

SHAME: COUNTERTRANSFERENCE IDENTIFICATIONS IN INDIVIDUAL PSYCHOTHERAPY

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Shame is a universal experience felt by patients and therapists alike. Yet, the experience of shame, with its profound sense of inadequacy and worthlessness, is anathema to the competent and compassionate self-image of most therapists. In order to help therapists understand their own shame and their countertransference identifications to patient shame, this article first describes the nature of shame, its developmental progression within interpersonal relationships, and the defenses commonly employed to cope with shame. Because the experience of shame involves the activation of devalued and devaluing internal representations, therapists may develop concordant or complementary countertransference identifications. These countertransference identifications are influenced further by the patient's primary reaction to shame, which includes withdrawal, attacks on self, avoidance, and attacks on others. Each of these reflects a habitual reaction to shame that is displayed in the patient-therapist relationship.

The experience of shame, which in its extreme form can be incapacitating and destructive, is a universal phenomenon felt by patients and therapists alike (Pine, 1995). As such, it has proved difficult for therapists to address, especially when the patient's experience resonates with the therapist's own unresolved shame, leading to countertransference identifications that complicate the therapeutic process. A clearer understanding of the nature of shame, its developmental progression within interpersonal relationships, and the defenses frequently used to cope with it, may help therapists understand and better manage their own countertransference identifications.

The Nature of Shame

Shame involves a complex combination of emotions, physiological responses, and imagery associated with the real or imagined rupture of relational ties (Lewis, 1987; Spero, 1984). When shame is experienced, internal representations become polarized into devalued and devaluing introjects, reflecting the rigid and immutable quality of shame where vivid images predominate, and words are used obsessively to condemn and to humiliate (Lewis, 1971). Because of the unmodulated affective intensity associated with introjects, individuals experiencing shame often are unable to contain both types of internal representations. As a result, one of these internal representations is externalized through projection or projective identification, resulting either in the experience of exposure to a condemning and devaluing audience or in the experience of contempt and envy of a devalued other (Morrison, 1989). Shame also includes a sudden and intense sense of loss (Alonso & Rutan, 1988; Piers & Singer, 1953). There is a loss of self-cohesion when aspects of the self (i.e., internal representations) are compartmentalized and externalized, resulting in a sense of emptiness. There is also a loss of object relatedness, due to the experience of being inade-

The author gratefully acknowledges his colleague, Peter Kahn, M.S., for his helpful comments and suggestions.

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quate in the eyes of a condemning audience, not for one's actions which would result in guilt, but rather for one's essence, resulting in shame (Lewis, 1988). This sudden and intense feeling of loss results in a profound sense of aloneness, emptiness, and abandonment associated with shame.

When faced with this excruciating experience, individuals enlist a wide variety of activities designed to protect the self from feelings of inadequacy and loss of self-cohesion, including narcissistic grandiosity, violence, promiscuity, social withdrawal, and a variety of compulsive behaviors (i.e., drug abuse, gambling, eating). These defensive activities develop over time to cope with the affective intensity of unassimilated introjects which are activated in shame (Lewis, 1987; Nathanson, 1994; Spero, 1984).

Developmental Progression of Shame

The amalgam of shame that is observed in psychotherapy includes elements from a host of previous life experiences and memories. In fact, some believe that shame is an innate affect characterized by averted gaze and facial blush, with eyes and head downcast (Tomkins, 1963). This early form of shame takes on psychological meaning as it is commingled with repeated childhood experiences with significant others, resulting in adulthood shame (Nathanson, 1992). Regardless of whether shame is innate or develops from experience, the child-caretaker interpersonal matrix is thought to play a fundamental role in infant brain development and in determining subsequent manifestations of shame (Schore, 1994, 1998).

Shame evolves through infancy and childhood as trust in an attachment figure is betrayed (Lewis, 1987). When the interpersonal environment between infant and caretaker fails to provide sufficient affective attunement, it creates a contextual experience where one's affective needs, and ultimately one's sense of self, are experienced as unworthy and shameful (Basch, 1985). Infant research has demonstrated that affective attunement, characterized by the caretaker's ability to match the child's experience but in a different modality, plays a crucial role in learning and in regulating emotions (Stern, 1985). Affective attunement organizes the child's internal world by providing an empathic translation of the child's activities, feelings, and thoughts into a modality that can be shared by both child and caretaker (Appelbaum, 1994). Disruption in this shared emotional experience contributes to a sense of

isolation and aloneness observed in shame (Basch, 1985). A similar pattern was noted by Broucek (1982), who related shame with the infant's disappointment in the caretaker's response to communication of pleasure. In other words, an early form of shame is triggered and evolves as individuals feel betrayed, alone, or disappointed within the context of interpersonal relationships (Nathanson, 1994).

Repeated emotional experiences with primary caretakers (either positive or negative) contribute to the development of characteristic ways of making sense of one's experiences. These organizing principles, which are themselves unconscious, play a persistent role in determining how later experiences are understood (Stolorow & Atwood, 1994). In shame, the repeated experience of misattunement is subjectively organized as a rejection of the self—of one's developmental longings and emotional needs. Rejection here refers to the subjective experience that follows a misattuned response. It may include punishment, misunderstanding, abuse, or neglect. Because rejection refers to a subjective experience, however, a misattuned response does not necessarily involve a conscious rejection by the caretaker. Most caretakers have relatively little knowledge of infant biological and psychological development and, therefore, may inadvertently contribute to moments of misattunement.

The subjective experience of repeated emotional misattunements contributes to the growing sense of unworthiness, inadequacy, and defectiveness associated with shame. These misattunements threaten the emotional bond between child and caretaker. An initial misattuned response creates a secondary longing for an attuned response that could provide emotional sustenance and restore relational ties (Stolorow, 1994). If this secondary longing is met with further misattunement, however, developmental yearning and affective needs, as well as the experience of inadequacy and unworthiness, are sequestered to prevent further disruption in what is now experienced as a tenuous relational bond. The developing child begins to react to new situations, rather than to perceive them as opportunities for new learning. Defensive maneuvers, such as the desire to hide or to release aggression, begin to evolve in order to protect the self from the awareness of developmental longings that have remained unmet and are now associated with an inherent sense of badness (Morrison & Stolorow, 1997).

In summary, the experience of shame evolves through repeated emotional misattunements with primary caretakers. In adulthood, shame involves an overwhelming feeling of unworthiness and a sense of condemnation. This results from the activation of internal representations which become intensely polarized as devalued and devaluing introjects. The self is experienced as inadequate, inferior, and defective (devalued introject) in the eyes of a condemning audience (devaluing introject). This excruciating experience triggers complex but predictable defensive strategies.

Defenses Against Shame

Projection and projective identification often are employed to defend against the experience of shame. More specifically, these defenses are used to manage the internal representations that have become polarized as devalued and devaluing introjects. Simple projection, which is mainly an externalization process, often amplifies the experience of shame by reinforcing the organizing principles associated with shame. When the devaluing introject is externalized, others are seen as critical and condemning, justifying withdrawal and avoidance responses (Mollon, 1986). On the other hand, when the devalued self is externalized through projection, others are perceived as defective and inferior, justifying the release of aggression through contempt, envy, and rage (Morrison, 1989). This externalization of the devalued self occurs as a way to avoid the overwhelming experience of inadequacy. Shame may be experienced, but it is quickly covered over by contempt, envy, or rage.

The defenses against shame, however, are more complex than the projection of devalued or devaluing introjects. Because of the disruption in affective attunement, loss of self-cohesion, and loss of object relatedness associated with shame, there is a simultaneous desire to reestablish object ties (Lewis, 1987; Spero, 1984). Yet, the externalization process associated with projection reinforces the experience of separateness and does not reestablish the longed for reunion. Projective identification, on the other hand, is a way of relating to others by which unwanted internal representations are projected *into* another who is induced to behave in a manner consistent with the projected material (Horwitz, 1983; Ogden, 1979). In the treatment of shame, either the devalued or devaluing introjects are externalized through projective identification, and the other

person is induced to enact the part. The externalized aspect remains available to the self in the newly created interpersonal matrix. This creates a sense of reunion and helps to assuage feelings of abandonment and emptiness, which accompany shame (Hahn, 1994).

This process can affect psychotherapy when the patient's devalued and devaluing internal representations resonate with the therapist's unresolved shame, resulting in countertransference identifications and enactments. Through projective identification, the patient unconsciously tries to induce the therapist to behave in a predictable manner, enacting a disavowed aspect of the patient's self. A relational pattern is established in which patient and therapist enact orchestrated roles. The disavowed and externalized introject becomes available to the patient as the therapist participates in the patient's internal drama, thereby decreasing feelings of separateness associated with shame. This allows for the reestablishment of object ties, albeit in a gravely compromised fashion.

Countertransference Identifications

The concept of countertransference has developed over the last few decades. Contemporary views define countertransference as "a joint creation, in which both the therapist's past conflicts and the patient's projected aspects create specific patterns of interaction within the therapeutic process" (Gabbard, 1993, p. 13). This conceptualization is particularly salient in the treatment of shame for two reasons. First, patients externalize an aspect of their shame as a way to cope with or manage overwhelming feelings of badness and inadequacy associated with the activation of devalued and devaluing introjects. Second, therapists may find their own shame activated as they resonate with their patients' devalued or devaluing introject. Because of this mutual activation, some therapists may feel a corresponding sense of inadequacy, while others may have feelings that complement their patients' experience.

According to Racker (1968), concordant countertransference identifications occur when therapists identify with the experienced self of their patients. Complementary countertransference identifications, on the other hand, occur when therapists identify with a disavowed aspect of the patient's experience. In the treatment of shame, concordant and complementary countertransference identifications occur in tandem with the pa-

tient's devalued and devaluing introjects. When these introjects resonate with their own shame, therapists may inadvertently collude with patients' desire to hide or to release aggression, thereby interfering with the therapeutic process.

Countertransference Reactions When the Devalued Introject Is Internalized

The long-term result of repeated childhood misattunement is an anticipation of further misattunement and the subjective experience of unworthiness. The internal representation of the self is pervasively negative (i.e., devalued introject), and the externalized introject is of condemnation (i.e., devaluing introject). The ensuing anticipation of censure and rejection can be so intense that these individuals conceal their need for an attuned response from themselves or anyone else (Morrison, 1989). As patients, these individuals fear rejection and either do not reach out to their therapists or behave in ways that insure connection but in a compromised fashion. They believe that their therapist will devalue and reject them if they reveal their sense of inadequacy or longing for an attuned response. Patients harboring a devalued introject may respond to their shame with one or more of the following reactions, including withdrawal, attacks on self, and avoidance. Whereas these reactions can co-occur, they will be described separately for heuristic purpose. Each of these reactions subsequently can affect the way in which countertransference is manifested.

Withdrawal Reactions

Withdrawal reactions are used to prevent the anticipated condemnation from a devaluing other. Whether subtle as in averted eye contact or obvious as in social isolation, withdrawal reactions include all the ways in which individuals attempt to become detached and isolated in order to hide their feelings of inadequacy from themselves and others. These reactions are an integral aspect of shame. As Nathanson (1994) stated, "Whenever we allow ourselves to experience shame affect at its fullest, we tend to withdraw as the affect mechanism fosters the gesture of turning away" (p. 796).

Concordant countertransference identifications of a patient's devalued self resonate with the therapist's experience of shame, resulting in feelings of helplessness, incompetence, and unworthiness. Because these feelings are difficult to contain, some therapists engage in parallel withdrawal reactions. These can be subtle, as in

simply corresponding with patients in averting eye contact, or they can be more pronounced. Therapists unable to bear the jointly experienced shame may withdraw from their patients by becoming emotionally detached or absorbed in technique (Brabender, 1987). This may be accompanied by some intellectual justification of the patient's need for therapeutic neutrality or with an obsessive preoccupation with technical accuracy, both of which sacrifice an emotionally attuned connection. Therapists who are reacting to shame through withdrawal will deliver interventions that seem perfunctory or disingenuous. The content may be correct, but these interventions lack an affective connection with the patient's sense of unworthiness and inadequacy. This lack of affective attunement helps therapists avoid experiencing their own shame.

Complementary countertransference identifications of patients engaged in withdrawal are characterized by a sense of resignation and detachment. Instead of identifying with the patient's sense of unworthiness, therapists identify with the devaluing introject and passively concede that the patient cannot be helped. Therapists engaged in complementary identifications may not be aware of experiencing shame because the patient bears the devalued introject and the subjective experience of unworthiness. Therapists do not feel incompetent or incapable of helping the patient. When the predominant reaction to shame is withdrawal, therapists who engage in complementary countertransference identifications are not hostile or blatantly rejecting. Instead, therapists in this countertransference dynamic conclude that the patient does not want help, is beyond help, or cannot be helped. As a result, a therapeutic working alliance does not develop, and therapy may be allowed to fail before it has a chance to begin.

Case Illustration

A 24-year-old male graduate student participated in individual therapy for 6 months with a female therapist. He presented for therapy complaining of depressed mood and suicidal ideation. He lived at home with his parents and had few friends. He did not date and denied having any sexual experiences. He complained of his father, whom he said expected him to succeed academically, and he also complained of his field of study. He frequently expressed a wish to move to another state in order to escape his current situation. These plans were poorly articulated and not enacted. Therapy focused on his depressed mood and suicidal ideation, but he was soon diagnosed with personality disorder, not otherwise specified (NOS), with schizoid, schizotypal, and obsessive-compulsive

traits. Therapy proceeded slowly. After about 3 months of therapy, he reported masturbating several times per week, fantasizing about men, and wishing he were a woman. After this revelation, his therapist reported feeling embarrassed and unsure about exploring sexual issues. In supervision, she acknowledged feeling detached from him and the therapeutic process. He became less engaged in therapy and missed several appointments. She expressed little hope for significant improvements and had difficulty articulating what progress he had made in 6 months of therapy.

This brief case example illustrates the result of complementary countertransference identification when patients engage in withdrawal reactions. This patient, who experienced a strong sense of inadequacy, felt profoundly ashamed of revealing his sexual fantasies. He managed his shame through withdrawal. His withdrawal was so pronounced that by age 24, he had never lived away from home, but he was not close to his parents, either. Administrative interventions, such as requiring the patient to pay for sessions in advance, could have decreased his use of missed appointments as a withdrawal strategy, but it would not have helped elucidate the therapist's countertransference reactions. His therapist remained detached and had a sense of resignation about his difficulty making progress. When he was able to articulate what may have been a core issue, she was unable to help him. Therapy floundered and ended without him being able to explore his sexual identity or his shameful self-representations.

Attacks on Self Reactions

Attacks on self are used by individuals for whom overwhelming fears of separateness or disconnection are the most salient feature of shame. This is a more complex reaction than withdrawal, which includes primarily a "turning away" from a devaluing other. Attacks on self stem from the confluence of a sense of unworthiness with a fear of rejection. It is important to note that this sense of unworthiness does not necessarily reflect objective inadequacies. A sense of unworthiness develops from repeated failures in empathic attunement whereby one's sense of self and one's normal developmental yearnings were experienced as unworthy of attention and nurturance. Attacks on self occur as a preemptive strike in order to insure some type of interpersonal connection and are thus a self-protective reaction. It is considered an attack on self because significant aspects of the self are denied, rejected, or subjugated in reaction to a sense of helplessness about being found wanting in some respect. As a result,

some of the behaviors in this category are designed to insure interpersonal connectedness, but at a tremendous cost to the individual's self-esteem (Nathanson, 1994). When in relationships, individuals engaged in attacks on self constantly monitor the other in order to fit in and be accepted. This interpersonal hypervigilance prevents individuals from participating in relationships in an authentic and genuine fashion. In extreme cases, individuals experience themselves as helpless, dependent, and submissive and may even subject themselves to abuse in order to preserve some type of interpersonal connection.

Self-injurious behaviors also fall in this attack-on-self category. Self-mutilation is a complex reaction to shame because it reflects several underlying dynamics. In some individuals, self-mutilation reflects a crude attempt to eliminate their unworthiness. These individuals attempt to eradicate their profound sense of badness by actually cutting or burning it away. This type of self-mutilation is motivated by a desire to remain connected to other individuals, but one feels compelled to eliminate one's sense of badness before that connection can occur. Other individuals engage in self-mutilation as a way to alleviate feelings of numbness, which they experience with their own bodies. Recall that the experience of shame involves a loss of self-cohesion, which in its extreme form is manifested as a sense of disconnection from the physical characteristics of the body. These individuals experience a sense of relief or aliveness as a result of physical pain and the sight of their own blood, which restores a rudimentary sense of connection with their own bodies and their sense of self.

Therapists engaged in concordant countertransference identifications with patients who are attacking themselves become action oriented in response to their own helplessness. Therapists resonating with the patient's devalued self over-identify with their patients' helplessness and unworthiness and overreact to their self-compromising or self-damaging behaviors. Therapeutic interventions become focused on overt behaviors, rather than on the internal representations. Therapists may offer suggestions, advice, and recommendations with the stated purpose of helping their patients curtail self-destructive behaviors. The countertransference purpose, however, is to prevent therapists from experiencing their own helplessness over a sense of disconnection. Therapists become overinvolved with their patients in an at-

tempt to compensate for the mutual feelings of separateness. In extreme cases, any attempt to understand the patient from the patient's subjective perspective is lost as the therapist prematurely attempts to "fix" rather than to understand.

Complementary countertransference identifications with patients experiencing an attack-on-self reaction potentially are very damaging to those patients. Through the process of projective identification, therapists are induced to feel and to behave in a manner consistent with their patient's externalized devaluing introject (Ogden, 1979). In other words, therapists identify and resonate with the patient's critical and condemning introject, which has been externalized. Therapists resonating with this devaluing introject are not aware of their own shame. They develop a contemptuous attitude, perceiving the patient as inadequate, disgusting, and shameful. Because this transference-countertransference interplay includes hostile and aggressive qualities, therapists' interventions may be overly confrontive and critical. Therapists may erroneously justify expressing their anger by thinking that these patients make everyone feel angry (Hahn, 1995b; McCallum, 1995). Therapists may inadvertently vilify a patient without realizing that they are enacting a disavowed aspect of their patient's internal drama. Other therapists may foster a negative dependency where the patient repeatedly brings forward shameful characteristics and receives condemnation rather than acceptance. Alternatively, some therapists may make premature admonitions to terminate treatment if patients do not immediately comply with treatment recommendations. The patient's experience of inadequacy or worthlessness is reinforced by the therapist. If both patient and therapist are unable to break out of this transference-countertransference constellation, a therapeutic impasse results.

Case Illustration

A 24-year-old single student, pursuing a degree in premedicine and working 32 hours per week in a microbiology laboratory, sought treatment to address a history of sexual abuse by a female relative, conflicts with her father, and symptoms suggestive of depression. She also reported engaging in self-mutilation and self-starvation. During the preceding 5 years, she reported having two suicide attempts and one involuntary psychiatric hospitalization. The first 4 months of therapy were characterized by supportive interventions as she struggled to cope with interpersonal difficulties with her father and boyfriend. When she began to explore feeling "dirty" and "empty," she experienced an increase in suicidal ideation, self-injurious behaviors (e.g., excessive use of over-the-

counter and prescription medicine), and disordered eating habits. Her self-injurious behaviors escalated to self-mutilation. She stated that she was attempting to remove a sense of feeling dirty which she said covered her body. On several occasions, she stated that she enjoyed cutting herself because it made her feel good, particularly when she felt overwhelmed with feelings of unworthiness. As her therapist felt increasingly unable to connect with her in a therapeutic manner, he became more action oriented. He developed a suicide prevention contract and regularly reviewed it with her. He referred her to a psychiatrist and a dietician and had regular contacts with her physician. On one occasion when she stormed out of his office stating that therapy was not helping her and that she would "never" be back, he contacted her mother and boyfriend. These repeated attempts to connect with her were futile. She reported experiencing daily suicidal ideation and engaging in self-mutilation several times per week. She refused to consider hospitalization and threatened to kill herself if she was hospitalized against her will. Her therapist felt powerless about his inability to connect with her in a way that would reestablish a therapeutic alliance.

This vignette illustrates a transference-countertransference dynamic whereby a therapist experienced concordant identifications with a patient who reacted to her shame with attacks on self. Both patient and therapist felt a profound sense of inadequacy and helplessness. The patient felt increasingly desperate, and acted as though the only way to secure her therapist's attention was to engage in self-mutilation and report having suicidal ideation. Her therapist lost perspective of his therapeutic goals and focused on narrowly defined interventions as a way to connect with her. Therapy did not proceed until the therapist set limits by insisting that she consider whether she wanted to be in therapy. If she did, she was required to demonstrate a commitment to therapy by engaging in behaviors that were conducive to her health and well being. Every time she reported engaging in self-mutilation or another maladaptive behavior, her therapist confronted her commitment to change. He also did not allow her to explore childhood sexual abuse and feeling dirty or empty until she could demonstrate behaviorally that she was strong enough to do so. By breaking out of a helpless countertransference, the therapist was able to reclaim his therapeutic role and reestablish a mutual working alliance.

Avoidance Reactions

Avoidance reactions include narcissistic defenses, such as grandiosity and mistrustful detachment, which are designed to compensate for repeated failures in empathic attunement. These childhood failures in empathic attunement play a fundamental role in the development of shame.

Stated differently, "From early recurring experiences of malattunement, the child acquires the unconscious conviction that unmet developmental yearnings and reactive feeling states are manifestations of a loathsome defect or of an inherent inner badness" (Morrison & Stolorow, 1997, p. 79). Narcissistic defenses are erected to protect the self from becoming aware of perceived failures in empathic attunement, as well as from the subsequent sense of inadequacy and worthlessness that ensues from these experiences. Narcissistic rage, also known as humiliated fury, often occurs with avoidance because it helps individuals avoid feeling their sense of inadequacy. Attacks on other, as it is referred to here, will be discussed in the next section because it is an instance in which the *devalued self* is externalized and projected onto others.

Avoidance reactions also include many strategies employed to divert attention from perceived inadequacies and the overwhelming feelings of unworthiness that accompany them (Nathanson, 1994). Examples include a variety of compulsive behaviors, such as drug use, sexual exploits, compulsive eating, gambling, excessive competitiveness, and so on. When avoidance reactions fail their defensive purpose, patients experience an excruciating sense of badness and inadequacy associated with shame. This is often seen when the avoidance behavior creates more problems in the individual's life or when the individual is "caught" performing an avoidance behavior that was kept a secret from others.

Concordance countertransference identifications occur when therapists resonate with the devalued introject and collude with their patients in avoiding the exploration of underlying feelings of inadequacy. By engaging in mutual avoidance, both patient and therapist do not experience an acute sense of unworthiness. If they experience anything at all, they experience a sense of dread or a vague sense of apprehension, resulting from a partial realization of the shame that is being stirred. Therapist avoidance may be manifested in several ways. Therapists may have the conscious or unconscious desire to dissolve the therapeutic relationship by canceling appointments, being repeatedly late for sessions, forgetting key historical information, making blatantly unattended interventions, and so on. These behaviors are a crude attempt to limit exposure to situations that trigger shame. Alternatively, therapists may avoid experiencing shame through a mutual feel-

ing of excitement about behaviors that bring narcissistic pride. Therapists may gain vicarious pleasure from a patient's sexual exploits, for example, without attempting to explore the early failures in empathic attunement that contributed to the establishment of these defensive tactics in the first place.

Complementary countertransference identifications occur when therapists resonate with the externalized devaluing representation. Therapists are not aware of experiencing feelings of inadequacy or shame. Their patients also may not be aware of feeling inadequate as long as the avoidance reactions effectively detract from shame. When the primary reaction to shame is avoidance and therapists are resonating with a devaluing introject that has been externalized, therapists feel a sense of disgust or contempt about their patients' avoidance behaviors. The overt behaviors become the focus of attention, but the focus has a critical, disapproving, or superior quality to it. Furthermore, therapists may be unable to feel a sense of compassion or to understand that the overt behavior is a manifestation of shame avoidance. A case illustration will be presented in the next section.

In summary, when the devalued self remains internalized and the devaluing introject is externalized, individuals experience an excruciating feeling of badness in the eyes of a condemning audience. Individuals experience a profound sense of separateness and attribute this disconnection to their unworthiness. Reactions to this manifestation of shame include withdrawal, attacks on self, and avoidance. Each of these reactions entails a distinctive interpersonal style that is manifested in the treatment setting. Therapists may experience concordant or complementary countertransference identifications, depending on whether they resonate with the devalued or devaluing introject, respectively. These countertransference identifications occur within the interpersonal context created by the patient's primary reaction to shame. For some patients, on the other hand, the experience of shame involves the externalization of shameful characteristics. When the devalued introject is *externalized*, the experience of shame and therapist's countertransference follow a different pattern.

Countertransference Reactions When the Devalued Introject Is Externalized

When the devalued introject is successfully externalized, the individual does not experience a

profound feeling of unworthiness. The other is perceived as defective and inadequate, justifying the release of aggression. The internalized self-representation remains relatively free of shameful defects because most of the defective characteristics are externalized onto others. When this occurs, individuals do not experience a sense of exposure or vulnerability because inadequacies no longer reside within the self. Individuals who struggle with shame, however, rarely succeed in completely externalizing the devalued introject. These individuals experience oscillating internal representations and therefore alternate between devaluing others and feeling an overwhelming sense of inadequacy.

Attacks-on-Other Reactions

Attacks on other occur when the internal representation of the self is protected by the externalization of a pervasively negative (devalued) introject. This constellation is the mirror opposite of the dynamic seen in withdrawal, attacks on self, and avoidance, where the self is perceived as defective (i.e., devalued self-representation) and the other is perceived as condemning (i.e., externalized devaluing introject). When the devalued introject is externalized, the other is perceived as inadequate and unworthy, justifying one's contempt. Contempt is a hostile response that is manifested socially in gossip, prejudice, and certain types of aggressiveness (Mindell, 1994). Through projection of one's inadequacies, others are endowed with negative features and become the object of devaluation. When projective identification is used to externalize the devalued introject, another person is induced to behave in an inadequate and inferior manner. In extreme cases, the need to feel adequate is so great that the individual defending against shame resorts to physical violence (Wallace & Nosko, 1993). These various manifestations of attacks on other are designed to protect the self from the experience of inadequacy and vulnerability by giving the individual a sense of power and control over the devalued introject that has been externalized.

Concordant countertransference identifications with patients in an attack-other mode occur when therapists resonate with patients' devaluing introject and denigrate someone or something external to the therapeutic process. Instead of avoiding or withdrawing from the villainized other, therapists join patients in condemning and attacking external objects. Therapists who identify with the de-

valuing introject fail to explore the veracity of the patient's accusations, and thereby deny patients the therapeutic opportunity to engage in self-reflective curiosity. This concordant countertransference identification occurs as a way to prevent therapists from experiencing their own sense of shame. Both patient and therapist persist in accusing or blaming others as if the accusations were true. No attempt is made to examine the processes by which these accusatory conclusions are being made. In other words, the way in which meaning is being generated by both patient and therapist remains unexplored and, therefore, intact. This occurs when therapists criticize patient's spouses, parents, employers, institutions, or whatever the patient is denigrating, condemning, or blaming as a way to prevent feeling inadequate and unworthy. Both patient and therapist experience a sense of triumph as the devalued internal representation is externalized and someone else is vilified. As a result, neither patient nor therapist experience a sense of worthlessness or inadequacy.

When therapists resonate with the externalized devalued introject and develop a complementary identification, they become targets for hostile attacks and accusations. When projective identification is used to externalize devalued self-representations, therapists are induced to feel and behave in an incompetent manner. A therapist caught up in this transference-countertransference interplay believes that the patient's accusations are justified. Small therapeutic blunders or brief moments of misattunement are magnified by both parties, giving credence to the accusations. Therapists often respond to this dynamic by making special accommodations or subjecting themselves to more criticism as a way to compensate for their perceived blunder. These therapist reactions, however, only perpetuate the patient's externalization process because the patient continues to perceive the therapist as weak and inadequate.

Case Illustration

This 23-year-old single, White male was referred for psychotherapy by his physician due to anxiety and sadness following the break-up of a 1-year, live-in, relationship. During the first interview, he complained that his boss was not interested in him and did not appreciate the quality of his work. He noted that his mother was not demonstrative of her affection for him and that his father was a harsh disciplinarian. He remembered feeling frustrated as a child and being physically abusive of his next younger brother as a consequence. His dating history was characterized by attempts to dominate and control his girlfriends. While he presented a facade of self-

confidence and self-assurance, psychological testing with the Minnesota Multiphasic Personality Inventory-2nd ed. (MMPI-2) revealed that he harbored chronic feelings of inadequacy and required reassurance from others to bolster his self-worth. Test results also indicated that he experienced difficulty sustaining interest in his daily activities and eventually felt bored and restless. He coped with stress by being impulsive, particularly sexually, or by smoking marijuana.

During the first several sessions, he acknowledged feeling lonely but mistrustful. He also reported feeling afraid of being betrayed and embarrassed. His therapist, who missed these important allusions to the evolving transference, focused instead on his drug use. The patient scoffed at the suggestion that there might be underlying motives for it. Shortly before discontinuing therapy prematurely, he reported having suicidal ideation and fantasies of hurting others. When he returned 4 months later, the patient did not smoke or engage in other obvious avoidance strategies. He became openly hostile, however. He criticized the office furniture and the magazines in the waiting room. As therapy progressed, the patient revealed his interpersonal exploitiveness and his tendency to "break rules" for personal satisfaction. His therapist reported in supervision that he kept a psychological distance from this patient. When the patient began to disparage psychological theories and science in general, his therapist felt increasingly helpless and incompetent. When challenged by the patient, the therapist was unable to process the patient-therapist relationship or to provide a therapeutic response. The therapeutic process remained in a stalemate until the therapist reclaimed his therapeutic role. Observation of the patient's tendency to denigrate others while feeling superior to them did not significantly alter his interpersonal stance. The patient finally became more receptive to treatment when his therapist used anger to confront his distorted and unyielding relational stance within the therapeutic relationship. After a series of confrontations, accompanied by unequivocal expression of the therapist's commitment to his treatment, the patient acknowledged having chronic feelings of insignificance and unimportance.

This vignette illustrates the dangers of complementary countertransference identifications with patients engaged in avoidance and attacks on other. Both patient and therapist experienced significant difficulties tolerating their mutually activated shame, and their attempts to make a genuine interpersonal connection were marred by their mutual defensiveness. The therapist avoided addressing the patient's shame by addressing his drug use until the patient discontinued therapy. When the patient returned for treatment, the therapist resonated with his externalized, devalued self and felt inadequate. The patient's uncertainty about being important and significant to others, including to his therapist, developed as a result of his interactions with his parents, whom he perceived as harsh and emotionally unavailable. Instead of recognizing that the patient was attempting to communicate his profound feelings of unworthiness, the therapist initially played a complementary role and was unable to help the patient become receptive to introspec-

tion. The therapeutic process resumed after the therapist used anger to break out of the patient's intractable defenses.

In summary, attacks-on-other reactions involve the externalization of devalued introjects through projection or projective identification. These shameful characteristics are perceived in others who are then condemned and criticized as a way to avoid experiencing a sense of inadequacy and unworthiness that accompanies shame. When therapists develop concordant countertransference identifications, they collude with patients in condemning someone or something external to the treatment process. This defensive dynamic gives both patient and therapist the impression of an alliance. It is not a therapeutic alliance, however, because no attempt is made to address the underlying shame. When therapists develop complementary countertransference identifications they experience an overwhelming sense of inadequacy and often behave in an incompetent manner. Furthermore, they become targets for hostile accusations and actually believe that the accusations are justified. In this transference-countertransference constellation, therapists feel a tremendous sense of failure and some may attempt to compensate for their perceived inadequacies by making special accommodations in order to prove their loyalty or worthiness.

Treatment Considerations

The actual treatment of shame is relatively straightforward. It involves the creation and maintenance of a safe environment wherein the disclosure of shamefulness is accepted by others and oneself (Alonso & Rutan, 1988; Basch, 1985; Lear, 1990; Morrison, 1990; Tantam, 1990; Zaslav, 1998). This is accomplished by providing a supportive and emotionally attentive relationship. As Basch (1985) stated, "The long period of affective mirroring that these patients need . . . permits them to overcome the unconscious anticipation of the rejection of their affective needs and the shame that they experience whenever they dare to reach out in that direction" (p. 35). Revealing one's badness and experiencing the therapist's acceptance creates an environment that weakens the expectation for condemnation and rejection. Within this safe, supportive, and accepting environment, self-acceptance unfolds.

Shame is a complex experience to treat. Some patients react to shame by feeling a profound

sense of inadequacy and unworthiness (internalized devalued introject) and by perceiving others as critical and condemning (externalized devaluing introject). Others react to shame by feeling relatively impervious to shame (internalized devaluing introject) while perceiving others as inadequate and defective (externalized devalued introject). Therapist countertransference develops when aspects of the patient's experience resonate with one's own experience of shame. Concordant countertransference occurs when therapists identify with the patient's internalized introject. Complementary countertransference occurs when therapists identify with an externalized introject. Both types of countertransference identifications can lead to a therapeutic impasse and dissolution of the therapeutic relationship. Depending on the magnitude of countertransference shame, some therapists may need to pursue psychotherapy to resolve their own parental misattunements. Other therapists will be able to use their countertransference to gain a subjective understanding of their patients' difficulties.

When therapists develop concordant countertransference identifications with patients whose *devalued introject remains internalized*, they develop similar feelings of inadequacy and unworthiness. Instead of developing corresponding reactions to patient withdrawal, attacks on self, and avoidance, therapists can use their subjective experience to inform them of the patient's profound and overwhelming sense of shame. By using their own awareness of shame, therapists can in turn help patients translate their emotional, physiological, and interpersonal reactions to shame into words. These words are now used to communicate, to share, and ultimately to connect with an accepting other. This supportive and relational process does not change the past. It changes the patients' ways of generating meaning and making sense of their experiences (Stolorow & Atwood, 1994).

When therapists identify with the externalized devaluing introject, however, they are not aware of experiencing shame. These therapists are consciously aware of feeling a sense of resignation, contempt, and moral superiority. These complementary countertransference identifications, which are triggered by the patient's projection or projective identification, develop due to therapists' inability to experience and contain their own shame. By identifying with the devaluing introject, therapists avoid experiencing their shame,

and fail to help their patients integrate the devalued and devaluing introjects. Once therapists become aware of this unconscious process, they can experience their own activated shame and begin to address the patient's shame therapeutically.

The management of projective identification of shame consists of a conceptual understanding of the dynamics involved, and, more importantly, a willingness to affectively experience the material that has been externalized. Once therapists realize that they have been identifying with the patient's devaluing introject, they understand an aspect of the patient that is outside of his or her awareness. Armed with a conceptual understanding and an emotional awareness, therapists are ready to observe the patient-therapist process and encourage introspection (Hahn, 1993). The goal is to develop a collaborative endeavor in which the devalued and devaluing introjects become consciously available for discussion, rather than being unconsciously enacted by both parties. In the course of this exploration, it is appropriate for therapists to acknowledge that they have identified with a devaluing introject as a way to avoid experiencing shame. This self-disclosure will strengthen the therapeutic alliance. By taking responsibility for their affective reactions and containing both the devalued and devaluing introjects, therapists help patients pursue their own affective integration (Maroda, 1991).

A similar approach is used when patients *internalize the devaluing introject*, and disparage others rather than themselves. Therapists caught up in a concordant countertransference identification collude with patients by devaluing someone or something external to the treatment process. In order to break out of this counterproductive dynamic, therapists must become aware of what is occurring, observe the process, and encourage introspection. By encouraging patients to develop an analytic attitude of self-reflective curiosity and by disclosing their use of devaluation of others as a defense against shame, therapists help patients reclaim disavowed and split-off introjects. While some patients will access their feelings of inadequacy and unworthiness, most will need an active therapist who persistently attempts to mobilize affect for them (Basch, 1985).

When therapists engage in complementary countertransference identifications with patients who have internalized a devaluing introject, they experience a profound sense of inadequacy. Therapists have a considerable amount of difficulty

extricating themselves from this transference-countertransference dynamic, because the patients' criticisms match the therapists' countertransference self-perception. Processing the patient-therapist relationship and encouraging the development of self-reflective curiosity will help patients who have a certain degree of insight. The relational stance of this dynamic, however, is highly reinforcing for patients because it prevents them from feeling shame and gives them a sense of superiority over their therapists.

When patients exhibit a rigid relational stance that is not responsive to change, therapists often must rely on confrontation. As Cashdan (1988) stated, "By confronting the patient's habitual ways of structuring relationships, the therapist challenges the very nature of the projective identification" (p. 119). Confrontation is done behaviorally and verbally. Behaviorally, therapists confront patients' habitual ways of structuring relationships by ceasing to enact the incompetent, shameful role that is expected of them. In other words, therapists become active participants in restructuring the boundaries of the therapeutic relationship and the expectations for therapy. In doing so, therapists recover their therapeutic role. Therapists also verbally challenge the undermining purpose of the patient's attacks and criticisms, while simultaneously affirming a commitment to develop a therapeutic relationship.

If confrontation does not alter this relational stance, then the judicious use of therapist anger may be considered in order to dissolve the patient's intractable defensive maneuver (Hahn, 1995). This is a controversial subject in the psychotherapy literature, but it has received a steady stream of support. The judicious use of therapist anger may be used to dispel distortions and to provide an interpersonal connection when traditional approaches have failed to do so (Epstein, 1979; Maroda, 1991; Winnicott, 1949). The purpose of the patient's relational stance is to avoid interpersonal intimacy in order to avoid the reactivation of past disappointments and a sense of unworthiness. Yet, the patient yearns for an authentic interpersonal connection. Modulated therapist anger provides patients with an authentic affective response. It communicates that the patient has had a strong impact on the therapist and that the therapist can express emotions without losing control or dissolving the relationship (Maroda, 1995). The judicious use of therapist anger should not be used to demand that the patient be

someone else. It is a technique that can be used to help patients break through their intractable defenses so that they may begin the working-through process. It should only be used in limited situations when traditional approaches have failed and when the therapist is willing to remain therapeutically available for the patient. (For a more complete discussion of this topic, see Gans, 1995; Hahn, 1995a; McCallum, 1995). If confrontation and the expression of therapist anger are effective, a shift gradually will occur in the patient-therapist relationship, and patients will begin to address the experience of shame that has impaired their ability to form satisfying relationships. By reestablishing a therapeutic relationship, patients can reveal their feelings of inadequacy and not experience the anticipated rejection or condemnation. More importantly, psychological development resumes when the patient-therapist relationship alters the perceptual frame within which past and present relationships are understood (Ogden, 1991).

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