CLINICAL ILLUSTRATION OF A THEORY OF SHAME

Warren Kinston, Sr. Research Fellow

Brunel Institute of Organisation and Social Studies, Brunel University, Uxbridge, Middlesex

Introduction

Clinical material can never prove a theory to be true. Indeed modern scientific method emphasises that evidence can only falsify a theory, never verify it. At the personal level, however, confidence in a theory can be increased through relevant evidence. The practising psychoanalyst needs theories in which he has confidence to help him in his daily interpretative work. He is not particularly helped when he learns that a theory he uses is false, and is relatively unconcerned by the degree of inner consistency and overall coherence of the theories he is prepared to use.

Kubie (1975) argued that Freud's lack of concern for the difference between metaphor and theory, between explanation and description, has been seriously damaging to psychoanalysis as a scientific discipline. However, as Bowlby (1979) pointed out, the clinician's job is not to investigate theories but to analyse and help individuals. The clinician who considers the issue of the scientific status of psychoanalytic theories an irrelevance still wants theories and ideas which are useful and relevant to his practice.

From the clinician's viewpoint, "good" theories have two characteristics. First, such theories increase sensitivity to important psychic phenomena which otherwise would be, or have been, neglected. The work of Melanie Klein, whatever its conceptual weaknesses, greatly increased awareness of a whole host of clinical phenomena: envy, greed, manic defence, reparation; and something similar may be said of Kohut. The second and crucial characteristic of "good" theories

is that they enable the clinician to see patterns or order where previously there had been confusion. Here lies the major problem with theories: even if they are "true", they may be misapplied to give the clinician a sense of relief from confusion. Clinical material, if provided in sufficient detail, can illustrate a theory most helpfully. It shows the analyst at work and indicates the type of material that can be ordered by the theory. This paper endeavours to illustrate the key feature of a recently propounded theory of shame (Kinston, 1983).

Background

A theory of narcissism

In recent years, I have been developing a theory of narcissism (Kinston, 1980, 1982, 1983) which endeavours to find a place for the enormous variety of clinical phenomena which must be subsumed by such a theory. The prime task in the construction of the new theory was to show that it included the two major conflicting, or rather diametrically opposing, perspectives in the literature. These were re-labelled: "object-narcissism" and "self-narcissism" and given functional definitions. Early psychoanalysts accepted the duality of narcissism but modern writers appeared divided into two camps each of which only considered part of the phenomenology (see Fig. 1). The validity and significance of

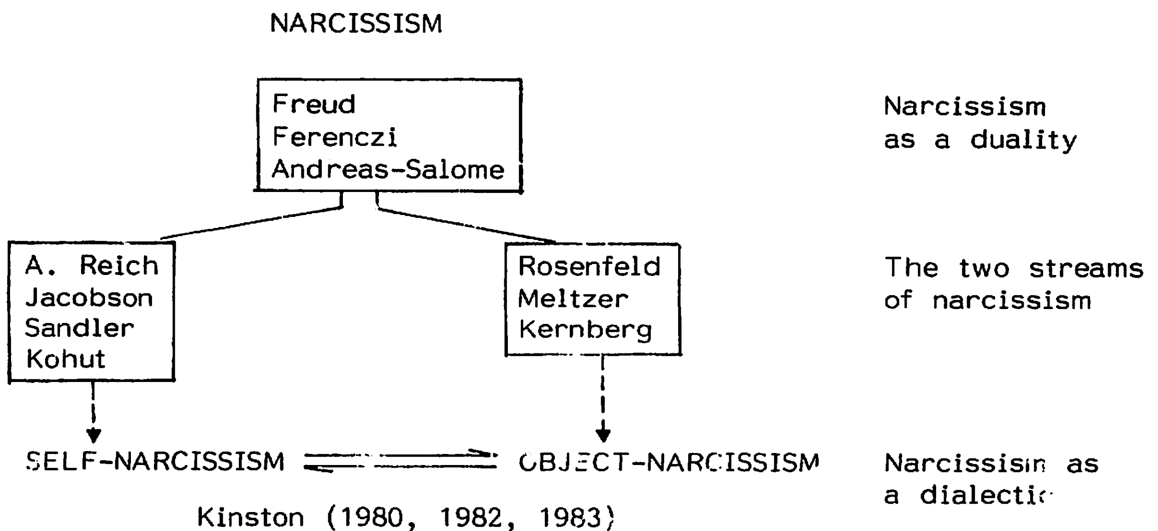


Figure 1. Development of the literature with respect to the dual orientation of narcissism.

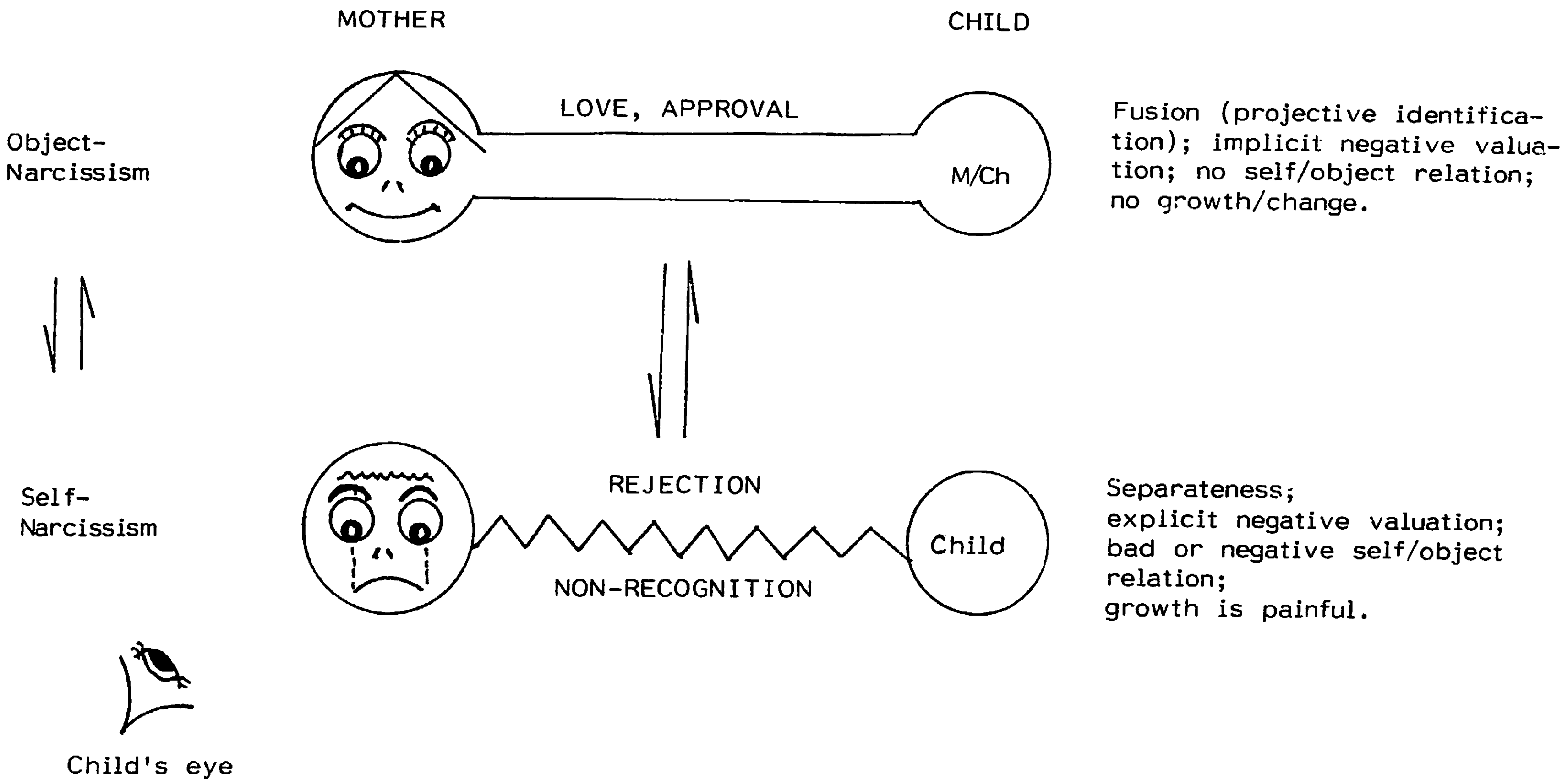


Figure 2. Schema for narcissistic development.

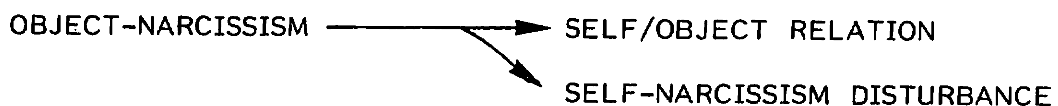
Table 1 Some distinguishing features of the three perspectives of object relations theory

Perspective	**Quality of object relations**	**Key concepts**	**Symptomatic forms**	**Phenomena in therapy**
Self-Narcissism	Negatively-valued self-images	Continuity; integrity and value of self-representation	Low self-esteem, self-doubt, sense of inferiority, feelings of uselessness	Valuation of analysis and analyst; vulnerability to analyst
Object-Narcissism	Fusion of self- and object-images	Dehumanisation of self, or other; self cut off from relatedness and and nourishment; denial of need	Self-sufficiency, indifference to meaningful other	Confusion with the analyst; indifference to analysis/analyst, collusive pseudo-analysis
Self/Object Relations	Self-image and object-image separate and linked by an affect-laden wishful bond	Instinctual and non-instinctual wishes from self	Phobias, obsessions, conversions	Sexual, aggressive, dependency and other wishes in relation to the analyst

each of the two views was further developed and confirmed by constructing an intrapsychic schema which is universal in child development and pathological in certain circumstances (Fig. 2). Object-relations theory provided an encompassing framework able to include, distinguish and link instinct theory (via self/object relations) to the new theory of narcissism. The clinician using object relations theory could easily decide which perspective was active in the session (see Table 1).

The theory aimed to integrate and encompass existing ideas, and also to expand the awareness of psychoanalysts using only a limited perspective. Kinston (1980) exemplified a previously undescribed experience susceptible to conventional interpretation, and Kinston (1982) described patterns of clinical phenomena which could be exptected on the basis of the theory. These particularly concerned transitions between states of self-narcissism and object-narcissism which are the defining feature of narcissistic vulnerability (Fig. 3). Because psychoanalyses depend upon the re-experience of self/object relations in the transference, the transition from object-narcissism is of particular interest to analysis. The pattern to be looked for, called the "positive therapeutic reaction", has been described with detailed clinical illustration in Kinston (1984).

1. A move from object narcissism to self/object relations is accompanied by appearance of negatively-valued self-images or other self-narcissistic pathology.



2. In the active presence of self-narcissistic disturbance, self/object relations are unstable and tend to be replaced by object-narcissism.

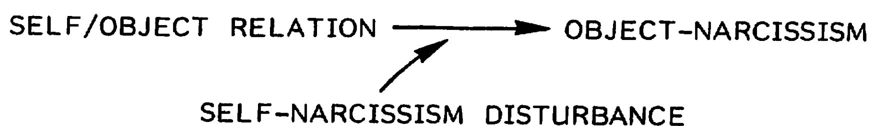


Figure 3. Narcissistic vulnerability: Transitions between object narcissism and self-narcissism in the transference.

A place for shame

Shame appeared in the clinical vignettes presented in papers referred to above, and there was a sense of it being a key emotion which called for some interpretative comment. At that time, I was unaware of what the form or content of any specific interpretation might be and I handled it much as I would handle any affect in a session. Because its significance seemed greater than this, I turned to Freud and commenced a survey of the psychoanalytic literature. The picture there was fragmentary, contradictory or unsatisfactory. Most authors who examined shame, but not all (e.g. Hartmann and Lowenstein, 1962), affirmed that it was a distinct experience that had tended to be ignored and undervalued. However descriptions of the shame experience and the theoretical siting of shame as a concept were generally non-specific. I was searching for a specificity for shame much as Freud had sought it for guilt and anxiety.

I slowly came to some firm conclusions. First, shame was important both as an experience and as a concept, but it did not fit well within the usual models of the mind. Second, the experience of shame was distinct from that of guilt, inferiority, failure, etc. and this must be reflected in any theoretical formulation. Third, the experience of shame was closely linked to that of embarrassment and humiliation and might well be referred to by patients in these terms. (To paraphrase Bion (1967, p. 161) "I am not talking of occasions when patients use the word 'shame', but of shame itself".) With these principles in mind, I listened carefully to my patients and continued reading, but now outside as well as within psychoanalysis. A pattern soon emerged and the full details were then written up in a theoretical paper (Kinston, 1983).

The distinctive phenomenology of shame was compatible with its description as a signal that a move from a state of self-narcissism to object-narcissism is likely. In substantiating this hypothesis in Kinston (1982), it was necessary to show that it was theoretically consistent with known psychoanalytic relations between the shame experience and other experiences such as guilt, exposure, inferiority,

exhibitionism, rejection, sexuality, aggression and so on. Characteristic shame phenomena such as the unconscious sense of shame, shame propensity, shamelessness and mechanisms for dealing with shame could then be explored in the same paper as a further test of the specificity, consistency and coherence of the theoretical formulation.

This paper has been written to link the theory even more closely to clinical experience. Illustrative material will therefore be provided with session details from four analysands. The material aims to show my early recognition of shame, search for a clinical pattern involving shame, testing of that pattern, and methods of interpretation. The cases are in chronological order and affected by the development of my thinking on narcissism and shame. Wurmser (1981) recently provided a comprehensive clinical document of shame which ran to over 300 pages. Within the confines of a brief paper, it is impossible to emulate this. It is crucial, however, that my core hypothesis be clearly demonstrated using clinical material with which psychoanalysts can identify and which they can relate to their own practice. In the end the reader must judge for himself whether the ideas are helpful and usable or not.

Clinical material

Case 1: Mr. X

Material from Mr. X's analysis was presented in Kinston (1980) and included references to shame (called "humiliation" by the patient). In the initial phase of the first session reported, the patient had felt shame and I assumed that this was a characteristic of his "emotional 'true' self". I assumed that humiliation was simply one of a number of unpleasant emotions he often felt which contributed to his ure to move to a state of object-narcissism, a state which was maintained through masturbation and nasty glee. After moving him from the object-narcissistic state to genuine relating by interpreting details of his negative-valued self-image, I offered the following interpretation which gave his humiliation a slightly special position. "To be yourself, whether it is angry or affectionate or whatever, is associated with feeling humiliated." (p. 389)

Sometime later in the analysis, he presented material that led me to think that shame or humiliation preceded states of object-narcissism and were not simply emotions that characterised his self-representation. At this stage I avoided including such a conjecture within the interpretation. The session to be reported commences with Mr. X in a state of object-narcissism, without any complaint of shame, and possibly behaving "shamelessly" in the judgement of the analyst. Shame appears at the point of transition from object-narcissism to self-narcissism and then as self/object relating becomes firmly established it disappears, again. The absence of shame at the end of the session had a quite different quality from that at the beginning, the analysand being suitably described as "unashamed".

Session:

Mr. X began the session speaking in a rather boring and laboured fashion. He claimed that he had to say something and compared coming to the session to serving time or drawing a pension. I commented on his mechanical state of mind and this led to Mr. X continuing a little less mechanically. He described an episode which had recently occurred. He saw a woman at the bus-stop and though he knows her because she sells newspapers in the Underground kiosk, he did not know what to say to her. He felt very mechanical at that time: he thought of talking about the weather but that seemed hypocritical, or about the bus being late, but that seemed routine. Finally, when the bus came, he said "Here it is". She seemed quite happy with this interchange. On the bus, he sat a couple of seats away and when he reached the Underground Station, he was unable to buy a paper from her as it seemed too contradictory. He continued as follows:

Mr. X: How do you talk? How should I get her going? It is as if I have to press the right button - but that treats her as a clockwork toy and there's no satisfaction in that. It has to do with what is the right thing to do. That is, I should speak to her. It's the same with my cousin and girl-friend. If I do, I'm a good boy - but I'm not there.

Dr. K: It's the same speaking in the session.

Mr. X: But it would be intolerable to say nothing and have the feeling that I can't do anything. Of course, when I talk, I'm not really making contact, but it allows me to blame the other person and say to myself: "Well, I've tried, but they're not responding".

Dr. K: This is your cover. The question is: do you want to talk or not?

Mr. X: I don't know. I don't know what I want to do. No.... I know. I want you to talk.

Dr. K: If that's what you wanted, why not say so. Your mechanical state of mind seems to have cut you off from this experience.

Mr. X: Yes, that way I can say that I'm not bothered.

Dr. K: Then you have no existence and no relationships.

Mr. X: If what you mean by a relation is being in humiliated dependency

(silence)

I try to stay as mechanical as I can in the circumstances. Simply letting things flow is inimical to me. I don't feel comfortable.

(silence)

I'm helpless.

(silence)

I want to be silent, but how can I justify this.

Dr. K: That sounds like a sense of guilt.

Mr. X: I'm wrong because I'm existing in my own right.

(silence)

I don't think I'm mechanical now. I don't feel humiliated.

(silence)

The other day I was talking about my self-effacing tendencies. Well, I've crawled out into the open from under my stone. I should crawl back.

(silence)

For me being human is dangerous. I'm taking advantage of you. I could destroy you.

Dr. K: Being involved in a human relationship means facing and dealing with your destructiveness. This frightens you.

(End of session).

The vicissitudes of shame are easy to follow. The session opens with Mr. X shamelessly and inaccurately describing the analysis on which he well knew his present and future life depended as being boring and trivial. Then the moment he faces his existential dilemma and need for a relationship he expresses an acute sense of shame ("If what you mean by a relation is being in humiliated dependency"). As this mental state becomes established, the sense of shame first becomes lightly unconscious and is expressed through a negation ("I don't feel humiliated any more"), and then more deeply unconscious and is expressed through a wish to hide ("I should crawl back under my stone"). Finally it appears to become insignificant and in an unashamed fashion he reveals genuine anxieties about his immediate relationship ("I could destroy you").

Case 2: Miss Q

While studying the issue of shame, I sometimes asked patients for help as described in the first of three extracts from the analysis of Miss Q.

Session A:

> Miss Q found it hard to tolerate my refusal to collude in games of pseudo-analysis. On one occasion after offering me material for rather obvious interpretation, she suddenly said: "I feel so resentful and humiliated". "Why humiliated?" I asked. "I'm the pursuer, I want to be pursued" she replied. I accepted her experience but persisted as to why it should be associated with humiliation. She said "It means I'm not paid attention to; I'm not valued; it doesn't matter whether I exist or not."

This last form of human relation was exactly what I was in the process of discovering as the universal childhood precursor of narcissistic disturbance. The child subsequently identifies with the other, does not pay attention to herself and attributes a negative value to herself. An external facade is built up which is given value by the parent and therefore by the child. In analysis, the facade appears as a state of object-narcissism. Humiliation seemed, in this vignette, to

be associated with the breakdown of the facade. The following session from the 5th year of analysis is typical of the material that has led me to believe that the reverse is true. Shame is associated with the move towards object-narcissism rather than away from it. The connection with breakdown of the facade is merely a reflection of the urge to restore it.

Session B:

Miss Q spoke for about 10 minutes saying how grisly and complaining she felt. She wanted to criticise me about something I had said some days previously. She felt that my attitude to her was wrong. A 5 minute silence then followed. Miss Q resumed by describing how her boy-friend had recently changed his plans and was now not going to see her. Her neighbours knew about this and she felt intensely humiliated by the change. It was as if she was of no account at all. She felt that because she was unimportant, she was not taken notice of. Another 5 minute silence followed.

Miss Q then began talking about a change in a cancelled session and as she did so, she got the details of the reasons, times, and other particulars mixed up. I could not tell whether she had noticed this. But suddenly she said "I'm all confused". A comment from me seemed called for and I described her emotional progress through the session: initially annoyed and dissatisfied, then unimportant and humiliated, and finally confused. Miss Q responded with some anger: "My objection to that is the same as ever. Am I supposed to just lie here and be angry for a whole session? What's the point in that?" I explained that I was not advocating that she should be in one state rather than another, but was simply pointing to her move from separateness and anger, to fusion and confusion, with humiliation as a signal of the move. The reason for the move, I explained, seemed to be that she objects to her own experience; she is the one who wishes to dismiss being angry and treat it as unimportant and of no account. This puts complaints about others doing this to her in a different light.

In Session B, I was still learning. The following vignette near the

end of the analysis shows an attempt to use my hypothesis. As is typical of a narcissistically vulnerable analysand, self/object relating generates the emergence of self-narcissistic pathology which leads to the urge to move to object-narcissism.

Session C:

The session commenced with the patient speaking about the holiday coming up and the end of the analysis which was to be at the subsequent holiday. Her associations had a genuine quality and she seemed to be in touch with many of her anxieties, as well as her wish for contact and her sadness. After a while, she began associating to slugs. She described how a friend put salt on them and they shrivelled up. She said she felt like that about the holiday. She was silent for a while and then said "I feel embarrassed.. some sort of sense of shame... I don't understand". I interpreted: "Being in touch with your feelings about the holiday is also being in touch with your idea of yourself as slug-like, repulsive and worthless".* She was silent. After five minutes, I added: "Your experience of shame, may be a signal that you are about to become or have become confused, mindless or out of touch". She immediately responded: "Yes, I was thinking - the idea of myself as worthless or repulsive is not my idea of myself - it is what you think, or another person thinks of me. I'm being rejected. This is why the holiday is coming. It's coming because you don't want to see me. This is why I must avoid contact with people. If I have relationships, then I can be, will be, rejected. I must cut myself off people - relate without really relating - put up my front".

*This rather unattractive looking comment did not feel so out of place in the context of the treatment process. Her explicit problem over feeling worthless and her conscious suffering from a sense of being loathsome has been in the material for years.

In retrospect, however, I missed perhaps a more central aspect of the slug metaphor: the slug's exposure and vulnerability to being hurt (killed?) without a protective covering. For Miss Q, being vulnerable or open to experience (self-narcissism) is equivalent to nakedness and it leads her to "put up her front" and be protectively covered (object-narcissism). The self-awareness and self-expression of her experience of the holiday and termination was intensely painful to her. Indeed her whole self, her whole body, was experienced by her as a wound - the after-effects of her childhood traumatisation (Cohen and Kinston, 1984). I was like the friend and my intervention (interpretation or silence), though aimed at aiding healing and growth, was like putting salt on an open wound.

The evidence from this session gave a sense of confidence in the reality of the theoretical pattern as well as its usefulness. I could predict changes and experience within the session and by understanding them I could make interventions which were highly specific and facilitating. For the next two illustrations, I have taken patterns extending over more than one session.

Case 3: Mr. S

Mr. S presented with an acute anxiety neurosis but refused to attend more than once per week with a variety of excuses. It became clear that this was part of an attempt to exert control over his experiences. He initially insisted on sitting up and carried on a social conversation much as if I was his physician. My non-acceptance of this role was ignored by him and he behaved in a compliant and polite fashion, filling the session with meaningless words below which his terror could be sensed. He tried the couch once and was left in a state of inarticulate pain and fear alternating with states of blankness. Some months later he returned permanently to the couch but the sessions were largely unproductive. As his initial fear decreased, so did the compulsive talking; but we were not much nearer his inner world. Neither dreams nor fantasy elaborations were available and my interpretations seemed to be seized on often more in an effort to comply than to gain insight. Eventually he reported that his external situation was much improved and that he felt comfortable and safe in therapy. Sessions then became characterized by long silences. The sessions to be reported were generated by an accidental error of mine, a phenomenon which often leads to contact with reality (Kinston, 1982).

Two consecutive sessions will be reported in detail. In the first session, Mr. S describes how a strong sense of embarrassment preceded a move to object-narcissism ("blankness"). In the next session, he refers to shame rather than embarrassment and is deeply involved in understanding it. He recognises that shame is both part of being in touch with himself (a manifestation of self-narcissism) and therefore positive, and part of an urge to turn away from reality (a manifesta-

tion of object-narcissism) and therefore negative. He then finds himself reliving an early experience of disappointing his parents, just prior to the end of the session. At the third session (not reported in detail) he reveals a way he disappointed them that goes to the core of his being. As object-narcissism is about fitting in with parental expectations, the patient's linking of shame to awareness of disappointed expectations is further confirmation of the theory of narcissism within which the theory of shame is being placed.

Sesson 1:

(Mr. S had been given a monthly bill the session before.)

Mr. S: After leaving last session, I wanted to come today with a blank mind. When I walked in then, I felt anxious and I wondered what I would think if I had no thoughts in my mind. (There followed comments about the days activities which trailed off into a silence.)
Things in this room seem to have a tinge of red on them. Red is danger - in that sense you are white.
I've got another strange thought - I don't know why - it's as if red is associated with punishment.
(silence)
When I'm silent, I think that you're going to criticise me.

(We had noted frequently his repression/suppression of a critical and complaining attitude to my silence, mainly from a fear of a massive retaliation. He felt the analyst was not playing the game and not being supportive and helpful as expected.)

Dr. K: Could it be that you want to criticise me and its easier to think of me criticising you.

Mr. S: Yes, as we've said before, it seems that I don't want, don't like to criticise you.
I've just remembered something.
When I walked out of the last session, I looked at the bill and I saw you had charged me for one session too many. I immediately felt guilty - even after checking my

diary to confirm I was right. I realised it would be sorted out.

(He then spoke about his own scrupulousness, wishes to avoid criticism and his dislike of finding me not perfect.)

My main memory of seeing the bill is feeling embarrassed. I don't know why.

(silence)

Dr. K: When you saw the bill you became aware that a mistake had been made and knew that this meant there would have to be a personal interaction with me. For a start I would have to be confronted with the error and would have to respond and just possibly show you that you were wrong. In any case there would be a variety of emotions and experiences including particularly your criticism of me and sense of guilt for mentally attacking me. The best solution was to blank out your mind and you decided to do this, as you explained at the beginning of the session. The embarrassment after seeing the bill was the signal that you were about to avoid personal contact by going blank - at which point you went blank.

Mr. S: I don't remember the matter about the bill at all from that moment of embarrassment till it suddenly came to me in the middle of this session.

(End of session)

Session 2:

Mr. S: After the pangs of embarrassment and the directness of last session, I feel introverted. I want to recoil into myself. The feelings so obviously outweigh -- are so out of proportion to the substance of the event. It's as if there is something wrong about them.

I want to get small - or sneak into a corner.

It's so as not to feel shame.

I feel a lack of confidence in my abilities.

I recriminate against myself for having mentioned the thing at all.

I'm telling myself I should have shied away from it. But

(Mr. S): I was, and I am, very bothered that I didn't, don't, want to face up to it. You know - I feel that it should have been better to have paid the extra session and say so what. It's not right.

(silence)

It was amazing the way the feelings emerged three-quarters way through last session. Now I feel small.

Dr. K: Could one connection with feeling small be the fact that when you were small you avoided facing things a lot?

Mr. S: I used to live in a fantasy world. I had a vivid imagination but was a loner. I stuttered and was very shy. Contact with people was embarrassing. I used to enter novels. Science-fiction - the escapist sort. Since coming here I've been reading disaster novels. It's my mood. When I was a child, my parents weren't there (he spoke on about this and gave anecdotes of not facing new ideas or situations).

Dr. K: By the way, I checked my diary and it was my error.

Mr. S: I still feel guilty. I knew I was 100% correct - if I hadn't thought that, I would never have mentioned it. This is what I am trying to face up to.

Coming here in the car, I felt small. I need reassurance, mothering. I lack confidence. I must tell myself over and over again that I did the right thing.

I have this very strong sense of shame tonight. It runs very deep: connected with feeling inferior. Why is it in my character like this? And why so much tonight?

Dr. K: It seems tonight as if you are moving between two poles: telling yourself that you should never have raised the matter, and telling yourself that you must face reality.

Mr. S: Well I think that the session and the events and tonight are constructive - something seems to be happening. I'm feeling shame intensely, partly because I am getting somewhere - but I do have this inner turmoil telling me to get away. Shame seems to be negative and controlling, trying to get me back to the fantasy world and away from the real world.

(Mr. S): I understand shame - its direct contact with the real world that I don't understand.

(silence)

That's the negative side. I can also feel shame in a positive way - as a genuine emotion, an involuntary feeling which just wells up.

Dr. K: Perhaps a feeling can tell you something.

Mr. S: It's possible. When things happen like with the bill, I make a decision, then I change it and I oscillate in a state of indecision. This is connected with shame. I'm ashamed of being the sort of person I am.

Dr. K: It's impossible for you to face reality if you are not you.

Mr. S: When I came here in the past, I often was physically here but not really here. Not in my mind. I never felt shame. I'm saying I don't want to be me.

(silence)

Someone wanted me to be someone else.

(silence)

There's a sense of disappointment about. Not mine. It's more like a feeling of expectations disappointed. It's linked to this constructive shame.

I must come to terms with the fact that I am what I am.

(silence till the end of Session).

At the next Session, he revealed for the first time that his parents wanted him to be a girl.

Case 4: Mrs. P

Mrs. P came to me 9 years after the completion of a successful analysis. In the final phase of this analysis she had got married and sometime later had a boy. Her difficulties recurred with the birth of a girl a few years after. However it was several years before she became seriously concerned about the distance she had put between herself and her family. After an initial period of settling into the analysis and feeling comfortable about being understood, she went into a prolonged phase of continued arguing, denying meaning in what

I said, putting up barriers to contact and getting confused by interpretations. The first long holiday was very difficult for her but on return she was pleased to be back. She rapidly developed a warm soft relation which soon turned into an anxious inability to talk which resolved with interpretations of her fear of spoiling the analysis. It became clear that, except within her family, Mrs. P operated with a social facade under which lay intense and primitive infantile experiences and much confusion. For example, an important piece of work just preceding the sessions to be reported, focused on her confusion between her mouth and her vagina and their associated sensations. This seemed to be important in enabling her to take from the analyst as interpretations were being experienced simultaneously as nourishing feeds and exciting penetrations.

Again, the pattern we are concerned to examine extends over two sessions. In the first, the patient is in a state of self-narcissism, in touch with her emotions and the value of the sessions. At the end of the session she refers to an experience of embarrassment and locates it in the Waiting Room. The waiting-room is the transition area between her different contexts - out of her social milieu but not yet fully in the analytic milieu. As a final comment in the session, it is part of her transition to the outside world (which she usually makes by looking at her watch about 5 minutes before the end of the session), and a transition, possibly, between one session and the next. There was no time for any interpretation, but, as I had expected, in the next session the patient presents in a florid state of object-narcissism: false, confused, and blocking out assistance from and relation to the analyst. This is interpreted using my theory of narcissism.

Session 1:

She attended in a very distressed state. The previous evening she had had sexual intercourse without taking any precautions against conception. She was panicky about being pregnant. She was uncertain about whether she wanted a baby, particularly as she was aware that she just wanted a baby, and not a child destined to grow up. I commented that the uncertainty concerned whether she would

accept the baby part of herself and that she had a strong wish to locate this part outside herself as a solution to having to own it at all. She went on to talk about going to a gynaecologist friend to have a coil (intrauterine device) inserted. She hated this procedure and referred to the previous interpretation which was equated to herself, to the baby and to a penis. My interpretation simply referred to her baby experiences. She replied thoughtfully: "I feel so vulnerable in the analysis...(silence)...in the waiting-room, I feel embarrassed..."

Session 2:

Mrs. P arrived 20 minutes late. Though she frequently had come a few minutes late, this was the first time lateness was substantial. She offered an apology couched in social terms though fully aware that lateness is to be analysed not to be pushed aside with politeness. She then described having forgotten to put the alarm on and rapidly became confused. Her sentences were ungrammatical and their sense jumbled. She said she did not understand my ideas about baby feelings but insisted that she wanted to come to the analysis. She also spoke about problems at work. During these associations, I made two interpretations which I thought might be helpful. On both occasions she said that she had been thinking about something else while I was talking. In both cases, the something else referred to uncertainty as to whether or not she should participate enjoyably and cooperatively in some group activity. I reflected to her that she had ignored the contents of my comments, and connected this behaviour with her uncertainty as to whether she should participate in the analytic process. When I pointed out the way she stopped herself taking anything in, she replied: "I don't want something inside me. I went and had the coil removed. I often don't listen to people". I replied: "If your social facade is not on, you feel so vulnerable - you are sensitive to being affected, like a baby." She was silent for a while, and then said: "Your arrangements make it all so impersonal. A series of patients come in... the common entrance... the door bell and electrical opening". I responded: "You make it impersonal because if it's personal, then you would be irritated or annoyed by these

things. You would want to criticise me. These are the sorts of experiences you think are horrible and that you don't want to have".

The Session ended here.

Conclusion

Because aggressive impulses are part of the human constitution which must be restrained for social reasons, guilt based on a fear of authority or on conscience is inevitable. Similarly, because of the unalterable nature of a person's past and the basis for his psychic constitution on that past, the urge to abandon psychic life so as to meet social expectations is equally inevitable. Shame developed as a signal that such an urge is about to be given in to. Once contact with psychic reality is abandoned, shame will no longer be felt. If an individual is securely in himself, shame is also rarely experienced. As the tendency to abandon oneself increases, shame appears, initially unconsciously as a wish to hide, and eventually painfully and intensely in the forefront of consciousness. At this point reassertion of the value of psychic reality and human relations is possible. This means tolerating a self-image with negative tonings, that is to say, feeling inadequate, pathetic, crippled, hideous, or whatever. No one finds this pleasant or desirable, but narcissistically damaged individuals, by definition, find it intensely painful and nearly unbearable. Unfortunately, once a state of object-narcissism is established in the mind, it can be difficult to shake off. The psychoanalyst can help his patients if he understands shame and associated phenomena as they present in transference.

Summary

The key feature of the author's theory of shame is that it reflects an impending move from a state of "self-narcissism" to a state of "object-narcissism". Clinical material is provided to demonstrate this discovery, and its application during psychoanalysis.

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