

Shame and Group Psychotherapy

Introduction

It is still not widely understood that shame experiences are prevalent in the group psychotherapy situation. This is

The basis of shame is not some personal mistake of ours, but the ignominy, the humiliation we feel that we must be what we are without any choice in the matter, and that this humiliation is seen by everyone. *Milan Kundera. Immortality. 1991.*

Whoever blushes is already guilty; true innocence is ashamed of nothing. *Jean-Jacques Rousseau, Emile.*

The capacity to feel shame is built into human beings, and it has a civilising effect in adapting a child to his family and culture. *F. English. Transactional Analysis Journal, 1975.*

Whilst shame keeps its watch, virtue is not wholly extinguished in the heart; nor will moderation be utterly exiled from the minds of tyrants. *Edmund Burke, Reflection on the Revolution in France. 1790.*

Because impudence is a vice, it does not follow that modesty is a virtue; it is built upon shame, a passion in our nature, and may be either good or bad according to the actions performed from that motive. *Bernard Mandeville. The Fable of the Bees. 1714.*

related to the fact that shame is most significantly an interpersonal emotion, involving one's relationship to others and also to oneself, and the main focus of group psychotherapy is the examination of relationship, both within and outside the group. Because it is a common experience in relationships and therefore an important affect in group settings, shame can have profound effects on the nature of group relationships and on the experience of the group matrix as a potentially safe container. Shame can be evoked by the group and result in the group being perceived to be harmful and aversive, leading group members to avoid participation in the group. Because of the

hidden nature of shame, it can be difficult for the group conductor to detect and work with it effectively. We are all

handicapped in this area by the lack of a coherent theory of emotion in psychoanalysis or any other field.

However, the theory that is perhaps of most use and significance in providing an orientation in this area is attachment theory. John Bowlby (1971), in his development of these ideas, posits that from its first relationships the infant is constructing mental models of self-with-other that serve as templates for further emotional development. If caretakers are reliable and able to give consistent, "good-enough" care the model that develops is one of love and interpersonal trust. If the caretakers are neglectful or do not meet the emotional requirements of the particular infant, then untrusting models of self-with-other form the templates on which future relationships are based. These templates, therefore, can be seen as providing the basis on which feeling states of self in relation to others are constructed.

The above can be related to object relations theory in highlighting the primacy of connectedness with others. This view of the shame experience emphasises that it is an experience of alienation, of being cut off or isolated from others. Indeed, threat or damage to social bonds seems to be the primary context for shame, be that a separation or some other severance of relationship. For James (1992), the pain of shame is the loss of love and the loss of feeling of unity.

Thus, shame:

- a). Is prevalent in groups
- b). Is an interpersonal emotion, a frequent and important influence on group relationships
- c). Can lead to an inability to use the group because of fear of exposure.
- d). Has implications for therapeutic technique and management of the group.

My belief is that the conductor is required, particularly in relation to shame prone individuals, to consider carefully the question of technique and approach. Incorrect understanding and therapeutic technique may lead to harmful and anti-therapeutic results.

The Shame Experience

Shame is an all or nothing experience in which the possibility of there being both either/or is completely lost. I am totally worthless from head to foot, other people will fully recognise how full of badness I am, and I am beyond the possibility of redemption. I lack all value.

The word shame is derived from the Indo-European root kam/kem, which means, "to cover, to veil, to hide and to wound". The experience involves

experiences of exposure, and the uncovering of sensitive, intimate and vulnerable parts of the self. The self is experienced as bad, defective and wanting (neediness is part of the experience). Lynd (1971) sees shame as the outcome of exposure to oneself of parts of the self that have been unrecognised because there is a reluctance to admit to these qualities. Self-dislike, self-condemnation and self-denigration are prominent in shame. What is common to all shameful

Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but throughout his adolescence and his years of maturity as well, and on into old age. *John Bowlby (1980). Attachment and Loss, Vol. 3: Loss. New York: Basic Books.*

Cultures change over time. Our culture has become more shame-driven as we have turned toward personal freedom, and beyond it to narcissism. The self, now the object and the subject, is more likely to experience shame. And we have simultaneously rid ourselves of the religious institutions that are capable of absorbing shame, so many of us lack mechanisms for securing forgiveness. *Michael Lewis, Shame, 1992.*

experiences is that an individual has not lived up to his personal expectations. A number of writers conceptualise this as a falling away from the standards set by the ego ideal. The exposure is not only to others but also involves exposure to one's own eyes. Shame is associated with helplessness, weakness and loss of control; it is an experience involving intense feelings of painful embarrassment, humiliated anger and a sense of devastation. There are feelings of shrinkage and diminution, which is quite the opposite of feeling a rooted sense of competence and self worth.

We live in an atmosphere of shame. We are ashamed of everything that is real about us, ashamed of ourselves, of our relatives, of our incomes, of our accents, of our opinions, of our experience, just as we are ashamed of our naked skins. *George Bernard Shaw. Man and Superman.*

Ashamed of the many frailties they feel within, all men endeavour to hide themselves, their ugly nakedness, from each other, and wrapping up the true motives of their hearts in the specious cloak of sociableness, and their concern for the common good, they are in hopes of concealing their filthy appetites and the deformity of their desires. *Bernard Mandeville. The Fable of the Bees. 1714.*

Shame has a harsh and intransigent character. It is irrational and absolute and there seems no possibility of anything being better. It involves feelings of contamination, impurity and pollution. We are unutterably wrong; we are unlovable and unworthy of any care or attention, only deserving criticism and negative reactions from others. There is no help for us, no possibility of improvement because of a sense of unalterable deficiency

lodged deep inside the self. We are conspicuous in our weakness, quite transparent, our badness visible for all to see. We compare ourselves with others who seem immeasurably superior.

Some writers have described shame as involving a perception of self as unsatisfactory, diminished, hidden and disguised (Thrane, 1979), comprising feelings of weakness, abnormality, dirtiness (Wurmster, 1987), including such

emotions as shyness, bashfulness, modesty (Nathanson, 1987), and an emotion experienced alone (Alonso and Rutan, 1988) and implying a loss of love (Lewis, 1971). Pines (1987) states that all authors agree that the shame experience can be significantly linked to loss of self esteem, to feelings of inferiority and failure, and hence to the issue of narcissism. Morrison (1983) also sees shame as involving a defect or failure of the self leading to a decrease in narcissistic self-esteem. The pain experienced in shame is seen to be linked with a sense of failure about what we are as well as that we would wish to be, either for ourselves or for others. Green (1982) sees shame as "the lot of fatality, a mark of the wrath of the gods, a merciless punishment barely related to an objective fault, unless it be that of immoderation". For Lynd (1971), shame has a close connection with the sense of identity and insight. It is provoked by experiences that call into question our preconceptions about ourselves. It compels us to see ourselves through the eyes of others and to recognise the discrepancy between their perception of us and our own oversimplified and egotistical conception of ourselves. It is clear that this must have implications for psychotherapy groups in which an important part of the process is to receive feedback from other group members, to "see ourselves through other's eyes" (Foulkes, 1964).

The emotions of shame are intolerable and may quickly be eliminated from consciousness. The experience is of a painful reduction of the self and a scorching sense of being known and /or seen by others. It is isolating involving lack of trust, and feelings of exposure, failure and inability or unworthiness to belong. I am ashamed of what I am, which includes my whole being and because of this an experience of shame can only be overcome if there is a change in my whole self.

Some commentators have seen the shattering of trust as an important aspect of shame, of which the sense of suddenly being out of key with the world is important. The unexpectedness of shame creates feelings of powerlessness that may include feelings of humiliation. Other commentators have written about the way in which shame separates us from others because it feels incommunicable, and also because of the nature of the relationship with others that comes with shame: of being inferior, reduced and denigrated, with no possibility of improvement, redemption or forgiveness. It is persecutory and allows no area of self-affirmation. Horner (1979) states that behind the feeling of shame stands the fear of contempt which involves fear of abandonment, of being emotionally starved. We can see that attachment theory and issues of separation anxiety are relevant in thinking about shame: the quality of attachment in shame-prone individuals is based on anxiety, an anxiety involving the expectation of engagement in hostile, critical and unsupportive relationships. This may also evoke a powerful fear of separation.

They are of those that rebel against the light; they know not the ways thereof. The murderer rising with the light killeth the poor and needy, and in the night is as a thief. The eye also of the adulterer waiteth for the twilight, saying, "no eye shall see me"; and disguiseth his face. In the dark they dig through houses, which they had marked for themselves in the daytime; they know not the light. For the morning is to them even as the shadow of death; if one know them, they are in the terrors of the shadow of death. *The Book of Job. Pocket Canon. Canongate Books. 1998.*

"Not knowing" can also evoke shame: not knowing information that we assume others in the group share disconnects us from group membership. It is a symbol of our inadequacy, our unworthiness to be included and to participate. Lack of connection with others is the most shameful of experiences and has the potential to stir up Oedipal fears of exclusion, and anxieties about an inability to compete, and our personal worthiness to be able to be

accepted and related to as an equal in the group. We may well feel that, if we seem to lack the skills to participate in the life of a group, or if we have broken the rules of the group, for whatever reasons, that this is the greatest shame. We are disconnected, isolated, shameful and alone, despised for our inability to participate and to know the rules of engagement. The only possibilities that appear open to us may be to avoid contact with the group, to drop out of participation altogether, and to isolate ourselves. The most difficult thing would be to bring our shame and deviation from group standards and norms openly to the group, even though this may enable us to reconnect with group membership. The fear is that our shamefulness will only be confirmed. "Knowing too much" or being too clever can also be a source of shame since it creates the possibility of provoking envy and criticism in others and can be confused with self-display and narcissistic wishes. This may be the source of anxiety about making interpretations or sharing perceptions about other group members, on the part of group members as well as the group therapist.

It is also the case that shame that is brought into the group, whether this is unadmitted but nevertheless obvious to group members at an unconscious or conscious level, or whether it is disclosed, is contagious and can easily "infect" other group members, evoking shame in them. This evoked shame may relate to memories and associations about one's own experiences of shame, or it may be connected with shame concerning group events, for example, the shame of having provoked shame in another, or the shame of having damaged or hurt another. The witnessing of intense shame can, in itself, feel shameful, and create feelings that can be experienced both as unmanageable and persecutory. Scapegoating of the shame-filled group member can then occur in an attempt to avoid and escape from feelings of shame. This process, then, has the capacity to be either constructive, if other group

members are able to share their own feelings of shame, in which case the shame-filled individual rejoins the human community, or destructive, if shameful feelings are experienced as unmanageable, and the shame-filled individual is then isolated in his feelings of shame, or attacked and scapegoated.

When a shameful act has occurred, and most especially when this act has broken a cultural taboo, such as an abusive act of any kind, shame has the potential to paralyse group functioning. In this situation, shame can silence a group, either by actually stopping all communication or by creating a group

For some are in darkness/And others are in the light/And those in the light can be seen/Those in the darkness cannot be seen. *Bertolt Brecht. Threepenny Opera.*

The origin of narcissistic rage must be sought in the childhood experience of utter helplessness vis a vis the humiliating selfobject parent.Such experiences of helplessness are unbearably painful, because they threaten the very continuity and existence of the self.... *Wolf, E. (1988). Treating the Self: Elements of Clinical Self Psychology. Guilford Press.*

discussion in which the shameful act is only referred to tangentially or through group association but is never able to be grasped and spoken about directly. The emotional atmosphere of the group may then feel extremely unsafe, and there may be the feeling of a horrific centre that cannot be spoken about and has to be avoided at all costs. The abuse infiltrates the group, and persecution is in the air. One's words can then feel abusive and silences are equally abusive.

The function of the group therapist, and indeed of the group, in this situation, is to speak about the group climate and to connect it with the event that cannot be discussed. The task for the group is twofold: it may have to, in time, act as a reality tester, and condemn the act for what it is. This may come as a relief to the perpetrator, since his fantasy of condemnation may be much more extreme than any reality. It also has to reconnect the perpetrator with the wider human community, and it can only do this by showing an interest in the motivations and dynamics behind the act and by other

group members acknowledging similar desires, anxieties, ways of defending themselves, and repetitive and potentially destructive behaviours. This leads to a positive group outcome in which "the horror" is defused through dialogue, mutual understanding and identifications. Negative outcomes result when a group is unable to enter into dialogue, and remains frozen, and when a group needs to see the shamed individual as different from themselves and projects all the shame into that individual, and this can lead to scapegoating.

These tasks are best achieved in a stranger group that is structured with the traditional boundaries of regularity, consistent space and time, confidentiality, and so on. When this scenario applies to a different type of group, for example a work group, in which there are ongoing working relationships and where there are real-life differences in status, authority, and power, and historical shames associated with rivalry, competitiveness, envy, jealousy, depriving others of opportunity, favouritism, greed, "having too much", "needing too much", "giving too little", avoiding responsibility, damaging or not supporting others, etc., then dealing with these difficulties within the work group may not be possible. This applies especially when the shameful act has been committed by someone in an authority, and therefore parental, position in the work group, especially if the transgressor has continued power of patronage and reward over group members. In this case there may well be significant griefs and losses. When the parental figure is displaced there is fighting in the group, which may be as much about ways of dealing with grief, loss and uncertainty as with feelings of anger or competing for position. Aggression and hostility towards the leader, based on transference, can play no small part in these transactions and an inability to process feelings of disappointment and betrayal by the group can easily lead to a spiral of anger, hostility, and other unmanageable feelings. Any unresolved anger towards

parental figures will be evoked: disappointment and disillusionment with the current leader will provoke rage, anger, and wishes to retaliate and humiliate the deposed leader. The tables will be turned.

"Rules of procedure" may be evoked by some to provide a secure holding in a new situation of uncertainty and anxiety, and by others the rules of procedure are used aggressively and as a shaming tool to punish the transgressor. The ability to think carefully about why the rules of procedure have been established and to come to an adult judgement about the transgression will often be lost.

In this climate of fear and accusation it is difficult for others to share their own areas of uncertainty or deviation from "proper" procedure. It is clear that the "rules of procedure", whatever their reasonableness and value, can have a role in defending members of the group against shame. If they are adhered to they can provide relief from feelings that one may be criticised by the group, thus sticking to them provides a "safe area of practice". It is also fair to say that a strict

There is a good reason the words "shameful" and "shamelessness" define the same conduct. You know you've behaved shamefully if you have exposed other people to needless annoyance or embarrassment. You don't know you've behaved shamelessly if you don't get this point. *Christopher Hitchens. The Death of Shame, Vanity Fair, March, 1996.*

Terror acts powerfully upon the body, through the medium of the mind, and should be employed in the cure of madness..... Fear, accompanied with pain, and a sense of shame, has sometimes cured this disease. Bartholin speaks in high terms of what he calls "flagellation" in certain diseases. *Benjamin Rush. Medical Enquiries and Observations Upon the Diseases of the Mind, 2nd ed., 7, 1818.*

adherence to the rules can sometimes function to support a sense of professional omnipotence, of boosting self-esteem, perhaps at the cost of making others feel inadequate and shameful. The cost may be to creativity and innovations in practice and the rules may be used by group members to resist potentially valuable innovations in practice only because they

provide security and an illusory sense of certainty. An innovator may therefore be scapegoated and shamed in order to maintain this defence. It is also clear that the rules may also, at times, become persecutory for some or all group members and it can then be seen that this type of institutional and social defence can easily break down and become ineffective and counterproductive.

When the leader has narcissistic traits, and shows no obvious shame, avoiding responsibility for her actions or perhaps subtly blaming others (the victimiser becomes victim), it is even more difficult for individuals in the work group to deal with this trauma, and there may be significant splitting and taking sides in relation to the group leader, which complicates workplace dynamics considerably. Of course, narcissists also break the rules, in the spirit of "the rules do not apply to me" or because they do not possess the ability to empathise with others and therefore do not understand, at a deep level, the rationale for the rules in any way that is connected with ordinary human relatedness, or because breaking the rules is part of a general impulsiveness: acting on feelings without thought. These leaders have considerable potential for destruction within groups partly because they do not possess the ability to protect themselves due to the lack of an anticipatory social antennae that is able to accurately foresee social consequences.

Additionally, if the leader is in the position of having created the organisation or is seen as representing the originator of the organisation because the mantle of successor has been bestowed by the deceased leader or the group, their fall will create many problems of self-esteem and shame within the group and individuals will then feel devalued and worthless and will perceive that the organisation has been devalued in the eyes of the outside world. There may well be problems in reforming a secure identity for "the sons of Adam" and

difficulties for a successor. However, it may be that, in some cases, there is a healthier outcome and that the fall of an idealised father figure enables his "sons" to form an identity separate and differentiated from the ideas of the originator. This, in time, may produce a healthier and more creative organisation than would have been the case if the leader's ideas and achievements had been idealised.

It is worth adding that, on occasion, the narcissist may persist in exposing their shameful conduct and continue to publicly humiliate him or herself because of a wish to humiliate an institution or work group that has been experienced as

A man desires praise that he may be reassured, that he may quit of his doubting of himself; he is indifferent to applause when he is confident of success. *Alec Waugh. On Doing What One Likes.*

Every man has his follies - and often they are the most interesting thing he has got. *Josh Billings.*

It was when I found out that I could make mistakes that I knew I was on to something. *Ornette Coleman.*

No one can make you feel inferior without your consent. *Eleanor Roosevelt.*

One of the misfortunes of our time is that in getting rid of false shame we have killed off so much real shame as well. *Lois Kronenberger. Company Manners: A cultural Enquiry into American Life, 1954.*

If one is ashamed, there is no better remedy than to practice benevolence. *Mencius (371?-289? B.C.).*

rejecting that individual as a result of the exposure of the shameful act. In this case continued public confession might be seen as an expression of aggression against that group, a wish to shame the institution by association, and perhaps additionally by aggressively revealing further shameful behaviour that has occurred. There may be a wish to bring that institution or work group down, ruin its reputation, and cast doubt on the legitimacy of the group. This behaviour may also be based on a wish to provoke scapegoating in order to limit or communicate unbearable feelings of exposure, shame, and humiliation. This may be a repetition of earlier group or family experience.

The group may also deal with these difficulties by either electing an inadequate replacement leader or making sure that the leader is inadequate and wanting. The leader is then a group expression of group-wide feelings of shame – and is a communication about these underlying feelings – and this leader may then be scapegoated. This process may free the followers from the shame (for a time), since the leader is made to carry all the feelings of shame for the group, unless the new leader is able to fight back against these projections. It is also possible that the election of a shameful leader may represent a wish for public exposure on the part of “the group”. Of course, all of the above defensive manoeuvres have as an outcome that the real and original cause of anger and aggressive feelings more easily escapes the wrath of the group. In focal conflict theory terms this scapegoat solution may represent a restrictive solution to the above conflicts.

The shame prone individual shares some characteristics with those characterising borderline and narcissistic personality disorders. Alonso and Rutan (1988) note that in cases of extreme vulnerability, as in some narcissistic and borderline disorders, shame dominates the emotional lives of these patients who have a lifelong vulnerability to regression on experiencing feelings of shame. Rycroft (1968), using a somewhat earlier conceptualisation of the nature of these disorders, sees shame as a neurotic symptom occurring in schizoid individuals who both overvalue themselves and possess insight into the fact that their self-overvaluation is not shared by others.

Another slant on the same area is expressed in Fairbairn's concepts of endopsychic structure and the

Past shame, past grace.
Saying.

Doubt is the brother of shame. *Erik Erikson, Childhood and Society, 1950.*

The only shame is to have none. *Blasé Pascal. Pensees.*

Shame operates most strongly in our early years. *Samuel Johnson. Notes Upon Shakespeare.*

Shame is like an atomic particle; we often know where it is only by the trace it leaves, by the effects it causes. *Michael Lewis. Shame. 1992.*

anti libidinal ego. The craving self that longs for a tantalising object can be understood as the self that is shamed by the unavailability of a responsive other. In Fairbairn's system, the primary anxiety is separation anxiety, and the response of the infant is to internalise the split image of the primary object in an attempt to have control over the bad and frustrating parts of this object. The internal saboteur, in Fairbairn's system, which is identified with the rejecting object, has a close relationship with shame, since it directs aggression the libidinal self, as well as towards the rejecting object, for being so needy and dependent. An additional idea is that in the "moral defence" the external object is kept as ideal and good at the cost of the infant feeling bad, worthless, and undeserving of love. The emotion of shame may well be an important motivating or driving force behind the resulting behaviours and feelings towards the self which Fairbairn says are "self-defeating beliefs and repetitive behaviours."

Feelings of shame, additionally, are intimately associated with the reciprocal emotions of disgust and contempt. Shame implies a fall in status within a particular group in the shame-full persons mind, and this felt status is often transmitted into the real relationships within the group by a process of emotional communication perhaps largely based on body language and eye contact (the process of projective identification). The shame-full individual is then perceived as inferior by the group which may well become tied to a moral ordering in that group (someone is inferior, to blame, at fault, lacking, or responsible). Attached to this lack of status, will be either real or imagined feelings in the other of disgust or contempt, and the presence of these feelings will reinforce the fact that one is of lower status and deserving of contempt. Contempt is reciprocal; contempt for oneself leads to contempt in the other which then reinforces self-contempt. Contempt justifies scapegoating and other aggressions. Shame, is then,

as I have indicated previously, an important social emotion, which defines our status and standing in the group.

Bullying (or scapegoating) frequently involves an attempt to humiliate, whether it occurs in the school playground, the family, the workplace, or at the level of the nation. The bully acts to shame and to humiliate and to use any difference in power in order to do this. The violence connected with bullying more often arises from a high self-valuation based on a narcissistic self-appraisal, involving egotism, an inflated self-concept, and arrogance. Perpetrators of bullying are typically people who think very highly of themselves. The bullying or abuse frequently occurs when the favourable view that individual has of himself is threatened or questioned by others and the scapegoating more readily occurs if that individual's self-assessment is not supported by actual achievements. In this situation, threats to self-esteem can prick narcissistic self-inflation, and an aggressive response, bearing little relation to the provoking situation may be the result. These are individuals who tend to be threatened by any display of competence in another that threatens their own self-assessment. The response is to shame and humiliate the

I never wonder to see men wicked, but I often wonder not to see them ashamed. *Swift. Thoughts on Various Subjects.*

The most curious offspring of shame is shyness. *Sydney Smith. Lecture on the Evil Affections.*

He who frequently becomes embarrassed in the presence of others is regarded as suffering from a foolish unjustified sense of inferiority and in need of therapy. *Erving Goffman. Interaction Ritual, 1967.*

In common usage one is primarily ashamed of oneself, while one is primarily embarrassed about one's presented self. *A. Modigliani. Embarrassment and Social Influence, 1966.*

individual who has threatened self-esteem. This, of course, involves the process of projective identification, which may be extremely destructive and persecutory, particularly if the scapegoated individual is susceptible to taking up and accepting these projections.

The above dynamics also appear in families, and can be seen powerfully in families where children become scapegoats. The

following baby observation provides an illuminating example of the feelings that may fuel this type of family interaction. This male child was 18 months old when this observation occurred.

Damien was sitting between his parents on the settee playing with a plastic toy. He seemed to become bored with the toy, threw it aside, and he pulled himself up to a standing position on the back of the settee. He clambered over the knees of his parents and repeatedly pulled himself to a standing position for some minutes. Suddenly, his mother began to shout at him, telling him to get down from the back of the settee. This surprised and shocked the observer who had discerned no difference in Damien's behaviour from that of the previous five minutes. The suddenness and unexpectedness of this together with the volume, harshness and aggression in the mother's voice together produced the sense of shock and surprise. Damien's father quickly joined in.

Damien initially seemed in shock, in a frozen state. He then howled and seemed extremely distressed. His parents continued their criticism and eventually provided comfort.

The above example is typical of interactions in this family. The observer was struck by the inconsistency of the parents who seemed to launch aggressive attacks of Damien for little reason, completely unpredictably. She eventually came to understand that one motive for their behaviour was a wish to avoid being shamed and criticised by the observer. They felt that the spontaneous behaviour of their son was "bad" and needed to be restrained and controlled. The observer often felt that her gaze became persecutory to these

parents and their response to their son was an attempt to avoid criticism and shame in the eyes of the observer as well as a transmission to Damien of the experience of being shamed.

How is Shame Recognised?

Shame can be difficult to recognise in the therapeutic setting simply because it is so difficult for patients to express these feelings verbally. Mittwoch (1987), for example, reviews how patients with strong doubts about their acceptability may withhold what is felt to be shameful until a late stage of treatment, or not at all. To acknowledge shame may only risk intensifying the shame, and the usual response is to keep shame hidden and consigned to an autistic, unrelated part of the personality if shame is consciously experienced. When it is not consciously experienced we are in the area of "bypassed shame", where the successful repression and elimination of feelings of shame make them relatively inaccessible to the therapeutic process. This difficulty in recognition may be added to by the therapist's difficulty in tolerating and thus recognising this persecutory and painful emotion in the event of the therapist having unresolved problems in this area.

There are, however, ways of recognising the indirect manifestations of shame. Lewis (1971) notes that certain words may be indicative of an experience of

I always take blushing either for a sign of guilt or ill breeding.
William Congreve. The Way of the World.

Her blush is guiltiness, not modesty.
William Shakespeare. Much Ado About Nothing.

The man that blushes is not quite a brute.
Edward Young. Night Thoughts.

Whatever else, embarrassment has to do with the figure the individual cuts before others....The crucial concern is the impression one makes on others.
Erving Goffman. American Journal of Sociology, 1967.

shame. He suggests that the following words are often used by people experiencing shame: uncomfortable, insecure, uneasy, tense, blank, confused, small, worthless, inadequate, stupid, foolish, silly, weird, helpless, unable, weak, idiotic, stunned, alone, disconnected, alienated, split, impotent. These words always communicate a state of being in a certain type of relationship with others involving an awareness of how we appear in their eyes. Overt speech content may be concerned with the deficiencies of the self, or what should have been said, or might have been said. Lewis also suggests that words such as resentful, bitter, spiteful, or an indication of holding a grudge are often linked to shame and rage experiences. This is because the person who causes us deep resentment and bitterness may well have been an individual who has created in us an experience of deep shame and humiliation. Kinston (1983) focuses on how an important issue or feeling can be hidden behind words and behaviour and these often involve feelings of shame. Examples are when a word or phrase makes something appear less severe or painful or downgrades an event, when there is a resort to abstraction, talking in general or oblique terms rather than referring to specific people or events, a denial or rationalisation of a feeling, defensive indifference, verbal withdrawal, distraction, changing the topic of conversation, projection - disclaiming the experience as one's own and placing it into others, and the frequent use of "fillers" such as "you know", etc. Rapid speech may also point to an experience of shame. Characteristic defences are to deny shame, to repress ideas, to counter-phobically affirm the self, to negate the other, and to engage in conflict and violence as a protective measure (these last two can be understood as examples of projective identification in which the other is made to experience feelings which are unable to be tolerated and are, as a consequence, located outside of the self). It is also clear that confession may be a defence against shame (as in

Nathaniel Hawthorne's "Scarlet Letter", in which public confession and exposure lead to the relief of a hidden and secret shame). In a group context, confession is often a positive event, leading to the reduction of autistically unrelated shame and a positive reality-testing of what are often greatly exaggerated feelings of personal failure and responsibility.

Lynd (1958) suggests that there are common defences against shame. One defence is to inhibit all exposure so that no shame is risked, refusing to recognise the traumatic feelings and using the mechanisms of depersonalisation and adaptation. Horner (1979) also sees defences as behaviours

that will restore the sense of integrity of the self, be it through schizoid withdrawal, which shuts out the object and its distressing and traumatising impact, or through repression, which prevents awareness of intrapsychic conflict. Lynd terms another defence "counter shame", a kind of manic denial of shame in which an individual seems to be shameless. Lynd also feels that bypassed shame is frequently associated with paranoid ideation, constructed to rationalise unacknowledged shame.

Lewis (1971), additionally, says that shame may lead to a wish to turn the tables and to triumph over the other. Shame may be warded off by arguing,

There can be nothing more humiliating than to see the shaft of one's emotion miss the mark of either laughter or tears. Nothing more humiliating! And this for the reason that should the mark be missed, should the open display of emotion fail to move, then it must perish unavoidably in disgust or contempt. *Joseph Conrad, A Personal Record. 1912.*

Shall it for shame be spoken in these days, Or fill up chronicles in time to come, That men of your nobility and power Did gage them both in an unjust behalf (As both of you, God pardon it! have done) To put down Richard, that sweet lovely rose, And plant this thorn, this canker, Bolinbroke? And shall it in more shame be further spoken That you are fool'd, discarded, and shook off By him for whom these shames ye underwent? *Shakespeare. First Part of King Henry 4th.*

Contempt is the weapon of the weak and a defence against one's own despised and unwanted feelings. *Alice Miller.*

There's nothing in this world can make me joy. Life is as tedious as a twice-told tale Vexing the dull ear of a drowsy man; And bitter shame hath spoil'd the sweet world's taste, That it yields nought but shame and bitterness. *Shakespeare. King John.*

anger, and blaming which shames the other and may lead to arguments about who is to blame, with each individual attempting to avoid the transfer of, and the experience of, shameful feelings. Therefore, resistances can range from passive withdrawal to rebellious acting out. We can understand both of these defensive techniques as relieving shame by producing a feeling of strength to the sense of self (Miller, 1989). Arrogance and grandiosity can therefore be defences against shame as can the defence of emotional aloofness. Compulsive traits have also been seen as defences against the expression of sadistic impulses and as attempts to make the self perfect so that shameful feelings of inadequacy will not be experienced (Miller, 1989).

When the relationship between patient and therapist has a tendency to be shame-filled, transference issues are heightened in intensity, and elevate the therapist as a significant transference figure in which the issue of relationships with authority figures will raise difficult issues of self esteem and the management of the patient's self concept and self structure. Such anxieties may be expressed as an anxiety about whether staying in therapy is indicative of the patient's strength, or of weakness, passivity, victimisation or submission to a controlling, cruel, therapist. Courtois (1988)

Pride goeth before destruction
and a haughty spirit before a fall.
Proverbs 14:18.

There are multitudes of men and women who... attempt to get rid of the sense of moral failure by identifying themselves with groups which condone or approve the indulgences which they are either unable or unwilling to give up. *Anton T. Boisen. The Exploration of the Inner World: A Study of Mental Disorder and Religious Experience, 6, 1936.*

The guilty think all talk is of themselves. *Geoffrey Chaucer. The Canon's Yeoman's Prologue, The Canterbury Tales, 1390?, tr. Nevill Coghill, 1951.*

The root of the guilt problem lies in human nature itself, in our failure as human beings to live in accordance with our potentialities and our vision of the good. *J. Glenn Gray. The Warriors: Reflections on Men in Battle. 1959.*

A great many people feel "guilty" about things they shouldn't feel guilty about, in order to shut out feelings of guilt about the things they should feel guilty about. *Sydney J. Harris. Chicago Daily News. 1971.*

addresses how patients may project their shame onto their therapists, expecting to be held in the same contempt they have for themselves. They may also feel that they are undeserving of the therapists positive attention and experience anxiety that the therapist will eventually discover their hidden badness. This may be based on an expectation of a re-enactment of non-protection or blame that may have been experienced in childhood.

Stierlin (1977) examines how, in shame, an individual typically tries to massively blot out or avoid self-observation, to metaphorically close his eyes or deny what has occurred. In the group this may mean that shame and guilt are avoided by

I am ashamed of confessing that I have nothing to confess. *Fanny Burney.*

We would frequently be ashamed of our good deeds if people saw all the motives that produced them. *Francois, Duc De La Rochefoucauld.*

Success always occurs in private, and failure in full view. *Anon.*

Many a man is praised for his reserve and so-called shyness when he is simply too proud to risk making a fool of himself. *J.B. Priestley. All About Ourselves and Other Essays.*

When they discover the centre of the universe, a lot of people will be disappointed to discover they are not it. *Bernard Bailey.*

Honest criticism is hard to take, particularly from a relative, a friend, an acquaintance, or a stranger. *Franklin Jones.*

Whilst shame keeps its watch, Virtue is not wholly extinguished in the heart. *Edmund Burke. Reflections on the Revolution in France, 1790. Pelican Books edition, 1968.*

Shame is a disease of the last age; this seemeth to be cured of it. *Marquis of Halifax. Political, Moral and Miscellaneous Reflections, 1750.*

emphasising the sameness of everyone (a common defence with patients who experience agoraphobic-type anxieties), and by denying and avoiding conflict. All members try to prove that they will not hurt each other either in reality or in fantasy. There may be a denial of destructiveness (in reality or fantasy) in an attempt to create a feeling of harmony and togetherness.

As discussed above, feeling that one is weak, soft, loving or tender can evoke shame. Avoidance of shame may involve a shaming of the other. In the group this involves a "trading" of projective identifications in which each individual sees

himself as having a specific and limited difficulty that is felt to be caused by another or others in the group, and which can only be alleviated by that other person or persons. There is thus a complicated network of perceptions about others and dissociations about oneself in which each individual locates a particular quality of feeling in another. Foulkes (1964) discussed this in terms of the concept of the group matrix. One group member, in disowning personal weakness, may shame another by projecting onto or into them these dissociated aspects of the self.

Alonso and Rutan (1988) also feel that the negative therapeutic reaction is often related to the problem of reawakened but unexpressed shame. Here, the negative therapeutic reaction is a defence against the shaming that is experienced as issuing from the therapist or the group.

Lear (1987) also proposes that a number of anxieties arise in group therapy that are related to shame: The anxiety that it is a second rate treatment because there is only one therapist to so many patients; the fear that the patient will lose his identity in the group; that he will be unable to follow what is happening, will be unable to present a coherent problem; that somehow word of what happens in the group will get round to associates or family; a fear of losing control of feelings, that previous shameful group experiences will recur, that one will become tongue-tied or one's mind will go blank. These fears may evoke hiding tactics such as irrelevant talk, rapid change of group or personal topics, silence or confusion, pressure on the conductor to be controlling, and putting a group member in the limelight, with possible constructive or unhelpful consequences. Lear suggests that the fear in shame is that of abandonment, so that events of parting or departure in the group are likely to evoke past experiences of shame. The fear of abandonment and of being completely isolated is mentioned frequently in the literature on shame. Viewed in the

light of attachment theory, we might assume that the patient is anxiously attached to the therapist or group, and that this may be a repetition of feelings and anxieties evoked in earlier experiences. Seen in this light, it then becomes important that we try to foster a secure attachment to the group and to the individuals within it when we treat shame-prone individuals.

It is my own impression that patients who experience difficulties with shameful feelings frequently seem "impenetrable" to the therapist and other group members. These are patients who keep the therapist, and others, at a distance by

withdrawing, constant talking about trivia that does not yield to comment or interpretation, or other tactics which create distance. The danger is that premature attempts will be made to penetrate these defences before the patient is ready, which only increases resistance and shame, or leads to non-attendance or withdrawal from the group. It is important to recognise the fears behind these defences. Once penetrated, if this is premature, there may be no further defence

Someone must have slandered Joseph K. because one morning, without his having done anything wrong, he was arrested. *Franz Kafka, opening words, The Trial, 1925, tr. Willa and Edwin Muir, 1930.*

Alt. trans. Someone must have slandered Josef K., for one morning, without having done anything truly wrong, he was arrested. *Tr. Breon Mitchell.*

(The point, here, is that K. is arrested not because of what he has done (guilt), but because of who he is, and he is, with no warning, slandered, exposed and precipitated into a reality in which his defectiveness and culpability is obvious to all eyes. It is interesting that K.'s change of status seems to come as no surprise to anyone - certainly not to the other characters in the book, and, it can be argued, not to K. himself, as if K.'s underlying shamefulness had been obvious to all before the novel begins. Nothing that K. can do will change the judgement of others (or his judgement of himself?) and he is unable to find an explanation for his arrest because it concerns his whole state of being in the world, the fact that he exists at all. It is interesting that Eric Fromm discusses the "authoritarian conscience" in The Trial, whose virtue is obedience and greatest crime disobedience. These internal object relations to an authoritarian other might well be reattributed to a relationship to a shaming other).

against intense shame and humiliated exposure. The patient feels, and is, defenceless. In this situation, the only way forward is to help the patient to re-establish defences so that they can continue in the therapeutic process.

One subset of this type of patient is the group member who anxiously adapts to the needs of the therapist and group, attuning himself to the needs of the situation, rather than being able to explore his own needs and feelings. The transference relationship here may be towards a potentially shaming other who will criticise and be unable to tolerate any independence or demonstration of self-will or creativity, and the adaptation is one of presenting a subdued, uncreative, featureless persona that will not displease or provoke hostility.

Developmental Antecedents of Shame Experience

Most authors locate the origin of shame in early life and see the shame prone individual as being interrupted in a developmental process. Erikson (1950) states that a lasting propensity for shame and doubt arises from a loss of self-control and a corresponding "foreign" over control in the child's relationship with others. Thrane (1979) asserts that shame is debilitating when the child is a mere extension of the parent and is denied the opportunity for self-development. Kinston (1983) describes how the child is caught in a painful bind of either pursuing self-interests and development or being a narcissistic extension of the parent. If the child exists as himself, there is rejection and/or resentment in the parent. If the child complies, the result is a destruction of that child's experience and liveliness.

Demos (1983) describes three components necessary for the development of a healthy sense of self-esteem and which are often missing in the shame-prone child: 1) a sense of competence. 2) A willingness to trust inner experience 3) a feeling of relatedness or lack of isolation. When a child cannot develop these qualities there is a struggle with feelings of shame and/or a lack of a sense of self. Mollon (1984) asserts that a basic experience of shame occurs when the self reaches

True guilt is guilt at the obligation one owes oneself to be oneself... False guilt is guilt felt at not being what other people feel one ought to be or assume that one is. *R.D. Laing. Self and Others. 1961.*

Use every man after his desert, and who should 'scape whipping? *Shakespeare. Hamlet, 1600.*

Out, damned spot! out, I say! *Shakespeare. Macbeth, 1605.*

Guilt, n. The sense of sin as seen through your own eyes, as distinguished from shame, which is the same thing viewed through the eyes of others. *Edmund Volkart. The Angel's Dictionary: A Modern Tribute to Ambrose Bierce, 1986.*

Guilt is a private shame; shame is a public guilt. *Anon.*

out and is met with an unresponsive or uncomprehending maternal environment. This can also occur if the mother intrudes on the baby at a stage that is too soon for the baby to be able to tolerate and manage the stimulation. Mollon's view is that many patients who are particularly shame-prone seem to have controlling mothers who devalue the father and need to undermine the independence of the child in a variety of ways. This conceptualisation suggests that an experience of

invalidation and disconfirmation, which may not be restricted to the child alone, is the environment in which the shame-prone individual develops. In this environment, it is only possible for the child to internalise the parent in a context of a dependent, submissive, and admiring relationship. The child has to "be something" for the mother, rather than the situation in a more ordinary environment in which the mother accommodates to the child, and this leads to intense and painful feelings of abandonment.

Lear (1990) also suggests that shame and humiliation experiences are a result of early assaults on the self. Loss of an attachment, then, is accompanied by feelings of intense shame and disintegrative anxiety, since the inevitable conclusion the child draws is "I must be bad if I am rejected". In order for the child to be relatively shame-free it needs to attain a sense of mastery and self-control. The question of the secure formation of a sense of identity is crucial. The questions that arise, in the shamed state, are crucially questions of identity: "What is my identity?", "Whose is my identity?" and "What is my value?". It is unquestionably the case that a sense of competence, and of being able to value the self which this is based on, can only be attained, early in development, through contact with significant others who value the child and accept the child for what he is. This idea underpins, for example, the concepts of Bion's containing and Winnicott's holding, which have been the subject of much psychoanalytic thought and conceptualisation. The therapeutic implication is that a primary task of therapy is to aid and to foster a sense of being validated and valued when working with the shame-sensitive patient.

So live that you wouldn't be ashamed to sell the family parrot to the town gossip. *Will Rogers.*

Be not ashamed of making mistakes and thus make them crimes. *Confucius.*

The most important thing is to be whatever you are without shame. *Rod Steiger.*

We must also remember that significant caretakers may not be entirely at fault in fostering the development of the shame-prone individual. The evidence of, for example, baby observation shows that some babies are temperamentally more needy and therefore "difficult" than others. It is also true that wider family, sibling and community influences can have important effects on the developing child. Thus, there is a continuing influence, throughout the course of development, on psychic structures

that may mitigate the experience of shame. If this were not the case it would not be possible for group therapy to influence a pathological sense of shame.

The identification the child makes with the parent, however, does seem crucial. In "On Narcissism", Freud (1914) was the first to discuss a type of pathology arising from a disorder of identification in childhood, resulting in faulty identification with others and an associated idealisation of the self. This type of difficulty might now be conceptualised as a type of narcissistic disorder. Fairbairn (1952) writes specifically about identification and the shame experience seeing a connection between shame and a repeated experience of being in relationship with a "bad object". Since a child's feelings about himself are determined by identification, he comes to feel that he is himself bad if he experiences his parents as bad or even shameful. Loving feelings may then, by association, come to be seen as shameful and bad.

In clinical work with families in distress, parents are often seen who shame their children for their weakness, ineptness, messiness or badness. Such perceptions often seem divorced from the reality of the child's behaviour and actual misdemeanours and there is often a lack of empathy on the part of the parent for the child's suffering under their assaults. It is easy to understand that the sins the child is accused of are actually based on the parent's disowned feelings and impulses. This is a form of scapegoating which may be repeated in the group, since the shame-prone person may naturally present himself or herself as a scapegoat. The nature of this repetition then needs to be understood before that individual can be freed, firstly from the sense of fault that is the basis for shame, and then the behaviour that causes the repetition of the shaming situation.

Broucek (1982) suggests that early forms of shame appear by the fourth month of life, coincident with facial

recognition of the mother and dependent on the internal disturbance experienced when the communication-ready infant finds that the mother does not warmly respond to his or her affect. Shame arises from, and later becomes differentiated from, the "acute distress state" of infants. This occurs when the infant expects responses to its own communications that fail to arrive, leading to disappointment and shock.

This acute distress state occurs prior to the emergence of the self as self-representation. Thus, for Broucek, shame appears at around the time that the baby is developing his identity and a beginning individuality. I am essentially in agreement with this, but I would place the antecedents of shame even earlier than four months. I will use an excerpt from a baby observation report to clarify this.

Baby Observation Extracts: Experiences of Fragmentation

Example One

I would now like to present two fragments from two separate baby observation sessions on the same child in order

Corporal punishment is as humiliating for him who gives it as for him who receives it; it is ineffective besides. Neither shame nor physical pain have any other effect than a hardening one. *Ellen Key, The Century of the Child, 8, 1909.*

Having been poor is no shame, but being ashamed of it, is. *Benjamin Franklin.*

A sovereign shame so elbows him; his own unkindness, That stripp'd her from his benediction, turned her To foreign casualties, gave her dear rights To his dog-hearted daughters - these things sting His mind so venomously that burning shame Detains him from Cordelia. *Shakespeare. King Lear.*

There smites nothing so sharp, nor smelleth so sour as shame. *William Langland.*

The god of soldiers, With the consent of supreme Jove, inform Thy thoughts with nobleness, that thou mayst prove To shame invulnerable, and stick i' th' wars Like a great sea-mark, standing every flaw, And saving those that eye thee! *Shakespeare. Coriolanus.*

to illustrate my thinking about the antecedents of shame affect.

First Observation

Becky is ten weeks old. She cries almost constantly throughout the hour-long observation. It is as if there is an internal source of persecution, which, despite the comfort her mother tries to provide, can only be temporarily, ameliorated. Her cries are shrill and the observer experiences them as increasingly intolerable over the period of the observation. The observer wonders how her parents are able to cope with such a needy and distressed baby day after day. They talk about their difficulties and the contrast with their relatively easy first baby.

During this session, the observer notices Becky, on a number of occasions, seeming to "hold" herself by focusing intensely on a source of light, either the light from the window or the light from the shade on the ceiling. She fixes her eyes on the light, seeming to "clamp" herself to it, as if glued to this distant object. The light seems the most important object in her immediate universe, and the fixed attachment to it has a quality of intense need and a desperate clinging to this object. It seems to the observer that she is trying to climb out of her physical body, the source of her sense of persecution, trying to lose herself in this external object. However, the adhesion to the light is easily lost; a slight noise, a slight change in the way her mother rocks her, breaks contact with the light. It is as if an invisible thread, willed into existence, its path following the

rigidly maintained link between eye and the source of light, had suddenly snapped. The result is a sudden shock, Becky's head recoils as if the string had been cut, Becky is "in body" again, and frantic and desperate crying ensues. The experience seems to be one of terror, fragmentation, shock, disintegration and disorganisation.

I would suggest that this experience is akin to shame: of suddenly experiencing traumatic loss of control, persecution related to non-holding and lack of containment, an experience of fragmentation and disorganisation, and perhaps most importantly the loss of connection with the needed object, plunging the self into a situation of aloneness and isolation.

People generally bear guilt more easily than a sense of inferiority.
Anon.

People in our culture have a morbid tendency to avoid blame, because they do not wish to take the trouble to change their conduct in any way: blame avoidance and blame-transference are therefore endemic amongst us. These are substitutes for repentance and renewal. *Behaviour Research Project (Texas), in Lewis Mumford, The Conduct of Life, 1951.*

We are all exceptional cases. We all want to appeal against something! Each of us insists on being innocent at all cost, even if he has to accuse the whole human race and heaven itself.
Albert Camus. The Fall, tr. Justin O'Brien, 1956.

Blame is most readily averted by being so much like everybody else that one passes unnoticed.
John Dewey. Introduction to Human Nature and Conduct: An Introduction to Social Psychology, 1922.

Becky seems to be experiencing abandonment by any containing object, deprived of comfort, she seems completely alone in the middle of a persecuting environment (does she locate this persecution inside, is there a difference between internal and external at this age?). In this state, she becomes "impenetrable", ordinary comforting is not enough, and the effort to contain her distress becomes exhausting for her parents. Her eyes had established a containing relationship with the source of light (rather than to her mother, perhaps eye fixation is here similar to the function of eye

contact when the baby is at the breast). Shame, in the feeding relationship, may relate, at this early stage, to a disruption in contact with the mother, when eye contact and the loss of a sense of connection with the mother is lost. It is interesting that there is good reason to suppose that Becky suffered from a powdered milk intolerance in these early months that made it difficult for her to feel that the the mothering she received was comforting, soothing, non-persecutory, and reliable. It may be the case that establishing eye contact and a pseudo-feeding relationship with a physical light source was a desperate attempt to soothe herself and to establish some external source of comfort that was more in her control than her own mother. When Soya milk was substituted, Becky suddenly, literally overnight, became a more contented baby who was much more able to use the relationship with her mother. It seemed to the observer that, from one week to the next, he was observing a different baby.

It is interesting that music also served a soothing function. The observer visited at the time when a popular soap opera was transmitted on TV. It was quickly noted by the observer that, on the occasions that the TV was on, Becky instantaneously responded to the first bars of the theme tune at the beginning and end of the programme. Even when she was in acute distress, she had been crying constantly for 20 minutes, and her mother's best attempts to soothe her had failed, she became entranced at the sound of the music, she directed her attention to the source of the sound, and she stopped crying. This occurred even in the middle of family bustle and noise, but it was not uncommon for her parents to respond to this with an almost mystical silence, as if something significant was happening, there was a sense that the silence should not be broken and there was a feeling of sharing in an important experience. Her mother told the observer that this music had seemed to calm Becky even in the

womb and she had told her husband, who had been sceptical, that her baby was responding in this way. Becky continued to respond to this theme music into the second half of the second year of her life, although more infrequently than before.

From my own struggles in learning to play an instrument I can say that one of the most important aspects of music is the presence of a reliable pulse, even if this changes, throughout the music. There is nothing that will more reliably destroy the listener's pleasure in a piece of music, even more than accurate intonation, than an unreliable or absent sense of pulse. Why should this be the case? My own thoughts are that pulse in musical performance performs the function of rocking, comforting, and holding, harking back to the basics of mothering in early infancy. Our early experiences, then, may well determine our likes and dislikes in music, how predicable we like music to be, how well we can tolerate complexity, ambiguity, unpredictability, and the presence of conflict and distress in music. How far are we able to wander from a secure base? Or, on the other hand, are we tied to a rigid and absolutely predictable base and unable to explore anything more demanding or different. To seek out music at only one emotional level seems impoverished, yet this may be the predominant mode of music-seeking in our own society, and perhaps this is partly influenced by society-wide influences such as marketing pressures and class identification (and the whole issue of identity: seeking to define an identity in one's choice of music, which group one belongs to, how music defines a certain type of self-concept, how choice is based on whom one wishes to identify - adds a further layer of complexity). And how much is a compulsive need to collect or catalogue based on a need to fill a neediness that is based on the lack of parental care giving in this early period?

Second Observation

Becky is 20 months old at the time of this observation. Shame, and blame, in this family, is associated with not showing that one is grateful, being "selfish", or wasting or refusing what is offered. This seems to be based on an anxiety that resources may not be sufficient and whether there will be enough to go round, but the result is an insistence on rigid patterns of sharing which can lead to difficulties in meeting the individual needs of the children.

In this observation, Becky refused to give up a toy to her brother David. Mrs M. insists that Becky give the toy to David. There is anger and criticism in her voice and manner. Becky screams, which takes the observer back to the early observations, since the quality of crying and her distress are similar to that I saw in earlier months. Her present experience seems to be one of shame in response to disapproval, feelings of abandonment, and rage towards the source of shame.

Example Two

The following observation is of a three-month-old baby. These parents had been very influenced by an increasingly popular text advocating creating strict regimes for the baby from an early age. Their persistent advocacy of this manual and approach could be taken to indicate a high level of underlying anxiety that was, however, concealed by an apparent self-confidence and definiteness of viewpoint – almost proselytising for this approach. The observer felt that

this self-confidence was a symptom of a persistent rigidity, concreteness of view, and an inability to empathise with the distress of their child and she felt that the imposition of a regime was a substitute for the lack of a real empathic ability.

On this occasion two relatives of Susan, the baby's mother, were visiting for lunch. Susan had prepared the meal and had just sat down with the guests

when her baby, Ben, began to cry. He had been left with his father in another room.

Although Ben's cries became piercing and distressing, and the observer felt impelled to respond to the baby and distressed at the stridency of the baby's cries, Susan was apparently unaffected and she sat until she had finished her meal.

Her only response was to comment, in an annoyed way, that Ben was angry and in a rage, as if this was not permissible and as if she had missed the level of distress that was also apparent to the observer. The observer reflected, afterwards,

Authoritarian organisations are past masters at deflecting blame. They do so by denial, by rationalisation, by making scapegoats. *Norman F. Dixon. On the Psychology of Military Incompetence, 1976.*

Ah! Take flight away from human sight, go, find some consolation! Shall I stay? Shall I climb the grey hills in fearful desperation? Through this world I seek in vain, and my grief wins no relief for all my bitter shame, while the servant wins a traitor's name. *Translation of text to J.S. Bach's St John Passion, by Peter Pears and Imogen Holst from the recording by the English Chamber Orchestra conducted by Benjamin Britten. (Tenor aria following Peter's thrice-repeated denial that he knows Jesus. In the bible, shame has the power to be destructive unless it is overcome by seeking forgiveness. It is most often experienced when an individual has acted against God. So, in the New Testament, St. Peter is ashamed after he denies Christ, but he is able to accept God's forgiveness. In contrast, Judas Iscariot, who betrayed Christ to the authorities, was unable to seek forgiveness and was driven to kill himself as a result).*

There is a shame that bringeth sin, and there is a shame which is glory and grace. *Ecclesiasticus 4:21.*

that her partner seemed to feel that he had to cope with the baby by himself and had no permission to interrupt Susan's meal so that she could take care of the baby.

The observer went to the adjoining room to continue observing the baby and was told by Daniel, the baby's father, that Ben was probably hungry. However, he seemed to feel that he could not interrupt Susan to satisfy the baby's need. Ben's cries became increasingly insistent and distressed.

When Susan eventually emerged Ben was too distressed, initially, to take the breast. After an attempt to calm Ben by singing to him (an oft-repeated song that the observer felt often had a quality of being imposed on Ben in an intrusive way rather than responding to him), Susan told him, angrily, to "Shut Up".

The above is just one example of similar situations during the course of this observation. Susan seemed to view her baby's needs and Ben's expression of these needs as manipulative. Her view was clearly that, if she gave in to the baby's demands, she would "spoil" the baby and only increase these demands. She seemed to view Ben's distress as wilful, aggressive, and manipulative.

One can only hypothesise about the likely effects of such parenting, but it seems not unreasonable to conjecture that this baby has a high likelihood of feeling ashamed of neediness since his mother could not allow him to express neediness and she was unable to respond to his needs in a simple and direct care-taking manner. In later life he might well become an adult who feels ashamed of being needy (but who is also vastly

needy) and who tries to conceal these needs through a variety of defence mechanisms.

The Potential Space and the Therapeutic Process

It seems, to my mind, to be the case that the shame-prone person has never acquired an effective transitional object, and there is therefore a deficit in the area of the transitional space. I will argue that the primary aim of therapy with these individuals is to facilitate the creation of an effective transitional space. This implies the creation of a presence where there was previously an absence. I understand this in terms of Guntrip's description of non-relating as "the presence of an absence" and his descriptions of the internal world as being populated by dead objects in the schizoid state (Guntrip, 19). The task, then, is to populate the internal world with more vital and alive objects by providing relationships in the group that "get inside" and revitalise the personality. It also implies that there is a new ability to play. I will argue that shame is the primary affect underlying disorders of the self, the primary emotional reality we relate to in these disorders, and that we need to understand and affect if therapy is to be successful.

The concept of the transitional object is closely tied to a number of other psychoanalytic concepts. It is, for example,

Man is the only animal that blushes. Or needs to. *Mark Twain.*

Emotional Appeal: the attempt by advertising to stir up negative or positive emotions to motivate a purchase. Much marketing and advertising is geared towards creating fear, guilt, shame, love, pride, or joy in the potential customer rather than evoking dispassionate appraisal on the basis of objective criteria. *Dictionary of Business, Oxford University Press. 1996.*

Doth not even nature itself teach you, that if a man have long hair, it is a shame unto him? But if a woman have long hair, it is a glory to her. *1 Corinthians. ch. 11, v. 14.*

associated with the development of self-soothing capacities, which is in turn related to the idea of the "holding environment" in which a mother provides an effective holding relationship for the baby. Winnicott (1951) discusses the mother's capacity to provide this secure holding relationship in her role as the "environment mother" which enables the infant to find its self. Bion (1970) thinks about this in terms of containment, which concerns the mother's internal processing of the infant's anxiety. Holding is therefore an interpersonal process, an "arms around" relationship in which, if all goes well, the baby is able to take it for granted and just "go on being". In this way, the baby is able to build up internal objects, based on introjection of aspects of the caring relationship it has been exposed to. The relationship with the environment mother thus enables the baby to build a sense of self and to develop a relationship with a transitional object, "the first not-me possession". By interacting with the transitional object, the baby can act as if it is in full control of its mother. However, when child rearing emphasises the needs of others at the expense of the self there is a discrepancy between the true and the false self. A suppression and denial of the true self then occurs.

Although the concepts of containing and holding are descriptions of similar processes in therapy, there are important differences. Winnicott (1965), for example, says that a therapist often conveys "in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced", but with more disturbed patients "the main need is for an unclever ego-support, or a holding. This "holding", like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to fall for ever". Bion's concept also relates to an early stage of development in which the infant uses methods of communication that predate the ability to

think. It is a more active concept than that of holding, and Bion talks about the need of the mother to process the infant's communications and to turn it into thought. The process of giving meaning to unverballed and unprocessed communications is important here, involving the eventual formulation of an interpretation which gives the patient a feeling of being understood and therefore contained.

By the time that the transitional object is formed, the mother's soothing abilities come to be part of the self. A sense of mastery and competence comes about as a result of the mother responding to the infant's cry - it can then connect its own activity with relief from distress. If all this is adequate there occurs an internalisation of comforting functions, the gaining of ego defences against anxiety, and the development of basic trust. A situation, which is able to evoke a feeling that the environment is basically trustworthy, may well be the most significant aspect of this developmental phase. Trust comes from a sense of being held, an understanding that there is a "being held", and a belief that relationships will contain, and be willing to contain, anxiety.

This may be thought of as related to the development of a "potential space" in which inner and outer realities can interact, and where there is a sense that an outer world, separate from the self, exists (Winnicott, 1975). The child displays this potential in demonstrating the ability to play symbolically, which can only occur when there is a sense that the world is safe enough. The ability to play arises from the development of a transitional space. The necessity for relationships which embody trust is of major importance; without trust anxiety fragments attention and concentration and makes it impossible to play.

Therapy with the Shame Prone Individual in the Group

If we are to take the above seriously, it is clear that the holding environment of therapy is required to be different from that of childhood and/or that of potentially shaming interactions that are currently anticipated in working with the shame-prone individual. We may be thinking here about a patient who possesses little psychic space to play and who has to be helped to create the potentiality of playing, by creating an area in the mind or in the group that is playful.

The general aim, in therapy with shame-prone people, is to help individuals to tolerate the experience of shame, to accept it and to be able to share it with others in the group. This expression of shameful feelings hopefully assists in reducing feelings of isolation and the avoidance of closeness and intimacy that is part of the shameful experience. The aim of becoming completely shameless, which is a common wish and fantasy of group members, is of course unattainable, and persistence in this expectation merely fosters a cycle of wished-for perfection and ultimate shame.

A full understanding of the role of shame in groups can only be achieved when it is understood that the nature of the group therapy situation is that exposure is enforced, about what one says or does not say, about what one does or does not do, about what one is or is not. The group experience involves changing perceptions and calling into question ways of behaving and thinking, and patterns of attachment and relationship and this process may well evoke shame, but will hopefully create more self-awareness. However, shame involves a feeling of self-exposure, so that the chance of conflict between the therapeutic goals and the wish to conceal is always a potential. The group is an extremely powerful therapeutic force, which is intimately tied to its capacity to evoke powerful feelings of shame. If feelings of shame become

too intense, this may result in a stubborn and persistent negative therapeutic reaction.

Many writers have taken the view that, if faced up to and discussed, shame can be ameliorated in the group context, and that disclosure of shameful feelings is necessary for therapeutic success. Alonso and Rutan (1988), for example, state that reduction of shame sets the stage for better integration of self and a subsequent increase in self-esteem that furthers personal development. Lynd (1971) takes the view that "if shame can be fully faced, it can inform the self, and become a revelation of oneself, society and of the human situation". Although I am in broad agreement with this view, I also feel that, in some cases, exposure to the group process and to the disclosures of others may be powerful enough to dissipate shame without personal disclosure of shameful feelings. When there is a danger that shameful feelings will be too overwhelming, it may be necessary to let the group have an indirect effect in this way.

How, then, is the group able to be an effective instrument for modifying problems of shame? This is, of course, closely tied to the wider question of how the conductor and the group will be able to provide a "good enough", facilitating environment that is able to promote growth and development. Most certainly, understanding, empathy, and an active adaptation to the needs of the group members are requirements, and may be seen as constituting metaphorical and symbolic replacements of maternal care. In my view, what is important is the creation of an atmosphere that enables playing and experimentation with new ways of behaving, and in this process "interpretation" may be of secondary importance. The therapeutic setting may be said to provide a "potential space" for the group members, an intermediate area of experiencing that goes on between group member and group member, group member and conductor, group member and

group, allowing the emergence of a transitional process from which transitional objects and phenomena can develop along with a capacity to play. The use of language as an area of shared experience is an important aspect of this process - language that does not quite belong either to you or to me, but which belongs to the shared space of the group, in-between all group members.

Thus, the major function of therapy can be seen to be analogous to that of the primary mothering person in infancy. The group matrix is able to repair deficits by facilitating organisation and integration of various aspects of the self. The group matrix can also facilitate the attachment process and the associated increased tolerance of loss and separation.

To my mind, being able to facilitate and enable playing in the group is extremely important. What do I mean by "play?" First, that group members begin to question and then to modify their ideas about the world. In play, fantasy is allowed to mingle with reality. The group member is able to make up stories, twist, mould, or manipulate ideas. In doing this there may well be a sense of taking control over something that previously seemed uncontrollable. Play is the ability to modify, to experiment with, and to manipulate previously rigid ideas about the world. Part of this involves a change in perception of the group conductor and other group members, so that an individual begins to perceive that someone has some characteristics different from those previously assigned. A process which is likely to be curative of shame will involve a benign group experience in which expected criticism does not occur, and a feeling of being accepted, despite one's failings and faults.

A real advantage of group psychotherapy is the possibility of vicarious experience. Thus, the group member can learn that others share feelings and a sense of shame, without being exposed to overwhelming exposure. If the group is able to

become a benign and potentially benevolent experience, the group member may eventually be able to reveal his shame. Theoretically, the therapist can assist through his clarification, enlightened judgements, and forgiving acceptance. Acceptance by other group members may help in that they talk about their own difficulties and this makes the group process easier and less daunting. Alonso and Rutan (1988) suggest that, since shame is related to loss, the enforced constancy of membership creates courage and the possibility of re-establishing empathic contact if this is felt to be broken or withdrawn. This constancy provides the opportunity for a corrective emotional experience. They also suggest that the group provides an opportunity for empathic mirroring and acceptance in which self-esteem can grow and that self-esteem is also enhanced by the fact of having membership in a valued community. In this way, tolerance for the imperfect self grows and shame comes to be seen as part of the human experience rather than as a painful, corrosive and demeaning experience.

Group members who are prone to experience shame frequently come from families where shame, scapegoating and other traumatising dynamics are endemic. A proportion of these individuals will have continuing life experiences of being victims of others, of being blamed, humiliated and shamed in relationships. In a group, other group members may then enter into a particular type of relationship with these individuals, based on a scapegoating dynamic - scapegoating in group contexts can be understood as an attempt by the scapegoaters to deny and to attack a hated part of the self, acknowledgement of which cannot be tolerated. Group members attack another group member who "stands in" for their fear of and anger towards their own passivity and victimhood, and there is blaming and shaming of the group member who is the recipient of projections.

Anna Freud first discussed the defence of identification with the aggressor, and this may well be another aspect of the above situation. The aroused hostility and aggression towards a scapegoat in the group can be disturbing and unsettling to all concerned, since the attacking group members cannot avoid their aggression, and who may feel shame about their behaviour. The group container may become shame-full, which may well hinder open exploration of group processes and dynamics. If there is able to be an honest acknowledgement of feelings of hostility, anger, shame and guilt, and an exploration of roles and identifications with the aggressor, victim, abuser, or bystander, the group can become a learning experience of enormous potential.

Such exploration of the scapegoating dynamic may well not be easy to achieve. Tantum (1996) suggests that when aggression in a group becomes particularly stuck, as in the scapegoating of a group member, it may help if the conductor redirects the aggression back to himself. However, he adds that expressing direct anger towards the conductor is one of the most difficult things to achieve in a group and the conductor's management of this will be important in terms of containing feelings and modelling the management of difficult feelings in the group.

However, there are some potential dangers in the group treatment of shame-prone individuals. These difficulties arise when mirroring is not experienced as empathic but as intrusive and shaming. This can easily occur and the therapist must therefore be constantly aware of the possibility of fuelling "malignant shame" which may become an enclosed system that may be difficult to breach or influence. The literature points to the potential difficulties in treating these patients. Mollon (1984) says that the failure to take account of shameful feelings may seriously impede successful psychotherapy. He warns that a therapeutic stance that is oblivious to the

pervasive role of shame in narcissistically disturbed patients tends to provoke a sado-masochistically tinged relationship and a therapeutic stalemate in which the patient is constantly struggling to master narcissistic injuries unknowingly inflicted by the therapist. Goldberg (1988), in an important and significant paper, states that a "therapeutic misalliance" may be due to the clinician's slowness in recognising that the patients suffering is deriving from shame, and that therapeutic attitudes based on an explanation of psychopathology as being caused by "moral masochism" may shame the patient into therapeutically stultifying, pseudo-guilty confession. He says that low self-esteem subjects, especially, are not helped by attempts to expiate their unconscious guilt.

Rosenfeld (1978) provides further help in thinking about managing persecutory transferences. He writes:

“When this primitive superego is projected onto the analyst and he interprets destructive aspects in the patient which are clearly shown in the material, in dreams and in projection into other people, the patient is overwhelmed with anxiety because he hears the analyst saying that he is 100% bad. This threatens his whole self with death, disintegration, and madness, for he will try to find omnipotent ways of escaping from this danger. The patient in this state is unable to think about his own problems and impulses because he has lost the capacity for self-observation, and all his attention is focused on the analyst who, in the patient’s perception, sees the patient as extremely bad and destructive. To defend himself against this catastrophe the patient becomes icily defensive; in addition, he identifies himself with the primitive superego and accuses the analyst in a very violent manner. The patient is

severely shocked in this situation because interpretations have a terrifying effect on him; he feels that the analyst, like his mother, had not been able to introject and understand the patient's projected primitive superego. At that moment the process of projective identification gets out of hand and a transference psychosis becomes manifest where the patient misperceives the analyst and sees her as his superego".

Being "100% bad" is to feel intense shame. Although we cannot avoid the above dynamics in therapy, surely we have a responsibility to think about framing our interventions in such a way as to minimise the possibility that "malignant shame" or "transference psychosis" will emerge as a long term and chronic condition.

It is, unfortunately, very easy for the group conductor to put the group into "accommodation" mode, which may merely re-create the family culture of childhood for some patients. In a recent supervision session, for example, I heard that the co-therapy pair had thought that, in a group for the over 65's, a group discussion about dogs and dog food had been an "avoidance" of "real" issues. In this situation, an interpretation to the effect that the group is avoiding discussions of matters of greater significance may lead to the group feeling that it has to satisfy the exacting needs of the therapist. The resulting group climate may well consist of "accommodation" by the group members in order to avoid further shaming by the demanding therapist. It is really far better to "value" the communications of group members that are, in reality, rich communications about dependency, the need for relationships, loneliness and isolation. "Interpretations" are better directed to questions and comments about the importance of dogs, how it feels to have something dependent on oneself, etc. If the

therapist chooses to focus on group, or individual, symptomatology, rather than on trying to understand underlying causes, there is a danger that he will be experienced as reprimanding and telling-off. This may lead to a kind of sado-masochistic re-enactment in the therapy setting. It is possible to be experienced, not only as a matter of transference but also based on the reality of the situation, as being too intent on one's own therapeutic agenda, to the neglect of the client and their experience of their own world and needs.

What, then, should be an appropriate therapeutic technique in relation to shame? My feeling is that there are two clues that are helpful to us in finding an answer to this question. Since the worse frustration the shameful patient can feel is not to be understood, and since shame and humiliation are related to a failure in the mastery of the self, therapy must take care of these feelings and find ways of containing the distress arising from these difficulties as it occurs in the group context. A key quotation, to my mind, comes from Winnicott (1975) who wrote, "It appals me to think how much deep change I have prevented or delayed in patients in a certain category by my personal need to interpret. If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever". The key here is patience, humility and trust in the patient's innate capacity for growth. Of course, this is not always present or able to be utilised by the patient, but perhaps it is always present as a potential. However, a real attempt must be made to avoid premature, destructive exposure. This can be extremely difficult to accomplish in the case of the most sensitive patients we treat. The therapist must primarily attempt to build trust, which involves a demonstration of empathic understanding towards the patient. In this enterprise, there must always be an attempt to be aware of signs of shame and self-esteem problems such as

experiences of self-disgust and feelings of inadequacy and worthlessness.

Thus, it is important not to be in too much of a hurry when faced with a group member who is prone to experiences of shame because too sudden a confrontation with deep anxiety, particularly when someone on whom that individual is very dependent initiates this confrontation, can be a traumatic experience. Mollon (1984) recognises this problem when he discusses the problem of the patient developing a false self-formation, in this situation, in order to please and perhaps placate the therapist. Most importantly, it seems politic for the group conductor to take care in focusing on guilt-provoking emotions and behaviours such as rage or greed. Patients who are prone to experiencing shameful emotions often need a great deal of support in order to stay in touch with feelings of emptiness, despair, pain and anxiety, about which they may feel ashamed. To focus on their failings and weaknesses before they are ready and able to do this will only provoke further, and perhaps debilitating, shame. An initial focus, which achieves a balance between recognising essential strengths and also some weaknesses, seems a good starting point from which therapy can develop. The creation of a safe environment that is facilitating, unobtrusive and unwounding is, to my mind, the initial priority. Lear (1990) provides a more detailed discussion of how to respect and define defences, and how to discourage self-revelations too soon or too extensively, according to a judgement of what an individual can cope with.

Finally, what can be expected to be a successful outcome to the treatment of shame disorders? A common view is that that if the patient is helped to articulate and understand feelings of shame, these become increasingly tolerable and less overwhelming in intensity. Lear (1987), for example, tells us that experience can teach us that shame can have a positive value and that if these experiences can be integrated they can

be less alarming, and the associated feelings more readily contained. Tantum (1990) writes that "recovery from long-standing shame seems to confer a richness of personality and a depth of sympathy with others which may be admirable. When this stage is reached a symbol of shame may be metamorphosed into a badge of courage". My own thoughts are in agreement with this perspective: that the success of therapy will depend on the ability of the group conductor, the group, and the individual group member, to transform a negative, intensely shameful experience into something that can be viewed as a positive source of growth, self-knowledge and connection with others. Work on issues of shame in the group leads to an increased ability to give and receive, to be open and direct, to show concern and care, and to relate in a more "real" way, rather than from a basis of concealment. These changes, of course, produce healthier ways of relating to others. In pursuing these goals, the modality of group therapy seems to have a great deal to offer, since the heightened evocation of shame makes this emotion potentially more accessible to treatment than may be the case in individual treatment.

However, it may be that the main therapeutic factor is that the group member feels that he or she is able to join a community in which they feel that they belong and are accepted, and even intense shame is able to be understood, accepted, and most importantly, identified with by other group members. If the group can convey that shame is shared by all and the shame-filled individual is not rejected but an important part of a functioning group, that individual re-joins the human race. There may also be some repair of damage that may have occurred in childhood - if shame was evoked by experiences of non-contact and un-relatedness, a sense of belonging and being an important part of a group may, together with the analysis, be an important part of any healing that occurs.

There is a possibility, however, that this may represent an idealisation of group psychotherapy, and that all we can hope for is to be able to cope better with feelings of shame so that it does not occupy the whole picture and is not completely overwhelming of the self and its functioning.

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