

## **Shame in the Transference/Countertransference Interaction**

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The phone rang just before Gwen's session, and I thought I could probably squeeze in a brief conversation before I asked her into the office. Since I had been anticipating a call from the blood lab, I picked up, expecting a routine report. Some jarring, surprising medical news. Jesus Christ - my transplanted kidney was in jeopardy, the creatinine had risen, meaning that my kidney function was decreasing. And there was Gwen in the waiting room, our last meeting before my scheduled week away. I shook my head vigorously, reached for composure, and then quietly invited her in for her time. The following vignette represents a composite picture from several patients, to assure confidentiality and respect for privacy.

Once in the office, her eyes fixed on the couch, but then moved quickly to the chair opposite me. "I think I want to sit, this time, to see you before you go." He spoke yearningly of wanting to keep an image of my face, and then alluded to the photograph of me that he had taken some weeks before, a photo that he kept on her desk, causing some friction with Shell, her husband. "I guess I worry." I quietly repeated her last word. "Yes, that something will happen....to you." "Like a plane crash?" "Or that you'll get sick, and they won't know what's wrong; they won't be able to ... help you." "To save me," I amended; feeling still the churning and fear initiated by the phone call minutes before. As was often

true, Gwen was pretty close to the pulse. "I guess I'm afraid that you won't come back, that we won't be able to continue."

Gwen felt overwhelming sadness as she anticipated my leaving because she was indeed fond of, and concerned about me. My reminders that I would be gone for only ten days did nothing to allay her fears. I listened with as much composure and attentiveness as I could muster, but at the same time I was absorbed with my own concerns. "What if the levels of creatinine kept climbing?" Now my mind started racing. "What if I lost this replaced kidney, and had to go back on that god-awful dialysis?" Gwen was complaining that she wasn't sure I understood how frightening my trip, my absence, was to her; that it was bringing back terrifying memories of her father's absences and inattentiveness, of his lack of interest or discernment about his daughter. I listened as carefully as I could, but my own needs broke through. "God, will this hour ever end so I can call Dr. X to find out what the hell is going on?"

In what was by now the "background", I heard Gwen saying "I really don't know if you're aware of how desperate I am." It felt like she was speaking from within my own unconscious! While trying to be as aware as possible of her terrors, my own kept prevailing. In the seconds preceding my speaking, a confluence of thoughts and feelings raced through, approximating the following:

"Gwen is a therapist, a gifted one. Maybe I **am** conveying my own preoccupation – maybe it **is** like her father's absences, but this is real. I too am scared. It's not just her. We've worked well before at untangling impasses

between us, often with my sharing what's on my mind, by disclosing my thoughts as they relate to her. She already knows a lot about my kidney transplant; with fairly frequent schedule changes, I've had to tell her some details about these absences." I needed a few moments – I could sit quietly, watching, trying to convey that I have her only in mind. But she knows me, my moods – I can't, won't, fake it. Revealing my own fear might even let her know that I am fully aware of hers."

I paused, and then exclaimed abruptly, "You know, Gwen, it reminds me of the story you told of when you were mad at your parents and ripped up the raggedy dog doll that you loved." "What?" she blurted. "I never ripped up my dog doll – I loved that animal! You must be thinking of someone else." With the shock of recognition I realized that she was right, that I was recalling and retelling a story from a different patient. My own anxiety of the moment had so distracted me that I had merged my recollection. "God, I wonder if I've chosen the right analyst – are you over the hill?" Her question cut to the quick – just then I was wondering much the same thing. "I'm scared about your going, I'm worried about you, about needing you, and I'm scared about staying with you. Do you really think I'd do something so explosive?"

I responded first to her feeling of fright. After asking for and hearing her further thoughts about what had frightened her, I acknowledged, "You know, I think I do understand your fear, Gwen. In fact, at this moment I'm scared too." I

found myself telling her, "Just a minute before you came in I got a call from the lab that my kidney function isn't looking so good; it was a surprise, and I'm worried." Gwen immediately expressed sympathy and concern – her first response was almost always that of a caretaker (which intuitively I had in mind, maybe even was counting on) – but then she became agitated and angry. "See, you don't really understand what I'm feeling, you don't even have me straight in your mind. Your feelings come first – you had to focus on your own distress, getting me confused with someone else at this time when I'm feeling so panicky, alone. It feels like there's no room for my concerns, my needs, for me – I'm crowded out." I was struck, parenthetically, by the progress implicit in Gwen's being able to recognize and express anger at this loss of recognition by my own problems, but I quickly felt queasy about what I had done.

Gwen's feelings rapidly shifted from anger to self-consciousness, and then to shame. She interrupted her angry outburst by expressing consternation at being so disrupted and unforgiving for a simple lapse by me, her distracted analyst, understandable given such a threat to my health. She was embarrassed, and said that she felt "stupid", "ridiculous" for being angry at me. Then she shifted from her response to my proclamation to feelings about needing me so desperately in the first place. "It's pathetic that I need you so badly, that I worry about your being incapacitated; I'm a grown woman, a group therapist, for Christ sake. I tell people in my groups that it's ok to need each other, we all do.

And yet, here, now, I feel like such a jerk to be so concerned, so attached to you.”

Gwen’s plight jarred me into focus, and I commented on her shame over her emotions – anger, and fear and need. At the same time I was able to recognize my own shame at having “left” her by confusing her with another patient, at having been so confounded by my own concerns, breaking the flowing expression of her distress. I said something like “Look, my own anxiety intruded on yours, Gwen, got in the way of your feelings.” She stared. “So you got angry at me, but it also made you self-conscious, ashamed. Then you felt humiliated at your anxiety about my going away. But I **had** intruded – that was real.” Her face softened, and she looked down. I said, “I think my own needs made you self-conscious, and then ashamed about your own needs and anger.” But more – I quietly said, “You know, I see that I’m ashamed too, for that – for having interrupted **you**, gotten you wrong, failed you as a competent analyst. I mean, here, I’m the shrink, and it’s **my** needs and fears that took center stage at that moment. In my club it’s not supposed to go that way; especially at a time like this, when I **am** leaving. I’m sorry,” I repeated.

This interchange between Gwen and me gradually calmed the tension between us. Paradoxically, she was able to return to her anger and, ultimately, to her disappointment at not having had the chance to work on her terror of my absence before it occurred, at the encroachment of my health problems on her need for my steady presence. Especially was she concerned that my confusion

might represent a waning of my intellectual capacities, but she also realized and explored the possibility that I had implicitly picked up on her aggression and sadism, including within the transference for my leaving her, as she recalled her father's frequent absences. The lack of certainty about my continuing health and alacrity as a base for our ongoing work together was not only a threat to Gwen, but also, at this moment, to me. I clearly felt shame for my "indiscretion", but also I had to grapple anew with the shame evoked by threats to my body. She, in turn, responded with remorseful self-hatred for the potency of her neediness and of her destructive fantasies. Her distress also made me anxious, since the discussion was not only about confusion and about air crashes, but really about death, incapacity, and losses; now I had to stay alive and alert for her as well. I yearned to take back my blunder, but we both recognized that by now it was a vital part of our exchange. We had to deal with it, and the anger and resultant shame it provoked.

Our separate shames and fears had commingled over our individual needs, and had, in fact, informed each other, both explicitly and implicitly (through gesture and tone, as shame so exquisitely does). I commented on these shared responses, and we talked together about them during this incident, which became a frequent guest in our work following my return from vacation. We alternately talked about her anger; my vulnerability and the "unpredictability" of my presence; the early dynamics surrounding the danger of my trip; my analytic fallibility; and, of course, our mutual shame. These concerns engaged us

in intense collaboration – to figure out the sources of our actions and the meanings of our separate shame. The collaboration that these tasks engendered served to overcome the breach that our separate needs had created, and to reunite us in reestablishing the goals of Gwen’s analysis.

### **Reflections**

I gave this episode considerable thought before I put it to paper for this symposium, primarily because of the lingering shame it evokes simply in the telling. However, I decided to proceed because this interchange illustrates the mutual interplay of shame as an example of the inevitable “intrusion” of feelings into the therapeutic pair, whether desired or not. Other factors in this enactment might all have served as relevant focii for discussion (such as the understanding and deepening that progressed from, or perhaps in spite of, it; matters of therapist **self-disclosure** and the impact of life events on the **person** of the analyst; dysjunctive and conjunctive intersubjective influences and pulls within the therapeutic system (Benjamin, 19\_\_; Bromberg, 19\_\_; Renik, 19\_\_; Stolorow, 19\_\_)). The purpose of their paper remains, however, to look at shame within the transference and countertransference; with this in mind, I will shape my considerations.

Considered from a traditional perspective, transference shame can be seen as the playing out of early developmental shame themes upon the person of the analyst, who may or may not enact a significant role in the present expression of the drama. For example, a man just entering analysis is afraid that

his words are hollow, and that he appears as an empty shell to his analyst. He feels that his analyst must be bored by him, and this causes considerable shame, which then makes him angry. After his analyst asked him to talk about anything that might have made him feel this way, the patient unearthed distinct memories of his father ignoring him, turning away, and telling him that the sadness and depression he had tried to talk about as a child was “ridiculous”, untrue.

Countertransference shame is frequently evaluated from the perspective of projective identification. I prefer to call this the “relocation” of shameful feelings from patient to analyst. This often occurs in the shape of **defenses** against the shame experience (eg., denial and rage), examples of Lansky’s “hidden shame”(Lansky, 2005). For example, one patient rids herself of shame by projecting it onto the therapist in the form of **contempt**; another’s expressed anger serves to turn passive into active, concealing with **rage** the shame of narcissistic injury; some patients find their shame unbearable, and **withdraw** from treatment (by quitting, missing appointments, or dissociating in the actual presence of the therapist). Each analyst will respond idiosyncratically to her patient’s shame-driven provocations, but it behooves us to attend to and recognize shame when it comes our way.

In part, we collude with patients to avoid dealing with the pain and consequences that countertransference shame induces in us, but this view risks what self-psychologists have criticized as “blaming the patient”, as though they were the instigator of our own shame. Rather, we analysts enter therapeutic

encounters with our own programs, our own immediate past experiences, our “invariant organizing principles” (Stolorow, \_\_; Fosshage, \_\_), as in the impact of my illness and the medical telephone call on my session with Gwen. This element, then, does not represent the traditional countertransference as implied in even contemporary analytic theory – the analyst’s response to feelings generated by the patient – but rather reflects imposition of the analyst’s reality on the template of the analytic encounter. The transferences, then, of both patient and analyst include elements of the immediate “here and now”, as well as past images and current responses to the other’s images. That aspect of my enactment with Gwen reflecting my response to the phone call might better be considered as the **actual configuration** of the particular response to outside events, rather than as a countertransference to the patient’s input. At that moment, I was unconsciously turning to Gwen, in her well-developed capacity as care-taker, to put aside her own needs and to respond to mine. I believe that, historically, it has been the intensity and discomfort of shared pain – analyst with patient – that for so long kept shame in the unacknowledged background as a significant psychoanalytic phenomenon.

But let’s return to Gwen and me, and to my reflections on the interactions that I have just tried to describe. Shame is vibrantly contagious between members of a couple – be they lovers, scholars, or therapist/patient. Not infrequently, the analyst will feel that she is somehow “failing” her patient – not providing the sustenance or assistance that the patient is seeking. From one

perspective, this represents “empathic failure”, but such feelings of insufficiency often originate in the analyst’s sense of shame. Shame, for analyst as well as patient, is difficult to sort out, as it is difficult to tolerate. The analyst’s shame may at times reflect the patient’s need – the need of the “other” – to clear herself of her shame, through its **relocation** it in the analyst described earlier as defensive/projective efforts by the patient to get rid of shame.

I don’t mean this observation to clear the analyst of responsibility for her mistakes, as some critics of “projective identification” maintain. Expression of my distress in this particular clinical interaction can hardly be offered as a “how to” of analytic practice. It happened, however – a dance/enactment between my patient and me, a depiction of tension between the two of us that could not easily be put to words. On reflection, in addition to my own internal tension, at that time I was feeling pushed, harangued by Gwen and her needs. I also felt some guilt at leaving her for vacation now – just as she was uncovering memories of abuse at the hands of her mother – in a manner that repeated abandonment by her father.

An additional factor fueling my enactment with Gwen had to do with her outside role as therapist and caretaker. We had explored in great detail her tendency to feel responsible for the burden of everyone’s woes – her children, her patients, and for my health and well-being. There was one time, however, when I accepted her character style and, in fact, turned to her for support and

succor. She, of course, intercepted this predilection of mine and confronted me with it, thus adding to my shame.

So, in this incident Gwen felt shame over her neediness, her anger, her dependence on me, and her childhood memories of helplessness. She felt weak, unlovable, and bad. I, on the other hand, felt frightened, fragile, needy, and – after my disclosure –temporarily ineffective as her analyst. For each of us, then, our experiences represented self-attributes that constitute what I have called “the language of shame” (Morrison, 1996). It was particularly over the feeling of neediness, I believe, that our mutual experiences of shame intertwined, interacting for both to generate the enactment between us. While remaining somewhat in the background, expectations for responsiveness and sympathy, and matters of mutual identification and projective identification/relocation, also played their part. These factors are typical of enactments in general, which frequently are wordless (even when generated by words), reflect intensity and pressure, in contributions (often dissociated) from each participant.

When I came back from vacation, Gwen had survived better than she had anticipated, providing some sense of mastery, a source of pride to counter the shame that she had felt over her neediness (as anger often does). She was, of course, relieved that I had returned, unharmed, and in timely fashion. I, in turn, had brought my own shame into the discussion, showing her that I had understood and empathized with her fear and her consequent shame. I also was

able to let her know of more recent information from my physician that made the call from the lab far less dire.

Having spoken openly of my own 'state' at the time that I had interrupted her flow, I felt that we had to move as well into consideration of her sadistic feelings toward me for leaving just at a time when she was uncovering memories of her mother's cruelty toward her and her sister while her father was away. An interesting contrast appeared in our discussion about our mutual anger in response to our shame – she at me for intruding in a way that made her aware of her neediness, and I at her for wanting so much from me at a moment when I felt weakened and couldn't attend in a way that she required. In our conversation, I reminded her of a comment I had made early in our relationship, when she was full of appreciative idealization; "You know, Gwen, there are going to be times when I'm going to fuck up." We both laughed. "You sure did," she chuckled.

### **Summary and Considerations:**

Shame had been long ignored in psychoanalytic canon because, I suggest, it causes such pain and remorse in both patient and analyst that an implicit pact evolved to disregard it. In the example with Gwen, shame underlies the interaction and it became imperative to work at bringing it into the consulting room. If shame, and its cause, remain concealed and unbearable, these must be handled delicately but persistently as a focus of treatment. Unacknowledged/

bypassed shame is the source of many a shipwreck in the navigations of treatment (H. Lewis, 1971). In the present instance, shame plays a role as both **instigator** and **result** of the interaction – a circumstance quite prevalent in the enactments of difficult treatment situations. Shame serves flawlessly both as stimulus to enactment, and subsequently as the sheepish feeling of having behaved badly, or out of control. When the analyst is able to recognize and acknowledge these feelings in herself, it is frequently useful to share this personal observation with the patient. By no means, however, do I advocate automatic self-disclosure; on the contrary, it evolves out of the particular interaction within the therapeutic dyad, as in my self-disclosure (of shame) with Gwen.

This paper proposes that shame, a most contagious of affects, frequently reverberates between patient and analyst within the shared relational matrix. Shame may reflect mutual experiences of feelings communicated one to the other, recognition of blame from the other or from oneself, or the outcome of enactments, often driven by different sources for each participant. The precipitants and manifestations of shame within the treatment dyad are often complex and ambiguous, but efforts at their clarification may ultimately serve to preserve the therapeutic relationship. An instance in my work with Gwen is examined to indicate some of these points.

End

