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Shame in psychotherapy

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Summary

Like fear, shame can impede therapeutic progress. Shame is a self-conscious emotion which, like all other emotions, must be regulated continuously. It is powerful and mostly negative, as shame pertains to the evaluation of the self or identity. The occurrence of shame in psychotherapy is inevitable and its regulation should therefore remain a continual focus of attention.

Keywords: Shame, self-conscious emotions, psychotherapy, transference, counter-transference

When considering which emotions hinder progress in psychotherapy, I find fear to be most prominent followed closely by shame. But while every manual on psychotherapy devotes a lot of attention to fear, I find that there is too little focus on shame. In the literature, shame is a topic addressed primarily by psychotherapists with a psychoanalytical background (e.g. Lansky, 2005; Nathanson, 1992; Seidler, 2000; Wurmser, 1981). Shame, which is often mentioned in the same breath as guilt, often forms an emotion which hinders the progress of psychoanalytic psychotherapy or psychoanalysis. However, focus on shame is not the exclusive domain of psychoanalytical psychotherapy. When a client in cognitive behavioural therapy is asked to list his feelings on his thought record, this is usually done by asking after the six basic emotions: anger, fear, sadness, enjoyment, disgust and surprise (Ekman & Davidson, 1994). It is thought that every emotional state can be reduced to being happy, angry, afraid, sad or ashamed, with the latter being omitted by many so that only four basic emotions remain. So, in many cognitive therapies, shame is not focused upon. Holinger (2008, p. 428), expanding on the psychology of affect and motivation, calls shame 'similar to and different from the innate affects'. However, shame is often an explicit focus of social workers involved in multicultural social services to help them understand how clients from other cultures perceive and label their complaints (Gomperts, 2011). Shame is usually also an important point of focus in dealing with traumas or abuse (Cogiscope, 2011) or eating disorders (Campbell, 2008). So it is the case that shame receives attention in specific areas of social services.

When I consult the books most used in psychotherapy education, however, the specific dynamics

of shame are hardly, if ever, addressed as a potential hindrance to therapeutic progress. In spite of this, I maintain that shame plays a role in all types of therapy, regardless of the particular therapeutic approach taken by the therapist (Schalkwijk, 2015).

In this article, I describe shame as a specific type of emotion that is self-conscious and in constant need of regulation. In my opinion, shame is a powerful, generally negative self-conscious emotion that is associated with the evaluation of the self or the identity. In particular, a high sensitivity to shame that, as a personality trait, dictates one's emotional life can cause severe neurotic suffering. After sketching the inevitable occurrence of shame in psychotherapy, I will discuss how it is addressed.

Shame is a self-conscious emotion

Humans are driven by all kinds of emotions, including anger, rage, lust, intimacy, interest, shame and pride, and we must manage to streamline all of these emotions. We are involved in a constant process of emotion regulation, as each emotion we experience prompts us to react (Lichtenberg, Lachmann & Fosshage, 2011). This reaction, however, is just as emotionally loaded, which, in turn, elicits reaction and emotion. This mechanism of emotion regulation is a dynamic process in which constant adjustments take place. The reaction to an emotion sometimes takes the form of concrete behaviour, but an inner reaction on its own is just as common. The psychological development from infancy to adulthood and adult functioning can be seen as a constant regulation of a never-ending flux of successive emotions. Someone seated in a church pew at the funeral of a colleague who feels the urge to cry can react to this by gently shaking his head and lightly resisting in an attempt to shake off the tears, or he can also give his thoughts free rein and suddenly re-experience the sorrow at the passing of a beloved grandmother four years prior, and this sorrow can then lead to dissatisfaction with his relationship with his partner, who has recently become distant.

The views on emotions in various psychological theories are progressively converging, as evidenced, for instance, by how neuroscientist Damásio (2010) defines emotions. According to Damásio, emotions are complex, largely automated action tendencies that

have arisen over the course of evolution. Most emotions have a specific, universal facial expression. The world of emotions takes place within a continual succession of activities at a purely physical level, which is then often supplemented by all kinds of cognitions and feelings associated with these activities.

When we experience an emotion, we observe processes that take place at the neurobiological, cognitive and intuitive level. Some emotions are characterized by the simultaneous awareness of these three aspects, but this is not always the case. Sometimes the physical awareness is dominant, as in the welling up of tears, while at other times the instinctive aspect is dominant, as in the sorrow regarding the deceased, beloved grandmother at the funeral. What Damásio calls evolutionary automated action tendencies is described at the individual level in psychoanalytical theories on emotion regulation and marked mirroring (Fonagy, Gergely, Jurist & Target, 2002). A translation of such action tendencies is the attachment style that has been internalised in the implicit or procedural memory (Jurist, Slade & Bergner, 2008). A child's earliest development is largely dominated by the regulation of emotions such as pleasure, surprise, fear or anger.

While the last two paragraphs dealt with the so-called basic emotions, the discussion of shame takes us into the domain of self-conscious emotions in which the focus is the perception of the self (Tracy, Robins & Tangney, 2007). Self-conscious emotions arise as a result of relatively complex processes and are less imbedded than basic emotions in biologically determined reaction tendencies. Self-conscious emotions can only emerge when the toddler has formed stable self- and object representations and developed a theory of mind and a reflective capacity. In other words, self-awareness must be present, which can be expected between 18 to 24 months. Self-orientation can be a contributing factor in a basic emotion such as fear or sorrow, but self-awareness, internalised self-representations and self-evaluation are prerequisites in the emergence of a self-conscious emotion. And, in contrast to basic emotions, self-conscious emotions are not associated with universal facial expressions.

Self-representation can pertain to the strictly individual self, but it can also refer to who someone is in a

relational, social or cultural context. This is the theoretical distinction between intrapersonal and interpersonal self-representations, which is probably comparable to what Modell (1993) calls the private and public self. In social psychology, self-conscious emotions are said to make it easier to achieve complex social goals: everyone wants to maintain their social status or avoid rejection by the group (Tracy, Robins & Tangney, 2007). Self-conscious emotions lead to behaviour that promotes the stability of social hierarchies and enable the restoration of balance after a line has been crossed.

Of all self-conscious emotions, shame is the most powerful because someone cannot detach oneself from it. Accordingly, in clinical practice, the phenomenon of 'signal shame' (in line with 'fear of fear') is occasionally observed. This is when someone feels ashamed in anticipation of the shame he is afraid he will experience. Shame is expected when the inner self and object representations are biting or critical, while guilt is more likely in the case of strict representations. One usually feels guilt coming on, while shame is sudden and feels like a loss of control. One moment someone is unscrutinized in his own world, and the next moment he is the object of evaluation. Someone often experiences this as though the eyes of the other make him ashamed, but it is usually above all the eyes of the internalised early object relations that make him ashamed. Nearly all scientific theories on the distinction between shame and guilt make use of the definition of Lewis (1971): shame calls the self or the identity into question (*Who am I, if I do, think or imagine this?*), while guilt involves an evaluation of the action (*Who am I, if I do, think or imagine this?*) It should, however, be noted that shame and guilt can occur simultaneously in daily emotional life. Yet research again shows that guilt mixed with shame is more inhibiting than shame-free guilt. Shame is contagious (Tangney & Dearing, 2002).

There are different ways of describing shame. Attribution theory research shows a number of evaluative thinking steps that determine whether an emotional observation leads to the specific experience of shame (Mills, 2005). Whoever feels ashamed appropriates the situation in which the emotion arises ('I'm connected to it') and describes this experience in rough, broad and stable self-attributions ('I'm some-

one who always...'). In comparison, whoever feels guilty also appropriates the situation, but then describes himself in temporary and specific self-attributions ('this time I didn't do something right...'). In psychoanalytical theory, the occurrence of shame is often explained phenomenologically: someone is ashamed when he suddenly feels scrutinised and the natural state of being without being conscious of this is broken. At this moment, he experiences aspects of himself that he would rather be rid of because they call the self, the identity, into question. There is an enormous disappointment in himself based on the experience that what you are really like is so far removed from what you had wanted to be (the 'ideal I'). The cohesion of the self is now threatened because, when you reject and want to get rid of the aspects to which you attach a negative value, you are also getting rid of an actual part of yourself.

From the perspective of developmental psychology, there are early precursors of shame in the process of attachment and emotion regulation. The disappointment of the baby when there is a failure in emotion regulation by the mother, leaves the baby to its own devices and can lead it to avoid contact with the mother because it expects to fall short in eliciting consolation and encouragement from her. The subsequent toddler phase is dominated by finding a balance between wanting to do something oneself, autonomy and maturity, on the one hand, and wanting to be taken care of, taking shelter and immaturity, on the other hand. In this age group, there are innumerable possibilities for failing and feeling ashamed. At this stage, shame usually still occurs in relation to the parents and in relation to actual, concrete behaviour, but some shame regarding expectations also already begins to emerge. This is certainly the case during the preschooler phase, when the preschooler wants to explore and conquer the world and has oedipal fantasies. He may now also feel ashamed about what he wants and what he fantasizes, regardless of what he does in physical reality. Starting in latency, the development of shame is dominated by the increasing cognitive abilities. In puberty, the place of psychosexuality, i.e. the perception of sexuality in one's imagination, is taken over by the capacity for actual sexuality, which leads to a strong physical self-awareness with comparable possibilities for shame about desires and fantasies.

Pathological shame

Similar to how one person may have more of a tendency than another to become angry, happy or pessimistic, people also differ in the degree to which they have a tendency to experience shame. Natural temperament, neurophysical thresholds, parental interaction and cultural imbedding all contribute to the development of this. Some people are so extremely sensitive to shame that they almost whisper while picnicking in a city park, while others are so extremely shameless that they blast their iPod through speakers in the same crowded park. Many of our clients fall between these two extremes and, in their therapy, shame will primarily occur as a temporary emotional state and then go away. Clients who are moderately shame prone will experience it primarily as an emotion that comes and goes without leaving much of a mark. In so-called bypassed shame, the intensity of the shame is proportionate to the event that caused it. However, when a client is extremely shame prone, this is regarded as a personality trait. This consequently determines to a large extent the client's outlook on life and, unfortunately, usually not in an optimistic way. The proportionality between the event and the intensity of the shame is disturbed: the client experiences more shame than is to be expected in connection with a specific event. In the most extreme case, feeling ashamed has become a prominent aspect of emotion regulation, meaning that this personality trait has permeated the individual's 'entire' emotional life. In some clients, this interplay is so powerful that it brings about pathological shame at a toxic level, which is accompanied by all kinds of psychological symptoms. While shame can have a positive effect, such as when it acts as a sign that unpleasant feelings are on their way, the negative effects usually dominate: inhibition, introversion, reduced empathic capacity, fear of losing control and suchlike.

Pathological shame is usually not related to actual events or temporary thoughts or fantasies, but is associated with unconscious, long-standing convictions and unconscious fantasies about negative self-esteem; inadequacy and not being worthy of love (Rizzuto, 2008). The unconscious fantasy is a combination of a number of connected thoughts the client has about himself that constitute the description of the self or the identity. The

development of this collection of thoughts begins with the development of language and self-image, at around eighteen months, and functions as a psychological backdrop against which all input is observed, stored, interpreted, remembered and answered. The unconscious fantasy provides the child a solution for everything: regardless of how conflicting desires, needs or emotions may be, security, self-respect and a perception of identity is nevertheless achieved by relating these to the unconscious fantasy – at least as long as this fantasy is relatively healthy and not too neurotic or pathological. Examples of a pathological fantasy include: 'My parents exclude me because I am filthy and disgusting' or 'People will keep liking me if I blame myself.' (Stroeken, 2008). An unconscious fantasy is pathological when it is not based on a realistic perception of actual events from the past, but rather on causal explanations that the child has constructed to cope with feeling associated with disappointment with or exclusion by the parents. The main source of shame is the unconscious fantasies that are associated with a self-image in which the child is a yearning and frustrated hero with an emotional message for the parents, who then do not adequately respond to this message (Rizzuto, 2008).

The inevitability of shame in psychotherapy

From the above, it is clear that the psychotherapist must focus not only on the basic emotions, but also the self-conscious emotions. Psychotherapy is a prime example of a situation in which self-conscious emotions appear that are associated with self-esteem or identity. What we experience and how we impart meaning is what and who we are.

Our psychological apparatus is in a continual flux of emotion regulation, with a tendency to maintain a pleasant, neurotic or pathological balance. In other words, while the client is in therapy to change, the emotion regulation mechanisms are simultaneously working against this. This is nothing we didn't already know: we attribute this resistance to the basic emotion of fear. From the focus on shame, however, I assume that self-conscious emotions are also continually evoked in the pursuit of change. The emotional appeal from the therapist makes the client aware of his feeling of self and self-conscious emotions emerge. Shame, in particular, which can damage self-esteem or lead to self-criti-

cism, prompts the emotion regulation system to employ defence mechanisms.

The inevitable occurrence of shame in psychotherapy can be understood by means of the analogy with the system-theoretical distinction between the content and relationship aspect of communication (Watzlawick, Beavin & Jackson, 1967). In psychological life, self-conscious emotions are always active at the same time as basic emotions, with the self-conscious emotions as it were constituting the relationship aspect: 'How is what I feel in therapy related to who I am?' In the emergence of a self-conscious emotion, one takes a third-person perspective: '... that part of the mind that speaks to us as its object' (Bollas, 1987, p. 42). This process of imparting meaning can also occur via the non-conscious or the dynamic unconscious. Therefore, regardless of whether the content is about actual traumas, depressive symptoms, phobias or fantasies, the client will always evaluate it with respect to self-perception.

Does the experience of shame require another, someone through whose eyes you see yourself and then feel ashamed? Theoretically, this is not the case, because you always experience shame both through the actual eyes of the other and the internalized parental eyes of infancy. On the other hand, neurobiological research shows that the specific physical phenomena of shame occur primarily when indeed another is present (Gruenewald, Kemeny, Aziz & Fahey, 2004). In this regard, recent research on shame and guilt is also interesting, in that it draws a distinction between an intrapersonal and interpersonal aspect, with corresponding cognitions and feelings (Fontaine et al., 2006). Intrapersonal shame is characterised by feelings of powerlessness and impotence, and by suffering from the situation that has caused the shame. I can thus imagine that even internet therapy can evoke shame as the experience of intrapersonal shame does not require the presence of others. In interpersonal shame, the primary issue is that the client feels scrutinised. He wants to disappear from the situation, have the earth swallow him up or hide.

Interpersonal shame occurs in treatment because, apart from the theoretical treatment framework, every treatment takes place in an intersubjective context (Orange et al., 1997). This intersubjective process between the therapist and client has the character of an open, interactive and communicative system. The system

theory tells us then that the therapeutic couple – just as every system – seeks homeostasis. Whether they want to or not, they strive towards maintaining the existing balance, regardless of whether this balance is pleasant or unpleasant. In several ways, therefore, shame inhibits the change the client professes to seek: intrapersonal shame causes the client to want to avoid a confrontation with emotions, but the interaction between the client and therapist also arouses interpersonal shame on top of this. Given that the psychotherapist also regulates his emotions in this respect, I think that both the client and psychotherapist strive for change in the client at the content level, while at the relationship level they enter into a dynamic in which change is in fact resisted. They end up in what Mitchell (1997) calls the transference-countertransference matrix.

The more the patient is challenged to probe his emotions and thus become emotionally unsettled, the more important it is that the therapist devotes attention to the occurrence of shame and its effects on how the client perceives the therapist. Incidentally, the same applies with respect to the use of humour. I like teasing during therapy and usually say it when I do so. Nevertheless, humour is only possible in therapy when there is a good working relationship and when the teasing avoids issues that could be experienced as shameful at that moment.

Clinical practice

In my daily work, I am continually on the lookout for the occurrence of self-conscious emotions. If, for example, a client begins the very first session by saying that my house number was difficult to see, it is quite plausible that this is an expression of excessive aggression. But seen from the perspective of regulating shame, I can also suppose that this striking opening line says something about his way of dealing with shame about having to look for assistance: "Since your nameplate was so hard to see, I had to make it overly clear to everyone that I was looking for where I had to be." Is the client primarily very aggressive or is his desire to ward off shame most dominant? The following anecdote describes an exceptional start to therapy, as the client immediately throws her shame into the open.

Lisanne, a 21-year-old student, expresses her shame as follows: 'As you can see, the way I move

is weird,' she says as she plumps into a chair. 'I put my bike in the rack across the street. I didn't think it'd be nice to block the sidewalk in front of your house. But when I crossed the street, some bleached blonde girl made a big show of parking her pink scooter on the sidewalk at your neighbours.' I notice her implicit mention of a girly girl shamelessly appropriating space with her scooter. She continues: 'I'm so painfully aware of my posture when I walk. Your neighbours must be thinking, "Why is someone with such a funny walk going to a psychotherapist when she should be going to a physical therapist?!" Now, she is describing shame about her gait and the need to go into therapy. Somewhat later she says: 'When I'm on my bike, I look at and judge everyone. At a red light, I can utterly annihilate other women in my thoughts for their appearance or clothing.' Again, she's probably talking about shame, where the cutting criticism of others is probably meant to cover up cutting self-criticism and shame about her own shortcomings. She looks at others in the way in which she continually looks at herself. Within the span of five minutes, her problem with shame has come fully into the open, but – knowing how fragile this probably all is – I will definitely not delve into it during the first session.

Intense shame damages the freedom of thought and feeling, particularly when it is accompanied by low self-esteem and absolutely when it is confused with a feeling of guilt. In long-term therapy, it is possible for unconscious shame to once again become perceptible. Memories resurface of the traumatic childhood feeling of being teased, being shy, blushing or being picked last in games at school. When these memories occur, a connection with one's sense of self can be made. In Lisanne's therapy, this transpired as follows:

'That must have been an awful experience for you. You wanted so much to belong, but you still weren't invited to Elsenoor's party. And, at the time, you knew for certain that you weren't invited because your mother often came to pick you up from school drunk and this had such a negative impact on your status in the class. You were, in a way, seen as the drunk girl. The fact that this made you withdraw doesn't surprise me.'

This is how I present my hypothesis to her that there is a connection between the shameful perception of her mother and her incorrect translation of this to a sense of self as though she herself was the drunkard.

Somewhat later, I could say: 'I think that you turned around feeling ashamed about your mother into feeling ashamed about yourself. Why would that have been necessary?' This is a cognitive aspect in psychoanalytic psychotherapy: trying to see that old thought in a new light. It is also an intervention that challenges Lisanne to examine the warding off of painful feelings of powerlessness by now actively excluding herself in social situations or, in fact, acting nasty towards girlfriends. But she might also be warding off disappointment and anger towards her mother due to her alcoholism, which would lead to a feeling of guilt in Lisanne.

This way enables anger to be discussed in the transference, such as when a client says he is disappointed in me when he notices that I have forgotten his birthday even though he had talked about it during the previous session. Sometimes, beneath this anger, there is also a kind of shame that he doesn't matter in my world, which has become apparent with my forgetting and then his disappointment that he doesn't occupy a certain position in my life.

My continual focus on the regulation of shame and guilt has led me to adopt a different working method over the past years. My approach is apparently quite consistent, as this was even pointed out to me a while back by a client. An analysand told me more or less the following: 'You know what I've noticed? Every time I say something shameful, you don't focus on what I'm talking about, but instead you first ask me how it feels for me to tell you this.' He is exactly right. My analysand had indeed discovered an important step in my modified method which, up to that point, I had not been so aware of: I work a lot in the area of shame and guilt as evaluations connected with self-perception. So I am continually looking at someone's perception of himself while he is describing something overt and concrete or a feeling. This creates a new area in the therapy, such that the therapist can switch between manifest and latent content as well as manifest and latent self-perceptions.

In this way, someone can feel guilty at a conscious level while further evaluation reveals that this guilt serves to ward off shame. The pain caused by shame is then covered up by the less painful guilt. I saw this, for instance, while treating a student who repeatedly made a proper mess of his study planning – from not

attending lectures to waiting too long before studying for an exam and even showing up a day late for exams on multiple occasions. He felt extremely guilty about this and formulated this clearly: 'What is it about me that I get myself into so much trouble? That's something I really have to figure out now.' Unfortunately, he didn't make any progress in this regard. His behaviour did not change and he continued to sabotage his studies. Therapy was at a standstill until it dawned on me that shame can be warding off by guilt. In his case, he could nullify guilt about waiting too long to study – or at least intend to nullify this guilt – which is less painful than experiencing the shame that he is afraid of finding out that he is not smart enough to pass an exam or to study, especially when compared to his talented older brother and sister. Up until that point, all kinds of interpretations about him actively sabotaging himself, selling himself short and other such things had not hit home, but after he was able to recognise the shame he could better understand these mechanisms as a protection against the fear of failure. The same mechanism can sometimes be observed in a victim of domestic violence. In order to cover up the shame that she has chosen a partner who is violent and that she is someone who allows herself to be hit, the fantasy emerges that she herself is guilty of the violence: "I provoked him."

Once I've grasped someone's style of dealing with shame, I often recognise this at unexpected moments. When a client whom I see as someone who has a tendency to ward off shame by directing anger towards others tells me that she had become unreasonably and incomprehensibly angry at her partner that morning, I explore, for example, the possibility that this was the result of having felt caught in the act by him, or at least having felt ashamed in his eyes. Later during the session, after this client had told me about having had fantastic sex with a stranger, it became clear to us why she had suddenly blown up at her husband, who had done nothing wrong at all.

Shame also always plays an important role in narcissistic dynamics, though the form it takes can differ enormously (Schalkwijk, 2011). Shame and narcissism have a corresponding psychodynamic: just as with narcissism, the feeling of shame often involves turning away from the other. Shame is a prime example of an emotion in which the focus is directed inwardly. The more someone is sensitive to shame, the more self-eval-

uation becomes a devaluation of one's own identity. It may well be that someone fails with respect to an ideal, but the feeling is about who someone actually is instead of that ideal. In the case of hypersensitive narcissism, an excessive amount of shame is often present. In these individuals, the shame primarily occurs when someone finds that someone approaches them as unfriendly, inconsiderate or selfish: their fantasized notion of their maturity or completeness is unmasked. The more someone is sensitive to shame, the more the shame can generate anger. This can be directed either towards the individual himself, leading to self-devaluation, or towards the outside world. In the treatment of the hypersensitive type of narcissism, shame is often easy to recognise and it is important to look for the hidden delusions of grandeur underlying this shame. In the case of arrogant narcissism, the "thick-skinned" narcissism, shame seems to be entirely absent and the individual is characterised by shamelessness. If the analyst succeeds in making a patient with such problems feel shame, this is an important impetus for resolving the narcissism. The rule of thumb is "shame is the enemy of narcissism."

My listening to shame is an extension of my focus on listening to the listening of the client, something that was brought to the fore by Schwaber (1983), amongst others. The patient can perceive all of my questions as an attack on his self-image. When a client exhibits resistance in his shame-specific way by, for example, withdrawing or in fact attacking me, I go back in my thoughts to potentially embarrassing interventions earlier in the session or in the previous session. This is similar to the technique in working with borderline clients: when they become angry, I ask them what I've done or said to arouse their anger in order to involve and regulate the anger in the transference. I actively ask them what I have said or done to activate self-conscious emotions in them.

Devoting attention to what the client perceives once his identity is at stake comes close to the technique that Steiner (2011) advises in clients emerging from psychic retreat. These clients are extremely alert to what can occur if they come out of their safe hiding place and enter into a relationship with the analyst. Steiner wonderfully describes how the client coming out of his hiding place is afraid and ashamed to be seen by the analyst and himself because it

means that he will lose the protection of his pathological organisation.

Concluding remarks

For most clients, going into therapy is a stressful step and they have often experienced a whole range of emotions about it prior to the first session. After all, they usually don't know what is in store for them. Some feel guilty because just by beginning therapy they are freeing themselves from a stifling relationship with a parent, while others are ashamed that they need assistance and feel belittled by the therapist in advance. During the intake session, I also devote attention to this aspect.

Once therapy has begun, giving shame serious consideration as a potentially hindering factor compels the psychotherapist – even if his work is symptom-focused – to also devote serious attention to the client's perception of himself, the therapist and the therapy. In a treatment method which does not deal with this in much depth, as part of a protocol-based treatment, for example, the therapist will at least have to make it clear to his client by means of small supporting comments or non-verbal facial expressions that he is aware that it is uncomfortable for the client to talk about his symptoms and expose himself in his irrational 'childishness.' Such interventions strengthen the working relationship.

Attention to shame helps us understand why a client sometimes only at the end of a number of scheduled sessions or after a long time in an open-ended therapy divulges shameful memories or symptoms. Naturally, he wants to postpone these kinds of disclosures for as long as possible, especially because they are so painful. This once again makes it clear why it is good practice to always stop treatment at a specific point and not suddenly on the day proposed by the client. It is specifically by offering room for reflection – even though this may only be by proposing at least one more session to wrap things up – that the client becomes aware that he still has a chance to raise a new issue which is the cause of suffering.

Paying attention to shame and guilt forces the client to reflect on his self-image. The hindrance to progress due to fear can be worked on by connecting it to the irrationality of thoughts and feelings, while working

on hindrance due to shame challenges the client to take an observational position with respect to the self. In my opinion, one of the main treatment goals is for the client to achieve a certain acceptance of himself and develop a self-soothing capacity. Whether the therapist's approach is symptom-focused or psychoanalytic, the ultimate common goal is that the client becomes autonomous. Insight gained into one's own self-conscious emotions strengthens the cohesion of the self and is therefore an important therapeutic goal.

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