Shame-Related States of Mind in Psychotherapy

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Current theory on self-conscious emotions emphasizes the importance of shame-related phenomena in psychopathology and psychotherapy. An appreciation of manifestations of shame in psychotherapy greatly deepens our ability to connect with and understand our patients' experience. The relative salience of the shame-prone patient's devalued-self or devaluing-other internalizations will have critical importance in the psychotherapy setting, guiding the types of interventions and stances that are most helpful. Knowledge of some predictable shame-related transactions involving envy, blaming, or overzealous probing can help the psychotherapist preempt mobilization of unnecessary levels of shame in treatment.

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In recent psychotherapy literature there has been a resurgence of interest in the emotion of shame. Much of this literature tends to be segregated within particular theoretical or research camps. This is unfortunate for clinicians, because a working knowledge of manifestations of shame and related defenses in the psychotherapy session invariably deepens understanding of our patients' experience and behavior. It is especially useful in work with angry, defensive, elusive patients who otherwise defy efforts to establish and maintain therapeutic alliance.

This article offers a review of some current theoretical and clinical material in order to update and sensitize psychotherapists in their work with shame-prone patients. Discussion and a clinical vignette detail the predictable clinical variation of shame-related states according to the relative salience of warded-off mental internalizations of a devalued self or a devaluing other. A brief discussion of subtypes of narcissistic personality further clarifies this bifurcation of intrapsychic structure in shame. Clinical strategies that allow the therapist to notice relevant state changes and intervene effectively with shame-prone patients are discussed. Finally, several shaming transactions often encountered in the psychotherapy setting are outlined so as to reduce our need to enact them with the patient.

States of mind are relatively coherent

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patterns of verbal and nonverbal expressions of ideas and emotions that can be reliably identified by observers.[1] The content, shifts, sequences, elaborations, and defensive maneuvers associated with these states are the raw material with which the patient communicates about and manifests a problem. Recurrent states of mind convey patterns of communication style accompanied by shifts in schematic views of self and other, generally associated with a predominant emotional experience. In the psychotherapy setting, repeated transitions from one state to another begin to reveal important patterns of feeling, perception, and interpersonal behavior.

When entering the prototypical shameful state of mind, the individual has a sense of an exposed, vulnerable, devalued self being scrutinized and found wanting in the eyes of a devaluing other. Acute shame may be experienced as a pang of secret discomfort associated with communication that explicitly or implicitly conveys themes of overall inferiority. For many patients with depressive disorders, shameful states involving globally degraded self-schemas may be central features in their psychopathology. Accompanying such states may be a sense of feeling filthy or unworthy, accompanied by urges to hide or disappear.

If manifested in the psychotherapy hour, such states of mind may appear as a profound but elusive sadness accompanied by rapid changes of topic or obscure statements that temporarily sever meaningful exploration of the issue. It will often be in these states, in which the patient experiences an implosion of self-esteem, that depressive phenomena are manifested. But the range of shame-related states is much broader.

Extremely shame-prone patients tend to suffer from persistent, oppressive appraisal processes in which all interactions (including those in the therapeutic context) are rigidly assessed in accord with the degree of perceived criticism, ridicule, judgment, or outright humiliation experienced. Like a computer application program, whether running conspicuously in the foreground or more quietly in the background at any given moment, these processes are never completely disengaged. They can be triggered into primary operation by any of a number of interpersonal events, or by internal processes such as memories, fantasies, and associations, or by reactions to internal states of arousal such as sexual excitement, rage, or exhibitionistic urges.

When phenomena are viewed consciously or unconsciously to be in substantial accordance with these appraisals, certain rigid, scripted behavioral complexes of defenses, cognitions, and emotional state transitions may emerge. For example, narcissistic patients may present signature states of mind in which shameful schemas about self and others are warded off in the form of grandiose, inflated self-regard experienced in the imagined presence of an admiring audience. This same narcissistic patient, when perceiving a lack of adequate attention or support from the psychotherapist, may experience other shame-related states, including fleeting episodes marked by painful feelings of emptiness or of being a despicable nothing.

Shame is also closely linked to volatile expressions of anger. There are shame-prone patients for whom bitter, resentful feelings of being unappreciated, insulted, mistreated, or humiliated contribute to hostile, hypervigilant states of mind. At the extremes of these presentations are narcissistic patients who readily react to perceived slights with "self-righteous rage"[2] and patients for whom shame is experienced or defended against in paranoid states in which others are seen as actively tormenting or accusing the self. For other patients, envious states or episodes of obsessive blaming of the self or others may be significantly related to defensive efforts to ward off entering into painful shame experiences. Finally, it is important to be aware that when working with patients who experience or ward off salient shame-related material, psychotherapists are apt to enter themselves into complementary states of mind in which shame-related themes predominate, providing important clues to the patient's problems.

GUILT VERSUS SHAME IN PSYCHOTHERAPY

In guilt, there is a concern about some action perceived to cause harm to another. This concern leads to regret over the guilty action and, usually, a motivation to make amends or apologize. The guilty self can be perceived as inordinately powerful because of its potential to harm others.[3] The goal in psychotherapy with a guilty patient might be to help the patient to feel less omnipotently responsible, to forgive herself for her actions, and to feel more deserving of happiness and less deserving of punishment. In shame, the person goes beyond evaluating a set of actions to making a negative evaluation of the entire self. There may be a corresponding urge to hide or to blame others. The shameful self is experienced as small, weak, and bad. The psychotherapy goals for a shame-prone patient might include helping the patient to feel whole, adequate, and essentially deserving to exist.

Patients frequently present complaining of remorseful, guilty states (e.g., "I don't know whether it's rational, but I blame myself for *X* and I feel *Y* about it and do *Z* as a result."). In this respect, guilt is both a vexation and a compelling topic. Talking about it may seem intuitively helpful to the patient, if only to the extent of confessing or getting it off one's chest so as not to confront it alone. On the other hand, a less likely presenting complaint would be: "I occasionally enter into shameful states of mind accompanied by fantasies of being filthy or even disappearing altogether. I so dread this state that I go to frantic lengths to avoid experiencing it." Even if someone were dimly aware of shame and defenses against it, it is unlikely that he would consciously enlist for therapy to analyze it, because by its very nature shame tends to be hidden.

Even a brief review of the phenomenology of shame reveals why this emotion has often been relegated to the margins of psychotherapy. The experience of shame includes states that have been described as "wordless."[4] There is imagery of scrutinizing or being the object of scrutiny. Shame is generally not experienced in well-modulated states of mind in which phenomena are clearly understood, experienced, or conveyed. Instead, shameful states are often characterized by subtle or covert discordances between verbal and nonverbal behavior. Attempts by the clinician to direct attention to such processes may be anxiously thwarted. Furthermore, object relations and ego integrity frequently suffer decompensation in acute shame. Along with this regression in defensive functioning comes a transient inability to think, upon entry into shameful states, that has been referred to as "cognitive shock."[5] Taken together, these phenomena do not augur well for the convenient exploration of shame in psychotherapy. The challenge will be to talk about something very difficult to notice or articulate, often while in a mental state that includes disruptive imagery, cognitive disorganization, and emotional dysregulation. Whereas the psychotherapy situation may inherently be a metaphor for confession in which guilt may be expressed and expiated, the sense of being exposed and vulnerable may actually lead to an intensification of shame-related issues accompanied by an avoidance of direct communication about them. In order to appreciate the importance of shame in mental phenomena, it is helpful to review some of the current thinking about shame and guilt.

TWO CURRENT VIEWS OF SHAME AND GUILT

Social/Cognitive Theorists

Social and cognitive psychologists[6] have been interested in the empirical study of "self-conscious" emotions such as pride, shame, guilt, and embarrassment. Research and thinking from this perspective view emotions as adaptive to human functioning and grounded in cognitive processes such as appraisals. Emotions can then be described in terms of social scripts comprising patterns of cognitions, affective experiences, motivations, and resulting functional behavior. This particular approach

views shame and guilt as different emotions. Guilt is seen as dysphoria or regret at an action that has harmed another. In this view, guilt is based in a tendency to empathic response, elicited by the perception of the suffering of others, that can be demonstrated as early as the second year of life.[7] Less important is the internalization of an unconscious fear of retaliation, which is so central to the psychoanalytic conceptualization of guilt.

Shame, on the other hand, is seen as related to a global and pervasive sense of the self as bad, defective, or deficient. Once mobilized, a state of shame brings a malignant focus on the self. Anticipation of such states can lead to avoidance or to striking out defensively at "accusers." According to this view, it is shame that is more harmful within the interpersonal realm. The emotion can trigger behavior that conflicts with shame's prosocial, adaptive functions (such as those that help an individual develop herself and her place in society) and can instead lead the person to cut empathic ties to others. On the other hand, guilt tends to motivate reparative, affiliative social scripts in which the guilty person reaches out to others in an effort to make amends. Guilt, although painful and unpleasant, is seen as less pathological than shame, and many of the dysfunctional attributions to guilt in the psychoanalytic literature are reinterpreted by these theorists so that the real culprit is shame, which has become fused with and misidentified as guilt.

Affect Theory

The work of Sylvan Tomkins[8,9] is influential with many modern affect theorists. Tomkins' work was in turn heavily influenced by Darwin's[10] observations about apparent hardwired emotional mechanisms in man and other animals. Tomkins specified nine innate affects, each associated with a relevant facial display. There are two positive affects (interest-excitement and enjoyment-joy), one neutral affect (surprise-startle), and six negative affects (fear-terror, distress-anguish, anger-rage, shame-humiliation, dis-smell, and disgust). Within this point of view, affects serve to direct attention to and amplify drives, producing motivation. The shame-humiliation axis is seen to have evolved as an auxiliary to the affect system.[5] Shame affect interrupts the interest or enjoyment amplifying a positive state, by producing loss of tonus in the neck, downcast and averted gaze, and blushing. Because they are evident in the infant (and across various animal species), affects are seen as separate from, although precursors to, adult emotions ("affect is biology; emotion is biography"). In the case of shame, the affect originates as a mechanism triggered by any meaning-free impediment to positive affect in the infant.

By adulthood, experience has become "coassembled" with shame affect so that any of eight types of triggering events (including loss in competition, sexual failure, betrayal, or the knowledge of secret, intimate information by others) is capable of initiating a shame experience. Nathanson[5] further specified a sequence in which, once the shame affect proper is triggered (including relevant physiological responses), there are scripted ways (the "compass of shame") in which people deal with the shameful emotions. In withdrawal, the person turns away from the triggering stimulus, by means ranging from embarrassment to pathological withdrawal and depression. The individual may accomplish avoidance of shame by calling attention to anything that brings pride or by engaging in avoidance behavior such as substance abuse. According to this view, much of narcissistic pathology can be seen as "an avoidance script for the management of shame experience"[5] (p. 19) In the attack-other mode, others may be put down in order to adjust the balance of power between self and other. In the attack-self mode, the person may deal with shame by demeaning himself in order to maintain ties to others. For affect theory, the emotions of shame and guilt (as well as emotions like shyness or discouragement) are variants of the shame affect but are experienced differently because of differing coassemblies of perceived causes and consequences. In the case

of guilt, for example, the shame affect has become coassembled with fear of reprisal or punishment.

SHAME-PRONENESS AND PSYCHOPATHOLOGY

Tangney et al.[11] used the Test of Self-Conscious Affect (TOSCA) to operationalize the construct of shame-proneness. The TOSCA is a scenario-based instrument that yields a state or situational measure of shame-proneness, encompassing characteristic affective, cognitive, and behavioral responses. Shame scores by college students on the TOSCA were significantly and positively correlated with all types of psychopathology as assessed on a variety of instruments. In particular, shame was positively correlated with the tendency to make internal, stable, and global attributions for negative events ("I did it, I always do it, and it affects everything") and was negatively associated with internal, stable, and global attributions for positive events. In this view, shame-proneness is associated with a depressogenic attributional style. On the other hand, guilt-proneness was only moderately related to psychopathology, and correlations were ascribable entirely to the shared variance between shame and guilt. This finding supported the authors' notion that shame is uniquely and particularly linked to psychopathological attributional styles in which the self is broadly devalued in connection with stressful events. Guilt per se ("shame-free guilt") is viewed as not only nonpathological, but actually quite adaptive.

In another study, Tangney and colleagues[12] found proneness to shame among college students was significantly positively correlated with indices of anger, hostility, irritability, resentment, suspiciousness, and paranoid ideation. They concluded that shame often results in feelings of anger and hostility combined with a tendency to project blame outward. Tangney[13] further emphasized the link between shame and anger by noting that shame-prone people are not only likely to experience more anger, but are more likely to manage their anger in maladaptive ways, such as acting out their particularly hostile intentions. In addition, shame-prone individuals believed that angry feelings were likely to result in negative or destructive long-term consequences. On the other hand, guilt was negatively or negligibly correlated with indices of anger and hostility. Guilt was further associated with a tendency to accept responsibility and a decreased tendency toward anger and hostility.

These findings support the clinical observation that recurrent states of mind in which shameful emotions predominate or in which patients go to maladaptive defensive lengths to ward off shame are very often at the heart of the psychopathology that brings them to treatment. Guilt and shame generally coexist. Guilt about actions may be more readily discussed, but it is shame-related states that uniquely involve negative or degraded holistic self-conceptualizations that lead to problems in functioning. A deeper understanding of these empirical findings emerges as we look at the characteristic mental internalizations that accompany states of shame.

INTRAPSYCHIC STRUCTURE IN SHAME-RELATED STATES

Shame-prone patients evidence one or more states in which there is simultaneous activation of internal mental representations or person schemas[14] corresponding to a scripted sequence in which a weak or devalued self is found to be wanting, deficient, or aberrant in the eyes of a devaluing other. For a particular patient, various states may be readily or recurrently entered, or they may be rigorously warded off at the expense of self-integration or adaptive interpersonal functioning. In either event, these states of mind are important because much psychopathology is manifested in them.

As Nathanson[15] points out, the "growing child accumulates and stores experience as an

image colored by the affect that accompanies it. This leads to the clustering of memories linked by their relationship to specific affects" (p. 32). In an adult shame-related state, the representations of devalued self and devaluing other, as internalized in mental experience, embody an accumulation of memories, conditioning events, fantasies, thoughts, beliefs, expectations, and other phenomena that have become fused with the shame affect. A person may have multiple shame-related states, and for each one the devalued-self or devaluing-other internalization may be more or less salient at a given time.

It is useful clinically to be aware of this bifurcation of mental internalizations because it helps us to notice the prevailing polarity of the patient's active internal shaming dialogue. The devalued self/devaluing other bifurcation also has profound implications for the psychotherapy process itself when defensive operations around either aspect of the shame experience become mobilized and projected onto or into the therapist (in projection and projective identification, respectively). In fact, projective defenses are so common in shame-prone populations that it is worthwhile to examine them in some detail.

In projection, the patient will falsely attribute disowned feelings, impulses, or thoughts to others. The process of projection thus holds a mirror to aspects of the self too ugly to directly own or confront. In projection proper, the recipient of the projection does not participate actively in the process. It is the patient's unconscious needs rather than any realistic qualities of the recipient that determine the relevant perception. Projection tends to be a silent process in which the recipient is often unaware that it is occurring. As a result, it is not uncommon for psychotherapists to be surprised when they learn about absurdly unrealistic projections made upon them by patients in the course of treatment.

In projective identification, on the other hand, partly split-off internal representations may be aggressively projected into another person, who in turn behaves in a manner consistent with the projected material; the disowned material as thus embodied in the behavior, feeling state, or attitude of another person remains available to the patient. In projective identification, rather than the recipient merely being seen in accord with unconscious needs of the projector, an additional incitement is enacted with the recipient in order to achieve an interpersonal outcome that is, to varying degrees, unconscious. Because projective identification is an interactive process, the psychotherapist who receives these contents will generally be aware on some level that a powerful transaction is occurring. Disowned material so projected may then become the subject of manipulation within the treatment as the patient attempts to control or modify these contents while keeping them at arm's length within the treatment relationship.

Projective Defenses Involving the Devalued Self

With projective identification of devalued self-schemas, the psychotherapist may be made to feel about herself as the patient feels about himself. By paying attention to shifts in her own self-evaluation, the therapist may become sensitive to ways in which she has become the spokesperson for aspects of the patient's malignant self-esteem. In his update on projective identification, for example, Goldstein[16] described a case in which a woman with "chronic feelings of inadequacy and low self-esteem" (an internalization of a devalued self frequently seen in shame-prone, depressed patients) projected her inadequacy into the therapist by systematically and unconsciously undermining and devaluing his efforts until the clinician began to doubt his own adequacy as a therapist. Feelings of weakness or deficiency are common countertransference reactions to work with patients whose shameful sense of enfeeblement is enacted projectively, causing the psychotherapist to contain a sense of inadequacy or badness.

In the case of projection proper, the thera-

pist may merely be seen by the patient in accord with perceptions consistent with a devalued self that he wards off from himself. In these cases, the patient may reveal contemptuous or devaluing attitudes toward the therapist that can profitably be tied in treatment to a disowned weak, bad, or defective self temporarily superimposed upon the psychotherapist. Because projection may be silent and rather subtle, it will be useful to be alert for hints of reactions by the patient that suggest the psychotherapist is seen as unable, incompetent, or of insufficient status to provide adequate help. When the therapist is able to tolerate these projections openly and without corresponding shameful retreat, this provides a powerful message to the patient that it is safe to bring forward and examine this internalization of a devalued, incompetent self.

PROJECTIVE DEFENSES INVOLVING THE DEVALUING OTHER

When the polarity of the treatment reveals a more salient emergence of the devaluing-other internalization, this may be a signal to slow down the treatment and to reestablish or deepen the alliance between patient and therapist. In the case of projective identification of this devaluing-other agency, the therapist may be caused to feel and behave toward the patient in accord with an internalized but partly warded-off critical, demeaning, or disapproving agency. Negative countertransference reactions with shame-prone patients often signal instances in which the therapist is pressured to accept a disapproving stance toward the patient. The psychotherapist will in this case function as a spokesperson for the patient's self-contempt. Understanding this function enables the psychotherapist to refrain from abandoning the supportive stance while reflecting and encouraging exploration of those self-critical attitudes that the patient generally turns toward himself.

When the devaluing-other contents are projected outright, the therapist may be seen by the patient as hostile or condemning, although the patient may not explicitly complain of this perception. Hints of these types of projections, in which the psychotherapist is seen to embody a criticizing agency that the patient wards off from himself, may be manifested in various distancing maneuvers or in wounded reactions to routine interventions. All other considerations being equal, supportive approaches are likely to be the most helpful to the patient when the specter of a devaluing other becomes prominent in the psychotherapy hour. A supportive stance is rooted in attitudes and behavior that convey to the patient that the psychotherapist accepts him and is on his side in the struggle to continue with painful work despite impulses to hide from or disavow what is being learned.

A brief case example illustrates some of the ways in which these aspects of shame are typically encountered clinically.

Case Example

Ms. A. is a single woman in her thirties who began psychotherapy in the aftermath of a breakup of a 5-year relationship with a boyfriend whom she described as narcissistic, immature, and unable to make a commitment to the relationship. Her internalization of a devalued, degraded self was the object of treatment in psychotherapy. She worked directly, and rather successfully, to free herself of pathogenic beliefs that she was fundamentally unlovable and unworthy of the love of any suitable man. Much of this change was accomplished by transference testing[17] in which she would ostensibly make the case that she was fundamentally unworthy and rationalize instances in which she had been mistreated. When the psychotherapist did not agree with her negative self-characterizations, the patient gained increased insight into her internalization of a devalued self and felt more freedom to act and feel as though adequate. Then she met a man in a bar who was sexually interested in her. She described him as a disreputable and sleazy individual who was lying to her and was also lying to his live-in girlfriend. At the same time, she portrayed him as someone who was attractive and the best option she had.

As she had some further dates with him, the psychotherapist began to warn her that this man was unworthy of her. Finally, Ms. A. confessed that she felt very anxious prior to the previous week's session because she feared the psychotherapist's increasing disapproval of her.

In this instance the therapist had been the recipient of the projective identification of Ms. A.'s partly warded-off disapproving, devaluing-other agency, to which the patient reacted anxiously when her dating activity with an unsuitable man did not meet with approval. During this period, there was a shift in her internal shaming dialogue as she began to feel safe enough with the therapist to begin to bring forth an internalized critical, disapproving agency through projective identification. In this state, the therapist was pressured to accept projections as a disapproving parent criticizing Ms. A.'s self-schematization as a desperate, inadequate woman. This helped the therapist to better understand (briefly become the spokesperson for) the patient's self-contempt, which was in part related to Ms. A.'s accumulated experience with her critical father. The psychotherapist remained supportive but still did not encourage the relationship, and she quickly broke it off. By termination of treatment she was seriously dating a supportive, stable man whom she later married.

Shame in Narcissistic Personalities

Narcissistic personality disorders are seen to be linked to defenses against shame,[18] and so it is illustrative to apply this model to two subtypes of narcissistic personality disorder. Gabbard[19] has distinguished an arrogant, grandiose, interpersonally insulated subtype (oblivious subtype) from an oversensitive, easily hurt or ashamed subtype (hypervigilant subtype) within the spectrum of narcissistic personality disorder. It is important to emphasize that these subtypes specify endpoints on a theoretical spectrum and that people exhibiting either of these subtypes of the disorder are likely to display other shame-related states in which other internalizations and defenses predominate.

Oblivious Subtype and the Devalued Self

Obviously, a grandiose "not-devalued" self, admired, envied, or appreciated ("not devalued") by a "not-devaluing" audience represents the converse of the prototypical shameful self/other schematization. In this apparent caricature of warding off, the self-schema of a large, powerful self exhibitionistically taking the center of attention nicely maps the antithesis of an internalization of a small, enfeebled self hiding from scrutiny in the generic shameful state. These patients spend considerable time in states disavowing an internalized devalued self. There may be projections in various states where the psychotherapist is made to feel or is seen in accordance with the devalued-self contents normally kept at arm's length. In these episodes, self-doubts induced in the psychotherapist may offer clues to devalued-self contents notably absent in the patient's typical presentation. Horowitz[2] has also described mixed states of mind in narcissistic personalities in which there is simultaneous activation of shame, anxiety, and anger related to defenses against degraded self-schemas. These confused, angry, disparaging states may offer opportunities to delve into fears the patient has about confronting aspects of an internalization of a self organized as defective or deficient. Extrapolation may often be required to deduce and explore the existence of these selfobjects in a way the patient can tolerate.

Gabbard[19] attributes to the oblivious narcissist a "heavily armored self," often only dimly aware of the psychotherapist's existence. Existing representations of others tend to be impoverished and distorted. They fail to include rich empathic fantasies about independent others who think, feel, and function in ways beyond mirroring the self. Transference interpretations, or interventions that rely on an ability to

consider hypothesized projections onto the psychotherapist, may be met with confusion or even resentment. As the designation implies, part of the goal in treatment with "oblivious" patients is to help them apprehend, elaborate, and enrich their internalized representations of other persons in the world who are reacting realistically to acts of the self.

Hypervigilant Subtype and the Devaluing Other

Whereas oblivious narcissists may primarily fend off devalued-self schemas, the hypervigilant patient manifests a preoccupation with devaluing-other internalizations and associated appraisals. Instead of adopting a grandiose stance, in which the shameful script is turned on its head, these patients are particularly obsessed with imagined hurtful scrutiny, overattending to sources of perceived criticism or slight. They tend to neutralize their sense of being shamefully evaluated by internalizing others as tormentors who unjustly devalue the self. The psychotherapy setting will therefore be replete with instances in which the psychotherapist is accused of having mistreated the patient in various ways.

Entrance into states in which other people are seen as unfairly demeaning the self (who only wants his due) may set the stage for ready escalation of anger or rage, with a capacity for loss of self-cohesion. As the anger escalates, defenses become more primitive. With deterioration of self-integration come more problems in living and more distortions in interpreting the behavior of self and other.

These patients need support but tend not to have well-developed internalizations of a supportive other person worthy of trust. The challenge is to forge a collaboration with the patient by promoting a supportive stance even when the patient aggressively projects disapproving contents into the psychotherapist. Some of the goals of treatment with these patients are to help them reduce their preoccupation with evaluation by others and to develop a less victimized identity.

Focusing Attention on Shame-Related States

Inexperienced therapists may miss shameful states altogether, either by failing to notice subtle shameful phenomena,[20] by attributing what is actually shame to guilt (or vice versa), or by not having a clear idea of the distinction. Associated with entrance into shameful states of mind may be sudden defensive shifts of topic, along with facial features of lowering of eyelids, head turned down, and gaze averted. There may be signs of discomfort, including laughter, smiling, or psychomotor agitation. Speech may become suddenly inarticulate, vague, rapid, or evasive. Be alert for references to hiding or wanting to avoid or prematurely terminate psychotherapy. The patient may become emotionally unavailable or unable to discuss certain material openly. The presentation may either be overmodulated, with excessive control or restraint of expressive behavior; undermodulated, with undercontrolled, impulsive presentations; or a mixture of both (shimmering state).[21]

Shame may be experienced or warded off by the patient and manifested to the therapist in overmodulated states in which the patient seems relatively unable to articulate his experience of the process. On the other hand, in undermodulated states, in which the patient's expressions of ideas and emotions are dysregulated, the patient will describe or manifest abrupt, even explosive shifts of emotions, including anger, rage, or sudden self-righteous accusations that may surprise the psychotherapist in their intensity. Mixed or shimmering states of shame have competing elements of defensive distancing from the psychotherapist and signs of emotional turmoil.

With experience, shame-related states may be more easily discerned, but they are not necessarily best reviewed in real time, or even during the session in which they occur. Patients are able to understand, confront, and change their most debilitating pathogenic beliefs in a state of relative psychological safety and

emotional stability.[22] Thus, it is useful to get into the habit with such patients of carefully reviewing previous sessions for shamed reactions, and to try to accomplish these reviews when the patient appears controlled and emotionally shored up. The patient will often be better able to process these issues from the relative safety of a fresh new moment in which events are reviewed without the embarrassment of the current, active self having committed the "sins" being discussed or the current, active other (as embodied in the therapist) having committed the particular slight or cruelty involved. In this way the therapist will avoid overwhelming the patient by unnecessarily provoking shaming transactions in the treatment itself.

COMMON SHAMING TRANSACTIONS IN PSYCHOTHERAPY

Even the most tactful work with shame-prone patients nearly inevitably leads to certain predictable, scripted transactions in psychotherapy that mobilize shame on the part of patient or psychotherapist. The danger is that when these patterns intensify, there is the potential for escalation in which the psychotherapist unwittingly fuels further shameful behavior by unconsciously identifying with the patient's devalued-self or devaluing-other internalizations. If these patterns are prepared for, there is less likelihood of acting them out to a harmful degree. The following are some of these transactions.

Envious Transactions

In envy, the patient's attention shifts to an external object both idealized and degraded.[23] The object envied may be seen as immune to the relevant shameful quality in order to ward off a devalued self in the envier. There is also a hostile component to envy in which the other is taken down a peg in order to decrease the perceived distance between self and other. The psychotherapist working with shame-prone patients must be prepared to tolerate envy by the patient and to deal with projective identification in which there is pressure to envy the patient. It is common for these patients to brag about success, money, or sexual exploits in order to test whether the psychotherapist can tolerate feeling envious without attacking or retreating from the patient.

If envy is used primarily to ward off a sense of a devalued self, an idealizing identification may prevail. For example, a comment such as: "I wish I had your bright future as a doctor" may challenge the psychotherapist to tolerate being envied, as the patient reveals a despondent self. In this case, an interpretation like: "You worry about your future" may enable the patient to discuss feelings of hopelessness without feeling so vulnerable to exposure. On the other hand, a more hostile envy is expressed in the comment: "When you go home tonight to your nice house you will forget me, while I return to an empty house and struggle to get by." In this expression of envy, the patient also reveals a projection of an unavailable, devaluing other onto the psychotherapist. An interpretation such as: "You wonder whether it is safe to open up with me" might help the patient regain a collaborative sense of the treatment.

Blaming Transactions

Blaming may be seen as an attempt to fix or change the locus of "wrongness" and is often employed as a defense against shame. Externalization is a subtype of blaming in which agents external to the self, or out of its control, are held responsible for the perceived defect or error. If we look carefully at blaming transactions, we learn the nature of the wrongness and get clues as to why it is being projected or denied. For patients who engage in compulsive blaming, there are generally states of mind associated with self-blame (which correlate with depression) and those associated with blaming others (in which other-directed anger or rage may be present). These may alternate in pendulum fashion. Narcissistic patients may have states in which blaming is mixed and highly

fluid and related to vulnerabilities of the moment.[24]

Because the psychotherapy situation easily mobilizes feelings of inadequacy and perceived moral judgment, shame-prone patients often blame or feel blamed in regard to the issue of whether they are functioning satisfactorily in treatment. They may explicitly blame themselves for failing to improve, or they may blame the psychotherapist for their lack of improvement as a defense against a devalued self seen by the patient as so defective that it is beyond help. Often there is a countertransference urge on the part of the psychotherapist to turn the tables and restore blame to the patient for what is clearly the other's "fault."

For some patients, blaming may become particularly malicious, associated with escalation to rage. In these cases, it is helpful to incorporate some anger management techniques into the treatment to help the patient disengage early in the escalation cycle; if the patient is allowed to escalate without sufficient limits, there will ultimately be more consequences to be ashamed about. One goal of psychotherapy with these types of patients is to help them appropriately localize responsibility without resorting to blaming.

Overzealous Helping Transactions

The shame-prone patient is vulnerable to feeling deflated in the course of delving too rapidly into various aspects of experience. Horowitz[2] has urged "tactful slowness" in the process of enabling narcissistic patients to apprehend painful discordances between grandiose perceptions and reality. Psychotherapists are used to paying attention to the patient's reactions in order to gauge and adjust the pace of psychotherapy. This is also true, of course, in the case of shame-prone patients, but it is complicated by the subtlety of some shame-related reactions. Undermodulated reactions, including anger or other obvious signs of dysphoria, will sometimes clearly emerge upon requests for more information or attempts by the psychotherapist to home in on a particular issue. For example, when attempting to direct a narcissistic patient's attention to a particular significant pattern of interpersonal dysfunction, the psychotherapist might be angrily accused of failing to give the patient credit for his accomplishments but always focusing on his deficits. A series of such reactions guides the therapist to slow down and work more incrementally on enabling the patient to feel supported while exploring smaller, less painful components of dysfunctional cognitions, feelings, or behavior.

Overmodulated states of shame may be more difficult to discern because the patient may avoid clear communication about them. Optimal pacing with these patients requires good working knowledge about shame and its manifestations, along with a habit of routinely exploring various shameful reactions (both implicit and explicit) within the treatment. For example, patients who have experienced severe psychological trauma and those with addiction problems are particularly prone to manifest shame in the form of indirect or subtle tests of their safety in the treatment setting.[25]

SUMMARY AND CONCLUSIONS

As the study of emotion proceeds, clinicians benefit by inheriting more sophisticated techniques to uncover hidden aspects of emotional life. Affect theorists remind us that global psychiatric descriptors like "depression" and "dysphoria" unfairly aggregate at least six different families of negative moods, glossing over fine nuances of interplay among affect, cognition, memory, imagery, and defense that we encounter clinically. With increased awareness of patterns of emotional state transitions comes the ability to notice and clarify for a shame-prone patient, for example, ways in which a hurt, stubborn, childlike self resentfully licking its wounds repetitively gives way to an angry critic ready to blame the psychotherapist for its own failures. Interpretation of this sequence might cement alliance, leading to deeper exploration of a defective, painfully

exposed self always lurking in the background of each interpersonal interaction.

Cognitive and social psychology research reminds us that the distinction between shame and guilt has been blurred; the two emotions have very different implications for adaptive functions as well as for psychopathology and psychotherapy. Knowledge of this distinction leads to a keener ability to observe and make useful interventions that accurately underscore the patient's fundamental distress. Consider, for example, the not uncommon situation in which the psychotherapy focuses on self-conscious emotions stemming from a missed psychotherapy session. A guilt-focused interpretation such as "You feel you let me down by missing our last session" might, for a primarily shame-prone patient, appear to be an accusation of wrongdoing, provoking blame at the psychotherapist for blowing a minor inconvenience out of proportion ("making mountains out of molehills"). Conversely, a shame-focused interpretation like "You feel you are a terrible person for missing our last session" might mobilize pseudo-compliance in the primarily guilty patient, who might falsely agree to this premise so as not to disappoint the psychotherapist.

Paying attention to the relative salience of devalued-self or devaluing-other projections within the psychotherapy hour will help guide the clinician to appropriate interventive strategies. All other things being equal, delving into themes about degraded self-schemas may be better tolerated by the patient when the polarity of the treatment deals with the devalued-self aspects of shame. When devaluing-other aspects prevail, it may be a signal to adopt a more supportive, less probing stance. Preparing for the inevitable scripted transactions encountered with shame-prone patients will help prevent unnecessary levels of perceived shame by the patient and keep the psychotherapy setting safer to enable deeper work. Finally, it is important to remember that work with shame-prone patients results in frequent challenges to the psychotherapist's "grandiose professional self."[26] Shame-related sensitivities in the psychotherapist are easily mobilized in work with these patients, and when we have assessed our own particular narcissistic vulnerabilities we are in a better position to clarify projections that originate from the patient.

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