SHAME IN THE THERAPEUTIC DIALOGUE  
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The first step across the threshold into therapy is so often a painful one. Patients enter therapy with a volatile mix of hope and dread. When therapy is sought only after many other attempts at solving life’s challenges have led to naught, patients view therapy as their last recourse. A sense of urgency pervades the description of their problems. If therapy does not work, they do not know where they will turn. They must reveal their “failures” to a total stranger. They do not know whether or not this stranger will scorn them, be kind to them, like them, or perhaps be indifferent to them and their sufferings. The patient is often awash in dread and shame, and usually unable to speak of it, because the relationship is so new and frightening.

I recall the first time I ever sought therapy. I was in college. I was referred to a local clinic. I had to tell my story to a “gatekeeper,” who then assigned me to a therapist. I remember that I felt very ashamed of myself in the gatekeeper’s presence. His cool, aloof, business-like demeanor exacerbated my sense of myself as a “second-class person.” I thought of myself as a disgusting, spoiled baby for having the problems which were propelling me into therapy. I also worried that he would disdain me, believe I was exaggerating, and feel disgust towards me. He might also decide therapy would be pointless for me. I was so encased in my own shame, and fearful of his shaming attitude, that I spoke in a robotic monotone throughout the interview. Needless to say, he thought I most certainly needed to be in therapy!

The first meeting with a new patient is not an easy time for the therapist, either. The therapist is vulnerable to self-doubt and shame-anxiety in the initial meeting: will I be able to help this patient? Will I be able to feel feelings and have an attitude toward this patient which will be beneficial to this patient’s treatment? Will I be able to like or respect this patient in a relatively consistent manner? Or perhaps my work with this patient will confront me with how woefully inadequate I am, and even worse, how cold-hearted (or jealous, angry, etc) I am, such that I do not have the necessary human qualities to be in this business.

Thus, to differing degrees, both therapist and patient may bring to the encounter a concern over being stripped bare, exposed in one’s defects. And from the moment of first meeting, much of the trajectory of the patient-therapist relationship is shaped by the shadow of shame, either as a potential or as an actuality, in the dialogue which occurs over the course of the therapy. In my opinion, much of the success of any in-depth therapy is contingent upon the therapist’s capacity to tolerate the ever-present risk of shameful exposure, and on her resilience in the face of shame itself.

In prior chapters, the reader has been shown how thoroughly shame permeates our psyches, how so many of our problems in living are created and shaped by shame. Shame, fear, and guilt; these are the “feelings about feelings,” the boundary keepers, the affects which color our lives like a background wash on canvas, lending a faint or intense hue to whatever other thoughts and feelings may be occurring.

One aim of therapy is to increase the range and intensity of a patient’s affectivity. Shame about what he feels, or how intensely he feels, interferes with a patient’s capacities for contacting and self-regulation. It is difficult to contact, and bring into awareness, feelings and
thoughts and perceptions about which one feels ashamed. Thus, shame inhibits awareness, and shame inhibits contact. For instance, in the contacting process, one’s affectivity is evoked, one thing leads to another, and before he knows it, the patient is plunged into the shame of experiencing a forbidden feeling, a feeling which exists outside his I-boundary. Thus, work with shame, and the rigid cage in which it keeps one locked up, is often the “stuff” of therapy.

This chapter is focussed on one particular dimension of shame in psychotherapy. I shall focus on shame and its vicissitudes in the therapeutic dialogue. I shall not focus on how the therapist might identify and work with patients’ shame issues in a more general sense. Rather, I will attend to working with and being sensitive to, shame as it occurs as a product of the interactions between therapist and patient.

There are elements of the therapeutic situation which lend themselves to evoking shame in the patient. For one thing, the therapist is more important to the patient than vice-versa. In the case of patients whose fundamental self-image is not colored by shame, then the shame of this differential is short-lived, and the resolution of it leads to increased empathy and compassion for his attachment needs. However, the patient whose self-image is laced with shame may, for a prolonged period of time, believe he is an unwelcome, burdensome or loathsome intruder in the consultation room. Such a patient will likely be exquisitely sensitive to the signs of the differential, easily wounded by its emergence, and assimilate it readily into a fixed belief that the difference is the confirmation of his unworthiness, and of the therapist's understandable distaste for the patient and his needs.

A related element which is potentially shaming is the uneven exposure of patient and therapist. The patient reveals more of himself than the therapist does. The therapist is revealed to the patient, to be sure, but not nearly to the same degree. The difference in exposure breaks a social code of reciprocity. The one who breaks the code by "going too far" usually feels ashamed. Also, as with the difference in importance described above, this differential establishes the therapist in a relatively more powerful position. The therapist can more easily hurt the patient through carelessness, misattunement or defensiveness. Simply the awareness of the power differential can evoke shame over one's powerlessness.

Another element which is not intrinsic to the therapeutic situation, but is a common occurrence, is that the patient is sometimes shamed by the therapist's seeing too much. In my experience, a patient first needs an experience of my affective participation with him before he can appreciate my observations as being made from a position of being an ally rather than a cop. Observations made cavalierly have the same shaming potential, signaling a disrespect for the seriousness of the patients' struggles to establish their most creative adjustment in their lives.

**THE THERAPIST’S SHAME**

A final element, and perhaps most important, is the therapist's own most human tendency to avoid her own shame, through such defenses as blaming, denial, contempt, and subtle and gross efforts to transfer the shame onto the patient. Wurmser (1981), described three major modes of shame (different from variants of shame, such as embarrassment, mortification, self-loathing, humiliation, etc). He suggest that there is shame proper, which is the
direct experience of shame. Then there is shame anxiety, the experience of anticipating shame as an immediate danger. Anxiety about the immediate possibility of shame will usually set into motion aversive or avoidant defenses. That means that the forming figure of interest which has given rise to shame anxiety will be abandoned in favor of a new figure, that of self-protection. Finally there is shame as potential. The potential for shame leads to the development of a character style meant to ward off shame, which is an ever-present danger. People whose foundational self-image is laced with shame are likely to be sensitive to shame as a potential in all interactions, hence they develop a character style which is meant to counteract that possibility (e.g., defensive grandiosity, or hiding and dissembling).

To some extent, all of us have developed character patterns design to reduce our potential for being shamed. However, a therapist who is predominantly organized around avoiding experiences of shame—that is, a therapist who is dominated by shame as a potential—will likely be highly constricted in her therapeutic approach. A major problem with such therapists is that their character style operates largely outside of awareness—so as to avoid shame! Instead their constricted therapeutic styles are easily rationalized as correct and appropriate therapeutic stances. A good example is the authoritarian, "expert" stance one finds in the conduct of classical psychoanalysis.

Among gestalt therapists, there are those whose dread of their own shame prevents them from embracing the radically field-theoretical precept that all psychological phenomena are intersubjective in nature (both in origin and in emergence in the here-and-now). Thus, if a patient is suddenly confused, a defensive therapist might consistently ask how the patient is confusing himself (often a shaming intervention itself). The therapist who can tolerate the possibility that the therapist herself might feel some shame if she comes under scrutiny as a partner in the intersubjective field is free to also ask the patient what part she may have played in his becoming confused.

Another defensive shield which can be used by shame-avoiding therapists of all persuasions, is an epistemology which asserts that the therapist's perspective is more legitimate and "correct" than the patient's perspective. When therapists think of their patients as "distorting" or "projecting," for example, they are assuming that they have privileged access to what is "real." There are many therapists who have such an epistemology. I do not mean to assert that all of them intend to reduce their potential for being shamed. I am suggesting that such an epistemology can be used for such a defensive purpose, and often is.

In general, shame-avoidant therapists are reluctant to expose their work, and tend to blame and counter-shame the patient under the guise of "confronting the patient with another perspective," or "confronting the patient with reality." They are also reluctant to seek out supervision, and often--most unfortunately--reluctant to go into therapy themselves. Because of their tendency to hide, they rarely get a chance to learn about their own shaming tendencies, and shame-avoidant constrictions.

By and large, I think easier vulnerabilities for therapists to learn about in their work are shame proper and shame anxiety. It behooves therapists to be aware of what situations typically evoke their shame and shame anxieties, and the defenses (especially shame transfer) they use to protect themselves. That awareness might short-circuit escalating shame-counter shame spirals characteristic of so many impasses in therapy. The awareness might also enable therapists to be courageous and forthright in acknowledging their contribution to disruptions and impasses in the therapy process. Such acknowledgment is usually the first step in resolving a
disruption or impasse, and ultimately enriches the therapeutic dialogue as a whole. Examples of my shame, shame anxiety, defensiveness and recovery will be included in the vignettes to follow.

THE DISRUPTIVE EFFECTS OF SHAME IN THE THERAPEUTIC DIALOGUE: IMPASSE, RECOGNITION AND RESOLUTION

So often, shame provoking incidents occur when a therapist is too centered in her own perspective, and out of touch with the patient's experience, even in a small way. While I do not wish such painful experiences on my patients, they do often lead to a clearer illumination of a fixed gestalt, and to a chance for new, reparative contact between the therapist and patient. A relatively benign example occurred between me and David. David was intense, and easily injured. He was coming to see me for a period of three months while his therapist took a maternity leave. In our first meeting, he asked if we could arrange a regular weekly session time. He said it would help to anchor him during this difficult time. He was feeling bereft and abandoned by his therapist, and frightened that the therapist's new baby portended a loss of his place in his therapist's heart and mind. As our discussion unfolded, I told him that although there would be occasional exceptions, we could meet regularly on Friday mornings.

A few weeks later, I told him, in a rather matter-of-fact tone, that I would have to reschedule three of our subsequent sessions. In our next session, he expressed hurt and righteous anger at my casual attitude. He said it meant to him that I did not take our interim work seriously, that I was just biding my time with him. Frankly, I was surprised by the intensity of his reaction. I felt a flash of reciprocal righteous anger, saying to myself, "how dare he attack me, I have gone out of my way to accommodate him, surely he must know it was not easy to carve out a regular time of such short notice!"

My angry reaction was defensive. I had experienced his righteousness as shaming to me, and I wished to defend myself against my rising shame by shaming him for shaming me! I also recognized that I had presumed that he was aware of the demands he had made upon my schedule. I had simply been so absorbed in my own perspective that I had not noticed that his vantage point was quite different from mine. In the course of our explorations, he described how he had never had any impact on his parents and on how they treated him. They were dismissive of his aims and desires. I asked his how I had dismissed him. He said I ignored his need to plan, and his feelings about needing an anchor and needing me to see our work as important. He said he felt like he was just a flat line, someone I did not need to contend with. I told him, appreciatively, that he had now brought himself to me as someone to contend with. I also said I had been insensitive to his needs and had been preoccupied with my own. He was excited and relieved that we could work/fight this problem out between us.

This exchange laid the groundwork for later therapeutic work. There were other times when he came upon limits of my availability. One example was that I ended our sessions on time, and "coldly," whereas his primary therapist tends to run overtime quite regularly. He was also encountering some limits with his son, who was trying to protect his psychological space from my patient's intrusions. With me, he threatened to quit therapy. With his son, he wrote a letter aimed at punishing him by withdrawing from him.
For my part, I acknowledged that my stricter time boundaries must be a surprising insult, given how his regular therapist works. At some point I also told him that he was not the only one who was distressed by my apparent coldness at the end of sessions. It is as though, once the official session is over, I "turn off." Although it is something I have worked on, I have been unable to remediate that style fully. I rue the impact on my clients, and recognize they are left to make their accommodations to a difficult moment.

When he settled into a more reflective state of mind, I called his attention to the pattern I had noticed; whenever he came upon someone's limits he seemed to be deeply wounded, and he reacted with self-protective withdrawal. He smiled slyly at my reference to self-protective withdrawal, and said he doesn't just withdraw, he tries to hurt the other person as well! He laughed at himself. As we continued to explore, it became clear that someone else's limits were intensely shaming to him. He took them as a personal rejection of him because he was not worthy of more serious consideration. We discovered that my openness meant to him that I was not intentionally shaming him, even though he felt ashamed. This was an exciting revelation to him. He began to understand that another's self-centered behavior may have little or nothing to do with the other's feelings towards him.

He began to reassess his situation with his son, and other situations in his life from this new perspective. He also began to recognize that when his feelings of shame emerged, it was a sign that his worst ideas about himself were being triggered. He began to pause and examine the situations, and his ideas about himself, instead of simply jumping into action. An example was that the next time I hurt him and it triggered his worst ideas about himself (and his belief that I agreed with his negative self-evaluation), he called and left an angry message threatening to quit. But he came for his next session, and said he was hurt and angry. I said, "hurt and angry enough to want to quit, eh?" He smiled softly and said that he knows now that he says that. He realized soon after his call that he did not want to quit, he wanted to get my attention.

The above vignette has many elements in it pertinent to the topic of shame as it occurs in the therapeutic dialogue. One element is that the scheduling difficulties were a concrete enactment of a common shame trigger in therapy: the therapist is more important to the patient than the patient is to the therapist. The vignette also demonstrates a common occurrence when shame is evoked: a reciprocal shaming process. It is not uncommon for one who is threatened with growing shame to protect one's self by attacking the other in a shame-provoking manner. This is shame transfer. This can set into motion an escalating shame-blame cycle. The therapist here bears responsibility for breaking through this cycle by inhibiting her desire to retaliate, or at least by interrupting it after she has acted upon it.

Another element in this vignette is the place of self-disclosure in working with shame in the therapeutic dialogue. There are many ways in which therapist self-disclosure is relevant. Sometimes the therapist may reveal to the patient a way in which their vulnerabilities are similar. This seems to be shame reducing when done judiciously. In the case above, I took responsibility for my contribution to his distress. This seemed to do two things: one is that it reassured him that his complaints would be heard and taken seriously so that the shame of being dismissed would not be repeated in our discussion about how dismissive I had been. Also, it did convey something of my human frailties or limitations, which equalized us a bit, even though there was a painful differential which could not be denied.

The above example illustrated a common event in psychotherapy. The therapist is momentarily misattuned to the patient's shame propensity, and says or does something which
provokes the patient's shame. The resolution of such episodes is usually relatively easy, and
highly fruitful, as described above. It does require of the therapist that she be willing to suspend
(bracket off) her own perspective temporarily while she immerses herself in the patient's
perspective (empathic immersion).

Other, more highly charged interactions are more difficult for therapists. The principle
remains the same; the therapist strives to bracket her own perspective and reactions
temporarily while immersing herself in the patient's perspective so that both patient and
therapist together may grasp and articulate the patient's experience. Yet sometimes that
process can founder on the rocks of the therapist's defensiveness. When people feel ashamed,
or threatened with the possibility of shame, they act aversively. This means essentially, that
whatever forming figure was being supported by their interest/excitement, now becomes
interrupted. The interest/excitement is withdrawn from the forming figure, and the patient--or the
therapist!--either withdraws or defends himself by means of aggression or compliance. The
aggressive reaction from the patient can be particularly stressful for therapists when done
repeatedly, especially since the aggression often takes the form of overt or covert shaming
criticisms of the therapist.

An example from my own practice is the case of a patient who is profoundly ashamed of
himself for needing, for having a separate mind and will, at times for even being alive. His most
dominate variant of shame experience is humiliation. In fact, we both consider it a
developmental achievement (an expansion of his I-boundary) for him that he recognizes
feelings of shame now, for in our early years he only knew he constantly felt humiliated. Every
interaction with his wife, with me, with his bosses, was filled with the awful specter of humiliation
as an ever-present possibility. And the interactions often did humiliate him. This experience
was so common and so intense that he quit work, and has only slowly over the years begun to
work at jobs which offer greater responsibility as he has gained more capacity for contacting
which does not inevitably become organized as humiliating for him.

In our early years I nicknamed him (privately) my "silent patient." He lamented that there
was nothing he could say which did not lead him to feel humiliated. And he repeatedly pouted
and harangued me for "not caring," and for being purposely insensitive to him. Slowly,
painstakingly, our relationship has evolved to one where we can laugh freely with each other,
explore shame-laced material of his, and occasionally disagree with each other. Yet there are
still times between us when he attacks my intentions, accusing me of being cruel, punitive,
uncaring, secretly despising him because he is such a monster. He becomes harsh and bitter,
and needs me to reassure him vehemently that I am still in his corner.

His tirades are wearing on me. I feel misunderstood and unappreciated. I am constantly
tempted to point out to him how he lashes out at me. When I feel injured and ashamed, I very
much want my tormentor to acknowledge what he is doing to me. Whenever I take such a tack
with this patient, I merely shame him more deeply because he already feels so monstrous. He
is quite aware that he lashes out at me, and he feels shame and self-disgust for being so mean.
This sets another spiral of recrimination and self-recrimination in motion, along with escalating
his angry demands on me that I disprove his fears about my own feelings towards him.

We have been through this cycle many times, because at some point my patience wears
thin and I try to relieve the pressure on myself by getting him to see how he is pushing me
away, or punishing me, or whatever. Recently he gave me an opportunity to react differently,
and more therapeutically with him. I had responded with some excitement as he told me of a
new resolve he felt to explore a particular problem in his life. Later he called and left an angry message on my phone machine. He had interpreted my excitement as a sign that I was impatient with him, and that he was finally going to deal with something which I had long wanted him to face. Needless to say, he felt humiliated as well as angry. He said he did not need a return call, he just wanted me to know how he felt when it was fresh, because he knew he might shut down by the time of our next session. My first reaction was defensive. I was angry and hurt that he had not appreciated my resonant excitement for him. I knew that confronting him would be an enactment of my own needs, and I knew from experience that a confrontation would only shame him more deeply, so I wanted to work with myself to get to the point that I could work differently with him at our next session. I became more acutely aware of my own pattern; I want someone who hurts or shames me to recognize what he is doing to me. I felt compassion towards myself for that desire, while at the same time recognizing that my patient was trying to tell me how I had hurt him. I was able to decenter from my own needs enough to appreciate his perspective. I felt better prepared to meet with him the next day.

I spent the first part of the next session helping him to articulate and to understand his perspective, and at some points I also told him--to the best of my knowledge--how I had been feeling (pleased for him, excited, not impatient). When the disruption had been fully understood, we both began to reflect on the process which had taken place between us. It became an opportunity for us to examine the shame spiral which affects both of us. The most important lesson for me in working with him, is how hard it is for me to decenter from my own defensiveness at times, and how closely related my defensiveness is to my shame.

It does seem to me that the biggest impediment to working through therapeutic impasses--and perhaps the most common therapist contribution to the development of an impasse--is the therapist's difficulty with her own shame. What follows is a description of how my defense against my own shame (in this case, humiliation) contributed to an impasse, and how the impasse was resolved in part by my acknowledgment of my difficulties. This case was first reported in Hycner and Jacobs (1995).

This is a patient with whom I wrestle with seemingly intransigent countertransference difficulties. Unfortunately, this man's characterizations of me when he is disappointed in me confirm my worst fears about myself as a cold and heartless person. I react to what I experience as a humiliating exposure by withdrawing psychologically, thereby compounding his sense of my destructive defensiveness. Eighteen months into treatment, this recurrent pattern brought us to a point of impasse. I had, by this point, admitted to having countertransference difficulties, and I was working to lessen their impact on the therapy, although without much success. In agony, he sought a consultation with a colleague of mine. He was in an excruciating bind. He was very attached to me, and could not imagine surviving without me. On the other hand, this pattern was also "killing" him. The consultation proved useful for both of us, in underscoring his desperation. I decided to tell him more about what I knew of my countertransference difficulties. I told him that I felt humiliated, and dreaded that his characterizations might prove to be true of me, and my defense against the humiliation was withdrawal. That session was transformative for both of us. By articulating my experience, directly with him, I am less dominated by my dread of humiliation. My patient was deeply moved, and relieved in that by my admission of my own agonizing self-doubts he was freed of the burden of trying to "work around" my problems. Now they could be addressed directly and empathically as they occurred. He no longer feels responsible for pushing me away, although he is saddened that this particular pattern has been so painful for both of us. I cannot describe in words the increased intimacy, humility, and depth of relating which has occurred between us, but it is quite palpable to both of us.
Another event in which my shame played a part occurred recently between us. Needless to say, we have continued to plod along, sometimes working smoothly together, sometimes awkwardly. We work awkwardly when I sense he is angry and blaming towards me, yet he has no such awareness. I find myself determined to get him in touch with his anger so that it can be talked about directly. He is sometimes aware that he is, in his words, "having a tantrum." Yet still he cannot identify his anger or his scolding criticism of me, which I remain convinced is present in the air. I sometimes become sharp and annoyed with him at these times. I feel out of control and moderately ashamed of my poor therapeutic temperament, yet I also recognize I feel desperate to protect against feeling humiliated once again.

A few months ago, I became annoyed again. He reacted with hurt and withdrawal to protect himself. As we explored his wish to withdraw, he said that my annoyance (which I had acknowledged), struck him as similar to his father's annoyance just before his father would fly into a rage. He said my tone of voice was similar to his Dad's. I asked if he had the experience with me that my annoyance escalated. No, he said, he had not. Yet, something sinister and dangerous was in the air. We attended again to my tone of voice. I asked if something else was in the tone of my voice. He brightened with an "aha!" of awareness. He said, "I know what happens when you get that tone of voice. You have made up your mind about me. You have decided what THE TRUTH is, and nothing I say can change your mind. So I might as well withdraw rather than be annihilated by your unmoveability!" To my chagrin, I recognized myself in his description, and said so. I had become entrenched in my version of the truth, and became defensively condescending in addition. He had no recourse within the confines of the consulting room, no "court of appeals."

Interestingly, since that time he has begun to be able to identify with his own experience of anger and criticism towards me. It has been difficult for him, but by concentrating attention on his facial expressions he is gaining awareness, not only of his angry and defensive shame-based attacks on me, but of his intense fear of acknowledging his anger and defensiveness.

Another crucial trigger for shame in the therapeutic dialogue is embedded in the story just told. Perhaps the most common trigger for shame is when one is treated like an object when one wants to be treated as a subject (Broucek). This is commonly the burning shame of victims of racism. In the vignette above, once I had "made up my mind," then my patient could no longer expect me to relate to him as a subject. He was now merely an object to me, and needed to protect against the humiliation of such a reduction.

THE HEALING EFFECTS OF SHAME IN THE THERAPEUTIC DIALOGUE:
TRANSFORMATIVE CONTACT

Up until now I have called the reader's attention to the shame potentials in the therapeutic dialogue, and to the therapist's defensiveness which may exacerbate therapeutic disruptions and impasses when shame is at issue. And I believe that shame is at issue in most impasses, and when disruptions become escalated into impasses.

My point here is not that shame can, or even should be avoided. It is inherent in much of the pain which patients bring to us. But our sensitivity in responding to shame can
enhance the therapeutic process. An interaction which ameliorates shame that has been aggravated by a therapist's intervention can instill hope. The positive experiences of resolving shaming interactions can provide a template of hopefulness against which work on deeply embedded shame issues can take place. A patient gains confidence that the therapist is sensitive to his shame, and that he can turn to the therapist to help him regulate his exposure to that painful affect. This will allow him to work, even with his intense shame, because he can enlist the therapist as his ally in wading through the pain of facing his most deeply embedded shame.

There is another side to the problem of shame in the therapeutic dialogue, and that is the transformative power of the resolution of shame issues within the therapeutic relationship. This is in keeping with a gestalt therapist's faith that healthy contacting begets healthy contacting. But it runs even deeper than that. In long term therapy, a patient invests the therapist and the therapeutic relationship with enormous hopes. As I said at the beginning of the chapter, therapy is often a last resort. Many patients have told me that the success or failure of therapy is a "life or death" proposition for them. Sometimes life or death is quite literal, most often it refers to psychological life and death. These patients bring their most problematic feelings, thoughts, and beliefs about themselves into the therapy relationship. One patient told me, in our first session, that he desperately wished for a place where he could be fully himself, depression and all, in a relationship where the other person would not have to be compromised in relating to him.

Arnold Beisser, author of The Paradoxical Theory of Change, once said that while there is not much a therapist can directly offer a patient, she can offer a patient permission. That permission is the permission to be themselves. I think that patients are constantly assessing our interventions for whether or not we offer permission to have the feelings, aims, and needs which they have. They note our posture, tone of voice, choice of words. And when they do not find permission, they often assume that their feelings aims and needs are "beyond the pale." This means they do not belong in human company anymore. This is a fundamental shame self-statement: I am not fit for human belonging.

One of the things patients need permission to experience, is their shame, and their defenses against their shame. This can be a very uncomfortable experience for the therapist, as I have illustrated above. Certain patients have developed character styles which include the use of blaming and shaming as self-protective, or defensive, means of coping with their injuries and their shame. It is not easy for therapists to engage the patient in explorations--especially explorations of the therapist's impact upon the patient--when the patient criticizes and shames the therapist. It requires of the therapist that she tolerate her own shame throughout sessions stretching over long periods of time. Most, if not all patients are shaming of the therapist at certain times in the course of a long term therapy, even if that is not a primary style. A senior colleague of mine told me that she supports herself by reminding herself that if she is feeling shamed by the patient, it may well be a sign that the therapy is actually on track! The patient may be feeling safe enough in the consulting room to risk bringing the most noxious aspects of his personality into the relationship (Brickman).

If a therapist can relate in a relatively non-defensive manner, be alert to her shaming impact--even the most inadvertent shaming impact--and consistently work to acknowledge her defensiveness when it is having an impact on the patient, then a transformative process can be set into motion. Because if shame episodes (episodes in which the therapist has played a contributory role) are repeatedly examined and resolved, the patient with a shamed self-image
begins to evolve a new experience of himself. He begins to trust that the therapist will reliably work to understand--and help the patient to understand--how the therapist has been hurtful, shaming, etc. This trust enables him to be bolder and bolder in asserting his perspective, his needs, his aims, his feelings, aspects of himself which may have been too shameful to reveal ever before. He discovers that no matter what he says, and no matter even if he hurts and gets hurt along the way, the patient and therapist together will work things out. This leads to a self-perception as one who is worthy of being met, instead of someone worthy of derision, dismissal and rejection.

Thus, the most basic shaming self-statement, "I am unfit for human company," has the most potential for resolution by paying close attention to the vicissitudes of shame between the therapist and the patient. In my opinion, the resolution of what Bob Lee calls internalized shame is one the greatest gifts we offer to patients.

REFERENCES


1. In this chapter, masculine pronouns will be used in reference to patients. Feminine pronouns refer to the therapist.