsciously aware that something is different in the relationship.
From a developmental perspective shame is envisioned at this stage to be a precursor to social learning. Secondary intersubjectivity is notable because it incorporates a negotiation of shared attention toward an external object or event. Trevarthen (1998) forwards subject-subject-object triangles, for example, which are understood to be a scaffold for the developing infant's understanding of the actions of others.

From this vantage point, the therapist also offers the patient a scaffold for working through shame. The therapist continues to hold the majority of the responsibility in the dyad, but her focus shifts from one of pure regulation to an additional role of articulating, in a tolerable manner, that shame is present. The goal at this stage is for the therapist to "lend" the patient ego, or from a contemporary perspective to "lend" the patient the capacity for mentalization in an effort to begin to recognize and tolerate shame. Therapeutic actions at this stage include developing a shared language, psychoeducation, and the use of social referencing. Additionally, the therapist must be able to tolerate the countertransference reactions that are associated with the complementary roles that are enacted in shame dynamics.

*Developing a Shared Language*

Observing and making note of the language used in session offers the therapist a chance to begin developing a shared repertoire for discussing shame. As discussed in Chapter Four, shame is rarely talked about directly, but rather through the use of what Scheff (2003) considers "code words." Developing a shared lexicon allows for a nuanced
differentiation of the patient’s internal experience and minimizes the chance that the therapist is making assumptions about the dynamics under consideration.

Shame, guilt, and other self-conscious emotions are not typically circumscribed experiences but more often experienced in conjunction with one another. That said, patients often refer to self-conscious experiences with a global referent (e.g., “I feel guilty”). This referent may have multiple meanings to the patient and it would benefit the therapeutic dyad to spend some time deconstructing the phrase. Ekman (2001) states, “The distinction between shame and guilt is very important, since these two emotions may tear a person in opposite directions. The wish to relieve guilt may motivate a confession, but the wish to avoid the humiliation of shame may prevent it” (p. 65-66). When the therapeutic dyad can be more deliberate in labeling experiences, it is less likely that shame will be lost in the therapeutic exploration and more likely that the distinct motivations and cognitions associated with self-conscious emotions will become part of the dialogue.

In addition to having a common repertoire, the use of metaphor offers the therapeutic dyad a way to turn shared attention toward an external object or event. This process echoes Trevarthen’s (1998) secondary intersubjectivity in which the dyad begins to negotiate turning shared attention toward an external object (i.e., subject-subject-object triangles). Cooper (2006) suggests that this process allows the child to rely on the caretaker as a means for developing a relationship with the object. This represents an early manifestation of empathy and criteria for mentalization. In therapy,
metaphor becomes one type of external object that the therapeutic dyad might use as a focal point of shared attention.

Seiden (2004) considers metaphor to be the vehicle through which therapist and client discover and create experience together. Metaphor may be brought into the session by the patient or the therapist, or it might be co-constructed as the therapeutic dyad begins to develop a language that is unique to their relationship. Perhaps most importantly, Seiden (2004) states that metaphor makes intensely felt experiences and emotions, like shame, more palatable. Most often, metaphor takes place in a "Winnicottian creative space" that "evokes creative capacities of mind in both the maker and receiver" (Seiden, 2004, p. 642). He views metaphor as a safe means of organizing experience that allows for continued exploration without having to commit to the idea or feeling as one's own. Thus metaphor allows the therapeutic dyad a chance to "try on" certain emotional experiences while the ownership remains "out there." Furthermore, by witnessing the therapist share thoughts and feelings that arise in response to the metaphor, the patient has the opportunity to effectively borrow (Cooper, 2006) the therapist's experience. In this shared space, the dyad begins to expand what can be tolerably experienced together.

Psychoeducation

The intense physiological response that occurs during shame warrants some direct discussion in the therapeutic encounter. As demonstrated, shame is associated with a dysfunction in the Hypothalamic Pituitary Adrenal Axis (HPA-Axis), an increase in
the stress hormone cortisol, and a physiological response that, in many ways, mimics a stress reaction (Rohleder et al., 2008; Pallanti & Quercioli, 2000). Regardless of whether the patient is describing shame as a circumscribed emotion or using “code words” to express her experience, there is room to help the patient understand the impact that dysregulation has on physical and physiological well being. Moreover, this discussion facilitates the exploration of skills for building one’s capacity for distress tolerance.

Using the patient’s language for describing dysregulation, the therapist may utilize appropriate teaching moments to discuss the physiological impact that shame may have on one’s body. Advocating a compassionate stance of self-care, the therapist may then introduce to the patient the need to broaden coping strategies for tolerating dysregulation in an effort toward minimizing the physiological impact. Distress tolerance skills, like those taught in Dialectical Behavior Therapy (Linehan, 2001), can be adapted to the patient’s needs and integrated into a psychodynamic, relationally centered therapy as appropriate. Again, it is important to underscore that the goal is distress tolerance and not eradication of the affect. Developing a capacity for tolerating distress both deepens one’s ability to listen to emotions as they arise and to use these experiences to inform choices and behaviors.

Social Referencing

During secondary intersubjectivity, the infant begins to look to her mother to “know” what to feel (Emde & Sorce, 1983). Similarly, the patient may be thought to look toward the therapist to “know what to feel.” Social referencing in therapy offers
the therapist an opportunity to normalize shame as part of an emotional repertoire, to articulate that cognitions that are evoked during shame may be distorted, and to begin to deconstruct and understand the patient’s defensive structures. Importantly, the patient’s defensive style will be a key feature in understanding the pace at which these things might happen.

Rather than avoiding shame for fear of triggering dysregulation in the patient, the therapist may work to introduce and normalize shame as part of the emotional repertoire that exists in all human relationships. Generalizing the experience, especially when speaking in displacement—e.g., “I could imagine that most people in that situation might struggle with some feelings of shame”—helps to locate shame as part of the human condition and not something the patient struggles with in isolation. Referencing shame with greater frequency when discussing emotions in general—e.g., “So often these deep feelings get mixed up with feelings of shame”—keeps shame from being excluded as a somehow intolerable or unacceptable emotion. When the therapist introduces shame with some frequency, but does not attach it to the patient directly, a message begins to develop that shame is a universal experience and something that can be discussed in the therapeutic relationship.

Building on this idea, when a patient describes cognitive distortions about self, the therapist might use these opportunities to wonder about shame—not with an air of interpretation but with a stance of curiosity. These exchanges further offer an opportunity to begin to deconstruct the relational dynamics as well. An important goal
in these exchanges is to separate shame from the self and to locate it within the relationship—e.g., “When someone responds in a manner that is filled with anger, it seems like the shame is so intolerable that you shut down and tell yourself you were wrong.” This kind of statement does not define the patient as a victim nor as free of responsibility but rather implicates both members of the relationship—the doer and the done to—in creating the emotions that were felt.

Furthermore, Harper and Hoopes (1990) suggest that shame-prone individuals develop rigid emotional patterns associated with shame and that uncovering this defensive pattern is a necessary aim of psychotherapy. Because shame is often fleeting, and quickly defended against, it might be discussed as part of an emotion chain—e.g., “I wonder if when you feel rejected, the feeling of shame quickly transforms into anger?” or “It seems when you allow yourself to have a need, a sense of shame creeps in that quickly turns to that old doubt that you aren’t worthy.” Incorporating shame into an emotion chain both works to normalize shame as one of many emotions, to link shame to distorted cognitions, as well as to draw attention to shame as a central feature of the individual’s conflict. In this way, the defensive affect does not become the central recipient of attention but begins to be understood as one of many ingredients in complex emotional reactions.

Social referencing might be thought of as psychoeducation. From a psychodynamic perspective, however, it is argued that the patient is borrowing from the therapist’s “capacity for mentalization” to try to gain perspective on the situation.
Importantly, the response that the patient has to the therapist’s remarks must be monitored closely. Certainly, someone who relies heavily on narcissistic defenses or is well described by Modell’s (1993) cocoon transference will not likely be able to work with such social referencing for a long period of time. In other words, intersubjective development cannot be rushed. If a therapist notices that the patient becomes dysregulated in a manner that feels unproductive, the patient may not yet be ready for these discussions and the interventions that are associated with primary intersubjectivity may be more developmentally appropriate therapeutic interventions.

**Therapeutic Stance**

Again, the most difficult aspect of therapeutic work at this stage may be the therapist’s willingness and ability to tolerate the affective experiences that are associated with the relational aspects of shame. The affects that the patient mounts in defense of shame may be directed toward the therapist and evoke deep reactions. For example, if the patient is in a shame-rage cycle (H.B. Lewis, 1971), the therapist may have difficulty sustaining an empathic stance as she becomes the recipient of the patient’s rage. This is complicated by the notion that in this secondary stage of intersubjective development, the patient is not in a position to appreciate the subjectivity of the therapist. Thus, trying to appeal to the patient to heed the subjective aspects of the relational exchange is not only beyond the patient’s capacity in the moment but may also be perceived of as unempathic.
Equally difficult is the need for the therapist to tolerate being the *perpetrator* of objective relational exchanges, or, as Benjamin (1995) states, to tolerate “being the destroyer” of the other (i.e., the destroyer of some aspect of the patient’s self) in the moment. Returning to traumatic interactions, Davies and Frawley (1994) forward four transference-countertransference arrangements that reflect how survivors of traumatic experiences attempt to be in relationship with old objects. These positions reflect complementary self and object representations that have frequently been dissociated, or otherwise split-off, from consciousness. Like the work of Grand (1997) and Brothers (1997) that was reviewed earlier in the chapter, Davies and Frawley (1994) go on to state that these dissociated transference-countertransference arrangements will be necessarily enacted in therapy. For therapy to be successful, the therapist must be willing to take on each of the roles in these arrangements at certain points in therapy and, over time, to begin articulating and working through these relational exchanges. The working through is a long process, however, and the therapist must first tolerate the affect of these complementary positions for sustained periods of time.

The four transference-countertransference dyads are as follows: the unseeing, uninvolved parent and the unseen, neglected child; the sadistic abuser and the helpless, impotently enraged victim; the idealized, omnipotent rescuer and the entitled child; and the seducer and the seduced. Each of the four dyads is described by objectification in which one member is acting (e.g., Benjamin’s *doer*) in a manner that fails to recognize or regulate the other member (e.g., Benjamin’s *done-to*). Using the first dyad as an
example, Davies and Frawley (1994) suggest that any time abuse happens at least one adult in the child’s life has consciously or unconsciously remained unaware. As a result, this caregiver not only fails to recognize important aspects of the child’s self that have experienced trauma but in doing so the caregiver is also unable to attend to necessary mutual regulation. This dual failure of recognition and regulation significantly increases the chance that shame and other traumatic affects will become tied to these aspects of self. Moreover, cognitions such as “I was not worthy of being rescued” become associated with intense dysregulation and may further generate deep shame.

Furthermore, the complementary roles of “sadistic abuser” and “helpless victim” align with Garfinkel’s (1957) dynamics of degradation. Taking this dyad as an example, the therapist will inevitably find herself in positions of being treated sadistically (e.g., the recipient of rage in Lewis’s shame-rage cycle), as well as responded to, at times, as if she is the sadistic abuser. In this dyad one is either degraded or degrading—a dynamic whose currency is shame. Defending against either of these experiences will only serve to keep the relational configuration in a dissociated state and therefore the possibility of what might be tolerably explored in therapy is constrained. In the best of circumstances the therapist is asked to “embrace objecthood” (Broucek, 1991) and all of the feelings involved as a means of understanding the patient’s experience, while simultaneously trying to maintain a state of subjective awareness.

Davies and Frawley (1994) posit that traumatic interactions can only occur when the relationship is in a complementary doer and done-to position. It is this quality that
ties trauma so exquisitely to shame. Even those patients who do not have a trauma history, per se, will revert to these complementary positions during exchanges that are imbued with shame. The therapist will inevitably be treated as Benjamin’s (1995) *doer* or Ossorio’s (2006) *denouncer*. In those moments it is argued that the patient sees the therapist in only this objectified role. Embracing this role, rather than defending against this role, is some of the most difficult work for the therapist.

Importantly, assuming a position of non-response in these moments as an attempt at neutrality will not alleviate the therapeutic conflict. Emde & Sorce (1983) suggest that if mentalization comprises the sentiment “I know that you know that I know” or “I feel that you feel that I feel...”, it also is reasonable to think that the following sentiment is possible: “I feel that you know that I feel unempathic.” In other words, even if the therapist is taking a stance of what looks like neutrality, the patient may be picking up on verbal and nonverbal, conscious and unconscious cues that the therapist does not feel empathic. The work of finding an empathic stance in the midst of shame and its related defenses is tantamount to authentic relational exchanges.

*Clinical Example: Obsessive-Compulsive Disorder*

Obsessive-Compulsive dynamics remain centered on issues of self-control and are traditionally described to be the result of exceedingly high superego standards. For individuals who contend with these dynamics, shame may be embedded in any experience of being “out of control,” loosely interpreted as being out of line with the ideal self, or overpowered by another person. Perseveration, rituals, doubting and
checking, as well as the overwhelming fatigue that accompanies shame preventive strategies are indicative of intolerance for personal failings. Additionally, these strategies help the individual keep what they perceive to be a destructive or destructible self (S.B. Miller, 1996) in check.

Because these individuals are invested in behaviors that contain their anxiety and have created a number of rituals that keep them far away (psychically) from the feeling of shame, particular attention must be paid to developing a shared language that, over time, makes room for a range of self-conscious emotions. Psychoeducation and building distress tolerance skills are further necessities for the patient whose very self is experienced as on the line.

In obsessive-compulsive dynamics, shame is an inherent possibility for the destructible self who fears being overpowered by another (e.g., via impingement or emotional flooding). As such these individuals may often privilege self-control over relational connectedness. Clinical presentation may be consistent with Modell’s (1993) cocoon transference. Alternatively, the self may be experienced as destructive when the individual feels her impulses are so powerful that she may do harm to others. In this circumstance, shame is used defensively to warn the individual against expressions of aggression or desire. In order to do this, the individual must abandon what Broucek (1991) refers to as the “indwelling self” in the service of self-stopping. This creates confusion as to whether one has gained or lost power. Furthermore, S.B. Miller (1996) contends that the process of dampening the natural desire to express authentic aspects
of self, related as it is to unacceptable or "bad" parts of one’s self, is innately shameful as well.

In these defensive positions, it is easy to see how the patient may be interacting at a complementary, or objectified, level of relating. The therapist is unconsciously perceived as either the doer (Benjamin, 1995), capable of destroying the patient via impingement, or the done-to (Benjamin, 1995), capable of being destroyed by the patient’s expressions of aggression or rage.

Broucek (1991) notes that Obsessive-Compulsive dynamics render the self to be a composite of inhibitory behaviors rather than a self that is engaged in the relational world. S.B. Miller (1996) captures this sentiment when describing a patient who “had become more effective in stopping the self than in using the self” (p. 76). This type of self-control demands that the individual objectify herself, paradoxically entering a shame-sensitive position. Miller (1996) states, “The self is viewed as a collection of functions that are adequately or improperly executed and is viewed without regard to inner life as something to be recognized and valued” (pp. 47-48). Not unlike the Obsessive-Compulsive rituals embedded in eating and body dysmorphic disorders, the self becomes an object that never quite lives up to the ideal.

Understanding the way in which the self is experienced by these individuals is pivotal for successful therapeutic work. The therapist must convey an authentic understanding of how high the stakes are in these moments and must further validate the reasonableness of the defensive stance given these stakes. Furthermore, the
therapist must be willing to tolerate the feelings that abide the enactments of doer and done to, destroyer and destroyed, as a means for working through the shame.

Nevertheless, conflict results in the fact that this ideal self is held in tension with a more authentic, “indwelling self,” often resulting in vacillations between rigid control and libidinal (sometimes rebellious) indulgence. S.B Miller suggests (1996) that these individuals often struggle with their relationship to sensual pleasures like sex and food—with shame, ever vigilant, attending both the controlled self that negates the authentic desires, as well as the “uncontrolled” self that allows such pleasures.

The conflict between a desire for a mechanistic, or perfectly performing, self and a feeling self similarly offers a particular dilemma for therapy. If the therapist privileges relational connection and emotional expression, the patient may feel the need to dutifully live up to this expectation. However, the patient’s dutiful attempt to assert her emotional self may stir up the shame that attends out-of-control urges, as well as fears about being overpowered by another. An empathic stance with such a patient may not entail emotional catharsis as much as a deep appreciation for the patient’s need to protect herself. The therapist must consider how deeply intertwined the defenses and the self have become. Broucek (1991) suggests that when working with these individuals, modifying defenses is, at times, equivalent to modifying the self—a process that can lead to depersonalization and feelings of potentially shaming exposure.
This conflict is captured in brief therapeutic work with a recent patient—a highly successful woman who, at fourteen years of age, was prematurely given the responsibility of initiating evaluations for the psychiatric hospitalization of her father whenever he became manic. She developed a sense of herself as an exceptional caretaker, but became anxious and frightened anytime she needed to be cared for. Her striving to be “perfect” was a defensive shield against feelings of being out of control, as well as a means of distancing herself from her feelings of anger and aggression, and she often attended therapy with the “problem already solved.” Our shared attention was frequently turned toward some past event that she had negotiated and in this way she could show me her emotional self (once removed) and yet remain completely autonomous. Additionally, this strategy prevented her possible disappointment in me as she didn’t “really need me.” About six months into treatment she arrived to a session with a terrible cold and when I wondered about her need for care, her face turned bright red and she quickly dropped her head into her hands, started rocking back and forth, and began to moan. She looked up on occasion to see if I was watching and stated “It’s (the blushing) not going to stop, I need it to stop!” After a moment, I stated “Oh, look what we did”—this recognition of the complementary roles of *doer* and *done-to* and my willingness to assume the position of being experienced as the perpetrator, triggered a quick shift in her demeanor—she reestablished eye contact and was quickly able to “put it behind us” as something that was already managed in the past. From
time to time we used this exchange as an object, not unlike a metaphor, to discuss the
shame that was associated with her experience of needing others.

Tertiary Intersubjectivity

Trevarthen’s tertiary intersubjectivity is defined by the capacity for second-order
symbolization, which facilitates perspective taking, empathy, and mentalization (Bråten,
2007). At this stage of intersubjective development, the child is able to participate in
roles that are defined by Ogden’s (1994) third—in other words, to participate in
relationships that appreciate the full subjectivity of self and other. These relationships
are defined by regulation and authentic recognition.

Interventions tailored to this stage of development reflect that the shift from
objective to subjective ways of relating has been successfully fostered through clinical
interventions like those discussed thus far. Following Benjamin’s (1995) theory that
relationships consistently oscillate between objective and subjective ways of relating
however, it is clear that the therapist must use judgment in determining what level of
relating the therapeutic dyad is in at any moment. Even when the patient develops the
capacity for working in a more subjective manner, she will also have frequent times of
regressing back to earlier states of relating in which the interventions of primary and
secondary intersubjectivity are warranted.

From a position of tertiary intersubjectivity, the patient is no longer dependent
on defenses against shame but is able to tolerate an exploration of the relational
dynamics of shame proper. The responsibility for the exploration in these moments is
shared between the patient and the therapist. The goals at this stage include:
understanding the relational dynamics that contribute to shame, distinguishing between
healthy shame and toxic shame, and taking responsibility for choices or behaviors that
have appropriately evoked shame.

Subjective Recognition: Working in the Third

For shame to be recognized in a subjective manner, by definition, requires that
the relational dyad is looking back on an experience. This is because shame cannot
occur in moments that are described by authentic, subjective ways of relating (Buber,
1923/1970; Benjamin, 1995). Rather, the assumption is that the therapeutic dyad
experienced some sort of enactment in which complementary roles of doer and done-to
were taken on and that they have resisted the temptation to overlook or defend against
the shame. If the therapist has succeeded in establishing regulation and withstood the
experience of being objectified, then the dyad has a greater chance of re-establishing a
subjective way of relating and the enactment becomes an object, metaphorically,
toward which shared attention can be used to explore and process shame experiences.

In these moments of authenticity, the therapist is charged with the task of
acknowledging how her actions may have been experienced as shaming. Certainly,
there are legitimate times that the therapist should apologize or assume responsibility
for a statement or action. More generally, however, acknowledgment is not apology
nor even, necessarily, an assumption of responsibility. For if the therapist apologizes to
“make the shame go away” this unintentionally keeps the patient in the done-to position and further entrenches power dynamics and shame dynamics within the therapeutic dyad. Rather, what is called for is a more complicated stance because the therapist must balance an attempt to acknowledge the patient’s perception/felt experience that the therapist has been shaming with an attempt to remain authentically engaged (i.e., not to function from an objectified stance).

The therapist must attempt to appreciate what the patient was feeling and thinking in the moment and given such, how the interaction may have evoked shame. Similarly, this dialogue opens an opportunity for the patient to begin exploring her role in the affective exchange. In addition to understanding why shame was evoked, the patient may begin to better understand her defensive style and to appreciate that the here-and-now relationship with the therapist is not the same as the shame-infused self-and-object internalizations of past relationships.

Distinguishing Between Healthy Shame and Toxic Shame

Letting go, even momentarily, of defenses against shame gives the patient greater freedom in her relational world. However, with freedom comes responsibility. The patient begins to explore the manner in which toxic shame has impacted her relationships. The patient must contend with the impact that her defenses against shame has had, as well as to recognize that she has not been able to bring her full self to relationships. There is relief in coming to understand that shame is a universal emotion. Additionally, there is a more authentic appreciation for the complexity of shame in
human relationships. However, one challenge of this more complex recognition is that the individual must begin to acknowledge that some of the time, some of her shame, may have been warranted. Put another way, she comes to recognize that some of her shame is "healthy" and not toxic, in that its role is to help one to negotiate relationships versus compromising a core sense of one's very being.

Taking Responsibility

When thinking about the experience of shame, it is easy to feel compassionate toward another. However, when thinking about the defenses against and outcomes of shame, it is easy to quickly lose this compassion. Gilligan (1996) has drawn a direct link between shame and violent actions. H.B. Lewis (1971) identifies shame as the trigger for shame-rage cycles in which others are treated with hateful rage. Gottman (1999) looks at the destructive role of contempt, and its counterpart shame, in marriages. Grand (1997) makes a link between shame and perpetrators of incest. Lansky (1992) identifies the dysfunctional adaptations that families make to protect a shameful parent. He goes on to associate shame with suicide attempts and gestures.

As has been discussed throughout this project, toxic shame represents a threat to the very core of one's being. However, when working with shame therapeutically it will become apparent that it is likely that the person has defended against shame in a manner that, ironically, often evokes shame. The paradox here is that whether the defensive behavior was a snide remark toward one's partner, an unempathic comment, or an extreme act of violence—the ensuing shame that is felt in response to the
behavior was likely healthy. When toxic shame has been processed, one realistically begins to experience healthy shame—that signal to oneself about the appropriateness of their behavior toward others. In other words, the message that informs the person that she was not interacting in a manner that aligns with the basic assumption, described in Chapter One, that all individuals have basic value.

What becomes problematic is that this reactive shame may trigger a cascade of toxic shame reactions related to the patient’s own relational history. Coming to terms and working through toxic shame, then, includes the hard work of accepting responsibility for those actions that were destructive. The recognition of one’s responsibility and the ability to empathically reach out toward the recipient of shame is fundamental to therapeutic work at this stage of intersubjective relating. Interestingly, a number of studies have looked at group therapy as a mode of working with shame in perpetrators of violence and sexual assault (Alonso & Rutan, 1988; Wallace & Nosko, 1993). One might imagine that the group modality offers a chance to “undo degradation,” (Ossorio, 2006) in which the roles of perpetrator, denouncer, and witness are present but in a compassionate context and with the shared goal of relocating shame to its rightful position in the human repertoire of emotion and not as a definitional aspect of self.

Clinical Example I: The Absence of Shame

The absence of felt shame poses particular therapeutic challenges. Though sociopathy, perhaps more than any other diagnosis, is associated with the absence of
shame and remorse (DSM-IV-TR), it is much more common to encounter an individual who sometimes feels shameful but at other times perpetrates an act that would typically evoke shame but instead maintains a felt sense of innocence. Grand (1997) understands this more common incongruity through the lens of early childhood trauma. Unlike persons with psychopathic traits, who knowingly commit acts of violence/sexual assault in an attempt to maintain control, Grand suggests that perpetrators with histories of childhood abuse tend toward a schizoid presentation. She states, “He or she possesses an incestuous self that lives without speech, without consciousness, and without dread” (2002, p. 63). Here, it might be added that the individual also lives without shame.

Grand (1997) outlines a neo-Kleinian theory, developed by Ogden and others, that supports the existence of a presymbolic narcissistic modality that precedes and ultimately co-exists with traditional Kleinian paranoid-schizoid and depressive positions (p. 474). In normal development, this presymbolic mode provokes the creation of a psychic skin, also known as an adhesive self (Mitrani, 1994). It is the psychic skin that is responsible for a feeling of self-continuity. Similar to H.B. Lewis’s (1971) work on self-boundaries, Grand (1997) reasons that “the skin barrier generates a rudimentary distinction between inside and outside, self and other, and gives rise to the experience of self-agency” (p. 474).
Trauma, according to Grand (1997), is an impingement that destroys the developmental achievement of creating a psychic skin and thus, the ability to experience self as whole. The result of this impingement is a return to a state of existential terror. In an attempt to quell the terror, the individual returns to a primitive, presymbolic position and Grand suggests that the traumatized individual “search(es) for the restoration of being through the establishment of sensory containment” (1997, p. 474). In this position the individual is solely concerned with achieving sensory continuity. The primitive nature of this position precludes the individual from experiencing others as subjective beings, or for this matter even as being alive. Rather, others are experienced as “inanimate objects” (p. 474) and they are associated only with the utilitarian function of helping the individual achieve a sense of cohesion. This model speaks to the impact of the unspeakable and unsymbolized bodily experience that occurs in our most primitive ways of being with others. The lack of shame is congruent with the individual’s inability to appreciate the other as subjective, or even animate for that matter.

Powerfully, Grand captures this notion in stating, “The innocence of traumatized childhood and the guilt of incestuous perpetration are thus located and confounded in the same sequestered and wordless self” (1997, p. 475). This is a poignant reflection on how one individual may both wrestle with significant toxic shame that constrains their sense of self, but also with healthy shame that is evoked in an attempt to regulate current relationships.
Clinical Example II: Moral Masochism/ Depression

As has been demonstrated, the experience of shame in psychological disorder is nuanced and multifold. The role of shame in mediating relationships differs across diagnostic categories. For example, in contrast to the isolation that shame elicits in obsessive-compulsive dynamics, shame facilitates connection in moral masochism. In contemporary literature, a parallel between moral masochism and certain forms of depression is frequently drawn (Markson, 1993). Following S.B. Miller’s (1996) lead, it will be referred to as moral masochism here, with the understanding that much of the following discussion can be applied to certain depressive disorders. One benefit of using the terminology of masochism is that it underscores the complementary sadistic-masochistic (doer and done-to) roles that get played out relationally.

S.B. Miller (1996) further sees similarities between the interpersonal dynamics of moral masochism and those of narcissism, though she reasons that their relationship to pain differs. Miller (1996) argues that while a person with narcissistic tendencies believes “I can blow you away with my anger,” a person with masochistic dynamics believes “I can kill others with my badness” (p. 152). In other words, shame becomes a core feature of the individual’s self identity.

Cooper (2006) suggests that pain is a necessary agent in development that “serves the person’s need for individuation and is part of a gratifying accomplishment” (p. 119). Mastery of pain, rather than avoidance, is reasoned to be a developmental achievement in the construction of self and he cites “the pleasurable fatigue after a

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day’s work or the ecstasy of an athlete’s exhaustion” as examples of constructive uses of pleasure-in-pain. That said, Cooper (2006) goes on to suggest that regardless of what theory is used, “libidinal pleasures and aggressive satisfactions will be sacrificed or distorted if necessary to help prevent the shattering disorganizing anxieties that arise when the self-system is disturbed or the ties to the object disrupted” (p. 121). A person will give up pleasure for the safety or satisfaction of maintaining a coherent self.

Shame serves as one of several types of psychic pain that can be employed in masochism. In masochistic dynamics, self-infliction of shame is used as respite from a greater pain, or acts as an aggressive attack against that which is hurtful or unwanted about the self (McWilliams, 1999). In the earliest years of life, shame develops for the infant who does not receive regulatory responses from the parent. Over time, however, S.B. Miller (1996) suggests that the child may use shame experiences as the only known of entering the parent’s world (e.g., the world of a depressed parent) and maintaining connection. She cites Novick & Novick’s (1991, p. 317) statement that, “For these children, the gap was not between the real and the ideal self, but between the real and the ideal mother-child relationship.” She goes on to state:

The active use of shame as a tool for managing one’s world speaks to both early and later shame developments. The earliest roots of this variety of investment in shame and attachment to it in some cases would include an infant’s or young child’s experience of needing to be bad or worthless in order to exist for the primary caregiver, to gratify the caregiver, or to be like the caregiver and thus connected to that person. Early ways of being bad or diminished may include experiences of being dirty, stupid, selfish, inept, ill, or babyish (p. 153).
It might also be said that other ways of being bad include being emotional, needful, and independent, as well as being different—even if different includes being successful, proud, and pleased.

In understanding the etiology of shame in moral masochism, S.B. Miller (1996) highlights the child who is provoked—by way of disappointment, violence, or neglect—into an understandable rage but is then told by a parent “you’re out of control” or “you’re a wild animal” (p. 152). This child may come to believe that her indwelling (Broucek, 1991) self is bad as a means of protecting necessary relationships. Reminiscent of Fairbairn’s (1954) work, it is thought that in order to keep oneself from noticing the insensitivity of the other, the child unconsciously agrees to play a role in the caregiver’s world (S.B. Miller, 1996). In this instance, the child heeds the message that becoming shameful is preferred. The child unconsciously makes this experience ego-syntonic and, as Cooper (2006) states, the experience becomes “I am frustrated because I want to be, because I force my mother to be cruel to me” (p. 121). Miller (1996) gives a number of poignant examples of this dynamic including: the physically abused child who becomes shameful in order to provoke less humiliation in the parent; the adolescent who shares his parent’s shame in an effort to remain attached to the parent during the normative stage of separation; and the competent child who becomes shameful in an effort to ameliorate her mother’s insecurity by avoiding any chance of overshadowing her mother.
Shame can be affiliative in other ways, as well. Cooper (2006) suggests that in the face of the shame that attends rejection,

[t]he object is perceived as excessively cruel and refusing; the self is perceived as incapable of genuine self-assertion in the pursuit of gratification; the gratifications obtained from disappointment take precedence over genuine but unavailable and unfamiliar libidinal, assertive, or ego-functional satisfactions. Being disappointed or refused, becomes the preferred mode of narcissistic assertion to the extent that narcissistic and masochistic distortions dominate the character (p. 122).

He goes on to say, “To the extent that narcissistic-masochistic defenses are used, the aim is not a fantasied reunion with a loving and caring mother; rather it is a fantasied control over a cruel and damaging mother. Original sources of gratification are secondarily derived from the special sense of suffering” (p. 122). In other cases, the young child may learn that the caretaker will tend to her around shameful needs. A soiled diaper, even long after “appropriate” evokes shame but also tending care. S.B. Miller (1996) states, “Later in life, the person soils herself through dirty speech or dirty business dealings and feels ashamed but also reassured and thus driven to self-soiling” (p. 163). We might easily find these dynamics in addictive as well as other self-injurious disorders.

For the developing child the complementary roles of sadism and masochism often become internalized, further complicating the shame experience. A child who uses a defensive set of moral codes to negotiate her early relationships, for example, will ultimately turn such codes against the self. An adult with an abuse history, who is
beginning to access feelings of anger toward her abuser, may experience her anger as too similar to the abuser’s and will judge herself to be “bad” and “sadistic” (S.B. Miller, 1996). Or as Miller (1996) further suggests, the child of a passive parent, who is unwilling to assert her adult self, may experience normal aggressive drives as damaging and unwieldy. These aggressive aspects of self become disavowed and an individual with moral masochism may have incentive to keep this disavowal strong—if I am victimized and shame ridden, the unconscious reasoning goes, then I can’t be sadistic and humiliating.

An individual in therapy may become invested in her shameful self for a number of reasons. Destroying her own pleasure before the therapist (who may be experienced in these moments as the parent) may feel safer. Additionally, embracing the shameful self may be a way to alienate oneself from aggressive impulses that seem toxic. Finally, this stance facilitates an externalization of “conscience” or criticism and frees the individual from having to sit with her own actions—thus while her actions are rarely as toxic as she fears her core self to be, shame paradoxically frees her from authentically accepting responsibilities and normal injuries that occur in relationships. Maroda (2004) cautions therapists not to become too entrenched in emotions that are used defensively for they may serve to distract from the authentic conflicts.

This recently occurred with a male patient who struggled with his use of alcohol for over twenty years and arrived to therapy in the hope of better understanding his relationship with his wife. He frequently attempted to “clean up” his life though,
paradoxically, he recognized that during these times his wife often felt threatened and became highly anxious. As soon as he noticed that she might feel threatened, he would discontinue his attempts to develop outside interests, decrease drinking, or foster new friendships and would suddenly become filled with self-admonishments such as “I’m just a bum,” “I was wasting my time and money on trash (i.e., himself)” or “I wasn’t any good at that anyway.”

His presentation in therapy was most often one of contrition. His shame, in therapy (and in his marriage), served a number of functions. First by presenting a “shameful self” he was able to keep relational roles to expectable and safe standards. He often shared that his drinking history had been “such a burden for his wife” that he “needed to do whatever made her happiest.” Over time we were able to discuss the way in which his shameful self both hampered and served a purpose in relationships. Additionally by being “bad” he could exist both for his wife and for me without any sense of incongruity. As we began to explore his defensive use of shame, the complementary roles that had originally constrained our relationship (he as the “bad” man and me as the “good but judging” therapist) loosened. This was often frightening for him. As he began to trust that he could be a fuller version of himself in relationship, he simultaneously started to acknowledge some of the anger and hurt he felt in his marriage. Furthermore, he began to more authentically make the distinction between a narcissistically grand “bad self” and authentic experiences of regret and remorse for some of his past actions and behaviors. The remainder of the therapy was spent
exploring his ambivalence about “taking responsibility,” and beginning to work with another therapist in couple’s treatment in an effort to ask the same of his wife. The goals for both individual therapy and couple’s treatment assumed a parallel form of moving from roles of complementarity to authentic recognition.

Summary Remarks

This project has worked to appreciate shame from both an intrapsychic as well as an interpersonal dimension. Traditional models of psychotherapy offer a deep appreciation of the internal experience of shame. Contemporary relational models build on this understanding by focusing on the interpersonal construction of shame and the co-construction of defenses against shame experiences. Whatever model a therapist uses as a vehicle for making meaning of shame, it is perhaps the necessary shift from objective to subjective ways of relating that poses the greatest difficulty. In the early stages of working with shame the therapist must contend with her own history of and reactions to deeply negative affect. Later, as shame becomes more fully articulated in the therapeutic dyad, the patient is challenged to foster self-compassion while simultaneously assuming appropriate responsibility.

As therapists, the work of shame demands that we wrestle with our own deep questions about humanity, value, and self worth. Additionally, we must become comfortable with some of the darkest and most destabilizing emotions. More difficult still, there is an empathic stance of what Keenan (2004) refers to as mercy that is
demanded by this work. How one cultivates this stance, or any empathic response, is an ongoing question in the field of psychology. Continued exploration of working with shame in supervision, as well as an attempt to integrate shame in the coursework of training institutes seem a natural next step. That said, learning and knowing that we want to act from a stance of compassion, and being compassionate in response to shame dynamics and defenses are decidedly different processes. Requiring therapy of therapists and fostering conversations that look deeply at what children’s book author Maurice Sendak calls our “wild things” may further help to facilitate this stance.

From the perspective of the patient, the work of shame is multiply informed and deeply complex. The patient is first struggling to tolerate affect that is deeply destabilizing. As this shame begins to lift and the patient is able to respond to self with more compassion, she is then faced with her defensive actions and choices. Shame, then, becomes intertwined with notions of forgiveness and responsibility. The patient is left to contend with the dual nature of being both the doer and done-to.

We have much to understand about working with shame in psychotherapy. The distinction between formulating a theoretical understanding of shame and developing a personal way of being with shame, may explain some of the reasons that shame lived in the disciplines of theology and philosophy long before becoming a focal attention of psychodynamic psychotherapy. Furthermore, shame has been deeply explored in the field of trauma but is less comfortably discussed as a universal condition. Shame reminds us of our human vulnerability, for sure, but working with shame also seems to
offer the potential for relating to oneself and others with a greater depth, complexity, and fullness.
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