THE ROLE OF SHAME IN PSYCHOPATHOLOGY AND IMPLICATIONS FOR THERAPEUTIC PRACTICE

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Section A

Introduction

This thesis is comprised of four sections, each of which seeks to elucidate the nature of shame and its role in psychopathology. Section A provides an introduction to the overall thesis. Section B contains the main research component. Section C is a case-study. Section D consists of a critical literature review.

These four sections are conceptually linked by the theme of shame. This is an area of interest which personally evolved whilst working as a research psychologist, collecting clinical data, in a major MRC-funded randomised controlled trial (RCT) on unipolar depression in patients with a partner, and known as the London Depression Intervention Trial (Leff et al., in press). Participants were required to take part in two in-depth, semi-structured interviews, carried out by the author, and covering extensive aspects of their childhood and upbringing. The interviews also explored current self-concept and interpersonal functioning in a range of domains such as relational, occupational, domestic and parental roles. As this was a clinical research trial, interviews were required to be audio-recorded and participants' informed consent was obtained. It soon emerged that certain areas of participants' lives elicited shame in the course of the research interviews. Such areas included experiences of physical and sexual abuse, bullying, shame about behaviour or appearance,and concerns about overcompliance and passivity in past and current relationships. These areas also included experiences which exacerbated a pre-existing vulnerability to low self-concept, such as being made redundant. Evidence of shame was demonstrated by shrinking body posture, increased eye avoidance with

the interviewer, state shifts, digressions, under-reporting or minimisation of material, and abrupt changes of topic. At times, participants requested that recording equipment be switched off, both for reasons of "confidentiality" and, I began to suspect, shame. Participants would become less articulate and more hesitant when describing shaming events, or when constructing their personal narratives, often experiencing strong emotions such as anger or resentment, of which they had been unaware at a conscious level. Participants were often surprised at the strength of their feelings relating to material that was seen as irrelevant or "all in the past" - this being an example of "bypassed" or unconscious shame (Lewis, 1971), which would often take the form of other more acceptable emotions. Participants in the trial were also required to fill in a self-report measure to assess shame- and guilt-proneness, along with an extensive battery of other measures (both self-report and observer-rated) to assess shame-related phenomena such as guilt, social anxiety, submissive behaviour, internalised anger, negative automatic thoughts and attributional style. A diagnostic interview was also carried out by the author, the Present State Examination (PSE), to assess current clinical status. The Shame and Guilt Scale (Gilbert et al., 1989) was used to explore shame- and guilt-proneness, in addition to current self-functioning and childhood adversity factors, which had been assessed in the two research interviews.

The resulting research project (Section B) utilises three different paradigms to investigate the role of shame in adult psychopathology. Firstly, an extensive empirical methodology is used to look at participants' scores on shame and their inter-relationships with other depression-related variables. Secondly, a more qualitative paradigm is used which involves a content

analysis of interview data, and this explores in depth those childhood adversity factors which have contributed to, and maintained, the development of a shame-prone self. From this, childhood maternal indifference emerges as being highly significantly correlated with adult shame-proneness. And thirdly, a single case-study design is used to look at shame in one of the author's long-term psychotherapy patients, where there had been high childhood maternal indifference, and presenting within the context of a narcissistic personality organisation.

The next component of the project (Section C) describes a patient, seen by the author whilst working as a GP counsellor in the NHS, presenting with high internalised shame originating in childhood and resulting from an indifferent and rejecting parental style. The therapy uses a cognitive-analytic approach within a time-limited therapy (in this case, 12 sessions) to elicit the patient's underlying cognitions and beliefs and shows how these impact on, and shape, current behaviour. Being time-limited, it focuses less on the psychodynamics of unexplored feelings and minimises the transference in contradistinction to the case-study in Section B (Chapter 6) where the patient was in long-term regular psychotherapy for two years and the transference was actively explored and analysed. The case-study in Section C serves to illustrate how linking early parental rearing styles with current maladaptive self-beliefs and repetitive, and unproductive, cycles of behaviour can be explored and resolved within a predetermined and time-limited therapeutic framework.

The final component (Section D) reviews the usefulness of working with dreams in therapeutic practice and draws attention to the concept of "bypassed shame" (Section B, Chapter 2) where shame is often denied, disowned, unrecognised or reformulated by the patient. It is argued

that dreams provide useful clinical insights into patients' shame-generative material and can be used constructively, regardless of practitioner orientation. An analytic approach to working with dreams is postulated to be most relevant where there is unconscious, or bypassed, shame as this helps guide the therapist in eliciting material which may often be denied, minimised or unconsciously distorted.

Taken together, it is anticipated that these four components provide an interwoven and thematically-linked framework for exploring the role of shame in psychopathology and its implications for therapeutic practice. The composite thesis highlights the range of diverse yet overlapping approaches that can be taken by the practitioner in recognising, responding to and working through shame in the therapeutic encounter. It hopefully goes some way in extending our theoretical and clinical knowledge about this important affect.

Throughout the development of this study, my co-existing roles as research psychologist and counselling psychologist have converged and been mutually enriching. Although research interviewing does not share the same therapeutic focus, it does require the necessary practitioner skills of authenticity, warmth and accurate empathy in order to elicit and clarify important and sensitive information.

Section B

THE ROLE OF SHAME IN PSYCHOPATHOLOGY AND IMPLICATIONS FOR THERAPEUTIC PRACTICE

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"Nothing is more disillusioning than the discovery of one's own inadequacies" (*Jung, 1951, 'The Shadow' in Aion, Collected Works, 9, 2)*

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Acknowledgements

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My thanks also go to the Medical Research Council which funded the London Depression Intervention Trial from which this study has developed.

Declaration

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Abstract

Using a cross-sectional design, a self-report measure of proneness to shame and guilt was administered to 86 patients with moderate to severe depression, with the prediction that there would be a positive correlation of shame with severity of depression. Contrary to other, non-clinical studies, it was found that guilt but not shame was associated with levels of depression. Shame-proneness demonstrated a unique association with a stable attributional style for negative outcomes, general negative self-evaluation, submissive behaviour, negative automatic thoughts, social anxiety and internalised anger. Shame-proneness and guilt-proneness were both associated with dichotomous thinking or 'splitting'. A range of childhood adversity factors was also investigated derived from ratings on the Childhood Experience of Care & Abuse interview (the CECA) including childhood sexual and physical abuse. Contrary to prediction, no relationship was found between shame- or guilt-proneness and a reported history of childhood sexual or physical abuse. From the other childhood adversity factors, only childhood maternal indifference demonstrated a positive association with adult shame-proneness. Empirical findings are discussed including limitations of the measure used in this study to assess shame- and guilt-proneness. A content analysis of the CECA interview data showed that maternal indifference, as characterised by maternal emotional unavailability, was the most significant component. These results give empirical support to the psychoanalytic concept of the role of mirroring in childhood, and a clinical case-study is presented to illustrate the role of childhood maternal indifference and adult shame-proneness, presenting within a narcissistic personality organisation. Finally, overall findings are summarised and implications for working with the shame-prone patient in therapeutic practice are discussed.

Chapter 1: Introduction

"Shame, I do believe, is the most powerful emotion known to man; most discoveries and journeys of importance have been accomplished because of the ignominy that would be the result if the attempt was abandoned" (Iain Pears, 1997, *An Instance of the Fingerpost*)

Overview

The current study developed from part of a larger randomised controlled trial (RCT) known as the London Depression Intervention Trial (LDIT) which was set up to compare three treatment interventions for primary unipolar depression, and to assess differential relapse rates, in participants who had been in a heterosexual relationship of at least one year's duration. The three interventions were antidepressants plus education about depression (psycho-education), cognitive therapy, and systemically-based couple therapy for participant and partner. Assessments were made at three time points - at initial intake, at post-treatment (9-12 months after start of intervention), and at 2-year follow-up from treatment start date. All data in the current study were taken at initial assessment before randomisation into the trial and are therefore cross-sectional.

My personal interest in shame developed from my theoretical interest in its relative neglect psychodynamically as, from Freud on, far less attention had been paid to shame's clinical or theoretical relevance compared to guilt. Also, from a clinical or therapeutic perspective, it soon became clear that whilst discussing certain "shame-evoking" areas in their lives, participants would request that the audiotape be switched off while they talked about certain experiences during the research interviews. The taping of interviews was necessary as these formed an important part of the

research study and had to be rated. Participants' experiences often included distressing incidents in childhood (such as being bullied, mistreated, neglected or abused), as well as current issues relating to sexuality, sexual identity, domestic violence, rape and assault, or addictive behaviour, where these were perceived by the participant as undesirable and outside their control.

Such "fears of disclosure" were inevitably accompanied by physiological manifestations such as blushing, loss of eye-contact, self-consciousness, manifestations of powerlessness (sighing, shrugging etc.) and the wish to conceal information. There were also verbal signs such as "state shifts" - abrupt changes of topic, digressions, trivialisation, under-reporting or denial, particularly about material which was clearly still sensitive although often described as "all in the past" and therefore no longer seen to be relevant. Such behaviour served to highlight the pervasiveness of the shame feelings themselves, compounded by the shame of feeling ashamed (a form of shame about shame or "meta-shame"), which increased psychological unease. Sometimes participants revealed strong feelings of anger or resentment directed towards themselves, as well as perceived perpetrators, about incidents or behaviour which they would rather have left "forgotten". There was also a tendency for increased eye avoidance with myself as researcher, and more frequent and longer hesitations before answering questions or elaborating shame-generating material.

In the current study, three methodologies have been used to explore the role of shame in adult psychopathology within a moderate-to-severe depressed sample. Firstly, a quantitative paradigm was used to explore the association of shame with various symptoms and correlates of

depression, as assessed by standardised clinical measures (described in Chapter 4). Secondly, a content analysis of transcribed interview data was carried out, derived from participants' comments in an in-depth childhood adversity interview, to explore the association of shame with aspects of early parental rearing style (described in Chapter 5). The findings are then examined within the context of two major psychoanalytic theorists, Winnicott and Kohut, and focus on the concept of "maternal emotional unavailability". Thirdly, a single case-study is presented (Chapter 6) which highlights those aspects of adult shame-proneness which derive from the original dyadic relationship with the mother and manifested here within a narcissistic personality organisation. The final chapter (Chapter 7) summarises the overall findings and assesses their implications for psychotherapeutic practice with the shame-prone patient.

Introduction

It is generally accepted that shame is one of the most powerful, painful and potentially destructive experiences known to humans (Kaufman, 1989; Nathanson, 1994). Even the first story of the Bible, of Adam and Eve, is a story of shame. It recounts how they broke the social rules of the Garden of Eden, became aware of themselves as objects for the observations and judgements of each other and of God, and became fearful of those judgements and their consequences. This is the essence of shame - the fear of negative evaluations by others, via exposure of undesirable qualities about the self or one's actions (M. Lewis, 1992).

Indeed, the Indo-European root of our English word "shame" is from "skem", which is a word for cover, with connotations of wishes to hide and fears of exposure.

Many languages are richer than English in the basic shame vocabulary. Thus, French has both "honte" and "pudeur"; German has "scham" and "schande". These words differentiate disgrace as social (ie. scandal, criminality) from the inner personal experience of shame that has its roots in bodily experience. Noah's shame was that, in a drunken state, his genitals were exposed; Adam and Eve's shame was their nakedness in the sight of God and of each other.

Historically, shame has been regarded as the "Cinderella" of the unpleasant emotions, having received much less attention than anxiety, guilt or depression. Freud (1896) interpreted it as a fear of ridicule (ie. of social origin) whereas Piers (Piers, 1953) interpreted it as a response to failure to live up to one's ego-ideal (ie. of personal origin). Guilt is seen to occur if one transgresses an injunction derived from outside but represented in the superego, such as incest. It is conceptualised as a consequence of deeds, intentions or thoughts about others and is essentially linked with the idea of "bad conscience".

In short, shame occurs if one fails to achieve an ideal of behaviour set by society or oneself, whereas guilt embraces the notion of harming or seeking to harm others, and has been referred to as a form of "moral shame" (Kaufman, 1989). Kaufman has also referred to shame as the "affect of inferiority", while Scheff (Scheff, 1988) called shame the "emotion of deference". More recently, Susan Miller (1996) has argued that shame is now so often seen as "the bedrock of psychopathology" and "the gold to be mined psychotherapeutically" (p. 151) that there has been neglect of other emotions and their interface with shame.

There are still many differences of conceptualisation concerning the affect of shame, despite some evidence of a growing consensus, and as yet we still do not possess sufficient methodologies to explore these differences empirically. This study aims to investigate those unique concomitants of shame (in contradistinction to guilt) which contribute to psychopathology and the implications for therapeutic practice.

As Adler expressed in 1918 (q. Pines 1995, p.350) "Shame is a product of a feeling of relatedness and as such is impossible to exclude from the life of the human soul. Human society would be impossible without this affect". According to Pines (1990) our bourgeois post-enlightenment society has tended to emphasise the affect of guilt over shame, and inevitably psychoanalysis has reflected this. Also, many of the roots of such theories were laid down in times of self-analysis, when it was more difficult to "keep one's eyes open" to one's more shameful aspects.

Distinguishing Shame and Guilt

Guilt is less enduring than shame, as it relates more to actions than to identity; one can pay the price demanded by conscience, or society, and thereby be redeemed. The word "guilt" itself is related to "geld" (money), and represents debts that are to be paid - thus it provides a powerful motive for reparation. The re-emergence of shame in our literature accompanies the attention now given to identity and the concept of "self", in contradistinction to the narrower Freudian notion of a fixed and mechanical "ego", which was a product of his structural dynamic theory. This may be problematic for classical psychoanalytic theory, but according to Wurmser (1987), when the affect of shame is included into our vocabulary, and with it the language of self, it

broadens and deepens our vision theoretically and therapeutically. The point has now been reached where the role of shame is being increasingly recognised for the vital affect it is, and the role it plays in contributing to adult psychopathology.

According to Freud, shame was largely a reaction formation against sexually exhibitionistic impulses or wishes (Freud, 1905/1953); it was, he believed, developmentally prior to guilt and resulted in self-disgust and the wish to hide oneself. Freud argued that guilt emerged around the time of the Oedipus Complex, and was therefore more susceptible to the negative cognitions and self-rumination which characterise disorders of affect - melancholia (or depression) in particular. It is questionable however, given the historical evidence, whether Oedipus himself suffered from shame or guilt (the act of tearing out one's eyes could be seen as one of deep self-loathing or an act of atonement to the angry gods). Dodds (1951) argued that amongst the Ancient Greeks, guilt was linked with notions of sin and transgression against the gods whilst shame was seen as a response to fate. Oedipus contains elements of both, portraying the tragic hero as both initiator, and victim, of his actions.

There is undoubtedly a complex relationship between shame and guilt, and the likelihood is that many situations have the potential to elicit either emotion, or both (Tangney, 1992). Studies comparing structural and phenomenological dimensions of shame and guilt have confirmed that there are more similarities than differences in people's accounts of their experiences of the two emotions (Tangney, Miller et al, 1996; Wicker et al, 1983). In both studies, more similarities than differences between shame and guilt were reported, but the conclusion was that shame was the more intense,

incapacitating emotion and more likely to involve physiological accompaniments and feelings of self-disgust. In Wicker et al's study shame more often involved feeling inhibited and passive, while in Tangney et al's study shame was uniquely associated with feelings of isolation and regret. Levin (1967) believed some patients use guilt as a defence against shame; guilt can be less painful than shame because it carries a sense of power, whereas shame is characterised by powerlessness.

The traditional approach to the distinction between shame and guilt was that shame was conceptualised as a developmental precursor to guilt - an emotion that exists before one has internalised standards of good and bad behaviour which are socially-derived. Shame was viewed as the tendency to feel bad about misdeeds when caught by someone; guilt was seen as the tendency to feel bad about misdeeds because they violated one's own internalised standards (eg. Ausubel, 1955; Benedict, 1945; Erikson, 1950). In fact, this public-private distinction is still evident in some current theories (Buss, 1980; Hogan & Cheek, 1983). Buss (1980) presents this position as follows:

> "In brief, guilt involves *self-hatred;* shame involves *social anxiety* ... The best test of guilt is whether anyone else knows of the transgression. In true guilt, no one need know ... Shame is essentially public; if no one else knows, there is no basis for shame" (p.159; emphasis in original).

This idea is expressed in the following excerpt from *The Scarlet Letter* (Hawthorne, 1970): "There can be no outrage, methinks, against our common nature - whatever be the delinquencies of the individual - no outrage more flagrant than to forbid the culprit to hide his face for shame" (p.83). (Original published 1850).

But this traditional approach to the distinction between shame and guilt is too simplistic, and it has been argued

that shame may be experienced even when no one else is physically present (see Barrett & Campos, 1987; Creighton, 1990; Lewis, 1971, 1987; Stipek, 1983; Wurmser 1987). Tangney et al. (1994) in their study on children and adults, found that "solitary" shame was about as prevalent as "solitary" guilt. Neither did the degree to which others were aware of the respondents' behaviour vary as a function of shame and guilt for either children or adults. In fact, most current theorists who distinguish shame from guilt do so on a different basis.

Lewis (1971, 1987) has presented the most comprehensive position on the distinction between shame and guilt, and one that has had a strong influence on contemporary writings. According to her, shame and guilt differ in several ways, including the following: shame concerns moral transgressions *or* defeats (such as failure experiences), whereas guilt concerns moral transgressions only. Shame involves a focus on the self's deficiencies, whereas guilt involves a focus on negative events or acts for which one feels responsible. Shame involves a passive or "helpless" self, whereas guilt involves an active self, which often seeks to make amends.

Lewis argues that, in shame, the self is split into two functions - the self as an observing, disapproving entity, and the self as the object of such disapproval. This characterisation of the difference between shame and guilt has been highly influential, and major ideas from it are evident in most current theories of the difference between them (eg. Barrett & Campos, 1987; M. Lewis, 1991; Nathanson, 1987a). Therefore Lewis's (1971, 1987) conceptualisation of shame and guilt de-emphasised the objective content of eliciting events and instead highlighted differences in the individual's - or society's - *interpretation of the role of the self,*

particularly the manner in which self-relevant negative events are construed.

This shame-guilt distinction is succinctly portrayed in the following extract from *The Scarlet Letter*: "This child of its father's guilt and its mother's shame hath come from the hand of God" (Hawthorne 1970, p. 137) and highlights the social construction of gender-related distinctions in the appraisal of these two affects. This point is made by Tangney and her colleagues (1994) when they refer to shame and guilt as self-relevant *and* other-relevant emotions - uniquely and inextricably embedded in interpersonal contexts. Shame and guilt are seen to be determined less by the objective structure and content of an eliciting situation and more by the manner in which the situation is construed, with reference to both interpersonal and self-related dimensions.

Such a distinction, however, does not explore the possible *aetiology* of shame and guilt or why shame (more often than guilt) is associated with adult psychopathology. There is a lack in the literature on this issue, and the current study aims to investigate those childhood adversity factors and parental rearing styles which may contribute to shame-proneness in the adult.

Tangney and her colleagues also showed that, contrary to received opinion, a surprisingly high proportion of shame experiences involved private events (Tangney et al, 1994) questioning the assumption that it is necessarily socially-derived and publicly-contextualised. It seems possible that these private events may involve ruminations about personal shortcomings in the face of a real or imagined other. This reflects Nolen-Hoeksema's (1991) findings on the differential role of "ruminative" vs. "distractive" thinking in relapse prevention in

depression where "ruminative" could be defined as action-avoidant (shame) and "distractive" could be defined as action-facilitative (guilt).

Accordingly, issues of definition and operationalisation of shame and guilt measures have become central areas of concern to researchers in this field. There is evidence from other studies that respondents express more difficulties in talking about shame experiences than about guilt experiences when interviewed, although this does not appear to prevent them from doing so, and often at length, although the content is less specific (Lindsay-Hartz, 1984; Tangney, 1992). A related problem inherent in all assessments of dispositional (or trait) shame is the possibility that shame may, invariably, not be experienced at a conscious level (so-called "bypassed shame", Lewis, 1971). This may be the process observed when talking to participants about shame-eliciting experiences in their lives, where their strength of feeling genuinely surprised them, often after many years, and verbal and non-verbal signs of discomfort were manifested when alluding to these events.

Furthermore, the concept of dispositional or trait shame may be misguided, as recent research evidence suggests that shame may not generalise to a person's character or behaviour and may be mediated via specific markers such as "bodily shame" (Andrews, 1995; Andrews, 1997; Andrews & Hunter, 1997).

The Shame Experience

Lynd (1958) argued that the experience of shame has a close connection with identity and self-insight, and is provoked by experiences which call into question one's preconceptions about oneself which compel one to see oneself *through the eyes of others*. In other words,

recognising the discrepancy between others' perceptions, and one's own oversimplified and egotistical self-conceptions, is conducive to shame. Sartre (1956) redefined the essence of shame as the awareness of one's "Being-for-Others" and notes: "It is my body as it is for the Other which may embarrass me" (q. Mollon 1984, p.212). It is thus closely linked with ridicule, denigration, fear of negative evaluation, exposure or the sense of a "defective self". Lynd argued that shame, if faced up to, can increase insight and self-awareness; if denied, it can provoke the development of a defensive self, as found in the narcissistic personality. Thus, in Lynd's view, shame concerns the entire self, mutual social involvement, and alienation. Rycroft (1968) argued that shame is a persistent neurotic symptom which occurs in schizoid individuals who both over-value themselves but possess insight that their self-evaluation is not shared by others.

On a physiological level, shame is associated with the physical concomitants of blushing, eye gaze avoidance, head down movements, shrinking away, signalling the wish to hide or escape, and signs of self-consciousness (Gilbert 1998a; Tangney, Miller et al,1996; Wicker et al, 1983). It is often characterised by one's awareness of the discrepancy between one's self-perceptions and those of others, whether real or imagined (Lynd, 1958; Mollon, 1984; Sartre, 1956). This is in contrast to guilt, which derives from transgressions against moral laws or codes of behaviour and does not have the physical manifestations that are associated with shame (Lewis, 1971).

From an evolutionary perspective, shame is seen to originate from a desire for conflict-avoidance or submission, thus signalling acceptance of a subordinate position in the existing hierarchy; guilt has no such

clear evolutionary origin or function. When hiding is not possible, the nonverbal communication of shame, or "freezing", seems to act as a form of appeasement. Such behaviours include a hunched posture and eye gaze avoidance and serve the function of damage limitation (Gilbert & McGuire, 1998) and in mild cases may arouse sympathy and forgiveness (Keltner & Harker, 1998).

Tangney and Fischer (1995: p.10) extended the evolutionary focus of shame by making reference to its antecedents, responses and "self-control procedures" (Figure 1 refers).

Figure 1: Proposed Prototypical Script for Adult Shame

Antecedents: Flaw or deplorable action, statement, or characteristic of a person

A person acts in a dishonourable way, says something deplorable, or evidences a characteristic that is disgraceful or flawed.

Someone (other or self) witnesses this action, statement, or characteristic and judges the person (self or other) negatively.

Responses: Hiding, escaping, sense of shrinking, feeling worthless

The person tries to hide or escape from observation or judgment; he or she feels small, exposed, worthless, powerless.

The person lowers his or her head, covers the face or eyes, or turns away from other people. Sometimes he or she strikes out at the person observing the flaw.

The person is preoccupied with the negative action, statement, or characteristic, as well as with negative evaluation of self more generally.

Self-control procedures: Undoing and redefinition

The person may try to change the negative action, statement, or characteristic; disguise it; deny its existence; or blame someone or something else for it.

In addition to the notion of shame being grounded in a characteristic pattern of response or behaviour, as in Tangney & Fischer's model, it can also be grounded in one's identity and take the form of acquired or inherited shame.

Society and Shame

We may feel ashamed of what we are as well as what we *do* and this is inherent in Goffman's work on stigma (Goffman, 1963). It is also possible that one could be ashamed of *other people's* behaviour over which the individual has little or no control (an example would be being ashamed of "a family secret" that gets out). This is captured in the following quote from *The Scarlet Letter* (Hawthorne, 1970):

> "I know not whether these ancestors of mine bethought themselves to repent, and ask pardon of Heaven for their cruelties; or whether they are now groaning under the heavy consequences of them, in another state of being. At all events, I, the present writer, as their representative, *hereby take shame upon myself for their sakes,* and pray that any curse incurred by them ... may be now and henceforward removed" (p.9; emphasis not in original).

According to Andrews (1998) those of us who do not "measure up" to society's norms may experience a sense of "shameful differentness" (p.44) and the gap is likely to be filled by feelings of personal inadequacy and alienation. This reflects a genuine dislocation of the person from the community and the values enshrined in it.

The following quote from Janet Frame's (1984) autobiography, *An Angel at My Table*, captures Frame's childhood sense of "shameful differentness":

> "When I was a child, I was always excited by the adventure of a *first time*, and eager to share it with others. Now, I had missed so many experiences in ordinary living that my "firsts", out of step with the "firsts" of others, were felt to be a cause of shame" (p.124).

Conclusion

Therefore, my role as research psychologist in a major RCT on depression, where participants' recorded interviews covered sensitive and self-revealing aspects of their past and current lives, contributed to my existing theoretical interest in shame. In the current study it was decided to use three methodologies to investigate shame's aetiology and its role in the genesis of adult psychopathology.

There exist a range of models of shame and their diversity contributes to the complexity of shame's conceptualisation and measurement. However, there is a consensus that shame is experienced as a diminution of the self, in which one is exposed as flawed or deficient in some way. Wharton (1990) states that the focus of attention in shame is on the "self"; for guilt it is the "other". It is through the unique physiological concomitants of shame, such as blushing or gaze avoidance, that the attention of the other focuses upon the individual and makes them central in awareness.

One of the major challenges for research in this field is the differentiation of shame from guilt. This raises the issue of the notion of the self versus the notion of the ego. From Freud's case-studies it is seriously arguable

that Lewis (1971) was correct in believing Freud had misattributed his patients' shame feelings to guilt - ostensibly to fit in with his structural model of the mind which involved the concept of the internal superego or "conscience". Recent studies have established some commonality between shame and guilt. However, there is general agreement that it is the intense, enduring and incapacitating nature of shame which uniquely distinguishes it.

The traditional public-private approach to the distinction between shame and guilt has now been challenged and their differentiation has been established on another basis. Typically, shame is seen to focus on the self's deficiencies, whereas guilt concerns transgressions and a wish to make amends. Lewis (1971) focused less on the objective content of eliciting events, and stressed the importance of the individual's self-evaluations and self-appraisals in shaping cognitive and emotional responses as shame or guilt.

One serious deficit in the research literature is evidence concerning the aetiology of shame and guilt, and why shame (more than guilt) is associated with adult psychopathology. In order to address this more fully, the current study aims to investigate those childhood adversity factors which may be implicated in shame's early development and its maintenance into adulthood.

The distinction between "ruminative" versus "distractive" thinking in relapse prevention in depression (Nolen-Hoeksema, 1991) parallels the ruminative quality found in shame, where events are often dwelt upon, or replayed, in a way which impedes constructive or restorative action. Therefore, issues of defining and measuring shame and guilt, and the way they shape emotions, cognitions, behaviour and beliefs, have become central concerns of

shame researchers and clinicians alike. The affect of shame poses particular difficulties in that it may not often be conscious (cf. Lewis' "bypassed" shame) or may not generalise to all aspects of a person's life (Andrews, 1995; Andrews, 1997; Andrews & Hunter, 1997).

The phenomenological experience of shame (unlike guilt) is associated with fear of ridicule or denigration linked with the sense of a core defective self. In narcissistic personality disorder, such fears are denied and can promote the growth of a false or grandiose self, to overcompensate for deep feelings of inadequacy. Physiologically, shame has more physical concomitants than guilt, such as blushing or head down movements, which signal self-consciousness and the desire to hide. From an evolutionary perspective, this originates from the wish for appeasement and serves the function of damage limitation (Gilbert & McGuire, 1998; Keltner & Harker, 1998). Tangney and Fischer (1995) have extended shame's evolutionary focus by noting its characteristic antecedents and responses, and the psychological mechanisms by which it operates.

And finally, shame can also be inherited or experienced vicariously. Goffman's key work on stigma (1963) drew attention to the truth that people may feel ashamed of what they are, or what they represent, as well as what they do. And according to Andrews (1998) there is a sense in which deviation from the social "norm" can induce a sense of "shameful differentness" leading to feelings of isolation and dislocation.

It is anticipated that the findings from the current study may be used to inform and develop clinical practice with clients identified as being shame-prone or particularly sensitive to shame. In Chapter 2, a general overview of the literature is carried out which provides

an up-to-date account of the role of shame in adult psychopathology. This is followed by a discussion of the current methodological issues in shame research in Chapter 3. The studies which follow, Chapters 4, 5 and 6, provide three paradigms for studying shame. The final chapter, Chapter 7, summarises the overall findings and develops a therapeutic model of recognising and working with shame.

Chapter 2: A General Overview of the Literature

"At the moment you hate me because I've been instrumental in getting you something you're ashamed of wanting. I can't do much about the hatred, but I do think you should look at the shame. Because it's not really anything to be ashamed *of*, is it? Wanting to stay alive? You'd be a very strange sort of animal if you didn't ... Everybody who survives feels guilty. Don't let it spoil everything" (Pat Barker, 1991, *Regeneration*, Part I of the *Regeneration Trilogy)*.

Shame and guilt are universal affective phenomena and are often used interchangeably, as the above quotation implies. But numerous empirical studies (Ferguson et al, 1991; Lindsay-Hartz 1984; Tangney 1989, 1992, 1993) demonstrate that shame and guilt differ significantly along affective, cognitive and motivational dimensions. In shame, the focus of the negative evaluation is on the entire self. Guilt, on the other hand, generally arises from a negative evaluation of a specific behaviour or act involving harm (or wishing harm) to others, and the global self remains intact. In the literature, this is distinguished from maladaptive guilt, which is characterised by chronic self-blame and obsessive rumination. It is Tangney's view that guilt becomes maladaptive (or pathological) when it becomes fused with shame, and that it is the shame component that triggers a pathogenic sequence of affect and cognitions (Tangney et al., 1995).

There has been recent interest in the emotion of shame and its differentiation from guilt (Tangney & Fischer, 1995) and attention is now being paid to its clinical as well as theoretical relevance. As noted in Chapter 1, Freud viewed shame largely as a reaction formation against sexually exhibitionistic impulses (Freud 1905/1953). His main focus was on guilt, but Lewis (1971) argued that, in developing a primarily guilt-based theory (incorporated in his structural model) Freud mislabelled his patients' shame experiences as guilt. Significant

contributions to the study of shame have come from the exploration of the superego (Wurmser, 1987), affect theory (Nathanson, 1987) and identity (Lewis, 1971; Lynd 1958). More recently, shame has been highlighted as a key component in narcissism (Kohut, 1971; Morrison 1984, 1989), domestic violence (Lansky, 1987), schizophrenia (Morrison, 1987), depression (Nathanson, 1987ab), bi-polar illness (Goldberg, 1991) and eating disorders (Andrews, 1997). It has also been implicated in childhood sexual and physical abuse (Andrews, 1995; Andrews & Hunter, 1997; Andrews, 1998).

Lewis (1971) is one of the few theorists who has presented an integrated conceptualisation of the differential roles of shame and guilt in psychopathology. She suggested that the less-differentiated self of the field-dependent individual is vulnerable to the global experience of shame - and ultimately to disorders of affect (particularly depression). In contrast, the more clearly differentiated self of the field-independent individual is susceptible to guilt (by distinguishing self from behaviour) and to obsessive and paranoid symptoms involving vigilance directed towards "the field". This idea is captured in the concept of the "extended frame of reference of responsibility" in obsessive-compulsive disorder (Salkovskis, 1996). Lewis's views on shame are in line with current cognitive-attributional models of depression (Abramson et al, 1978; Beck, 1983) and Hoblitzelle (1987) has remarked on the conceptual parallels between Lewis's view and current cognitive views of depression.

Teasdale has made an interesting distinction between implicational and propositional cognitive systems ("hot" vs. "cold" cognition (Power & Dalgleish, 1997; Teasdale, 1993; Teasdale & Barnard, 1993). As Teasdale (1997b) notes, thoughts such as "I am worthless" are simple

statements of belief or propositions about the self. However, at the deeper implicational level, such a statement represents a rich activation of affect and memories associated with experiences of being shamed - similar to Bower's (1970) "associative network". Clearly, shame theorists and researchers are implicitly concerned with the richer, implicational, not propositional, level of reasoning. One problem, however, is that this form of processing may be difficult to verbalise or even have conscious access to (cf. Lewis' (1971) concept of "bypassed shame" where the shame is not consciously experienced and may take the form of another emotion, such as anger or rage). This may well limit the value of self-report measures in their attempt to capture largely non-conscious processes.

Among studies carried out with clinical populations, Andrews and Hunter (1997) found that shame directed at both one's character and one's behaviour was higher in patients whose depression had taken a recurrent or chronic course than in patients with a single short episode of depression. A study by Smith (1972) reported that severely depressed patients produced more shame than guilt themes, using a qualitative analysis of patients' descriptions of their earliest memories. But a study by Crouppen (1977) failed to replicate Smith's findings, and Hoblitzelle (1987) raised concerns regarding the validity of the Early Memories Test as an index of shame-proneness and guilt-proneness.

The current study is distinctive in that it is the first time the contributions of shame and guilt have been separately investigated in a moderate-to-severe depressed sample and its empirical findings have been reported elsewhere (Alexander et al. 1999). It uses a measure of shame- and guilt-proneness derived from evolutionary theory in an attempt to replicate the association between

shame-proneness and depression and to investigate its other correlates. The Shame and Guilt Scale was factorially validated on a non-clinical sample of undergraduates (N=96, mean BDI=7.5, SD 5.8) by Gilbert, Allan and Pehl in 1989, and was based on the work of Lewis (1986, 1987) and Hoblitzelle (1987). Preliminary analysis suggested a good separation of shame from guilt (Gilbert et al. 1989) although the actual correlation of shame with guilt was not reported. Their factor structure revealed one strong shame factor and two guilt factors (harming others and secretly cheating).

In a second study by the same authors (1989) the relationship was investigated between depression, submissive behaviour and shame in a small sample of depressed students (N=20, mean BDI=23.1, SD 13.5). It was found that *shame but not guilt* was strongly associated with levels of depression in both samples. In the non-clinical sample, BDI score correlated with shame 0.28 ($p<.01$); in the clinical sample, BDI score correlated with shame 0.55 ($p<.01$). The scale had a Cronbach alpha of 0.74 for shame and 0.75 for guilt; test-retest reliability was given as $r=0.75$.

The literature, however, is inconsistent regarding the relative importance of shame versus guilt in specific psychological disorders. Much of the inconsistency can be attributed to the fact that most theoretical perspectives have failed to make a clear distinction between them, and this has been mirrored by problems of measurement and differentiation. The importance of current methodological issues in the measurement of shame and guilt within a clinical context is discussed in Chapter 3.

The relationship between shame and guilt and various theoretical concepts is presented as a rationale for the

use of particular measures in the current study. Specific hypotheses that are to be investigated are outlined.

Shame and Depression

Shame has been seen as a major contributory factor in adult depression (Allan et al, 1994; Andrews, 1995; Brown et al, 1994; Gilbert et al, 1994; Tangney, 1993; Tangney et al, 1992). Gilbert 1997a and Gilbert et al, 1995 link shame directly with depression by emphasising their commonality, such as the emotional consequences of direct attacks on a person's self-esteem, events undermining a person's sense of rank, social attractiveness and value, and the effects of involuntary subordination. Shame and depression both relate to negative affective experiences involving self-relevant negative evaluations.

Gilbert (1989) outlined a number of depressogenic situations that resemble those drawn from life-events research (Brown & Harris 1978; Brown et al, 1987; Brown et al, 1994). Gilbert (1989) also refers to the concept of "blocked escape" and notes that one consequence of "fresh start" events that have been shown to relate to recovery from depression (Brown et al, 1988, 1992) is a reduced feeling of being trapped in a punishing situation.

Tangney, Wagner and Gramzow (1992) focused on exploring dispositions to shame- and guilt-proneness using the Self-Conscious Affect & Attribution Inventory (SCAAI) and replicated an association between shame-proneness and depression. However, their studies were conducted on university undergraduates and it is probable that a different pattern of results may have emerged if studying the shame and guilt correlates of depression in a clinical population. In fact, the guilt reported in much

of the clinical literature is an "insoluble" type of guilt - typically a "neurotic" or exaggerated guilt that is fused with shame (Angyal, 1965; May & Yallom, 1984; Menninger, 1938). It is this "shame-fused guilt" which, according to Tangney, Burggraf and Wagner (1995), is most likely to be linked with depressive symptomatology.

Tangney et al. (1995) argue that proneness to shame, not guilt, is a potentially maladaptive affective style with negative implications for psychological adjustment - depression in particular. Bibring's (1953) key psychoanalytic paper was the first to give an unequivocal role to the lowering of self-regarding feelings following an event involving loss, and the importance of loss in depression is now widely accepted. Those experiences involving a sense of defeat and powerlessness (derived from an act of submission in evolutionary terms) have been well established as a central component in depression (Allan & Gilbert, 1997; Price & Sloman, 1987). According to Beck (1974) the origins of negative schema provide a pivotal point in the early learning history of the individual. Beck comments:

> "In the course of his development, the depression-prone person may become sensitized by certain unfavourable types of life situations such as the loss of a parent or chronic rejection by his peers. Other unfavourable conditions of a more insidious nature may similarly produce vulnerability to depression. These traumatic experiences predispose the individual to overreact to analogous conditions later in life. He has a tendency to make extreme, absolute judgments when such situations occur" (p.7).

Gilbert (1998a) argues that such a description could equally well apply to the shame-prone individual. In cognitive theory, shame-proneness would be regarded as the result of the formation of early negative schema of the self, others and the world. It is important however

to note that Beck is not describing self-esteem as such, but a vulnerability to an affective disturbance.

Shame and Attributional Style

Because shame (unlike guilt) focuses on the global self which is relatively enduring, it is likely to involve internal, stable and global attributions or, in Janoff-Bulman's (1979) terms, "characterological self-blame", described in her research into depression and rape. An extensive empirical literature has shown a link between depression and a tendency to make internal, stable and global attributions for negative outcomes (Robins, 1988). To the extent that guilt involves a focus on some specific behaviour, the guilt experience is likely to involve internal, unstable and specific attributions for negative outcomes. According to Tangney et al. (1995) there is little theoretical or empirical support for a link between depression and a tendency to make internal, unstable and specific attributions for negative outcomes.

The attributional literature is consistent with the view upheld by Lewis (1971) and Tangney et al. (1995) that there may be a special link between depression and shame, but not guilt, because guilt would be associated with a less stable and global (ie. more flexible) cognitive style. Tangney, Wagner and Gramzow (1992) found a significant correlation between shame and internal stable attributions. However, it is possible to have a sense of a "bad self" without attributions of personal (or internal) causality - for example, one can feel shamed by a birth defect or a "family skeleton". Tangney and Fischer (1995) provide a comprehensive overview of the role of shame and guilt within various contexts.

Shame and Negative Self-Evaluation

Given the global negative self-focus of shame, it would be predicted that shame (unlike guilt) would be associated with general negative self-evaluation and low self-acceptance. Because shame also involves a real or imagined disapproving other (Lewis, 1971; Mollon, 1984) and general negative self-evaluations in response to negative events (Lewis 1986, 1987), it would be predicted that shame would be associated with self-consciousness, fear of negative evaluation and social anxiety (Gilbert et al, 1994). Mollon (1984) captures the essence of how shame involves an awareness of living negatively in the minds of others with a quote from the existential writer Sartre:

> "To feel oneself blushing, to feel oneself sweating etc. are inaccurate expressions which the shy person uses to describe his state; what he really means is that he is physically and constantly conscious of his body, not as it is for him but as it is *for the Other*" (p.212).

According to Pines (1990) the mother's refusal to accept and value the uniqueness and autonomy of the child produces shame. In the adult, depression may be viewed partly as a narcissistic disturbance, the disruption in the sense of self being central (Mollon & Parry, 1984). Tangney (1991) differentiates shame-proneness and guilt-proneness as two moral affective styles, where the former relates to "global, painful and devastating experience in which the self, not just behaviour, is painfully scrutinized and negatively evaluated" (p. 599).

Although empirical findings indicate shame can be experienced when a person is alone (Tangney et al. 1994) shame typically involves an awareness of how the defective self may appear to others, and is often associated with feelings of wanting to hide, disappear or shrink. Wurmser (1981) states that the basic aim of

"shame anxiety" is to hide. Because in shame the focus of the negative evaluation is on the entire self, it was decided to look at the self-evaluation and self-efficacy ratings from the Self-Evaluation and Social Support Interview developed by Brown and Andrews (Brown et al, 1990; Andrews & Brown, 1993) to see how these compared with scores on the Shame and Guilt Scale.

In 1902 Cooley coined the term "the looking glass self" in referring to the way we judge and feel about ourselves according to how we think others judge and feel about us. The "looking glass self" has three cognitive aspects: the imagination of one's appearance to the other person; the imagination of their judgement of that appearance; and some sort of self-feeling, such as pride or mortification. Theories of shame have followed a similar configuration and generally shame is seen to focus either on the social world (beliefs about how others see the self ie. social beliefs), the internal world (how one sees oneself ie. personal beliefs), or an interaction of both.

This passage from Dostoyevsky™ (*The Double*, 1864) illustrates the core of the shame experience:

> "Mr. Golyadkin wanted not only to run away from himself but even to annihilate himself, to cease to be, to return to the dust. At the present moment he was not taking in his surroundings, understood nothing of what was going on around him, and looked as though in truth none of the discomforts of the wintry night, not the long journey, nor the rain, the snow, the wind or any other ingredient of the bad weather, existed for him ... He was so bemused that several times, completely preoccupied, in spite of his surroundings, with the idea of his recent terrible disgrace, he stopped dead in the middle of the pavement and stood there motionless as though turned to stone; in these moments he died and disappeared off the face of the earth..." (p.166)

Grotstein's (1985) comment on the nature of projective identification could similarly apply to shame: "it...involves the desire of the infant - or the suffering adult - to become invisible, to disappear, or generally speaking, to negate his own existence" (p. 130).

Shame and Social Anxiety

Shame-proneness is recognised to be a major vulnerability factor for psychopathology (Dutton et al, 1995; Gilbert, 1992, 1997ab; Kaufman, 1989; Lewis, 1986, 1987; Mollon, 1984; Mollon & Parry, 1984; Schore, 1994). Tangney, Wagner & Gramzow (1992) found that shame (but not guilt) was significantly related to depression and anxiety in a student population.

Belsky, Steinberg and Draper (1991) and Belsky (1993), using an evolutionary model, suggested a direct link between early rearing environments and subsequent adult interpersonal behaviour and psychopathology (Gilbert & Gerlsma, in press). They argue that early environments act to select which social and reproductive strategies become activated within a personality. According to the authors, two basic strategies can be identified: type 1 - high alliance formation, affiliative, reasonably stable pair-bonding, and high care of offspring; type 2 - low alliance formation, relatively non-affiliative, unstable pair bonding and low investment in offspring.

In a sample of university students, Gilbert et al. (1996) found that recall of mother shaming, favouritism and feeling inadequate compared to a sibling, were significantly correlated with adult interpersonal problems of coldness, sub-assertiveness and introversion. These problems reflect similar difficulties in affiliative and co-operative relating, that is, in using

type 1 strategies, noted above. Therefore, early experiences of shame may become pathogenic because they affect interpersonal behaviour, and individuals who were chronically shamed in the past may adopt similar interpersonal behaviours in the present, such as being quick to respond aggressively, be submissive, avoidant, or feel chronically anxious (Nathanson, 1994). Such behaviours serve to increase vulnerability to psychopathology and maintain negative cognitive schema of self, others and the world.

Therefore, it would appear that anxiety is a central affect in shame experience and it is difficult to consider shame without it. As Leary and Kowalski (1995) note: "The defining characteristic of social anxiety is that unlike other anxieties, social anxiety arises from the prospect or presence of interpersonal evaluations in real or imagined social settings ..." (p.6).

In fact, according to Gilbert (1998a), social anxiety could be redefined as evaluation anxiety which, as the author notes, is precisely what Beck et al. (1985) did: "The experience of shame is important in discussions of social anxiety because the socially anxious person is fearful of being shamed in many situations" (p. 156).

The link between fear of negative evaluation by others, inferiority and self-consciousness is of particular interest, as it is these feelings which are intrinsic to social anxiety. As noted elsewhere by Gilbert (1992, 1997a) the central aspect of shame inferiority is that it is *involuntary*. According to Gilbert, if one voluntarily accepts a perceived inferior position and believes one's superiors will help, this will not elicit shame. To be defined as such, there must be some notion of a place or position one does not want to be in, or an image one does not wish to create and secondly, that this place or

image is associated with negative attributes from which one wishes to escape.

From a developmental perspective, parental shaming has been suggested as one source of social anxiety, for it sensitises the individual to the judgements of others and to the possibility of negative consequences (Gilbert & Trower, 1990; Trower & Gilbert, 1989). In Gilbert and Gerlsma's study (in press) recall of parental shaming is highly associated with social anxiety both before and after therapeutic intervention. The content analysis in the current study aims to explore the role of early adverse environmental factors in more depth.

Shame and Dichotomous Thinking

It would be predicted that shame, unlike guilt, would be positively related to the defence of "splitting" or dichotomous thinking, which involves a separation of good and bad images or thoughts about the self or others. The shame experience can be viewed as tapping into the "all-bad" aspects of the self. In contrast, the experience of guilt involves an implicit differentiation of self from behaviour whereby the self is not viewed in such global and dichotomised terms. Wharton (1990) explores the links between the Jungian concept of the "shadow" and shame, which is characterised by the use of early defences such as splitting, omnipotence and illusion, together with problems of separation. The frustration felt by the young child can be made more tolerable by omnipotent fantasies of self-fulfilment, and by splitting the frustrating object into a good one and a bad one, the infant can retain the good and push the bad away.

Many of the key cognitive-behavioural interventions for depression described by Beck (1983), Ellis (1971), and Ellis and Abrahams (1978) provide an effective means of

addressing *shame*-inducing cognitions (eg. Ellis' "shame-attacking exercises"). Shame, too, is associated with irrational beliefs and dysfunctional thoughts that are amenable to cognitive restructuring. Dutton (1994) found that shame-proneness was related to anger arousal in men who physically abused their wives, as well as to the use of "primitive defences" such as splitting and projection (Dutton et al, 1995).

Shame and Negative Automatic Thoughts

Given the association of shame with social anxiety and general negative self-evaluation, as well as fear of negative evaluation by others, it is not surprising that Richter et al. (1994) found moderate associations between recall of negative early rearing experiences and dysfunctional attitudes. Because internal experiences of badness, inadequacy and worthlessness are commonly associated with shame (Barrett, 1995; Nathanson, 1994) it would reasonably follow that such internalisation of "self as bad object" would lead to shame-proneness and an individual's vulnerability to generalised negative automatic thoughts about their self, the world and the future. Gilbert and Gerlsma contend that "via affectionate approval, non-shaming and non-favouritism, a parent enables a child to internalise a model of themselves as *a person of value with status in relationships*" (Gilbert & Gerlsma, in press; Gilbert 1992; Kohut 1977; Rohner 1986).

In contrast, early shaming relationships direct the child's attention to the difficulties of social relating, leading to various negative self and social cognitions related to internalised shame (cf. Cook's Internalized Shame Scale, 1996), unfavourable social comparisons and interpersonal problems (Gilbert et al., 1996). To explore

this further, it was decided to investigate whether there was a positive association between participants' negative automatic thoughts and their shame and guilt scores.

Shame and Submissive Behaviour

According to Harder (1995) shame is associated with a sense of helplessness or passivity in correcting a perceived fault. Guilt, conversely, involves criticism of a specific act (ie. the focus is not on the entire self), combined with intent to remedy or alleviate the problem. Therefore, in shame, global self-criticism is associated with a passive coping style, whereas guilt is associated with an adaptive (or non-pathological) response style. This idea is supported by the finding that shame is positively associated with submissive behaviour (Allan & Gilbert, 1997; Gilbert & Allan, 1994; Gilbert et al, 1995). Tangney and Fischer (1995) argue that feelings of shame tend to motivate behaviours that impede constructive action in social situations (eg. avoidance), thus supporting further the association between shame and passivity reported in the literature.

Gilbert et al. (1994) demonstrated that, as predicted by ranking theory, fear of negative evaluation (ie. helplessness, anger at self and others, inferiority and self-consciousness arising in shaming situations) is significantly correlated with submissive behaviour. As predicted in their study, inferiority experiences share an important relationship with submissive behaviour. Further research by Gilbert (in press) shows that, although a variety of submissive behaviours exists, there is increasing evidence that their function is mostly self-protective and used in contexts of perceived threat (Sapolsky, 1989, 1990ab). It is thought that shame-prone individuals utilise self-protective (rather than self-

enhancing) strategies to avoid their "flaws" from being revealed. There is also evidence that shame often presents as submissive behaviour in the context of social anxiety (Keltner, 1995; Keltner & Harker, 1998).

Research on the non-verbal behaviour of shame shows that shame involves submissive displays (eg. gaze avoidance, slumped posture and inhibitions on speech). This serves to appease others and limit possible attacks or threats. Shame displays, like submissive displays, are therefore "damage limitation" strategies (see Keltner & Harker, 1998 for a review).

Shame and Anger

Erikson (1950) was the first theorist to put forward the view that shame actually expresses anger or rage - although that rage is turned against the self and incorporates self-directed affects, such as feelings of self-disgust. Someone filled with shame would like to force the world to look away in order to keep their shameful situation from being seen. If possible, the shamed person would "put out the eyes" of the world, but failing that, can only wish to become invisible: symbolised in evolutionary terms by the "freeze" or "hide" response. According to Erikson (1959) the core essence of shame is that one is visible and not ready to be visible. Thus Oedipus' tragedy reflects a kind of projected shame, whereby in putting out his own eyes, Oedipus can experience himself as *invisible in the eyes of the world* and so vicariously escape unbearable feelings of shame.

Certain degradations or shameful experiences in childhood can lead to "narcissistic rage" (Jacoby 1994; Kohut 1972, 1977) whereby sadistic fantasies become a defensive form of reaction to shame. In psychoanalytic terms, this is

similar to the concept of "identification with the aggressor" where the shamed victim, in fantasy, identifies with their angry and aggressive persecutor, (eg. Jewish children in concentration camps impersonating their German captors).

Miller (1985) and others (eg. Lewis 1987; M. Lewis 1992; Retzinger 1991; Scheff 1987; Tangney, Wagner, Fletcher & Gramzow 1992; Tomkins 1987; Wurmser 1981) have commented on the relationship of shame to anger or rage, which Scheff (1987) calls "the shame-rage spiral". In general, these analyses derive from Lewis's description of "humiliated fury" (Lewis, 1971). Tangney, Wagner, Fletcher and Gramzow (1992) found significant correlations between the TOSCA shame-proneness scale, and hostility, anger arousal, and tendencies to blame others for negative events. Novaco (1976) described anger as serving the function of overriding less acceptable emotions, such as shame and guilt. Scheff (1987) highlighted the clinical significance of "shame-rage spirals" and reviewed the role of such spirals in therapy. Rage originating in shame and humiliation can be longlasting and have serious effects on the ability of people to form affectionate relationships (Lansky 1992; Nathanson 1994).

Research evidence also indicates that shame can engender a hostile, resentful, defensive type of anger (Tangney et al., 1992; Tangney et al., 1996) aimed at a real or imagined disapproving other. There appears to be a special link between shame and anger: once angered, shamed individuals are likely to manage their anger in an unconstructive fashion, according to Tangney and Fischer (1995). In contrast, guilt is less likely to foster feelings of anger, but when angered, guilt-prone individuals tend to handle interpersonal conflict constructively eg. by attempting to discuss things in a

non-hostile fashion. Dutton et al. (1995) found a stronger association of internal anger with shame than with guilt by using the MAI (Multidimensional Anger Inventory: Siegel 1986) and shame subscale of the EMBU (Early Memories of My Upbringing Inventory: Perris et al. 1980).

Retzinger (1991) and others believe that "shame-anger" arises from threats to a social bond - in particular attachment bonds. Lewis (1987) also seems to have held this view as she focused on the anger arising from separation (following Bowlby 1973) referring to it as "humiliated fury". On this view, it is possible to argue that shame-related anger, or "humiliated fury", is related to bond-breaking and loss of control of attachment objects. Gilbert (in Gilbert, 1998a) argues against this position, asserting that the infant who angrily protests is neither necessarily humiliated, shamed nor outraged.

Kaufman (1989) argues that shame ruptures the "interpersonal bridge" and causes disconnections between people: this is exemplified in the following quotation from Hawthorne's *The Scarlet Letter* (1970): "But the point which drew all eyes and, as it were, transfigured the wearer ... was that *scarlet letter*, so fantastically embroidered and illuminated upon her bosom. It had the effect of a spell, taking her out of the ordinary relations with humanity, and enclosing her in a sphere by herself" (p.81).

The self-psychologists (Kohut, 1977; Miller, 1996) argue that it is not proximity that is the domain of shame and rage but lack of mirroring ie. the absence of positive responding or approval-giving, withholding, indifference or lack of validation (see Gilbert 1992 for a comparison of Bowlby and Kohut). This is in accord with the

conclusions reached by Sidoli (1988) who places shame within a developmental context using information gathered from infant observation. Developmentally, it is argued that shame cannot really appear until the self has a sense of self and others as social agents who can approve or disapprove (Gilbert 1998a; Lewis, 1992, 1995; Stipek, 1995). Stipek offers evidence that lack of internalised positive mirroring experience might sensitise a child to later shame and affect social confidence. It would follow from this that maternal indifference in childhood, being the ultimate form of "non-mirroring", is likely to be significantly associated with adult shame-proneness. A child who experiences their mother as proud of them holds positive emotions of themself about themself (in self-psychological terms, a good self-object experience; Kohut, 1977). Thus, lack of recognition and dismissal of the self when the self tries to display something attractive and positive to others, can elicit shame affect.

Shame and Childhood Sexual and Physical Abuse

There is research evidence that childhood sexual or physical abuse is associated with feelings of shame or guilt in both sexes (Dutton et al., 1995; Gilgun & Reiser, 1990; Hunter, 1990; Tsai & Wagner, 1978) and with feeling shame of the body in adulthood (Andrews, 1995; Andrews, 1997; Andrews & Hunter, 1997). Therefore it was decided to explore shame- and guilt-proneness and the incidence of childhood sexual and physical abuse where the participant had experienced at least one significant episode of sexual or physical abuse, as measured by ratings on the Childhood Experience of Care and Abuse Interview (the CECA) developed by Bifulco et al., 1994.

Shame and Childhood Maternal Indifference

The relation between lack of parental warmth and subsequent psychopathology is well documented (Gerlsma et al., 1990; Onstad et al., 1993; Parker, 1979, 1989; Parker & Hadzi-Pavlovic, 1992; Parker et al., 1979; Perris et al., 1980). Bowlby (1969, 1973, 1980, 1988) argued that children have innate needs for secure and available "attachment objects". The negative consequences of failures and disruptions in early attachment relationships are believed to express themselves in negative internal models of self, and views of others as unreliable, unavailable or harmful (Bowlby 1988; Safran & Segal, 1990; Schore, 1994).

Kohut (1977) stressed the importance of mirroring (responding, valuing and praising the child) and Rohner (1986) stressed the warmth and acceptance of caregivers as important to the development of a good and robust sense of self. A lack of mirroring and acceptance, and withholding of praise by parent(s), can lead to the internalisation of a sense of self as unattractive, worthless and with little personal value (Gilbert, 1997a; Gilbert & Gerlsma, in press). These internal experiences of worthlessness, badness, inadequacy etc. are commonly associated with shame (Barrett, 1995; Gilbert, 1992; M. Lewis, 1992; Nathanson 1994). Therefore, individuals who have suffered from a lack of mirroring in childhood are more likely to suffer problems of alienation, feeling low in status, inferior to others and sensitive to status attacks.

There is further research evidence drawn from psychoanalytic theory that lack of mirroring in childhood as measured by maternal indifference, as opposed to maternal antipathy, could lead to shame-proneness and pathological self-blame in adulthood (Jacoby, 1994; Kohut

1971, 1977, 1984; Pines, 1990, 1995; Winnicott 1967). It was Winnicott's contribution to psychoanalytic theory that emphasised the importance of what mothers *did* for their infants. Winnicott (1967) suggests that "the precursor of the mirror is the mother's face" and that "the mother's role [is] of giving back to the baby the baby's own self" (p.137). When the infant looks at the mother's face it can see itself reflected back in her expression. If mother is preoccupied, it will only see how *she* feels. The infant will not be able to get "something of [itself] back from the environment" (p.137). The infant can only discover what it feels by seeing itself reflected back. If the infant is seen in a way that confirms it's reality and existence it is free to go on looking without feeling shame. Success in this area of "perceptual and expressive interaction" (Wurmser, 1981) assures the infant that he is lovable and can make things happen: important ingredients in the development of identity. Failure may induce a sense of profound helplessness and unlovability, the basic elements in shame, and lead to withdrawal.

It is this sense of maternal unresponsiveness or emotional indifference, in contradistinction to active antipathy towards the child, that so fundamentally violates and annihilates the child's developing self: antipathy being, at least, a form of response. From this theoretical framework, it was predicted that, from the range of childhood adversity factors, childhood maternal indifference would most likely be associated with adult shame-proneness.

Conclusion

The above literature overview shows that shame is associated with various correlates of depression: namely, a fixed attributional style for negative outcomes,

general negative self-evaluation, social anxiety, dichotomous thinking, negative automatic thoughts, submissive behaviour, internalised anger, childhood sexual and physical abuse, and childhood maternal indifference.

Chapter 3: Current Methodological Issues in Shame Research

"Long-famous glories, immemorial shames" (Wilfred Owen, *Spring Offensive)*

Research evidence shows that shaming experiences are more intense, more chronic and harder to assimilate than guilt-eliciting ones, and prove more difficult to recall in detail. In a study by Tangney (1992) college students were less articulate when describing shame- than guilt-eliciting situations; however, the shame descriptions were generally longer, although less specific in content. There is also evidence that shame is more linked to memories than guilt (Macdonald, 1999). These are interesting findings in that they draw attention to the ubiquity and complexity of shame experiences in everyday life.

There are numerous ways of disguising the shame experience. Lewis (1971) observed that certain words continually recurred in contexts of shame and were accompanied by the use of certain gestures. Some descriptions included feeling uncomfortable, insecure, uneasy, confused, worthless, inadequate, stupid, foolish, silly, weird, helpless, paralysed, impotent, disempowered, frozen, and so on.

These words all belong to the common experience of the self *in relation to another* (real or imagined). If the shame vocabulary is compared to that of guilt, fear, anger or grief, the shame repertoire is larger than those describing any other emotional experience. This indicates the prevalence of the shame experience.

Both shame and guilt are products of self-reflection by which the individual appraises, evaluates negatively or

reproaches his or her self because of a perceived shortfall, or transgression against, a personally important social norm or standard, yet their differentiation and measurement remain complex. There has been little detailed analysis of shame experiences in current research on shame and psychopathology and the measures that exist can be criticised either for failing to tap into important dimensions of clinically relevant shame, or confounding the operationalisation of shame with the pathologies under investigation (see Andrews, 1998).

There are currently four different ways in which shame is measured; self-report measures of shame-proneness (such as the scale used in this study); measures that assess generalised or global shame; semi-structured interviews that assess shame of personal characteristics and behaviour; and diary with interview measures of shame.

The first group of measures assesses shame-proneness in potentially shame-eliciting situations, such as the Shame and Guilt Scale used in this study. Similar measures most commonly used are the Dimensions of Conscience Questionnaire (DCQ: Johnson et al., 1987), the Test of Self-Conscious Affect (TOSCA: Tangney et al., 1989), and its predecessor, the Self-Conscious Affect and Attribution Inventory (SCAAI: Tangney et al., 1988). These questionnaires present a series of hypothetical, potentially shame-inducing, situations and try to identify individuals who are especially sensitive to feeling shame.

The second group of measures attempts to assess generalised or global feelings of shame, the assumption being that they assess dispositional or "trait" shame, which involves the endorsement of various negatively toned views of the self. Scales most commonly used

include the Adapted Shame and Guilt Scale (ASGS: Hoblitzelle, 1987), the Internalized Shame Scale (ISS: Cook, 1988), the Personal Feelings Questionnaire-2 (PFQ2: Harder & Zalma, 1990) and scales which measure views of how others see the self or "Other as Shamer" scales (OAS: Allan et al., 1994; Goss et al., 1994).

A third type of measure has been pioneered by Andrews (1995, 1997), who has developed a semi-structured interview with investigator-based ratings to assess chronic shame of personal characteristics or behaviour and this was originally developed to assess bodily shame. The measure was later developed to probe for additional sources of shame (Andrews & Hunter, 1997) drawing on Janoff-Bulman's distinction between negative judgements directed at one's behaviour, and negative judgements directed at one's character (Janoff-Bulman, 1979).

Finally, there are a range of diary with interview approaches to the measurement of shame, for example, the study of Macdonald et al., 1997 which is based on the structured diary method of Oatley & Duncan, 1992.

Measures of Shame-Proneness

In the Dimensions of Conscience Questionnaire, respondents are asked to imagine themselves in shame- and guilt-inducing situations and to say how badly they would feel on a 7-point scale. A shame example is "Your home is very messy and you get unexpected guests", and a guilt example is "Allowing someone else to be blamed for something that you have done". The SCAAI and TOSCA respondents are given hypothetical scenarios followed by four common responses to each (including researcher-defined shame- and guilt- proneness). Respondents indicate on a 5-point scale how likely they would be to react in each of the ways described. Some TOSCA examples

are "You make a mistake at work and find out a co-worker is blamed for the error" and "While out with a group of friends you make fun of a friend who's not there". In both cases, scores are added to assess shame, guilt and other emotions of externalization (or blaming others), detachment and two types of pride.

Although situations and responses in the DCQ and TOSCA were drawn from real-life shame and guilt experiences generated by participants during the development phase, the problem of their validity remains. Responses may not accurately reflect what individuals actually do or feel in real life situations (Brewin & Andrews, 1992; Coyne, 1992; Segal & Dobson, 1992). The shame measure of the TOSCA focuses primarily on self-labelling (such as feeling inadequate, stupid, a rat etc.). It lacks any measure of emotion and has few behavioural items. It should be noted, however, that various measures such as the TOSCA were designed to tap everyday experiences of shame so that people could identify with them.

More recently there has been criticism of measures like the DCQ which are based on researcher-defined shame- or guilt-eliciting situations (see Tangney, 1996). The assumption that feeling bad about shame-eliciting situations reflects shame-proneness (and for guilt-eliciting ones, guilt-proneness) is questionable, and does not take into account the complex relationship between the two. It is possible that many situations have the potential to elicit either emotion (Tangney, 1992) and that shame and guilt can be experienced sequentially, even simultaneously, by many people. There is evidence that self-reported emotional episodes involve complexes of different emotions experienced either in close proximity or even at the same time (Frijda et al., 1991; Lazarus, 1991; Oatley & Duncan, 1992).

Shame-proneness rests on the notion that shame often occurs in the context of evaluating personal behaviour in specific situations. This overlooks the fact that personal behaviour may not *be* the only focus for shame. It is likely that enduring shame about particular personal characteristics might be independent of shame felt as a consequence of personal behaviour. In a recent study involving depressed patients, Andrews and Hunter (1997) found that correlations between interview measures of behavioural, bodily and characterological shame did not exceed .40. Interestingly, an earlier study by Tangney et al. (1996) on the structural and phenomenological dimensions of shame, guilt and embarrassment in a student sample, showed that an unexpectedly high proportion of shame experiences involved *private* events. It would seem possible that these private events may involve ruminations about perceived personal shortcomings and may explain the ruminative quality of the thinking that shame shares with depression (Nolen-Hoeksema 1991). This challenges the role of observability in the shame experience and focuses more on the internalised "self-as-bad" as opposed to the external "public-self".

Generalised or Global Shame

Scales that most commonly measure global shame are the Adapted Shame and Guilt Scale (ASGS: Hoblitzelle, 1987), the Internalized Shame Scale (ISS: Cook, 1988), and the Personal Feelings Questionnaire-2 (PFQ2: Harder & Zalma, 1990). The ASGS and the PFQ2 both contain shame and guilt items whereas the ISS contains only items defined as reflecting shame, and consists of brief, self-defining statements or adjectives.

In the ASGS, shame adjectives are "reproached" and "ashamed" and guilt adjectives are "unethical" and "unscrupulous". Respondents are instructed to indicate how accurately a list of such self-defining adjectives describes them on a 7-point scale.

In the PFQ2, examples of shame feelings include "self-consciousness" and "feeling stupid", and examples of guilt feelings are "regret" and "remorse". Respondents are asked how often these listed feelings are experienced on a 5-point scale ranging from "never" to "continuously".

The ISS consists of self-defining statements such as "I think that people look down on me" and "I think others are able to see my defects". Respondents indicate the frequency of these feelings, from "never" to "almost always" on a 5-point scale, which are assumed to reflect dispositional or trait shame (see Harder et al., 1992).

But there is evidence that global, negative self-defining questionnaires tend to be highly mood-dependent (Andrews & Brown, 1993; Barnett & Gotlib, 1988; Brewin, 1985). It is not clear whether such measures are, in fact, assessing enduring characteristics present in the absence of negative affective states such as depression. As Andrews (1998) notes, scales such as these do not assess the duration over time of such feelings and, although the test-retest reliabilities of such scales are high, they have not been carried out over periods more than two months. This presents problems of validity and reliability relating to the use of such measures.

Chronic Shame of Personal Attributes and Behaviour

Andrews (1995) and Andrews and Hunter (1997) have developed a semi-structured interview with investigator-based ratings to assess shame of personal characteristics and behaviour, which draws attention to the body as often being the central focus in shame (Gilbert, 1989; Mollon, 1984; Sartre, 1956).

The original measure was developed to assess bodily shame alone (Andrews, 1995; Andrews, 1997) but was later developed to probe for additional sources of shame (Andrews & Hunter, 1997). Its development was influenced by Janoff-Bulman's distinction between negative judgements directed at one's behaviour and those directed at one's character (Janoff-Bulman, 1979). An example of the initial question on bodily shame is: "Have you felt ashamed about your body or any part of it?". This is followed by probes, if necessary, for respondents to describe their feelings in greater detail. There are three aspects to the interview, consisting of bodily shame, characterological shame and behavioural shame, and responses are rated on a 4-point scale (from "little or none" to "marked"). Reference is made to a series of examples and scored according to the frequency, intensity and focus of respondents' comments.

The three shame-components in the interview measure are independent and do not rest on the assumption that high-shame individuals will experience generalised shame. For example, a subject may report feeling intensely ashamed about his or her body, but not about his or her behaviour or character-related aspects of their self. This means the measure should be less vulnerable to mood state effects than those questionnaire measures which rely on more global or generalised self-definitions or self-statements. Although Andrews and Hunter's (1997) study

makes no underlying assumption that dispositional shame is being measured, the authors have found that such feelings, where they exist, are usually of long duration and often go back many years (see Andrews, 1995).

Diary with Interview Measures of Shame

Finally, there are a range of other diary with interview approaches to the measurement of shame. For example, Macdonald (1999) carried out a qualitative study asking psychotherapy patients to record weekly experiences of shame, guilt, hatred and disgust, followed by a research interview to provide an outline of the social context of each example, involving disclosure or non-disclosure of these recorded emotions. According to the author, the diary method minimises retrospective bias, which is greater for incidental as opposed to intentional remembering (Nickerson & Adams 1979, cited Oatley & Duncan, 1992). Oatley and Duncan (1992) used this technique to gather information about the incidence of emotion types in particular populations and to test predictions from Oatley and Johnson-Laird's (1987) cognitive theory of emotion. More recently, Rime et al. (in press) have used structured diaries in a number of studies examining the extent to which emotional experiences are "socially-shared" with other people.

The advantages of this method are that it provides a structured, prospective method of gathering data which is grounded in recent affective experience (the time-scale is usually the previous week). It is argued that detailed questions about affective experience yield considerable information about naturally-occurring events with minimum distortion due to memory bias. In Macdonald (1999) and Macdonald et al's (1997) study, psychotherapy patients were asked to record their experiences of shame, guilt, hatred and disgust in a basic "fixed response" box format

followed by a semi-structured research interview to clarify the context and outcome of these emotional experiences.

However, the process of filling in diaries, or other documentary accounts, has the disadvantage that they are intrusive techniques. The fact that a person is filling in a diary for the purpose of a research study may in some way alter behaviour, as well as the individual's experiencing and construing of emotions such as shame: in other words, there may be a reactive effect. Oatley and Duncan (1992) acknowledge that the diary method only captures a part of the emotional spectrum and that emotional experiences remain which are not amenable to valid self-report, and may not even be identified by the respondent.

In summary, the above evidence suggests that dispositional (or trait) shame may not be completely captured by existing measures. Situationally-assessed measures assume that dispositional shame reflects a tendency to feel shame in response to behaviour in certain situations. However, there is evidence to suggest that dispositional shame can be shown in other ways, involving a specific focus on physical or non-physical personal characteristics, that may or may not be reflected in everyday behaviour. Future strategies for measuring shame may involve using a variety of approaches: affect shame measures like Harder's Personal Feelings Questionnaire-2 (PFQ2); a self-evaluative measure like the TOSCA; and possibly some measure of respondents' beliefs about how others see them (eg. OAS scale). Since shame is a multi-faceted experience, and its expression is complex, it needs to be measured in a multi-faceted and sophisticated way.

Critique of Existing Measures of Shame

Although global shame measures do not focus exclusively on behaviour or shame-eliciting situations, the problem remains that they may only be reflecting negative affective mood states, such as depression. It is possible that high-shame individuals may concentrate on different aspects of their self or behaviour at different times in their lives, depending on their circumstances. Distinguishing between different aspects may therefore be arbitrary and research-led, but this issue can only be resolved by further investigation and the development of more sophisticated measures.

Conclusion

Clearly, manifestations of shame are numerous and complex and not all are represented in this range of approaches. Additionally, there is the problem of discriminating shame from guilt items in existing scales (PFQ2: Harder & Zalma, 1990). Given the problems of definition and operationalisation of shame, one solution may be to develop new questionnaire measures which ask direct questions about self-focused and behaviour-focused feelings of shame, rather than rely on researchers' predetermined definitions.

Particular objections to self-report scales, such as the one used in the current study, focus on their validation on non-clinical student samples and the use of dimensional measures of psychopathology to investigate complex clinical phenomena. Gotlib (1984) and Coyne (1994) argue that, in student samples, such scales are likely to be measuring no more than mild and transient negative affectivity and not actual clinical phenomena. Although existing measures of shame are often associated

with measures of psychopathology (Tangney et al., 1992), far more specialised measures for assessing pathological shame are required, such as shame affect rooted in trauma (see Gilbert, 1998a).

A further problem with scenario-based self-report scales is that they measure expressions of expectations of how respondents *believe* they would feel in certain situations. Such hypothetical measures cannot represent individuals' *lived experience* which may constitute an important clinical disadvantage of this type of scale.

Chapter 4: An Empirical Study of Shame and Shame-Related Phenomena in a Depressed Group

"Well" said Owl, "the customary procedure in such cases is as follows."
"What does Crustimoney Proseedcake mean?" said Pooh. "For I am a Bear of Very Little Brain, and long words Bother me."
"It means the Thing to Do."
"As long as it means that, I don't mind," said Pooh humbly.

(A.A. Milne, *Winnie-the-Pooh)*

Aims: Given the discussion in Chapters 1 and 2, this research sets out to explore shame in relation to various phenomena associated with depression such as attributional style, negative self-evaluation, social anxiety, dichotomous thinking, negative automatic thoughts, submissive behaviour, internalised anger, childhood sexual and physical abuse and childhood maternal indifference.

The aim of the current study is to investigate data collected by the author on a total of 86 subjects (57 female, 29 male) with a primary research diagnosis of moderate to severe major unipolar depression. As research psychologist in the trial[1], my role was to collect a wide range of clinical, cognitive and psychosocial data from the depressed patient sample. This included conducting an initial diagnostic psychiatric interview (the Present State Examination, an instrument in which I had trained) to assess current clinical status. All measures were taken at three time-points (see Chapter 1). Partners of the depressed patients were assessed by another research psychologist member of the team. The sample in the current study (N=86) is a subset of the participants who were randomised into The London Depression Intervention Trial (N=107), a major MRC-funded randomised controlled trial set up to compare the efficacy of three treatment interventions for depression. Further data on participants had been collected by the

author in two in-depth clinical interviews carried out at initial assessment and covering far-ranging aspects of childhood experience and current relationship and self-concept: the Childhood Experience of Care & Abuse (the CECA) and the Self-Evaluation & Social Support (the SESS) semi-structured interviews. All participants in the current study had completed a self-report measure of shame and guilt (Gilbert et al, 1989), along with a range of other clinical and cognitive measures, as part of their baseline assessment before randomisation into the trial.

The objective was to explore whether there were consistent aspects of childhood experience, derived from the childhood adversity ratings from the CECA (see Appendix 5) which contributed to shame-proneness in adulthood. A further aim was to explore how this related to current self-concept, cognitions and beliefs, derived from ratings from the SESS and the range of clinical and cognitive measures. Scores on the Shame and Guilt Scale provided a measure of current shame- and guilt-proneness.

Specific Hypotheses (Empirical): The major predictions were that in this clinical group shame (but not guilt) would be: 1. Positively associated with the severity of depression. 2. Positively associated with an internal, stable and global attributional style for negative outcomes. 3. Positively associated with general negative self-evaluation. 4. Positively associated with social anxiety. 5. Positively associated with dichotomous thinking. 6. Positively associated with negative automatic thoughts. 7. Positively associated with submissive behaviour. 8. Positively associated with internalised anger. 9. Positively associated with a reported history of childhood sexual and physical abuse. 10. Positively associated with childhood maternal indifference.

Method

Participants

In the current study, the sample consisted of 86 patients (57 female, 29 male), minimum age 21 years, who had been recruited into a major MRC-funded randomised controlled trial (RCT) of three interventions for the treatment of depression. The design of the study is cross-sectional (see Chapter 1) as all data were collected at initial assessment. There were standard clinical guidelines in place relating to the recruitment, screening, assessment and treatment of participants whereby patients were assessed using standardised assessments as discussed in the following sections. This reflected current good practice as laid down by MRC policy for the carrying out of randomised controlled trials. Participants were recruited in London from a variety of sources including GP practices, newspaper advertisements, the Maudsley Hospital Emergency Clinic and from other health care professionals. Ethical approval for the study had been obtained in 1990 from the ethical committees of the Maudsley and King's College Hospitals at its pilot stage. All participants were required to be in a heterosexual relationship of at least one year's duration. The requirement for heterosexuality was to provide homogeneity with earlier work by Vaughn and Leff (1976a) on the influence of family and social factors on the course of psychiatric illness (a comparison of schizophrenic and depressed neurotic patients).

In the London Depression Intervention Trial (LDIT: Leff et al, in press) those participants meeting initial entry criteria were randomised into one of three treatment conditions: antidepressant medication with psycho-education, cognitive therapy, or couple therapy (which actively involved the depressed patient's partner

in treatment). Treatment interventions lasted for 12-20 sessions, over 9-12 months. Depressed patients and their partners were followed up at two time-points: within a month of treatment completion, and at two years from start of treatment, to monitor outcome and establish clinical status, using repeat measures of the assessments completed at baseline. Six-weekly Beck Depression Inventories (BDIs) were given to plot the course of mood during the treatment phase and at the post-treatment and follow-up assessments, and at three-monthly intervals between post-treatment and follow-up.

All participants were required to have a primary research diagnosis of major unipolar depression at intake (Present State Examination (PSE): Wing et al., 1974) scoring Catego Index of Definition 5 or above, and to score at least 14 on the Hamilton Rating Scale for Depression (HRSD: Hamilton, 1960). Fifty-five percent of patients had experienced at least one previous depressive episode (mean=2.13, SD 1.63, range 0-10). All ratings on the following listed measures were made as part of an initial baseline assessment of depressed patients before randomisation into the trial.

Depressed patients and their partners were interviewed separately to assess their suitability for the study. Partners were screened with the Camberwell Family Interview (CFI: Vaughn & Leff, 1976b) by another member of the research team and were required to register at least two critical comments during the interview. Partners' critical comments *per se* were not a necessary indicator of a conflictual relationship although referrers' misunderstanding of the study's rationale, and participants' preference for couple therapy, may have resulted in a higher proportion of discordant couples being recruited. Participants were excluded if they had any psychotic features, bipolar illness, organic brain

damage, suicidal tendencies, substance misuse, learning difficulties or contraindications for antidepressant medication (such as pregnancy). They were also excluded if they had experienced an adequate trial of any of the treatment interventions within the previous three months. Participants were not screened for personality disorders as the only clinical requirement was a primary research diagnosis of major unipolar depression.

Randomisation

Participants were stratified according to whether or not they had a significant history of depression. A significant history was defined as a current episode of not less than six months' duration or a previous treated episode in the last three years. As 76.4% of the sample were defined as having a significant history, it is reasonable to assume that personality disorders may have been highly represented in this group. Finally, depressed patients and their partners had to agree to assessment and randomisation into the trial and informed written consent was obtained from patients, their partners, and patients' GPs. Participants were then randomly assigned into one of the three treatment groups by an independent administrator who was blind to treatment modality, as were the research team.

All data relating to the trial, including rated transcripts of participants' interviews, are held at the Medical Research Council, Social Psychiatry Unit, Institute of Psychiatry, London, in accordance with standard MRC criteria relating to the conduct of randomised controlled trials.

As can be seen from Table 1, a typical participant in this study was a white, early middle-aged, married woman, working part-time in skilled manual employment, with a significant history of depression.

Table 1: Participant Characteristics and Demographic Profile of Sample (N=86)

Gender: Male 34.1%; Female 65.9%

Average age of subjects=38.99 years (SD 11.09, range 21-72)

Average educational level=2.25 (SD 1.35, range 1-5) (where 2=School Leaving Certificate or CSEs)

Average occupational class=4.14 (SD 1.52, range 2-8) (where 4=IIIm skilled manual according to Registrar-General's definition, OPCS, 1995)

Employment= mean 3.42 (SD 1.84, range 1-7) (where 3=<10 hours p/t employment, and 4=>10 hours p/t employment)

Average BDI at intake=27.07 (SD 7.37, range 8-45)

Average HRSD at intake=18.78 (SD 3.93, range 14-34)

Average length of relationship=10.43 years (SD 9.76, range 1-47)

Average duration of current depressive episode=19.91 months (SD 35.53, range 1-240)

Significant vs. nonsignificant history= mean 1.24 (SD 0.43, range 1-2, where 1=significant history)

Significant history: 76.4%; non-significant-history: 23.6%

Average number of depressive episodes, including current =2.13 (SD 1.63, range 0-10)

Ethnicity breakdown=85.3% white; 9.1% black; 5.7% other

Marital status: 60.2% married; 39.8% living with partner

Measures

Shame and Guilt Scale. At the development stage of the above study (1990), very few measures of shame and guilt were available. Gilbert et al.'s (1989) 10-item scale included two 5-item subscales measuring each dimension (Appendix 1 and Table 3 refer). Shame was conceptualised in terms of dominant-subordinate relationships (sense of inferiority, being scrutinised, criticised and/or seen negatively by others). Guilt was conceptualised as arising from co-operative and caring behaviour, and most likely to be activated in situations of harming others, eg. exploiting or cheating (Crook, 1980; Gilbert, 1989). Respondents are asked to circle the number on a 5-point Likert scale that best describes the degree of upset they would experience in each of a number of shame- and guilt-related situations. Therefore, it provides a measure of shame- and guilt-proneness, by providing respondents with hypothetical situations to which they had to respond, as opposed to a measure of state or trait shame. On the shame subscale, the mean score of this sample was 17.8, SD 4.8, range 5-25, possible range 5-25, internal reliability 0.84; on the guilt subscale, the mean score of this sample was 18.1, SD 4.6, range 8-25, possible range 5-25, internal reliability 0.84 (see Table 2).

Beck Depression Inventory (BDI). This is the most widely used self-report instrument for assessing severity of depression (BDI: Beck et al., 1961; Beck et al., 1979; Beck et al., 1988) and is regarded as a robust measure of the severity of depression in a clinical population (Gotlib & Hammen, 1992). Based on 21 symptom-oriented items, a total score is calculated reflecting the number of symptoms and their severity. It measures both presence and severity of affective, cognitive, motivational, psychomotor and vegetative manifestations of depression. High reliability and validity have been obtained in

numerous studies (eg. Dobson & Breiter, 1983; Kovacs et al., 1975; Kovacs & Beck, 1978) and it has a satisfactory correlation with the Hamilton Rating Scale for Depression (HRSD) and other clinical ratings. Kendall et al. (1987) have outlined various recommendations and guidelines regarding the use of the BDI. The mean score of this sample was 27.07, SD 7.37, range 8-45, possible range 0-63, which is indicative of moderate to severe depressive symptomatology (see Table 2).

Present State Examination (PSE). The Present State Examination was developed by Wing et al., 1974. It is a standardised semi-structured interview designed to elicit the whole range of psychiatric signs and symptoms. There are obligatory questions and cut-offs. It is linked with a computerised program, Catego, which assigns respondents to a diagnostic classification. The Index of Definition (ID level) assigns a probability of the individual's being defined as a psychiatric case. An ID level of 6 or above indicates a severity level similar to that of a hospital inpatient. The mean score of this sample was 6.26, SD 0.69, range 5-8, possible range 1-8, internal reliability 0.8 (see Table 2).

Expanded Attributional Style Questionnaire (EASQ). This questionnaire (Peterson & Villanova, 1988) has the same instructions and format as the original ASQ (Peterson et al., 1982) but has improved reliability. Respondents are presented with 24 hypothetical bad events involving themselves. In each case, respondents are asked to imagine the event happening to them. They then write down "the one major cause of the event" and rate it in terms of internality (7) versus externality (1), stability (7) versus instability (1), and globality (7) versus specificity (1). All three dimensions of explanatory style were correlated with depressive symptoms as measured by the BDI. The mean score of this sample for

internality was: 37.91, SD 7.79, range 19-54, possible range 10-70, internal reliability 0.7; for stability: 36.85, SD 7.39, range 22-55, possible range 10-70, internal reliability 0.78; and for globality: 46.48, SD 10.66, range 19-70, possible range 10-70, internal reliability 0.79 (see Table 2).

Self-Evaluation and Social Support Interview (SESS). This is a semi-structured interview (see Appendix 6) carried out by a trained researcher (Andrews & Brown, 1993). Separate and independent ratings of positive and negative self-evaluation are derived from scales measuring self-acceptance, evaluation of personal attributes, and competence in interpersonal, occupational and domestic roles. Negative evaluation of the self (NES) is comprised of low self-acceptance, negative evaluation of personal attributes, and negative evaluation of role performance in a range of roles. Self-acceptance is defined as the extent to which a person accepts her/himself and feels happy or unhappy with the kind of person they are. General negative evaluation of personal attributes consists of statements (positive or negative) about the kind of person the individual thinks they are in terms of physical attributes (eg. pretty), emotional and intellectual attributes (eg. moody, brainy), personality attributes (such as affectionate), and moral attributes (such as trustworthy). All the relevant scales covering these areas are explicitly concerned with self-evaluation, rather than with self-concept in general. In the current study, inter-rater reliability ranged from 0.7 to 1.00 on the various dimensions.

All ratings are investigator-based, and depend on accounts of actual episodes elicited from respondents during the interview. Coders met for an initial training period that included a discussion and refinement of definitions associated with each dimension. The author

then independently coded all situations on a given dimension, meeting periodically for reliability checks with other coders. Discrepancies were discussed and resolved unanimously. Self-evaluations were graded on a 4-point scale reflecting the severity of the participant's report, with the highest point , "marked", for the worst account followed by "moderate", then "mild" and finally "little/none" where none was judged to be present. The range in this sample was 1 - 4, possible range 1 - 4.

The Separation and Social Anxiety Scale. This is a short self-report questionnaire with five items in each dimension of separation and social anxiety (Gilbert et al., 1995). The separation items are: being at home by myself; being separated from people I love; doing new things on my own; thinking that somebody I love might die; having no-one to share experiences with. The items of social anxiety include those which distinguish it from agoraphobia (Amies et al., 1983). These items are: meeting new people; going to an interview; being watched doing something; being teased; meeting people in authority. Respondents are asked to rate how they would feel in each situation on a Likert scale of 1 (not anxious at all) to 5 (very anxious). Results suggest an acceptable factor structure and reliability. The association of social anxiety with depression has been shown to be particularly robust in a depressed sample. The mean score for this sample for separation anxiety was: 17.83, SD 4.19, range 7-25, possible range 5-25, internal reliability 0.69. The mean score for this sample for social anxiety was: 16.99, SD 5.30, range 5-25, possible range 5-25, internal reliability 0.83 (see Table 2).

Dysfunctional Attitudes Scale - Form A (DAS-A). This is a self-report measure composed of items to assess

typical, relatively stable, depressogenic attitudes or assumptions, developed by Weissman & Beck (1978) and which, according to Beck's theory of depression, form the basis of depressive symptoms. It was designed initially as a 100-item scale from which two parallel forms (40 items each) were developed. The possible range of scores on the overall DAS-A is 40-280. The items are answered on a 7-point Likert-type scale. High internal consistency and test-retest reliability have been demonstrated (Blackburn et al., 1986). The "dichotomous thinking" subscale of the DAS-A was used in the current study as a measure to identify polarised thinking or "splitting". The mean score of this sample was 53.81, SD 16.52, range 16-88, possible range 13-91, internal reliability 0.88 (see Table 2).

Automatic Thoughts Questionnaire (ATQ-30). This is a 30-item questionnaire devised to measure the frequency of negative automatic thoughts (negative self-statements) associated with depression (Hollon & Kendall, 1980). Thirty items discriminated between criterion groups of depressed and non-depressed respondents. The resultant 30-item automatic thoughts questionnaire (ATQ-30) was cross-validated and found to significantly discriminate psychometrically depressed and non-depressed groups. It uses a 5-point Likert scale and scores range from 30 to 150. No differences were found between males and females on the measure. Factor analysis indicated a 4-factor solution, with a large first factor reflecting personal maladjustment, a second factor indicative of negative self-concept/negative expectations, and two lesser factors. The ATQ-30 provides a means of testing basic theory relating cognitive content to behavioural and affective processes, and in assessing changes in cognitions associated with experimental manipulation or with therapeutic intervention. The mean score for this

sample was 90.88, SD 23.73, range 44-141, possible range 30-150, internal reliability = 0.88 (see Table 2).

The Submissive Behaviour Scale. This scale was developed by Gilbert and Allan (1994) and Allan and Gilbert (1997) from the work of Buss and Craik (1986) who asked respondents to identify typical submissive behaviours. This generated a large number of examples of submissive behaviour. These were then given to a large group of raters who were asked how good each item was as an example of submissive behaviour. From this the most highly agreed upon items (16 items) were chosen to construct the Submissive Behaviour Scale (Gilbert & Allan, 1994). It includes items such as: "I agreed I was wrong even though I knew I wasn't". Respondents reply by giving their estimated frequency of these behaviours on a 5-point scale, from 1 to 5. This scale has satisfactory internal consistency and test-retest reliability; the reported cronbach alpha was 0.85 in both a student and depressed group (Allan & Gilbert, 1997). It has been used in a number of studies concerned with assertive behaviour (Gilbert & Allan, 1994), depression (Gilbert et al., 1995; Gilbert & Allan, 1998) and was found to be highly correlated (r=0.73) with the sub-assertive measure of the inventory of interpersonal problems (Gilbert, Allan & Goss, 1996). The mean score of this sample was 45.99, SD 9.92, range 23-73, possible range 16-80, internal reliability 0.84 (see Table 2).

State-Trait Anger Inventory (STAXI). This inventory (Spielberger, 1988) consists of 44 items which form six scales and two subscales. The subscale relevant to the hypothesis is Anger-in (AX/In), an 8-item anger expression scale measuring the frequency with which angry feelings are suppressed. The mean score of this sample was 20.25, SD 4.89, range 12-32, possible range 8-32, internal reliability 0.81 (see Table 2).

Childhood Experience of Care and Abuse Interview (the CECA). This is a semi-structured interview (see Appendix 5) carried out by a trained researcher (Bifulco et al., 1994). It yields a variety of childhood adversity measures including sexual and physical abuse as defined according to standard criteria, making the results comparable with other work in the UK and USA. In the current study, inter-rater reliability was 1.00 for sexual abuse and 0.9 for physical abuse. Sexual abuse was rated as absent or present and, where applicable, was categorised into six domains, ranging from two lesser domains eg. verbal only (rated 6); required to watch sexual activity (rated 5) ie. non-contact category, to touching of breasts, genitals (rated 4); oral sex (rated 3); violation involving an implement (rated 2); and penetrative intercourse (rated 1) ie. contact category. Physical abuse was rated on a 4-point scale ranging from 1 ("marked" eg. beaten up or threatened with a knife); 2 ("moderate" eg. kicked, bit, hit with fist or other item, slapped around face); 3 ("some" eg. object thrown, pushed, shoved or slapped - not face), to 4 ("little or none"). In the current study, 32% of participants had experienced at least one episode of sexual abuse before the age of 17 and 60% of participants had experienced some degree of physical abuse before the age of 17 according to these criteria.

In addition to childhood sexual and physical abuse, the CECA yields other measures of childhood adversity (such as antipathy, control and material neglect by parents). However, maternal indifference was selected as the dimension of special relevance for this study (see Chapter 2). Inter-rater reliability ranged from 0.65-1.00 on the various adversity dimensions (0.8 for maternal indifference). This scale reflects the amount of emotional neglect shown by the parent, as opposed to material neglect, which was rated separately. Hard

indicators of such indifference would be lack of interest in friends or schoolwork, and ignoring the child's emotional needs for comfort and reassurance when upset, or when needing to talk about problems. Maternal and paternal indifference were rated separately. This scale is distinguished from antipathy, also rated separately for both parents, which reflects dislike, denigration or active hostility towards the child, rather than non-responsiveness or emotional distance. In the current study, 68% of participants experienced maternal indifference according to these criteria.

All ratings are investigator-based, and depend on accounts of actual episodes elicited from respondents during the interview. Coders met for an initial training period that included a discussion and refinement of definitions associated with each dimension. The author then independently coded all situations on a given dimension, meeting periodically for reliability checks with other coders. Discrepancies were discussed and resolved unanimously. Accounts were graded on a 4-point scale reflecting the severity of the respondent's experience with the highest point "marked", for the worst experience of childhood adversity, followed by "moderate", then "mild" and finally "little/none" where none was judged to be present. The range in the current study was 1 - 4, possible range 1 - 4.

A previous review of the literature indicates that retrospective accounts obtained in this way are likely to be valid and are unlikely to be affected by depressed mood (Brewin et al., 1993). In addition, the reliability studies by Parker (1981) on the Parental Bonding Instrument (PBI) also support the feasibility of retrospective assessment of parental rearing. Results indicate a high agreement between PBI-scores and sibling ratings concerning the relations of the index person and

the parents. More recently, Bifulco and Moran (1998) have confirmed the reliability and validity of retrospective accounts of childhood obtained in this way.

Table 2: Means, standard deviations, ranges and internal reliabilities of measures in sample (N=86)

Measure	Mean	(SD)	Range	Possible range	Internal reliability
Shame + Guilt scale					
- Shame	17.80	(4.80)	5-25	5-25	0.84
- Guilt	18.10	(4.60)	8-25	5-25	0.84
BDI	27.07	(7.37)	8-45	0-63	-
PSE	6.26	(0.69)	5-8	1-8	0.80
EASQ					
- Internal	37.91	(7.79)	19-54	10-70	0.70
- Stable	36.85	(7.39)	22-55	10-70	0.78
- Global	46.48	(10.66)	19-70	10-70	0.79
Anxiety Scale					
- Separation	17.83	(4.19)	7-25	5-25	0.69
- Social	16.99	(5.30)	5-25	5-25	0.83
DAS - A					
- Dichotomous Thinking	53.81	(16.52)	16-88	13-91	0.88
ATQ - 30 (NATs)	90.88	(23.73)	44-141	30-150	0.88
Sub Beh Scale	45.99	(9.92)	23-73	16-80	0.84
Staxi (Int Anger)	20.25	(4.89)	12-32	8-32	0.81

Conclusion of Methodology Section

In summary, this randomised controlled trial has observed strict ethical and clinical guidelines concerning the recruitment, screening and treatment of participants and a range of standardised clinical assessments has been used, incorporating both self-report and observer-rated measures, to ensure validity and reliability.

Note: Appendix 2 contains further details of the London Depression Intervention Trial (LDIT) in relation to individual therapists and therapists' adherence to their respective treatment models.

Results

All statistics were performed using the SPSS package for PCs. The mean scores, standard deviations and ranges of all variables under investigation, and internal reliabilities of measures used, were reported in Chapter 2 (Table 2). Current analyses are cross-sectional as all data were collected as part of participants' baseline assessment before randomisation into the trial.

Psychometric Investigation of the Shame and Guilt Scale

The distribution of scores for each of the ten items was inspected for skewness and found to be satisfactory. A principal components analysis with varimax rotation was carried out with a threshold of 0.5 for the inclusion of a variable in the interpretation of a factor. This analysis produced a solution with two factors having

eigenvalues greater than 1 and these two factors accounted for 61.5% of the variance in the factor space. All 10 items loaded above the cut off on one of the two factors with no item loading on more than one factor (see Table 3). Factors clearly corresponded to the original distinction between shame and guilt items. The internal reliability (Cronbach alpha) for both shame and guilt in the current study was 0.84 compared with Gilbert et al's (1989) study which reported 0.74 for shame and 0.75 for guilt.

TABLE 3: Factor Loadings for the Shame and Guilt Scale

	Item	Factor 1	Factor 2
1.	To do something embarrassing in public (S)	0.75	0.15
2.	Secretly cheating on something you know will not be found out (G)	0.30	0.57
3.	To hurt someone's feelings (G)	0.11	0.88
4.	To be the centre of attention (S)	0.71	0.11
5.	To appear inadequate to other people (S)	0.76	0.32
6.	To behave in an uncaring way to others (G)	0.12	0.87
7.	To have something unfavourable revealed about you (S)	0.71	0.11
8.	To feel self-conscious in front of others (S)	0.82	0.21
9.	To behave unkindly (G)	0.20	0.88
10.	Not saying anything when a shop assistant gives you too much change (G)	0.15	0.56
Variance (%)		43.9	17.5

(S) = shame items

(G) = guilt items

Scores on shame and guilt were computed by adding the individual item scores. In this study, shame and guilt were moderately correlated ($r=0.44$, $p<.001$). In the current study, the mean shame score was 17.8, SD 4.8, range 5-25, and the mean guilt score was 18.1, SD 4.6, range 8-25 (see Table 2). Compared to males, females experienced significantly more shame, $t=2.32$, $p<.05$, and more guilt, $t=2.68$, $p<.01$. They also reported more depression on the BDI, $t=2.98$, $p<.01$.

Partial Correlational Findings

Table 4 reports six sets of correlations between shame, guilt, and the other variables under investigation. The first column reports the first-order correlation with shame. The second column reports the corresponding partial correlation controlling for BDI score, to test whether any association with shame is a function of severity of depression. The third column reports the corresponding partial correlation controlling for guilt, to test whether any association is unique to shame. The fourth column reports the first-order correlation with guilt. The fifth column reports the corresponding partial correlation controlling for BDI score, to test whether any association with guilt is a function of severity of depression. The sixth column reports the corresponding partial correlation controlling for shame, to test whether any association is unique to guilt.

Table 4. Correlational Analyses Involving Shame and Guilt (Partial correlations controlling for BDI, guilt and shame in parentheses) (N=86)

	Shame			Guilt		
	Controlling for			Controlling for		
	First order	BDI	Guilt	First order	BDI	Shame
BDI	.07	(-)	(.06)	.28**	(-)	(.28**)
No Eps Dep	.06	(.04)	(.03)	.06	(.00)	(.04)
Internal	.10	(.15)	(.08)	.07	(.07)	(.03)
Stable	.30**	(.39***)	(.23*)	.22	(.13)	(.10)
Global	.13	(.12)	(.07)	.15	(.08)	(.10)
NES	.23*	(.31**)	(.31**)	.10	(.08)	(.04)
Soc Anx	.56***	(.56***)	(.50***)	.31**	(.26**)	(.07)
Dich	.28**	(.29**)	(.16)	.29**	(.30**)	(.25*)
NATS	.24*	(.31**)	(.18)	.18	(.01)	(.09)
Sub Beh	.53***	(.53***)	(.45***)	.35***	(.28**)	(.15)
Int Anger	.32**	(.32**)	(.29**)	.13	(.08)	(.01)
CSA	.02	(.00)	(.05)	.12	(.09)	(.13)
CPA	.04	(.03)	(.04)	.06	(.05)	(.05)
CMI	.26**	(.24**)	(.26**)	.09	(.00)	(.20)
CPI	.16	(.14)	(.10)	.15	(.14)	(.10)
CMA	.03	(.01)	(.03)	.00	(.01)	(.03)
CFA	.06	(.06)	(.10)	.05	(.06)	(.10)
CPC	.03	(.05)	(.01)	.08	(.05)	(.01)
CPN	.17	(.05)	(.01)	.09	(.16)	(.14)

*P<0.05; **P<0.01; ***P<0.001 (1-tailed)

BDI	BDI score
No Eps Dep	No of episodes of depression
Internal	Internal attributional style
Stable	Stable attributional style
Global	Global attributional style
NES	Negative self-evaluation
Soc Anx	Social anxiety
Dich	Dichotomous thinking
NATS	Negative automatic thoughts
Sub Beh	Submissive behaviour
Int Anger	Internalised anger
CSA	Childhood sexual abuse
CPA	Childhood physical abuse
CMI	Childhood maternal indifference
CPI	Childhood paternal indifference
CMA	Childhood maternal antipathy
CFA	Childhood father's antipathy
CPC	Childhood parental control
CPN	Childhood parental neglect

Unexpectedly, shame was *not* significantly related to severity of depression as measured by the BDI. Also contrary to prediction, guilt was positively correlated with BDI scores. Table 4 shows that this correlation was still significant when controlling for shame. There was no association of shame or guilt with course of depression in terms of number of previous episodes.
Data were also analysed from female participants only, but still failed to find a significant association with shame.

Turning to the other variables, shame (but not guilt) had a first-order association with a stable attributional style for negative outcomes. This association could not be accounted for either by severity of depression or by guilt. In contrast, the other attributional dimensions were unrelated to either shame or guilt.

Shame (but not guilt) also had a first order association with general negative self-evaluation as measured on the SESS and as defined in Chapter 2. This relationship remained robust when severity of depression and guilt were controlled.

Both shame and guilt were correlated with social anxiety even after controlling for severity of depression. The partial correlations indicated however, that social anxiety had a unique association with shame, but not with guilt.

Both shame and guilt were correlated with dichotomous thinking (or "splitting") even when severity of depression was partialled out. The partial correlations showed that dichotomous thinking had a unique relationship with guilt, but not with shame.

Shame (but not guilt) was positively associated with negative automatic thoughts as measured on the ATQ-30, and this relationship remained robust when severity of depression was partialled out. Negative automatic thoughts were unrelated to guilt.

Shame and guilt were both correlated with submissive behaviour, even after controlling for severity of depression. The partial correlations indicated however, that submissive behaviour had a unique association with shame, but not with guilt.

In contrast, only shame had a first-order association with internalised anger, and this relationship remained robust when severity of depression and guilt were partialled out.

Against prediction, childhood sexual and physical abuse did not appear to be related to either shame or guilt in this sample and this finding was still upheld when the data were analysed by gender. In the predicted direction, shame had a first-order association with childhood maternal indifference, and this relationship remained constant when both severity of depression and guilt were controlled. Neither shame nor guilt had a positive relationship with any of the other childhood adversity variables (ie. parental antipathy, control and neglect) as predicted.

The partial correlations reported in Table 4 show that these associations between shame and other variables were not an artefact of depression severity.

Table 5: Correlation matrix for all variables in the depressed group (N=86)

	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	BDI	1.00																				
2	NoEpsDep	.14	1.00																			
3	Internal	.58***	.18	1.00																		
4	Stable	.55***	.16	.70***	1.00																	
5	Global	.36***	.22*	.33**	.50***	1.00																
6	NES	.12	.10	.23*	.18	.08	1.00															
7	Soc Anx	.21*	.06	.14	.24*	.04	.07	1.00														
8	Dich	.29**	.09	.45***	.47***	.40***	.31**	.19*	1.00													
9	NATS	.61***	.13	.84***	.85***	.28*	.15	.31**	.39***	1.00												
10	Sub Beh	.26**	.19*	.35**	.52***	.32**	.20*	.61***	.44***	.44***	1.00											
11	IntAnger	.18	.04	.30**	.40**	.19	.02	.23*	.27**	.41***	.42***	1.00										
12	CSA	.08	.24*	.24*	.02	.09	.03	.11	.10	.18	.08	.03	1.00									
13	CPA	.10	.05	.03	.04	.04	.00	.07	.22*	.14	.07	.08	.18*	1.00								
14	CMI	.24**	.10	.08	.15	.15	.07	.20*	.01	.24*	.29**	.24*	.23*	.33***	1.00							
15	CPI	.20*	.07	.10	.04	.05	.09	.22*	.12	.29**	.21*	.19*	.32**	.21*	.48***	1.00						
16	CMA	.13	.06	.07	.05	.09	.02	.10	.05	.07	.06	.05	.22*	.28**	.67***	.31**	1.00					
17	CFA	.03	.04	.07	.12	.01	.01	.08	.05	.08	.04	.03	.26**	.33***	.26**	.70***	.24*	1.00				
18	CPC	.12	.01	.03	.06	.03	.08	.06	.02	.09	.20*	.02	.16	.21*	.04	.04	.04	.10	1.00			
19	CPN	.03	.08	.06	.09	.01	.11	.16	.16	.03	.04	.07	.13	.32**	.40***	.38***	.40***	.32**	.16	1.00		
20	Shame	.07	.06	.10	.30**	.13	.23*	.56***	.28**	.24*	.53***	.32**	.02	.04	.26**	.16	.03	.06	.03	.17	1.00	
21	Guilt	.28**	.06	.07	.22	.15	.10	.31**	.29**	.18	.35***	.13	.12	.06	.09	.15	.00	.05	.08	.09	.44***	1.00

*P<0.05; **P<0.01; ***P<0.001 (1-tailed)

Exploration of the responses of the shame subscale suggest that the distribution is skewed to the top range of responses. This suggests that there is a ceiling effect with insufficient variance in this short scale for it to give a valid measure of shame. Future research would therefore need to explore the variables in Table 5 with a more valid scale for this clinical population.

However, there are other measures which relate to shame and may be taken as indirect indicators of shame. These include submissive behaviour, social anxiety and internalised anger.

Submissive behaviour

As noted in Chapter 2, there is increasing evidence that shame-proneness is related to increased disposition to submissive behaviour (Gilbert & McGuire, 1998; Keltner & Harker, 1998). Table 5 shows the correlation with shame is highly significant at 0.53 ($p<.001$).

Social anxiety

Similarly, the linkage of shame with social anxiety has been well documented (Gilbert, 1998a; Gilbert, Allan & Goss, 1996) and discussed in Chapter 2. Table 5 shows the correlation with shame is highly significant at 0.56 ($p<.001$).

Internalised anger

Tangney and her colleagues have researched the association of shame with internalised anger (Tangney et al, 1996; Tangney & Fischer, 1995, reviewed in Chapter 2) and this has also been upheld by the findings reported here. Table 5 shows the correlation with internalised anger is 0.32 ($p<.01$).

Table 5 gives the product moment correlations for all variables investigated in this study. Their inter-relationships are not discussed however, as the focus of this research is on the role of shame and its contribution to psychopathology.

Despite the Shame and Guilt Scale's limitations, these results suggest consistently high positive correlations of shame with other established shame-related phenomena and provide indirect indicators of shame-proneness within this group, thus enhancing its concurrent validity.

Multiple Regression

In order to explore these inter-relationships in more detail a series of multiple regressions was carried out for the pathological (dependent) variables of shame and depression. It was then possible to explore how the other shame-related variables in Table 5 might add to the explained variance in shame and depression.

The only significant variable to emerge from the regression analysis for shame was submissive behaviour ($p < .01$) accounting for 15% of the variance.

Table 6a Multiple regression analysis on shame scores (N=86)

Variable	B	SE B	Beta	T	Sig T
SubBeh	.16	.06	.39	2.75	.0086
(Constant)	10.86	2.80		3.87	.0004

R	R^2	(Adj.R^2)	SE	df	F	Sig F
.39	.15	.13	3.84	1	7.57	.0086

As the analyses carried out on the data are cross-sectional no inference of causality can be made from these findings. However, Table 6a shows that, in the current study, only submissive behaviour had a positive relationship with shame and none of the other shame-related variables added to the explained variance.

The only significant variable to emerge from the regression analysis for depression was an internal attributional style for negative outcomes (p <.001) accounting for 41% of the variance.

Table 6b Multiple regression analysis on BDI scores (N=86)

Variable	B	SE B	Beta	T	Sig T
Internal	.60	.11	.64	5.44	.0000
(Constant)	4.44	4.22		1.05	.2991

R	R^2	(Adj.R^2)	SE	df	F	Sig F
.64	.41	.39	5.90	1	29.61	.0000

Because the analyses carried out on the data are cross-sectional no inference of causality can be made from these findings. However, Table 6b shows that, in the current study, only an internal attributional style for negative outcomes had a positive association with depression and no other shame-related variable added independent significant effects.

Conclusion of Results Section

Together these data show that shame, as measured by Gilbert's Shame and Guilt Scale, is reflecting a more general trait of submissive behaviour. This demonstrates that the phenomenology of shame contains aspects of a submissive strategy of defence (Gilbert, 1989, 1998a; Gilbert & McGuire, 1998; Keltner & Harker, 1998). The

data also confirm the importance of an internal attributional style for negative outcomes in depression, in line with Beck's cognitive theory of depression (Beck et al., 1979; Peterson et al., 1982; Peterson & Villanova, 1988).

Discussion of Quantitative Findings

Factor Analysis of the Shame and Guilt Scale

A factor analysis of the Shame and Guilt Scale produced a clear solution corresponding to the original subscales. In their 1989 study, Gilbert et al's scale loaded onto three factors - one of shame and two of guilt (hurting others and secretly cheating). This may be because they used a non-depressed student sample whereas the current study used a clinical sample of moderate-to-severe depressed participants. The data show a "ceiling effect" with this scale, with data skewed towards the top end of the scale for shame but not for guilt, which may make it unsuitable to measure shame in clinical populations. The correlation between the shame and guilt subscales is small enough to infer substantial independence, while indicating some degree of covariation, reflecting the fact that both emotions involve negative affect and internal attributions of some kind. Tangney, Wagner & Gramzow's (1992) study, using the TOSCA (Test of Self-Conscious Affect), found a correlation of 0.45 between its shame and guilt subscales whereas the current study reports a correlation between subscales of 0.44.

Discussion of Correlational Findings

As all analyses are cross-sectional no inference of prediction or direction of causality can be made. However, in contrast to previous studies, shame was found to be *unrelated* to the severity of depression. Since Gilbert et al's (1989) findings were based on a primarily

female sample, the data were re-analysed from the female participants only, but still failed to find a significant association. One possible explanation for these findings may be that the items in the Beck Depression Inventory (BDI) are more reflective of pathological guilt or self-blame than they are of shame *per se*, thus generating this particular pattern of correlations (eg. two BDI items relate to feeling guilty and feelings of being punished). As noted above, given that there are only five shame items in Gilbert et al's measure, there is not enough variance at the top of the scale, accounting for the loss of correlation with the BDI which has a large variance (Shame & Guilt Scale = 5-25; BDI = 0-63). Harder (1995) and Tangney, Burggraf and Wagner (1995) refer to the role of pathological or "shame-fused guilt" in depression, which would clearly relate to feelings of being punished reflected in the BDI.

Another explanation may be the greater symptom severity of the participants in the current study, other investigators having used non-clinical, or mildly depressed, samples. A non-clinical, or mildly depressed, sample may show similar levels of shame, suggesting shame may have a more complex role in the aetiology of depression than had previously been thought. A visual inspection of the data, which confirms the ceiling effect with the shame subscale of Gilbert et al's measure, suggests it may not be useful for very depressed populations with high shame scores. Thus, shame-proneness may be linked to mild depressive reactions, or even to vulnerability to depression, but not influence severity once a person has become clinically depressed. In this case, guilt may play a more significant role.

Harder (1995) argues that the best way to assess as much unconscious emotion as possible may be self-report scales that try to capture the *subjective experience* of emotions, so that the full "shame meaning" of the feelings can be left unstated, as they are partly

unconscious. Participant self-reports that describe behavioural responses to situations may be more vulnerable to confounding by social desirability and repression. Harder argues that careful in-depth clinical study of participants could verify whether the measure used did or did not tap into unconscious emotional states. Guilt, being at a more conscious level and involving self-monitoring and self-judging cognitions, may lend itself more easily to situationally-assessed self-report measures such as the guilt subscale of Gilbert et al's Shame and Guilt Scale. However, this measure may not be the best instrument to tap global, possibly unconscious, feelings of shame, which may account for the failure to replicate the association of shame with depression in this particular clinical group.

Unlike other recent research (Andrews & Hunter, 1997) the findings in the current study did not reveal any association of shame with the course of depression. It should be noted however, that both the measure of shame and the way in which the course of depression were operationalised were very different in the two studies. In the current study, a measure of shame-proneness was used in hypothetical situations, whereas Andrews and Hunter measured the actual phenomenological experience of behavioural and characterological shame.

The hypothesis that shame (but not guilt) would show an association with an internal, stable and global attributional style for negative outcomes was partly supported for the stability dimension. This is consistent with Weiner's (1985) view that controllability is the crucial dimension differentiating shame (a response attributing failure to an internal and uncontrollable cause) from guilt (a response attributing failure to an internal and controllable cause). Empirically, uncontrollable causes tend also to be perceived as stable causes (Weiner, 1985). The failure to confirm the hypotheses concerning the internality and globality

dimension may again be accounted for by the Shame and Guilt Scale reflecting hypothetical situational responses, and not adequately tapping into the phenomenological experience of internalised shame. Guilt shows no such association with attributional style, as predicted.

The results confirm the views of Lewis (1971, 1976, 1986, 1987) in that shame seems to involve a generalised concept of a negative self (Chapter 2 refers) and involves general negative self-evaluation, as derived from the SESS scores. Guilt on the other hand, involves self-judgements about specific acts or behaviour, such as cheating or harming others, and incorporates an element of moral responsibility and wish for reparation. This differential focus on self versus behaviour received strong empirical support in a series of studies on counterfactual thinking (Niedenthal et al., 1994). For example, when asked to "counterfactualize" personal shame or guilt experiences (eg. list factors that might have caused the event to end differently), people were observed to more often "undo" aspects of the *self* in connection with shame, and more often "undo" aspects of their *behaviour* in connection with guilt. In the current study, guilt was not correlated with general negative self-evaluation, derived from the SESS scores, which was in the predicted direction.

The prediction that shame (but not guilt) would be associated with social anxiety was not fully supported. Both shame and guilt were related to social anxiety after controlling for the severity of depression, but only shame had a unique association with social anxiety. This adds support to Gilbert and Gerlsma's findings (in press) that parental shaming in childhood can sensitise individuals in the social sphere, and so generalise into adulthood as social anxiety.

The prediction that shame (but not guilt) would be associated with the process of dichotomous thinking ('splitting') was not upheld by the findings in this study. Both shame and guilt were positively correlated with the dichotomous thinking subscale of the Dysfunctional Attitudes Scale (DAS-A), guilt showing a unique association after controlling for shame. It is possible however, that this subscale simply reflects errors in thinking in line with Beck's model of "cognitive errors" in depression (Beck et al., 1979) and does not represent an adequate operationalisation of the concept of splitting which, in analytic terms, embraces more fundamental differences in the way that emotionally salient information is processed.

The prediction that shame (but not guilt) would be positively associated with negative automatic thoughts was upheld by these findings. This supports and develops the role of negative schema or negative self-statements in shame-proneness and provides evidence of how cognitive content may mediate and influence affect and behaviour. It is of interest that the Automatic Thoughts Questionnaire (the ATQ-30) factor-analyses primarily into a large first factor reflecting personal maladjustment, and a second factor indicative of negative self-concept/negative expectations of outcome. Because both dimensions may reflect enduring and characterological cognitive styles, a unique association with shame-proneness is consistent with this.

The results showed a significant correlation of shame with submissive behaviour, thereby replicating Gilbert et al's findings (Allan & Gilbert, 1997; Gilbert et al., 1995; Gilbert, in press). Although submissive behaviour was also associated with guilt, the data show that, consistent with evolutionary theory, it had a unique association with shame.

There also appeared to be a first-order association between shame and internalised anger, giving support to the concept of "shame-rage" spirals (Lewis 1971, reviewed in Scheff 1987).

There are now three studies demonstrating a positive association between shame, specifically "bodily shame" and childhood abuse (Andrews 1995; Andrews 1997; Andrews & Hunter 1997). Dutton et al. (1995) looked at the role of shame and guilt in the intergenerational transmission of domestic abusiveness in men. The current findings, that neither shame nor guilt is associated with childhood abuse, again suggests that the Shame and Guilt Scale may not be detecting more internalised aspects of shame. It is of interest that Andrews and Hunter (1997) also found no association between a reported history of childhood abuse and general shame directed at the person's character or behaviour, supporting the idea that it is bodily shame which may act as a particular marker of childhood trauma.

The prediction that shame would be positively associated with childhood maternal indifference was strongly upheld by the current findings which showed a first-order association. Unlike other studies (Gilbert et al, 1996; Gilbert & Gerlsma, in press; Richter et al, 1994) there was no association of adult shame with other childhood adversity factors, such as parental antipathy, control or neglect, which was in the predicted direction. This gives support to the psychoanalytic view that it is the role of positive mirroring in childhood which contributes to the development of a healthy and well-functioning self (Jacoby, 1994; Kohut 1971, 1977; Winnicott 1967). When parental indifference and antipathy are clearly differentiated and rated separately, as in the current study, it is the lack of an emotional response towards the child which appears to be particularly pathogenic. It could be argued that there is likely to be a different threshold for mothers and fathers since the latter

usually have less responsibility (even now) for the early emotional needs of their children, and this would explain the non-significant finding for shame and paternal indifference. Therefore, it would appear to be the absence of an "affirming object" that can seriously impede the child's emotional development and lead to crises of identity and subsequent shame pathology. Although psychoanalytic theory has long offered a rich source of ideas about such processes, only comparatively recently have these notions been translated into empirical questions to address current clinical issues (see Alexander 1992 on the role of attachment theory in sexual abuse).

Therefore, the positive association between childhood maternal indifference and adult shame-proneness may be understood in terms of this particular pattern of maternal interpersonal behaviour, potentiating the development of a "shame-laden self" which becomes incorporated into an enduring self-image in adulthood.

Discussion of Multiple Regression Findings

The multiple regression findings on shame support other research which shows that shame often presents as submissive behaviour, especially in situations of social anxiety (Keltner, 1995; Keltner & Harker, 1998). This may imply that the pathogenic effects of shame are due to its operation through submissive strategies. The other shame-related variables showed no such significant association with shame. It has been argued that the concepts of submissive behaviour and subordination provide important pathways from other psychological concepts, such as negative self-evaluation, negative automatic thoughts and social anxiety, to possible biological mediators (see Gilbert & McGuire, 1998 for a review). A parental rearing style which obliterates a child's emerging sense of self

may contribute to a submissive style of behaviour in adulthood.

The multiple regression findings on depression support other research which shows that depression is often associated with an internal attributional style for negative outcomes (Beck et al., 1979; Peterson et al., 1982; Peterson & Villanova, 1988). The other shame-related variables showed no such significant association with depression. Because submissive behaviour is not adaptive (ie. it can lead to a lack of control over social outcomes, rejection or marginalisation) it may confirm existing negative beliefs about the self which often characterise shame. This spiral can lead to further submissiveness and may constitute a vulnerability factor in depression.

In conclusion, the multiple regression findings reported in this study demonstrate the significant independent effects of submissive behaviour in shame, and an internal attributional style in depression, within this clinical group.

Conclusion

Taken together, these findings generate interesting questions about the conceptualisation, measurement and influence of shame and guilt and the part they play in adult symptomatology. In the current study, guilt (unlike shame) is associated with depression. However, items in the depression measure used (the BDI) are more reflective of pathological guilt than shame *per se* which may account for this pattern of results. It is also likely that the shame measure used, Gilbert et al's (1989) Shame and Guilt Scale, may not be tapping into the more phenomenological experience of shame. And finally, in this clinical group, comprising couples where one partner was moderately-to-severely depressed, guilt rather than

shame may have been more salient (ie. the issue of hurting others or being a burden in the relationship).

It is also clear that conclusions regarding the role of these two affects in psychological distress must be tentative until the outstanding conceptual and measurement issues have been more fully addressed (Chapter 3 refers). Considerable progress has now been made in constructing theoretically meaningful, psychometrically sound measures of shame and guilt - and the body of systematic empirical research on these important emotions has grown accordingly. Future shame researchers can anticipate the construction of more sophisticated assessment strategies as our understanding of these two emotions continues to evolve. No doubt, the coming years are likely to see interesting research developments that will clarify the nature and function of the measurement of shame and guilt and their differential contributions to psychopathology.

Chapter 5: A Content Analysis Study of the CECA Interview Data in a Depressed Group

Aims: Another way of investigating shame and its relation to childhood maternal indifference is by carrying out a content analysis on transcribed interview data from the CECA.

Research Question

The research question is to explore in depth the experience of childhood maternal indifference for each high-shame and high-indifference scoring participant, in an attempt to identify the mechanisms by which such experience may contribute to shame-proneness in adulthood. Where parents have jointly shown indifference this has been included in the interview data, when there is evidence that the mother's indifference is implicit in participants' responses. The research question to be addressed is, "Why, and by what mechanisms, does childhood maternal indifference make adults vulnerable to shame?"

Introduction to the Content Analysis Method

Almost every study reviewed in the introductory chapters used a quantitative method of analysis. Whilst research of this kind is important, and may be necessary to explore and test competing accounts of psychological phenomena, in some cases an over-reliance on quantitative

research methods alone may lead to a premature "narrowing of focus" and a corresponding neglect of the more human context of the phenomena under investigation.

While it may be possible to investigate neglected facets of the experience of shame using purely quantitative methods, the use of an in-depth content analysis from participants' verbatim interview comments, offers a number of advantages over a purely quantitative strategy. Firstly, such a method can be a useful means of examining "naturally occurring" phenomena in their ordinary settings. Secondly, it can offer a means of understanding phenomena in a holistic way which includes variables not pre-selected by the interviewer. Accordingly, such methods are well suited to the inductive stages of theory development. Finally, as Miles and Huberman (1994) note, "...[such] data, with their emphasis on people's *lived experience*, are well suited for locating the *meanings* people place on the events, processes and structures of their lives ... and for connecting those meanings to the *social world* around them" (p.10). This is particularly relevant to a "self-conscious" emotion such as shame which is often experienced within an interpersonal or social context, and is often dependent on an individual's appraisal or "meaning-making" of the experience in question.

Although content analysis itself comes within the category of quantitative methodology, it is seriously arguable that its flexibility places it at the interface with more qualitative research methods. In the words of Barker et al. (1996) "Content analysis provides a useful means of bridging quantitative and qualitative approaches, in that it applies quantitative analysis to verbal (qualitative) descriptions" (p.123). There has been an increase of interest in the use of such methods in psychological research in recent years (Hayes, 1997; Richardson, 1996; Robson, 1993; Stiles, 1993). This

appears to have developed partly as a result of a more critical view of the development of scientific knowledge (Henwood, 1996; Woolgar, 1996) and partly as a result of psychologists' interests in developing psychological knowledge in applied settings (Hayes, 1997). According to Miles and Huberman (1994): "...social phenomena exist not only in the mind but also in the objective world - and ... there are some lawful and reasonably stable relationships to be found among them" (p.4).

As Miles and Huberman point out, "no study conforms exactly to a standard methodology; each one calls for the researcher to bend the methodology to the peculiarities of the setting" (p.5). However, a key concern in the current content analysis has been to establish the reliability and validity of the conclusions drawn from the data. To do this, use has been made of inter-rater reliability and triangulation of data from other sources, as well as the presentation of data in display matrices (Miles & Huberman, 1994), negative case analysis and alternative explanations (Yin, 1989).

The method chosen in the current study, of content analysis using transcripts of recorded interviews, differs from the quantitative measures considered so far in that it often involves indirect rather than direct measurement and inference. It has been defined in various ways. Krippendorff's (1980) definition, that "content analysis is a research technique for making replicable and valid inferences from data to their context" (p.21) has the virtue of stressing the relationship between *content* and *context*. This "context" includes the purpose of the document or transcript as well as institutional, social and cultural aspects. It also emphasises that reliability and validity are central concerns in content analysis.

The semi-structured interview schedule used in the current study (the CECA: see Appendix 5) is aimed at eliciting participants' accounts of adverse experiences in childhood, with that of maternal indifference predicted as the most likely to be associated with adult shame-proneness. A distinction is sometimes made in content analysis between "witting" and "unwitting" evidence. Witting evidence is that which the participant intended to impart, whereas unwitting evidence is everything else that can be gleaned from the document or interview material.

The checklist of criteria suggested by Gottschalk et al. (1986) in relation to the use of personal documents in history, covers important concerns relevant to the accuracy of all documents and interview transcripts:

1. Was the ultimate source of the detail (the primary witness) *able* to tell the truth?
2. Was the primary witness *willing* to tell the truth?
3. Is the primary witness *accurately reported* with regard to the detail under investigation?
4. Is there any *external corroboration* of the detail under examination?

In order to satisfy these criteria the following points should be noted. Firstly, the participants in the current study were a depressed non-psychotic subsample who had given informed consent to this major research outcome study and understood its purpose. This means the first question can be reasonably confidently answered in the affirmative. Secondly, a previous review of the literature indicates that retrospective accounts obtained in this way are likely to be valid and are unlikely to be affected by depressed mood (Brewin et al., 1993).

Thirdly, inter-rater reliability on the CECA (ranging from 0.8 to 1.0 on the maternal indifference and abuse dimensions respectively) suggests a high level of inter-rater agreement. Fourthly, although there was no external corroboratory evidence in this study, reliability studies by Parker (1981) on the Parental Bonding Instrument (PBI), and Bifulco and Moran (1998), using the same interview (the CECA), support the feasibility of retrospective assessments of parental rearing. Parker's (1981) results indicate high agreement between PBI-scores and sibling ratings concerning the relations of the index person and the parents, and Bifulco and Moran (1998) have reported similar findings regarding the validity and reliability of participants' and siblings' retrospective accounts of parental rearing.

To summarise, the evidence suggests that memories of childhood are less sensitive to mood or time distortions than is often thought, and do provide reliable, useful and accurate sources of data.

Participants

While the empirical findings drawn from the clinical measures (Chapter 4) help elucidate the role of shame in adult psychopathology, it was hoped that an in-depth study of participants' childhoods would identify in finer detail those factors which may contribute to its aetiology. It was anticipated that participants' verbatim accounts of their childhood experiences would supply the richest source of the data of interest, and the Childhood Experience of Care and Abuse Interview (the CECA) was therefore selected for in-depth content analysis. A median split was carried out on the scores of the maternal indifference dimension of the CECA, and the

scores of the Shame and Guilt Scale, to allocate participants into high and low maternal indifference, and high and low shame and guilt. In this way a subsample of high shame/high indifference participants was identified (N=24) and this subsample was used in the subsequent analysis.

Measures

The Childhood Experience of Care and Abuse interview schedule (the CECA) was used to elicit participants' accounts of adverse experiences in childhood, with that of maternal indifference predicted as the most likely to be associated with adult shame.

Procedure

The aim of the content analysis was to extract units of meaning from the transcribed verbal data in a manner which permitted the quantification of the material in terms of frequency of occurrence of categories. There were two steps: firstly, the transcribed verbal material was divided into "units of meaning" (unitization) in a systematic manner, resulting in "themes" or "objects". The second step was to form mutually exclusive and exhaustive categories according to which the content of the transcripts could be sorted and quantified.

In the current study, some of the categories so formed were new, emergent categories, being directly derived from the transcribed verbal data rather than determined on an "a priori" basis by the researcher. Whilst

obviously reflecting pre-existing categories (or questions) from the CECA on childhood adversity factors such as parental antipathy, indifference, neglect and control, this method also lead to the emergence of new categories which were spontaneously elicited by participants and were not in response to directly-asked questions (such as themes of isolation, maternal jealousy etc.). Themes or objects were then assigned to their most appropriate categories. Quantification was derived by counting the number of objects assigned to each category (ie. a frequency count was performed) and statistical analysis carried out (a chi-square "goodness-of-fit" test) to ascertain the level of significance of occurrence.

One advantage of using a structured systematic approach such as content analysis is the possibility of assessing the reliability and validity of the analysis beyond the subjectivity of the author. Thus the identification of units of meaning, and the assignment of objects to their various categories, was independently performed by another researcher. In this case, inter-rater reliability was carried out with a post-doctoral clinical psychologist and Cohen's Kappa was computed (Howell, 1992). This showed an inter-rater agreement of 0.9 taking into account chance agreement, suggesting a high level of inter-rater reliability. Although some natural overlap between categories exists, each item was treated as mutually exclusive and assigned to one category only, to avoid confounding of variables in the final statistical analysis in line with good research practice (Robson, 1993, p.277).

Analytic Strategy

Validity of the analysis derived largely from the validity of the categories employed in addressing the research question, and the extent to which the data were actually captured by the categories created ie. the

"operationalisation" of category construction (Robson, 1993, p.277). Triangulation of data, in this case use of empirical data from other sources (see Chapter 4) provided an external reference-point for investigating those aspects of childhood maternal indifference which may predispose to shame-proneness in adulthood, such as the childhood construction of an enduring negative or "bad" self, with stable dysfunctional self- and other-beliefs.

All statistical calculations were carried out using the SPSS package for PCs in Windows '95.

Results of Content Analysis

A total of fifteen categories emerged from the transcribed verbal data of the high-shame/high-indifference subsample, a third of which (N=5) were emergent (or new) categories and did not reflect responses to directly-asked questions from the interview schedule. Examples of each category are listed below.

Academic Attitude: My Mum didn't help when I was having problems with a teacher. (Existing category)

Acceptance & Need to Please: I was always trying to please her. (New category)

Child as Reminder of Parent: Mother said I reminded her of my father. I felt unloved 'cos Mum hated Dad. I got the hate. (New category)

Emotional Availability: I couldn't go to Mother because it was like a brick wall. (Existing category)

Favouritism: I felt she favoured my sister because she was a very quiet child - I was outgoing and energetic. (Existing category)

Interest: Mother didn't take much interest in my life - father was often at sea. (Existing category)

Isolation: I was 'little fat Jackie', the ugly one. I always felt very alone. I sorted problems out myself. (New category)

Love & Approval: Mother was neutral in every way. She wasn't positive - but not negative either. (Existing category)

Material Affirmation & Celebration: Mother didn't always remember my birthday. (Existing category)

Maternal Jealousy: Mum was terribly jealous 'cos I went to grammar school. She was deeply resentful of spending money on school uniform for the school. She would say, 'If you'd gone to secondary school we wouldn't have had to spend so much'. (New category)

Maternal Loss: I can't remember what she was like - I lost contact after she left. (Existing category)

Physical Affection: I don't think Mother could show affection - she was very distant. (Existing category)

Psychological Control: I could never ask Mother about my natural father as she disapproved and would say, 'How do you think your stepfather would feel?' (ie. if subject were to make contact). (New category)

Rejection & Denigration: I'd hear things like my Mother saying she didn't want to get pregnant. She did things to try and get rid of me. (Existing category)

Social Attitude: Mother was very cold towards my friends. They had to wait on the doorstep and weren't invited in. Other families seemed warmer. (Existing category)

Chi-square Goodness-of-fit Test

A frequency count showed a statistical significance in occurrence of the various categories at the p=.005 level (chi-square = 83.5, df 14, p<.005). This means that if each category contributed equally there is only a .005% chance (confidence level >99.5%) that a chi-square value greater than 31.31 would have been achieved. Since the obtained chi-square value is 83.5, the null hypothesis can be rejected and it can be concluded that there *is* a significant difference between categories.
(Howell, 1992, pp.284-287).

TABLE 7): CHI SQUARE: COMPARISON OF OBSERVED (0) AND EXPECTED (E) FREQUENCIES

	Em Avail	Soc Att	Ac Att	Fav	Phys Aff	Int	Rej & Den	Love & App	Isol	Mat Aff	Psych control	Child as Rem	Mat Jeal	Mat Loss	Accept	Total
Observed (O)	27	16	17	18	14	11	18	11	6	5	6	3	2	2	1	157
Expected (E)	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5	157

TABLE 8): CATEGORY DISTRIBUTION BY FREQUENCY

Em Avail	Soc Att	Ac Att	Fav	Phys Aff	Int	Rej & Den	Love & App	Isol	Mat Aff	Psych Control	Child as Rem	Mat Jeal	Mat Loss	Accept
27	16	17	18	14	11	18	11	6	5	6	3	2	2	1

Chi-square Distribution for df=14, critical value of $x^2 = 83.5$, $\alpha=.005$ (p=<.005) (confidence level > 99.5%)

As can be seen from Tables 7 and 8, a very significant finding is that the category of Emotional Availability (n=27) is *one and a half times* that of the next two highest, Favouritism, and Rejection & Denigration (both n=18). This cannot be accounted for by the number of questions relating to these categories in the interview schedule, as there are three questions on antipathy and only two on indifference (Appendix 5 refers). Furthermore, there would appear to be no primacy effect, as two of the antipathy questions precede those relating to indifference. The significance of this finding will be discussed and explored within a psychoanalytic framework, because this has most conceptual relevance for the child's early inner experience of a "failing maternal environment" (Winnicott, 1958) and "lack of mirroring" in childhood (Kohut, 1971).

The category of Emotional Availability (79%) is characterised by such items as:

Mum was always working - there was never time.

I couldn't explain how I felt to my Mother.

Mother couldn't protect us. She didn't have anything in her to protect us.

I don't remember going to her with problems.

She didn't understand me.

I kept it to myself.

She was caught up in her own needs too much.

See Appendix 3 for full table of interview material from the CECA

Table 9 reports the breakdown of categories by participant. As can be seen from this table, 79% of total comments are in the category of Emotional Availability.

TABLE 9: DATA DISPLAY OF CATEGORIES FROM CECA BY PARTICIPANT (N=24)

Subject	Em Avail	Soc Att	Ac Att	Fav	Phys Aff	Int	Rej & Den	Love & App	Isol	Mat Aff	Psych Con-trol	Child as Rem	Mat Jeal	Mat Loss	Accept
28	●	●	●		●	●		●		●					●
36	●	●			●	●		●							
39	●		●	●	●	●			●						
46	●			●	●			●							
49			●	●			●	●			●	●	●		
51										●				●	
95	●	●	●			●	●								
118	●	●		●		●				●			●		
130	●	●		●			●								
132		●							●						
136	●					●									
143		●	●	●		●	●								
147	●	●	●	●			●		●		●	●			
158		●	●		●		●				●				
161	●		●	●	●										
164	●	●		●	●		●		●						
166	●	●	●	●	●	●	●			●					
175	●			●	●	●			●	●				●	
191	●	●	●		●	●		●							
201	●	●	●		●			●							
221	●	●	●	●	●	●		●	●						
223	●	●	●	●			●	●							
243	●														
248	●		●	●							●				
Total %	19 79%	15 62%	14 58%	14 58%	12 50%	11 46%	9 37%	8 33%	6 25%	5 20%	4 16%	2 8%	2 8%	2 8%	1 4%

Inter-rater Reliability

Inter-rater agreement of assignment of data to categories by an independent rater was 0.9 indicating a high level of reliability (Robson 1993, p.222).

Negative Case Analysis of Atypical Cases

There are six atypical interview comments which, on the face of it, appear to contradict the overall findings both within- and between- participants. However, these represent only 3.6% of the total interview data, and are explored in further detail below.

See Appendix 4 for full table of negative cases from the CECA

Closer examination will show that in three of these participants (S95, S147 and S201) relating to Material Affirmation & Celebration, the comments were in response to a direct question by the interviewer: "Did your Mother remember your birthday?" which all three answered positively. Indeed, the majority of participants in the sample answered this question simply and briefly in the affirmative, although occasionally qualifying this (such as having to share birthday treats with other family members, only getting "sensible" presents etc.) confirming the author's view that it would be unusual, particularly in the UK, for basic social conventions, such as birthdays, *not* to be celebrated - not least because of feared negative evaluations by significant others (neighbours, schoolteachers etc.) if this were not done. It is of note here that in total only five participants reported non-celebration of a birthday, confirming the atypicality of this pattern of response.

On the question relating to Academic Attitude, the fourth participant (S36) who said "Only Mum would go to meetings at school" must be taken in the context of her other remarks during the research interview, such as "There was no time for me - Mother was too busy running the hotel", "there was no interest in who I was with or when I came back after going out with boys", "I wasn't close to either parent - both were distant", "I couldn't

go to my Mother if I was upset - she was too busy running the hotel" and "there was little interest in my friends".

Relating to Emotional Availability, the fifth participant (S147) who reported "I could go to my Mum if I was upset" (stated early in the interview) must be taken in the context of her subsequent remarks, such as "Mum was always working - there was never time" and "I couldn't explain how I felt to my Mother", suggesting her mother's preoccupation with business and work concerns (in cases S36 and S147 both relating to financial necessity rather than maternal indifference or active disinterest in the child *per se*).

On the subject of expression of Love & Approval, the sixth participant (S191) who reported that "Mother was frightened to show her approval, 'cos of Dad's reaction" must also be taken in the context of her other remarks during the interview, such as "Mother was neutral in a way. She wasn't positive - but not negative either" and "there was never any encouragement. I don't really remember those sort of things". Such a description suggests a maternal overcompliance and "flatness of affect" (possibly her mother suffered from depression as a result of social circumstances) rather than active indifference or disinterest.

Such analysis of "atypical" cases highlights the salience of how such behaviours and attitudes were experienced by the child rather than their actual determinants and causes in reality - such as financial pressures or other constraints on the family. In other words, what was important for each of these respondents was that *their subjective emotional experience was one of maternal disinterest and unavailability,* which was often perceived as different and unfair, when compared with that of other families, often leaving the child feeling isolated and separate from others.

Conclusion

The advantage of conducting a negative case analysis is that the researcher can explore cases that do not appear to fit an emerging conceptual system. This is invaluable because it serves to challenge initial assumptions and categories, and hence can work as a check against the very real danger of building indefensible arguments from a corpus of data.

Therefore, from the negative case analysis in the current study, it can be seen that it is the subjective experience or "meaning-making" of events that is important for the child in shaping their inner world rather than the reality of circumstances relating to maternal preoccupations and behaviour, such as poverty or pressures of work (for example, S36's comments on Mother being too busy running the hotel).

Tangney and her colleagues in their (1994) study found that the most striking shame-guilt difference centred on the nature of interpersonal concerns - that is, with respondents' *interpretation of the interpersonal meaning of the event or behaviour in question*. Shame experiences were more likely to involve a concern with others' perceived evaluations or attitudes towards the self, whereas guilt experiences were more likely to involve a concern with one's effect on others. It could be argued, as Ausubel (1958), that what is important for childrens' emotional development is not what really happened, but how parental behaviour is *perceived*. Therefore, the current content analysis shows that, in shame, the focus is less on the *objective facts* of the emotion-eliciting event or behaviour in question, and more on the *meaning made* of the event and how that impacted on the child's sense of self (as bad, unloveable, invisible etc.). This seems particularly true in the experience of childhood

maternal indifference and the evidence suggests it may predispose the child to shame-proneness as an adult.

Discussion of Results within a Psychoanalytic Framework

The combined results of Chapters 4 and 5 support the view that it is the mother's emotional unavailability, as experienced by the child, which plays an important role in the development of shame-proneness in adulthood. Triangulation of data from all sources enhances the validity of these findings. For example, as discussed in Chapter 2, other-directed favouritism in childhood appears to potentiate social anxiety in the adult; rejection and denigration as a child appear to potentiate adult submissive behaviour. The research question: "Why, and by what mechanisms, does childhood maternal indifference make adults vulnerable to shame?" can now be more fully explored.

Shame and Attachment

These findings firmly support the conclusion that lack of parental warmth and emotional unavailability constitute an important vulnerability factor for subsequent psychopathology as reported in the literature (see Gilbert & Gerlsma in press). According to the authors, such data are generally interpreted as evidence that it is dysfunctions in attachment mechanisms that mediate early experiences and subsequent pathologies (Bowlby, 1973; Fonagy, 1996; Main, 1996). Attachment approaches highlight issues of interpersonal closeness and distance and, as "distance-regulators", operationalise interpersonal dysfunctions in terms of faulty attachment styles (such as avoidant, anxious, ambivalent or "mixed" attachment styles). In his later writings, Bowlby (1977, 1980, 1988) would seem to be more concerned with the implications of his theory for the nature of the therapeutic relationship. According to Bowlby, the role

of the therapist is seen as providing the patient with "a temporary attachment figure" and Bowlby (1977) states:

> "... a therapist has a number of inter-related tasks ... first, and above all, to provide the patient with a secure base from which to explore both himself and also his relations with all those with whom he has made, or might make, an affectional bond" (p. 423).

In keeping with this view, Gilbert's notion of shame as a "distance-regulator" in therapy (1997c) reflects an adult manifestation, in the therapeutic context, of the early disruption of a healthy and responsive relationship with childhood caregivers.

It is the relational position of the self which is crucially important in identifying the shame experience. For, in shame, the other is experienced in some way as unlike the self - alienated or with the potential to alienate. The other may be viewed as less caring about the relationship than the self (as abandoning, rejecting, affectionless etc.) or as the source of potential injury or harm. The other becomes focal in awareness and may appear as mocking, ridiculing, powerful, haughty, authoritative, controlling, unjust, hostile, unresponsive, detached or emotionally uninvolved. The other's self appears intact, whereas one's own self feels diminished, fragmented or dissolved. In either case there is a perceived chasm between the self and the other and this constitutes the essence of the shame experience.

Shame and Self-Esteem

Although self-esteem is essentially a self-evaluative construct and shame is an affective state, a corresponding trait or disposition exists in shame-proneness, being the tendency to experience the emotion shame (in contradistinction to guilt) in response to specific negative events, as measured in the current study by Gilbert et al's (1989) Shame and Guilt Scale.

Jung (1921) believed that the personality is artificially stunted when the process of its natural unfolding is arrested in some way. In his view, the greatest dangers to the unfolding of individuality are present during infancy and early childhood, when the young child's development is completely at the mercy of its caretakers. Such interaction patterns influence the child's emerging self-esteem and also the quality of human relationships into the present. Jacoby (1994) states "usually this artificial stunting has its roots in these early phases of life" (p.103).

At the turn of the century, Cooley's (1902) concept of the "looking glass self" emphasised the role of other peoples' evaluations in constructing one's sense of self (Chapter 2 refers). This has three aspects: imagining one's appearance to others; imagining their evaluation or judgement of that appearance; and some response to that imagined evaluation such as pride or mortification. Shame theories have followed a similar pattern, focusing on social beliefs (of how others see the self), personal beliefs (how one sees the self), or an interaction of both.

Mead (1934) emphasised the important role of significant others, especially early caregivers, in shaping self-beliefs and early self-appraisals. Such beliefs, according to Mead, are increasingly influenced by social attitudes as the child matures into adulthood. The important role played by early caregivers (especially parents) in the development of self-esteem was empirically investigated by Rosenberg (1965) and Coopersmith (1967). More recently, Andrews and Brown (1988, 1993) have shown how early negative experiences with caregivers influence self-esteem in adult females.

The important role of positive mirroring from others in endorsing adult self-esteem in succinctly captured by

Tolstoy in the following passage from *War and Peace* (1973: original published 1869):

> "After seven years of married life Pierre was able to feel a comfortable and assured conviction that he was not a bad fellow after all. This he could do because he saw himself mirrored in his wife. In himself he felt the good and bad inextricably mixed and overlapping. But in his wife he saw reflected only what was really good in him, since everything else she rejected. And this reflection was not the result of a logical process of thought but came from some other mysterious, direct source" (pp. 1373-1374).

These results also raise interesting questions about shame's association with maternal emotional unavailability which find support in the analytic and self-psychological ideas of Winnicott (1931/1988) and Kohut (1971/1985). Winnicott (1958) in his concept of "good enough mothering" and "the failing maternal environment", and Kohut in his concept of "mirroring" (1971, 1972), both address the central role of the mother in the construction of a healthy and shame-free self, despite the relative inattention to shame in their writings. More recently, Bifulco and Moran (1998) cite Bronfenbrenner: "It has been suggested that for healthy psychological development children need at least one adult who is irrationally enthusiastic about them" (p.49).

Psychoanalytic Expositions of Shame

Shame and Indifference: The "Failing Maternal Environment"

Shame is typified by an anxious self-consciousness where there is a perceived "loss of self". In the shame experience, the other's self appears intact whereas one's own self feels diminished, fragmented or dissolved. Winnicott (1945) referred to this sense of fragmentation when he argued that the infant started life in a state of "unintegration" with disparate bits and pieces of

experience. According to Winnicott, the infant has to draw upon the mother's organised perceptions in order to organise its own experience and in this way she provides a "holding environment" within which the infant is contained and experienced. "An infant who has had no one person to gather his bits together starts with a handicap in his own self-integrating task" (p.150). Winnicott referred to this state as that of "primary maternal preoccupation" in which the mother offers herself as a medium for her baby's growth and development, and supplies its needs in an almost magical fashion. Winnicott refers to "the moment of illusion" when the infant believes it has created the object that it has desired in fantasy, such as the breast when it is ready to feed. In this way, the infant begins to experience itself as omnipotent and the source of all creation, which, if successfully modulated by the mother, becomes the basis for the later development of a robust and shame-free self.

Winnicott (1967) saw this "bringing the world to the child" as playing a crucial and intricate role in self-development, and in the infant's "hallucination" with the mother's response, that gives the repetitive experiential basis for its sense of contact with, and power over, external reality. In this way, by providing the infant with a reflection of its own experience, despite its fragmentations, the mother provides a stable "holding" environment in which the child can self-integrate: "When I look I am seen, so I exist" (p.134). Empathic failure or emotional unavailability on the part of the mother undercuts the infant's imagined omnipotence, constricting its beliefs in its own creativity and sense of self - giving birth to shame. Another need in the infant is the ability to be alone, and to develop this capacity the mother must be able to provide a "nondemanding presence" when the infant is undemanding of her. This state of unintegration (which results from the mother's fine

attunement to the baby's needs and is the antithesis of maternal indifference), Winnicott calls "going-on-being". This awareness of the infant's need for being alone in the mother's presence becomes a central feature in Winnicott's concept of a stable and personal self. It is essentially an ability to bear formlessness and to tolerate uncertainty.

Shame and Indifference: The "Good Enough Mother"

Once such omnipotence has been established, it is necessary for the child to learn the reality of the world outside its control and to experience limitations. The "good enough mother" (1960) is able to facilitate this process by gradually failing to shape the world according to the infant's demand and this gentle decline in responsiveness should synchronise with the gradual exercise of active ego functions on the part of the infant, resulting in greater differentiation and interaction in their relationship. Such "graduated failure of adaptation" (p.246) is a prerequisite for the development of separation, differentiation and realisation of a strong sense of self. Winnicott therefore stresses the importance of the mother's capacity for appropriate and sensitive withdrawal from her infant in order to foster healthy psychic development and structure.

Winnicott believed that deficiencies in providing a "good enough" environment, and its graduated withdrawal, will adversely affect the emotional development of the child and that such failures are of two kinds: an inability to actualise and respond to "hallucinatory creations" and needs of the infant, and interference with its unintegration when in a "quiescent" state. While the first may be associated with emotional unavailability, the second is closer to the concept of "affectionless control" (Bifulco & Moran, 1998) or "emotional over-involvement" (Vaughn & Leff, 1976ab). According to

Winnicott (1956) both kinds of failure on the part of the mother are experienced as a terrifying interference with a sense of personal continuity, and both result in the experience of the "annihilation of the infant's self" (p.304), which is the essence of the shame experience in the adult. This results in the child losing touch with its own spontaneous needs and gestures, as these bear no relation to the way he or she is experienced by the mother, and a kind of "objectification" ensues.

Shame and "Objectification"

In defining objectification, Broucek (1991) states that shame follows as "a response to having one's status as a subject ignored, disregarded, denied, or negated" (p.8) which is an extension of the infant's experience of being gazed at unresponsively, with a "still face". He continues, "It is when one is trying to relate to the other as a subject, but feels objectified that one is apt to experience shame" (p. 47).

An example would be of a child experiencing joy over their newly-crayoned picture and proudly showing their "achievement" to their mother, who then proceeds to reprimand them for some fault in their attire. Such resulting "fragmentation" of the infant's experiences (Kohut, 1971) leads to a split between a "true self" (which lies dormant but available for rediscovery at a later date, especially during the therapeutic encounter) and a "false self", which is compliant and attuned to the claims and requests of others. The "true self", being the source of spontaneity, goes into hiding to avoid the possibility of "psychic annihilation" ie. of being rejected or ignored, while the "false self" provides an illusion of stabilised personal existence and can come to take over the caretaking functions which the environment has failed to provide. Thus, the integrity of the 'true self' (Winnicott, 1960) is protected by the "false self's compliance with environmental demands" (p.147), which

anticipates shame's association with adult submissive behaviour referred to in Chapters 2 and 4. This results in a separation of the cognitive and affective processes within the individual because of the need to maintain two opposing self-presentations.

Shame and "Personhood"

In Winnicott's (1971) view, a further aspect of the process of the development of a strong and shame-free "personhood" is the formation of "transitional objects", where the nature of the relation to the objects represents a developmental stage between "hallucinatory omnipotence" and the recognition of reality. In order to achieve "personhood" the individual must move from a state of illusory omnipotence to a state of objective perception and the process is not a clear linear progression. Winnicott argues that both children and adults continually vacillate between them. Relations with "transitional objects" constitute a third, intermediary and transitional realm through which the child can negotiate and make sense of their experience. The whole realm of transitional experiencing rests on a paradox whereby there is agreement between mother and child *not to question* the nature and origin of the object. The mother both acts as if the baby has created and controls the object, and yet acknowledges its objective existence in the world of other people. The withholding or unresponsive mother, who is unable or unwilling to enter the child's "magical world" in this way, cannot facilitate self-integration in the child, thereby laying the foundations for later vulnerability to shame.

Under the term "good-enough-mothering" (1960), Winnicott postulates specific environmental provisions on which the emergence of a healthy, shame-free self is contingent. Such provisions facilitate the shift from dependence to independence, from omnipotent conception to realistic perception, from unintegration to self-integration; and

it is such "good-enough-mothering" that determines the quality of the individual's life in adulthood. Because "personhood" is such a fragile phenomenon, Winnicott says there is always a tension between subjective experience and objective reality.

Shame and Alienation

According to his view, our total infantile development leads to an inevitable residual vulnerability where a part of us is ultimately inaccessible and isolated - feelings intrinsic to shame. Winnicott (1963) states: "At the centre of each person is an incommunicado element, and this is sacred and most worthy of preservation" (p.187). There remains, according to Winnicott, a "noncommunicating self" which is "truly isolate" and despite his relative inattention to shame, this statement encapsulates the apocryphal shame experience of isolation and alienation similar to Kierkegaard's "existential dread". The question remains (Winnicott, 1963) of "how to be isolated without having to be insulated" (p.182) and this again reflects his central concern of how to negotiate the gap between conflicting human needs for intimacy and solitude, openness and privacy, stability and change.

Psychotherapeutic Implications (Winnicott)

Such questions reflect those features of the therapeutic situation which bear most directly on early developmental processes facilitating the emergence of "personhood". In Winnicott's view, the earliest object relations consist of interactions between developmental needs within the child, and provisions or "supplies" offered by the mother. Winnicott argues for the centrality of "good-enough-mothering", defining it as an (initial) perfectly-responsive facilitation of the infant's needs and gestures; a nonintrusive "holding" and mirroring environment throughout quiescent states; the collusive

agreement to respect transitional objects; to ensure object survival - despite the intensity or destructiveness of the infant's needs; and failure to retaliate against such features of "object-usage". Winnicott (1948b) argues that the mother's personality and interpersonal parenting style have an enormous impact on the child's development, and maternal psychopathology, or deficiency, reverberates in the psychopathology, or deficiency, of the child: "The child lives within the circle of a parent's personality and ... this circle has pathological features" (p.93).

Winnicott saw the curative factor in psychotherapy not in its interpretive function but the manner in which the analytic setting provides missing parental provisions and fills early developmental needs. Schafer (1967) states:

> "On the other hand, as a benevolently curious or empathic therapist, the analyst may, for some patients, fill an ideal form that has lain empty for many years. And, in expressing appreciation of the analyst, such a patient may say or imply, 'This is how I wanted to believe a parent could be' or 'This is the idea of a good parent I once created'". Winnicott speaks in one place of a patient's "creating" his analyst (1948a). In this limited respect it is not a repetitious transference phenomenon that is contemplated: it is a form of remembering and of renewed invention and reality testing; it is a fresh and hopeful attempt by the patient to find a fit for leftover and tenaciously-held ideal forms, or perhaps even to create meaningful ideal forms for the first time (pp. 167-168).

Interestingly, from the cognitive therapy literature, Young (1990) has promoted the term "early maladaptive schemata" (or EMSs) to describe the persistent dysfunctional core beliefs which underpin enduring psychological problems. Young maintains that schemata are extremely stable enduring themes that develop during childhood and are elaborated upon throughout an individual's lifetime. He describes them as templates for the processing of later experience. Young postulates that maladaptive schemata are the result of dysfunctional experiences in the first few years of an individual's

life, and he emphasises their unconditional, self-perpetuating nature. He has gone so far as to propose that the therapeutic relationship be used as a "partial re-parenting" forum for the client who has experienced adverse parenting.

Such an idea has obvious parallels with the analytic psychotherapies (cf. Alexander & French's (1946) "corrective emotional experience") and underscores the importance of the therapeutic relationship when working with people experiencing enduring psychological problems, especially those originating in childhood. Patients presenting with issues relating to shame would be particularly sensitive to the Rogerian qualities of "accurate empathy", "non-possessive warmth" and "genuineness" in the therapeutic relationship (Rogers, 1957) in a (conscious or unconscious) effort to avoid repetition of the original pathogenic relationship.

Therefore, according to Winnicott (1948a), the function of psychotherapy is to compensate for parental failure in adaptation and "to provide a certain type of environment" (p.168). He argues that only if the appropriate facilitating environment is provided by the therapist can the "true self" be reached and allowed to grow in a way that is healthy and free from vulnerability to shame.

Shame and Indifference: Lack of Mirroring

It is this emphasis on the significance of the primary maternal environment for the development of a shame-free self that is reflected in the writings of Kohut (1971/1988) who has built on, and developed, Winnicott's ideas and woven these subsequent formulations into a more systematic framework of psychological theory. Both theorists focus on the significance of the infant's early maternal environment for the self's optimal growth and healthy integration.

Kohut's exploration of narcissism, conceptualised as a defence against shame, and his emphasis on a concept of self as an "experiential core of the personality", has led to an alternative paradigm for psychoanalysis known as Self Psychology. In this new framework, disturbances in the experience of the self are seen as primary, and object relational disturbances (involving withdrawal from relatedness, as in narcissism) are seen as secondary.

A theme of central concern is Kohut's concept of the "self-object" which refers to the caretaker's functions of mirroring and emotional availability for idealisation, which are needed to maintain the cohesion of the infant's self (an extension of Winnicott's "good-enough-mothering"). This means, for Kohut, the ability to resonate with her baby's needs so it becomes attuned to its own bodily functions and impulses, thus paving the way for a slowly-unfolding and healthy sense of self. Similarly, the self-object functions to maintain the cohesion of the self, akin to the role of Winnicott's "transitional object". But whereas Winnicott emphasises the priority of relational processes leading to the emergence of a shame-free self, Kohut focuses on the infant's world. That is, he centres on the view "empathically grasped" from within the infant/patient's experience, as opposed to a more external or objective viewpoint.

Shame and Empathic Failure

Such a concept highlights the significance of empathy for Kohut in the therapeutic process. According to his theory, empathic failure in the caregiver leads to a splitting off of the infant's "grandiose self" (a crucial stage of early self-organisation). Socarides and Stolorow (1984, 1985) comment: "The child ... becomes vulnerable to self-fragmentation because his affect states have not been met with the requisite responsiveness from the

caregiving surround and thus cannot become integrated into the organization of his self-experience" (p.106).

Pathology, according to Kohut's model, results when the cohesive self (the steady-state function) has been faultily developed so that the individual persists in turning to the outside human environment for help in maintaining the internal state which cannot be maintained autonomously. The regulation of a robust and shame-free self is, according to Kohut, virtually absent at birth and is only slowly acquired by empathic contact with the nurturing, soothing other who is experienced as part of the self ie. the self-object.

Shame and Grandiosity

Following from this, it is necessary to review Kohut's (1971, 1972) self-developmental theory as it relates to shame. Kohut grounded his schema of development in the notion that the infant begins life making use of two psychic states, one of which is grandiosity. The early grandiose sense of self is shared with the mother, or other caretaker, through exhibitionism. The infant's exhibitionism must be responded to warmly (mirrored) by the caregiver in order for the infant to gradually modify its grandiose sense of self, so that the mature self can emerge competent and ambitious, but no longer dominated by an archaic sense of power and greatness.

According to Kohut (1971) the second infantile state relevant to self-development is the child's experience of the "idealized parent imago" or "the idealized omnipotent selfobject". In this state, the infant relates *to the other*, not the self, as perfect and powerful. To the extent that the idealised other offers an empathic response to the infant's admiring interest, the infant shares in the object's perfection, and its own self-esteem is enhanced. Kohut believed that the two types of experience co-occur in the infant, rather than one

preceding the other (later referred to in his writings as the "bipolar self", 1977). He also believed that empathic responses from significant others are crucial to the positive outcome of both types of experience. In his view, empathic responses lead to modification of early grandiosity and to attenuation of early idealisation. Images of perfection gradually shift to mature "guiding ideals" and realistic aspirations.

Shame and the Need for "Self-Objects"

For Kohut (1977) therefore, the child is born into an empathic responsive human milieu where relatedness with others is essential for psychological survival. Self emerges at a point where "the baby's innate potentialities and the [parents'] expectations with regard to the baby converge" (p.99). But others are needed to provide a sense of cohesion, constancy and resilience, and Kohut terms these "self-objects" as, in the infant's mind, they are not yet differentiated from the self. These self-objects (who serve functions which will later be performed by the individual's own psychic structure) provide the experiences necessary for the gradual development of the self. Kohut considers the relations between the infant and its self-objects as the basic constituents of psychic development and structure. The healthy and shame-free self is seen as supported by its self-objects throughout life, and this understanding of the infant as both psychologically separate, and at the same time partially merged with its self-objects, has important parallels in Kohut's concept of the transference configurations in narcissistic personalities.

Crucial for shame theory is Kohut's additional notion that repeated empathic failure, as is the case in maternal emotional unavailability, leads to the splitting off of early grandiose images of self and other, so that these images are retained in their original, unrealistic

form and cannot be integrated into the personality. Whenever the original aims of the child are split off in this way (rather than being modified and integrated) the "nuclear ambitions" of the self are not realised and grandiosity acts as a defence against a vulnerable, and shameladen, self.

Shame and Narcissism

Kohut, whilst often referring to the *self-esteem* of the person whose personality is split off in this way, says little about shame *per se*. But he does conceptualise shame as the response to the flooding of the ego with grandiose-exhibitionistic libido. Therefore, one important prior condition for shame is the splitting off of the grandiose self. The person who has split off their early grandiosity is highly shame-vulnerable because split-off exhibitionistic libido may suddenly flood the ego at any time. Kohut (1971) describes why a person experiences shame: "because revelation at times is still accompanied by crude, unneutralized exhibitionistic libido" (p.149). In other words, when a narcissistic person tries to share the self with another, they do so in a way that activates and exposes their split-off, infantile grandiosity, and such exposure leads to shame. A further reference (Kohut, 1972) describes the relationship between exhibitionism and shame: "It will suddenly flood the reality ego with unneutralized exhibitionistic cathexes and overwhelm the neutralizing powers of the ego, which becomes paralysed and experiences intense shame and rage" (p.373).

For Kohut therefore, shame is intricately linked to narcissistic disturbances in self-structure. Shame is, in essence, a judgement-free, primarily physical and pre-verbal experience of flushing, shrinking and gaze aversion, which occurs automatically in response to exposure of the grandiose-exhibitionistic self. In his view, shame is a feeling state that functions to 'ground'

a person who is overstimulated by feelings of omnipotence.

Shame and the Transference

Kohut (1971) described three transference configurations which reflect his self-developmental theory of the mother-infant relationship, and which are characteristic of narcissistic personalities.

The first configuration Kohut described is the "mirror transference", when the patient derives a sense of wellbeing from the empathic mirroring of their grandiose self. In the second, the "idealising transference", the patient attempts to feel partially merged with the therapist as an idealised figure. In this particular configuration, it may be the process or technique of analysis that is idealised, and this bears some similarity to Winnicott's notion of the "environment mother", denoting the "mother-as-therapist's" *functions* as distinct from her/his *person*. In the third, that of "twinship", the patient feels they are the same as the therapist, and failures in empathy or disruption of analysis may cause the patient to regress to cold grandiosity, haughty withdrawal or hypochondriacal preoccupations with a fragmented self.

Kohut (1977, p.3) defines narcissistic personality disorders as "(1) defects, acquired in childhood, in the psychological structure of the self and (2) secondary structure-formations, also built up in early childhood". The latter include defensive and compensatory structures and Kohut refers to the "vertical split" or "false-self organisation" of the personality where repressed and unfulfilled needs for affirmation co-exist with displayed but denied grandiosity in the split-off part of the psyche. In narcissistically disordered individuals, ideals are perfectionistic (and often rigid) and they are

highly invested as goals towards which to strive. As such, they are shame-generative when the individual cannot achieve them. In other words, for those individuals who are hugely invested in idealised images of the self, evidence that the person cannot become their imagined self will bring shame, unless the evidence is denied. Such individuals are generally classified among the narcissistic personality disorders.

Shame and the "Nuclear Self"

Kohut (1985) also refers to the concept of a "nuclear self" - a deep and central structure established early in childhood, which struggles throughout life to realise its true goals. He remarks that Self-Psychology discovers "the depression of the adult in the depth of the child" (p.215), by which he means that the depression of the lonely child is based in the dim realisation that the future will not be fulfilled. Such an idea could similarly apply to shame affect. This experience is poignantly described in Janet Frame's (1984) autobiography, *An Angel at My Table:* "I would feel like a child excluded from her mother's attention...struggling constantly to move through a wilderness of deprivation, slowly planting tiny cherished blossoms in the waste" (p. 104).

Kohut's "nuclear self" is very close to Winnicott's notion of the "true self" outlined above, and Kohut notes that the aspirations of the "nuclear self" may be in conflict with the more "peripheral selves" who seek "easy adaptation and comfortable consistency": in fact, this was Frame's primary survival strategy in her precarious attempts at self-preservation, because of which she came to see herself as characterised by others' definitions of her, namely, "always eager to please and good with guests" (Frame, 1984). One implication of this for narcissistic personalities is that their grandiosity - which defends against painful feelings of shameful

inadequacy - attempts to maintain an illusion of independence: they are both afraid of dependence and of surrender to their deeper "nuclear self". This often leads to an air of superficiality and lack of depth, especially in the therapeutic encounter. Kohut argues that his approach to the treatment of narcissistic personality disorders is more consistently psychoanalytic and neutral than other approaches, which he sees as taking a moralistic and more challenging stance (cf. Kernberg). For Kohut, narcissism is to be understood and transformed into higher forms - mature ambitions, values and ideals - and not be regarded as a "bad" part of the self that needs eradicating.

Psychotherapeutic Implications (Kohut)

Kohut's (1977) view of the therapeutic process is that change takes place not through interpretation but through experience or "micro-internalizations" of the analyst's functions as self-object. He argues that much of the therapeutic effect produced by classical psychoanalysis stems from the empathic response to the patient, although this is not regarded as a salient factor in itself. His theory of compensatory structure suggests that early developmental failures which are not rectified via therapeutic reconstruction may be adequately ameliorated by satisfactory experiences with the transferential self-object, in the person of the therapist. Thus, it may be too threatening for a patient to acknowledge the depth of their mother's psychopathology, and subsequent inability to provide adequate mirroring, but a satisfactory experience with the "idealized" analyst can lead to a self that is strong enough to make a full interpretation of the earliest experience unnecessary.

Therefore, Kohut's depiction of the therapeutic process is consistent with the premises underlying his theoretical position. The analytic situation is defined in terms of an interpersonal field in which the participation of the analyst is essential. He states

(1977) that a "fundamental claim of the psychology of the self [is] that the presence of an empathic [...] observer defines [...] the psychological field" (p.32). Similar to Winnicott, disorders of the self, particularly the narcissistic disorders where shame is highly defended against, are understood as environmental deficiency disorders. The child has not been allowed, through the process of "transmuting internalizations", to generate healthy structures within the self, and so further psychic growth is constrained and a vulnerability to shame develops. In Kohut's view, in therapy the patient establishes a self-object transference in either a mirroring, idealising or twinship mode, which provides a kind of developmental second chance. The internalisation of the transferential relationship can then become the core of a compensatory self structure and the true "shame" self can be elicited, or uncovered, by the therapist, explored and modified.

Conclusion

In summary, although Kohut and Winnicott both focus on the importance of the early maternal environment and its implications, where it was deficient, for the therapeutic encounter, Kohut has formalised these ideas into a broader metapsychological framework, paying particular attention to the defensive role of grandiosity, and its converse shame, in personality organisation. It is interesting that both theorists see the curative factor in analytic psychotherapy not in its interpretive function, but in the manner in which the analytic setting provides missing parental provisions and fills early developmental needs.

Chapter 6. Case-Study: Childhood Maternal Indifference and Narcissism as a Defence against Shame

"It's quantity that counts, not quality" (quote from session 5)

Another methodology to study shame and its association with childhood maternal indifference is that of the single case-study.

Morrison (1989) argues that shame is the central affect of narcissism and M. Lewis (1992) appears to hold a similar view. He states:

> "The extreme pathology of prolonged shame produces narcissistic disorders and the disintegration of the self system ... Narcissistic disorders generate a wide range of symptoms including grandiosity, rage, inferiority, overidealisation, feelings of entitlement, and a lack of empathy. For me, the inability to cope with shame and humiliation underlies these pathological disturbances. Narcissists seek to avoid shame, and, when avoidance fails, engage in emotional behaviour that masks their underlying feeling" (p.11).

The quantitative and content analysis findings of the current study, with the latter being grounded in a subsample of high-shame/high indifference participants' verbatim interview comments, strongly suggest that it is maternal indifference, characterised by emotional unavailability and perceived disinterest in the child, which significantly contributes to shame-proneness in the adult. It is argued that these findings give strong empirical support to ideas drawn from the analytic and self-psychological literature, where shame is conceptualised as a highly important affect within narcissistic contexts (although Miller (1996) argues it is not necessarily always central). Accordingly, its development is seen to be largely due to the original personality-forming stresses on the child.

Background

I present here a case-study of such a narcissistic personality organisation in a patient I had referred to me as suitable for long-term psychodynamic psychotherapy, presenting with depression (her major symptom) and anxiety, underscored by a general unhappiness and sense of pervasive emptiness and failure in her life, particularly in her marriage. She was also experiencing problems with anger, strong control needs, feelings of deprivation, excessive rumination and a tendency to "black-and-white" (dichotomous or rigid) thinking which often resulted in interpersonal difficulties with the world in general, and her husband in particular. In the past she had suffered with intermittent panic attacks and these had recently recurred, although in a milder form.

The case material demonstrates those "shame" components associated with childhood maternal indifference (reported in Chapter 4) of internalised anger, a stable attributional style for negative outcomes, general negative automatic thoughts and beliefs, and general negative self-evaluation: the latter being narcissistically defended against in an attempt to deflect painful feelings of shameful inferiority and unworthiness.

Referral was originally made by her GP to the local NHS Psychotherapy Department for assessment, where she presented with symptoms of depression and anxiety, and self-report questionnaires showed narcissistic features of grandiosity, lack of empathy, feelings of entitlement, rage, cognitive rigidity, excessive rumination and a tendency to dichotomous thinking or "splitting" (including overidealisation and denigration). The assessor's view, a consultant psychotherapist, was that her depression was the result of unresolved Oedipal jealousy for her father, compounded by rivalry with her

mother, whom she perceived as emotionally detached and indifferent. It was concluded that she was suitable for long-term once-weekly psychodynamic psychotherapy with a female therapist. Names have been changed to preserve confidentiality.

Introduction to the Patient: Early Roots of Shame

The patient, whom I saw for two years once weekly, I shall call Kate. She was a 46-year old married woman, with a daughter aged 25, and two teenage stepchildren aged 14 and 16 who were living with her present husband's ex-wife. From a working-class background, and married for ten years, she had in the past taken occasional part-time work of a clerical nature, while her husband ran his own small electrical business. Towards the end of therapy, Kate had started work as a "Victim Support Scheme" counsellor and had decided that she would like to train professionally in the counselling field. She was a bright and articulate person, having passed her 11+ examination to grammar school, but never having followed a specific career, due to the constraints of becoming a single parent at the age of 21.

Her present husband and herself were homeowners and their house had been on the market for several years; its failure to sell, and difficulties with her husband's business, she attributed less to the impact of the recession than to his general lack of assertiveness and inability to make decisions. This general attributional style of "blaming others" was to recur throughout the sessions.

Kate's first significant relationship was at the age of 18, with a Catholic French Algerian called Claude, whom she met when he was working as a waiter in London. She reported that she was attracted to him by his being "different", that is, foreign and "exciting". She soon became pregnant and there was family pressure on her to

marry, which she did before the birth, and they went to live in Algeria. Although she loved the lifestyle, she left her husband when aged 21, and took their daughter, aged three, back to England, attributing problems in their marriage to "communication difficulties", his infidelity and their sexual incompatibility (she never achieved orgasm for the duration of their marriage). During this period she suffered an ectopic pregnancy which profoundly disturbed her, as she had not been prepared for the operation (induced miscarriage) which followed. For the next five years, she and her daughter lived with her parents followed by a ten-year period of independence, punctuated by two medium-term relationships, until she married her present husband at the age of 36.

Kate's family history was that a younger sister by two years, Barbara, had died of meningitis at the age of 7, when Kate was 9 years old. The death was "hushed up" by her mother and Kate remembers her mother saying, upon enquiries from neighbours, that she had "lost Barbara": no explanation was ever given. She later told me, in therapy, that she had been "terrified" her mother would "lose" her too. It came as a shock to Kate when, over a year later, she discovered her sister was dead. Kate also had another sister, then aged 2, and a baby brother born the following year.

She had two significant memories relating to Barbara, namely, seeing her in some kind of "transparent bubble" and was reminded of this when she later visited Madame Tussaud's and saw the waxen figure of Sleeping Beauty lying in a glass coffin - apparently dead *but her heart still beating*. The other was an image of her father crying at Barbara's graveside, when she was about 11, which particularly disturbed her, as she'd never seen him cry before and felt angry with him for being "weak".

It was significant that Kate had become confused in the past (and still was) over the dates and their ages at the time of Barbara's death. She had said at assessment that she was 9 and Barbara was 7, but in a later session said that was wrong and *she* had been 7 and Barbara must have been 5. That changed again when she realised her mistake, but she reported that, in her mind, she had often thought that she was 7 at the time of Barbara's death, because she had suffered "an amnesia" for the following two years. She'd said "Somehow I'd always stuck at 7" (Session 3), "There's a gap there" (session 11) and "It's always been jumbled up in my mind" (session 14). So, in other words, she had psychologically placed herself at her sister's age of death. Apparently, her mother would dress the two girls alike, to the extent that people often mistook them for twins, although they were about 18 months apart in age. During the course of therapy it was established that the first account was correct.

From a classical Freudian perspective, a family death at the time of such intense, complex and emotional developments and one which is, moreover, a "family secret", would no doubt engender strong repressive forces in the child's psyche to defend against the pain of loss, survivor guilt and shame at her triumph. Moreover, Kohut's self-psychological concept of a "self-object merger" (1977) is useful here as a way of making sense of the amnesia that Kate developed, because Barbara's death reflected her "death" too, psychologically speaking, at the same age. This chain of events resulted in the development of a "grandiose self", characterised by a strong self-reliance, rigid ideas about what was right and wrong, feelings of entitlement, rage if her view of the world was challenged and a tendency to "black-and-white", dichotomised thinking. One consequence of this was that Kate often had difficulty in "de-centring" and being able to view things from another's perspective.

This illustrates how defensive narcissistic needs can result in a failure of empathy, which is generally associated with shame-proneness (Tangney et al., 1994). In Kate, strong perfectionistic needs and ideals meant that anything short of perfection was valueless and hence shame-generating, and this theme became repeated in the transference.

After Barbara's death, as eldest child with a younger sister, then aged 2, and a brother born the following year, Kate had to take on premature responsibility for her siblings, as her mother was too depressed (and therefore emotionally unavailable) to resume this role. If Kate asked her mother why she was crying she was told "not to ask questions" and therefore eventually stopped asking. In this way, she was forced to take on an early adult role as caretaker which left her feeling resentful and controlled, unable to join her friends in ordinary childhood games owing to the extra burden of family responsibility. From this experience there developed a pervasive sense of feeling unprotected, unloved, invalidated, angry and let down, and an unwanted and precocious self-reliance emerged, while her true self and needs for unconditional love remained hidden. In adulthood, such needs were experienced as shame-generating and were therefore strongly defended against.

A further significant memory of later years was of being bullied as a young teenager at school when she attempted to go to the rescue of a younger classmate. It seemed particularly unfair to Kate that, in so doing, she had made herself vulnerable and her vulnerability had been abused. This was undoubtedly a "matching (shaming) event" which resonated with her needs for protection from caregivers and those in authority, and her expectation of being let down and abandoned.

Her understandable anxiety about secrecy had been triggered in her relationship with her present husband

whom she felt had a "secretive side" and was not always as open with her as she would have liked, particularly about how he spent his time during the day when he was away from her. This made her chronically angry, which became internalised as depression - her presenting symptom.

She also spoke of two significant recurring dreams, the first of which she would have as a child, especially when unhappy, and this was of being in an exotic and warm foreign land, where she felt free and unrestrained. It is revealing that her earliest memory was of the feeling of triumph she experienced after escaping from her baby harness while in the garden. The second recurring dream was of being chased by wild animals, usually dogs, in an open space where there was no chance of escape, upon which she would wake up sweating and terrified. The last time she recounted this dream she had managed to escape by knocking at the door of a cottage where a "kindly old lady" took her in.

It is interesting that on her honeymoon her present husband was attacked by dogs and she went to his rescue, resulting in one of the dogs biting her arm. She felt angry and shamed by him because he publicly told her off for "rescuing" him and this event ruined their honeymoon, setting the scene for her later concerns with feeling unprotected and let down. Indeed, in an earlier session she had told me that she'd always wanted an older brother to protect her and then, when she was old enough to understand this would never happen, asked her mother, "Why did you have me first?", thus generating a script of feeling let down and alone.

Seven years prior to the start of therapy, she had been hospitalised for a drugs overdose and subsequently prescribed anti-depressants for several months, which she felt had been of no real benefit. In an early session, she described her initial feelings of relief at

being taken into hospital and of being able to "hand over control" to staff in the short term, but this was quickly followed by feelings of panic at her perceived loss of control and the wish to escape.

Kate was in therapy with me for two years and, although understanding the implications of her childhood for her current relationship problems and inner conflicts, still very much saw her husband as "the problem". In addition to experiencing him as "secretive" and "sly", she often felt let down and shamed by him, and this became the source of much of her depression and anxiety. Her strong needs for security, reassurance, mirroring and unconditional love, were experienced as shame-generating as they conflicted with her need to be in control in order to feel safe. This dilemma repeatedly emerged in the therapy, and in the transference, and was difficult for her to reconcile. Her acceptance of the underlying fragility of her sense of self alternated with her withdrawal into haughty grandiosity, angry defensiveness or cold detachment, all of which served to defend against the underlying shame of her own neediness.

Formulation and Treatment Considerations

Formulations in therapy were expressed primarily in terms of Luborsky's (1984, 1990) Self-Psychology concepts of "core-conflicts" and "core-conflictual relationship themes" (CCRTs), the primary one being Kate's wish for ideal and unconditional (maternal) love and understanding, which was experienced as shame-generating. This was often expressed as the need for others to provide external structure for her, in order to make her feel safe.

Indeed, Kate's presenting symptoms of depression and anxiety, and emergent fears of her uncontrollable and destructive anger, could be understood in terms of this initial formulation. A subsidiary CCRT of wanting

something from someone (W=Wish), expecting it to be withheld (RO=Response from Other), and resulting in angry self-righteousness or haughty grandiosity (RS=Response from Self), was useful as a way of understanding those narcissistic personality features of grandiosity, perfectionism, self-preoccupation, rigid thinking and overwhelming rage.

In cognitive therapy terms, this sequence could be reformulated as comprising negative automatic thoughts or core beliefs such as "You can't trust anyone" and "I have to look after myself". Shame was experienced when others highlighted her unrealistic and perfectionistic ideals, when the rigid nature of her thinking was challenged, or when she stepped outside of her grandiose fantasies and viewed them more realistically (cf. Kohut's, 1971, definition of shame as the "revelation of exhibitionistic libido"). In the sessions, if Kate's view of the world was questioned or challenged, this resulted in angry attempts to stave off strongly-defended feelings of shame and vulnerability.

Theme 1: Shame and the Wish for Unconditional Love/Expectation of Indifference

One primary theme with Kate was her underlying wish for unconditional love or mirroring, often taking the form of wanting total compliance with her wishes, however unreasonable. Her expected response from others was that of indifference or rejection, which she then responded to with narcissistic rage, often displaced onto others or internalised as depression. With reference to her past, this configuration was explicable in terms of her deep wish for love and affirmation from her mother at a time when her mother was emotionally unavailable to her, owing to her preoccupation with her daughter, Barbara's, illness and death. Therefore, Kate came to expect indifference and emotional neglect from a mother who was not able to satisfy her needs for love and containment at

that time. Kate's response was to feel angry and deprived and to withdraw into a haughty and grandiose self-reliance, or prickly detachment, as a way of staving off shame-generating neediness and fears of emotional dependence.

Theme 2: Shame and the Wish for Protection/Expectation of Disappointment

Another pervasive theme, or dilemma, was when Kate felt deprived or vulnerable and wanted protection or guidance, became attached to someone and expected to be disappointed or let down. She then responded by feeling angry, shamed or persecuted by the person concerned, who in turn became her attacker and was seen as hostile. Her past experiences with her mother around the time of Barbara's death explained the development of this particular configuration. One example of this was during one session when she accused me of deliberately "confusing" her by not answering her questions:

> "... it's other people who have confused me and you're doing it now. Yes I *am* let down ... a lot of people think they're protecting me by not telling me what I want to know. *[Angrily] ... I only respect people if they answer my questions*".

It is of note that her mother's dictum when Barbara died was "not to ask questions".

In addition to these recurring themes were central "core conflicts" (Luborsky 1984, 1990) which often produced a form of "cognitive dissonance" (Festinger, 1957) as they appeared to be mutually exclusive, and therefore unresolvable. In fact, one of Kate's oft-cited criticisms of her husband was that things with him were "never resolved", illustrating her characteristic tendency to a stable attributional style for negative outcomes.

Core Conflict 1: Wish for Protection vs. Need for Control/Grandiosity as a Shame Solution

One of Kate's principal dilemmas was that in order to feel safe she needed to be in control, but this conflicted with her wish for total protection, which involved giving up some measure of her control. In other words, she wanted to feel contained without feeling controlled (reflecting Winnicott's reference to "intimacy vs. solitude" needs in Chapter 5). However, if she risked this, she felt vulnerable, ashamed and angry which in turn increased her need for control: thus was born a "shame-rage" spiral which became self-perpetuating and led to grandiosity as a defence against the rage and (shame-generating) feelings of vulnerability.

Kate's "grandiose self" functioned as a set of convictions regarding entitlement and self-righteousness and embodied an unshakeable belief that she was always right - an example of her narcissism as a defence against her underlying, general negative self-esteem. Other people tended to be regarded as extensions of her own mind or body, as if they were a mirror in which she could always be seen and admired.[i] An outside object was experienced as part of the "grandiose self" and its absence or perceived deficiencies could not be acknowledged or tolerated.

Acknowledgement of people outside her own mental sphere existed, but often possessed an existence in the abstract, ie. were experienced as unreal or idealised "imagoes". The image of her father crying at Barbara's graveside profoundly affected Kate because she saw him for the first time as less-than-perfect, *so he could not stay as the idealised parent imago in her mind*. Hedges (1983) writes: "Although these imagoes rely on stimulii[ii] from outside, they are organised according to an internal, narcissistic investment, placing oneself at the

centre of the universe and those idealised imagoes at one's beck and call" (p.62).

Thus, the idealising and mirroring needs of the self, conceptualised by Kohut (1977) as two poles of the "bipolar self", give the individual two chances of developing a cohesive and shame-free self. In therapy, Kate's move towards reconciling opposites and tolerating shame-generating needs, particularly of feared dependency with regard to her mother/therapist, provided her with a "developmental second chance" on the way to the formation of a more integrated and shame-free self.

Core Conflict 2: Wish for Escape vs. Need for Love/ Escape as a Shame Solution

This "core-conflict" involved two seemingly mutually incompatible wishes, which were Kate's longing for freedom which conflicted with her wish for protection and unconditional love. Her past history explained this configuration in terms of her wish to escape from premature, adult responsibilities, but activating her fear that such escape would deny her the longed-for protection and love that, historically, she had craved. Her earliest memory, of escape and triumph, and recurrent dreams of a foreign land actualised by her first marriage, were symbolic of this wish, as was the first dream she brought to the session.

Core Conflict 3: Wish for Love vs. Need for Control/ Contempt as a Shame Solution

A further pattern had developed of a wish for love, experienced as shame-generating, her expected response from others (of emotional indifference), and her defence against that response (anger and contempt). Kate's past experience of taking on premature responsibility for her younger sister and baby brother fostered a precocious self-reliance which was necessary for her psychological

survival. Because Kate felt her mother was unable to look after her, or respond to her emotional needs, she was forced back onto her own resources to look after herself whilst still craving the maternal love and mirroring that she needed (but resented). This was often exemplified in the relationship with her husband *when she felt she was the one who was protecting him*, and then feeling angry and contemptuous at this perceived reversal of roles. Such contempt was often displayed in the transference when the source of her security was threatened. In one session when I'd told her about a planned change of day for her therapy, Kate dismissed this as being "beyond my control", and therefore forgivable, as I was "in training". This was an example of her anger at feeling controlled, and her attempt to devalue or shame the therapist, who could no longer be tolerated. By denigration and contempt, Kate could keep herself "good" and project the "badness" onto the therapist.

Dreams and Shame

Kate's dream was set in Spain and depicted a flamenco dancer "performing" to an applauding and enthusiastic audience, an appreciative crowd of spectators. Kate thought she was there in the dream, both as spectator and dancer, but couldn't be sure. She had the dream after a disturbing event the day before when she had found her husband in his shop, unexpectedly, with "another woman" (his accountant), whom she described as sitting on a swivel-chair, mini-skirted, and making flamboyant gestures with her arms, which she demonstrated to me.

In classical analytic terms, this dream could be understood as the flaunting and discharged energy of a repressed and exhibitionistic self, wishing to be both seen and admired. In self-psychological terms, Kohut defines shame as the response to the flooding of the ego with grandiose-exhibitionistic libido (see Chapter 5). In

other words, it is born of an awareness of "the self flooded with exhibitionistic needs" (Kohut, 1977). However, the dream also expresses ambivalence about the desirability of being "centre-stage" (Kohut's "grandiose self"), because of the dreamer's slipping in and out of the spectator/dancer role. It clearly made use of "the day residue" of the previous day's events with the "other woman", and also connected with Kate's childhood dream symbolic of freedom and escape. The dream was also transferential in that the therapist was experienced as idealised and admired gipsy-dancer - an unconscious representation of myself as object of emulation (and, at times, envy). The dream also denoted the wish of the voyeuristic self in relation to narcissistic and libidinous impulses, displayed here in the form of extravagant dancing.

In Kohut's (1977) self-psychological terms, the dream provides an interesting example of a "self-state dream" which he defined as "an attempt to deal with the psychological danger by covering nameless processes with nameable visual imagery" (pp. 108-109). As a "self-state dream" it expresses the ambivalence of the exhibitionistic self in wanting to be both admired dancer ("the grandiose self") and hidden spectator ("the shame-prone self"). Kohut (1971) says a person experiences shame when "revelation ... is still accompanied by crude, unneutralized exhibitionistic libido" (p.149). As such, the dream expresses Kate's self in its struggle to maintain an emerging but fragile sense of confidence and self-integration in the face of exhibitionistic, and hence shame-generating, impulses.

In transferential terms, the dream represents Kate's use of the "idealising" and "twinship" transference modes (Kohut, 1971) in the process of the therapeutic relationship becoming internalised to form a stronger part of her functioning and less shame-full self, and as such, represents a "self-object merger" (Kohut, 1977).

Therefore, from a Kohutian perspective, the dream leads not just to an understanding of Kate's current "state of self", but also to an understanding of her current self-selfobject transferences with the therapist, and beyond these to their origin in her childhood, namely in the original dyadic relationship with her mother. Such dream material also reflects Winnicott's (1958) ideas on the "failing maternal environment" referred to in Chapter 5.

The Process of Therapy

Shame and Resistance

In the sessions, resistances usually appeared in the form of silences, confusion, denial, avoidance, intellectualisation, rationalisation, trivialisation, contradiction and digression, the latter often involving an abrupt change in content, or affect, signifying shame-generating material. One common pattern was for an uncomfortable, or shameladen, topic to be tentatively introduced and explored, and then dismissed with the comment, "I didn't want to get into that". This "state shift" (Luborsky 1984, 1990), sometimes denoted non-verbally by a sigh or silence, indicated that Kate no longer wished to continue as the topic was affectively charged.

For example, it was important for Kate to have the correct "labels" for her emotions in the sense that it was less shameful for her to talk about, what was in fact her jealousy, if she could redefine it as "anger" - a more acceptable emotion in her terms. One effect of these sudden changes of topic or definition was that she was able to subtly project responsibility onto the therapist, by implying it was the *therapist's* fault that she had "digressed".

Pines (1995) refers to this process as evidence of "bypassed shame", that is, the sudden dissociation that indicates the patient is threatened by the emergence of painful affect. Patients who fall silent, switch topics or begin to ruminate excessively on a limited area, bypass the threatening affect, which will often be returned to despite their resistance to it. Strupp and Binder (1984) write that:

> "Other forms of subtle resistance may be digressions to issues outside of therapy or preoccupation with childhood history - all in order to escape from what patients may experience as potentially dangerous antagonism between them and the therapist" (p.181).

This often occurred with Kate when shame-generating feelings were being discussed, and she would suddenly shift the focus onto her husband's "problems", often seeking me as an ally to validate her views.

It is generally agreed that resistances take many forms and all serve to protect the patient from experiencing painful affects which are related to conflict and are interwoven with transferential and countertransferential processes. Strupp and Binder (1984) continue:

"It can be seen that a therapist will be most likely to identify resistance if he or she attends to immediately observable behaviour" and this was illustrated early in the therapy. Kate chose to move from her usual chair to a sofa at the far end of the room. By thus placing a literal distance between us she could protect herself from her need for intimacy, which she saw as shaming (cf. Gilbert's (1997c) idea of shame as a "distance-regulator"). This occurred because, in the previous session, she had been particularly self-revealing and had become very tearful.

Such resistance could usefully be formulated in terms of Ezriel's concept (1950, 1952) of an avoided relationship,

a calamitous relationship and a required relationship, where for Kate, the wished-for but avoided relationship was one of intimacy; the calamitous relationship, arousing fear of the consequences, was one of indifference; the required relationship was the adoption of a compromise. In her case, the required relationship was one where she could feel in control in order to feel safe, and so conceal her wish for intimacy under a veneer of self-sufficiency, and indeed, this was the relationship she had with her husband. A number of researchers have suggested that patient challenges to the alliance reflect aspects of their underlying pathology, and that these junctures represent an opportunity for therapeutic change; however, if not handled sensitively, they may also bring about the temporary or permanent loss of the patient to therapy (see Safran & Muran, 1996).

Shame and the Transference

In the transference, Kate wanted me to provide a "good mothering" experience for her ie. to be infinitely available emotionally and possessing unlimited knowledge. In self-psychological terms, Kate's "idealising transference" was manifested in her dreams as the idealised (and envied) gipsy-dancer and the "kindly old lady" who protected her from the wild animals. This had important implications for Kate's "working through" of the negative transference. When her narcissistic rage with me did emerge, she quickly felt the need to make things all right again and to mitigate against the anticipated loss.

Indeed, one of Kate's many criticisms of her husband was that he "couldn't stand up" to her anger, and during the therapy she had similar fears that I, too, would not be able to contain, or stand up to, her anger if it was expressed, as she experienced it as overwhelmingly destructive.

In an early session Kate had asked me to "challenge" her more and stop her when she "talked too much" - a clear wish, expressed in the transference, for the longed-for maternal guidance, affirmation and structure that she felt she never had as a child. She had complained of feeling "stuck" in the therapy because I was not "providing the feedback" she expected, and was not giving her my personal views and opinions.

It could also be argued that Kate's deep need for structure was pre-Oedipal in the sense that it reflected the failure of the "environment mother" (Winnicott, 1958) to adequately mirror and contain her, and as such *was essentially concerned with this early dyadic relationship*.

Gradually, in the therapy, Kate came to recognise that I could not be the "all-perfect mother" and "provider of all the answers", although this realisation fluctuated at times with her anger relating to this perceived deficiency in her therapist. In one session there was an angry demand for me to provide her with "answers" - the repetition of the original pathogenic situation with her mother. Kate needed the recognition that this failure was not because of a bad therapist - but that this is "life". It is the belief that the therapist should/must be all-giving and all-knowing that maintained the difficulty. In this session, Kate is helped to move towards acceptance of a "good enough" therapist.

After a date for termination of therapy had been set, a vigorous re-establishment of Kate's defences emerged to mitigate against the anticipated loss, involving shaming and denigration of the therapist. In this session, Kate reported she had been ready to finish anyway, but would continue to the arranged date. In the event, her anger and devaluation of the therapist were worked through in the remaining sessions, and she approached the final

session with gratitude and sadness - a bouquet of flowers and tears.

Miller (1996) states that the therapist's capacity to receive gifts from her patient and to acknowledge such receipt is as important as the ability to give. She states:

> "The therapist who cannot allow herself to receive from a patient will threaten the patient's self-regard within the relationship and beyond it, especially if the patient is someone whose early caregivers could not find pleasure in the patient's gifts of love and trust" (p.219).

The transference tended to fluctuate from Kate experiencing me as an idealised, infinitely emotionally available, mother to a bad and withholding one, and this was clearly evidenced in her angry demand for "answers" to her questions. With a termination date arranged, Kate experienced a dilemma about needing to remain in control (ie. to leave me before I left her) conflicting with a wish to express gratitude for the emotional understanding, support and insight, she felt I had given her.

Another example of the transferential relationship with the therapist/mother was Kate's wish for others to intuit her needs and to understand them *without being told what they were*. It was a symbolic, regressive wish for a form of "magical communication" whereby she imagined she could gain immediate and total understanding and gratification of her needs without having to express them in any way. This originated from her childhood wish for absolute love from an "idealised mother" who would be perfectly attuned to her, and understand her needs, without verbalisation. This was the antithesis of the "real mother" to whom Kate had to keep talking in an effort to communicate and make her needs known, to the extent that her mother would tell her off for "always asking questions". An idealised and magical wished-for relationship with mother was the unconscious and primary

wish, where communication and understanding could take place *without the need for words*. An example of this in therapy occurred when Kate remarked, "I think you ought to know how to deal with somebody who feels in this state" without having communicated to me what she was feeling.

Throughout therapy Kate had often sought out my views in order to validate and shore up her precarious sense of self, and it was at such times that I became internalised as a "good mother" (in self-psychological terms, a good self-object experience) whilst simultaneously containing her disowned and unwanted (or projected) parts ie. the wild persecutory animals of her dreams. This had been illustrated in the sessions, where Kate experienced *me* as the one wanting control. In an earlier session she had remarked: "Control is a difficult question. Control can be easily shattered...the unpredictable can quickly happen and...the bottom falls out of my world. It's very fragile".

Critical Events in Therapy

Shame as Distance Regulator

Kate's changing from a chair to a sofa further away in the room was a critical incident in the therapy: justifying it to herself as her "feeling more relaxed" to sit like that, but symbolic of her underlying dilemma (ie. intimacy vs. control needs). My interpretation that it was a wish to place our relationship on a more equal, and hence more relaxed, footing was vigorously denied. This episode illustrated Kate's wish to feel equal with me, which could be understood historically in terms of her feeling superior to, yet controlled by, those around her: a feeling she had of her parents (particularly her mother) when she passed her 11+ examination and realised her own intellectual superiority. The resentment Kate felt at being placed, in her mind, in an "unequal

relationship" with me was also reflected in her current marriage, where she felt superior to, yet controlled by, her husband.

Developmental Contributions to Shame

Another significant event occurred when Kate told me for the first time of her ectopic pregnancy and the subsequent induced miscarriage, which was experienced as shaming, and how devastating the loss of a child could be. It was the first time, Kate said, she had ever allowed herself to really experience the grief of what a child's death means to a mother. Tearfully, she heard herself say, "It's a terrible thing to lose a child" and at this point could identify with her own mother's loss and grief at the time of Barbara's death. For the first time Kate understood that her mother's "not answering her questions" was not deliberate indifference or withholding, as she had always thought, but the manifestation of her mother's deep despair and inability to cope with a young child's demands at such a time. This was, in a sense, a "matching event" for Kate, resonating not only with the loss of her own childhood playmate (her sister, Barbara) but also the "lost child" part of herself that had to take on family responsibilities too soon.

Shame and Triumph

A further critical event in therapy was the very tearful session when Kate told me how she'd got confused over her age at the time of Barbara's death. She spoke of having an "amnesia" for two years and having been unable to remember anything until she was aged 9 or 10. In this session we explored how she had psychologically fixated herself at her sister's age of death, and how she had identified with her to the extent that she felt she was still living on inside her. Interestingly, her mother had always dressed the two girls alike. The "Sleeping Beauty"

memory was explored, and why this image had disturbed her so much, of the dead-but-still-living child-woman, encased in a glass coffin. She broke down and sobbed that she couldn't still be crying for her. I interpreted that maybe she was crying for the "lost child" part of herself too, that part that had been forced into taking on early adult responsibilities, and the anger and resentment this had engendered. From this, we were able to tentatively explore the shameful feelings of triumph and survivor guilt that Barbara's death had triggered (Barbara's death left Kate with a room of her own) and how her pervasive sense of "feeling blamed" may have had its origin in this. During this session, Kate rummaged in her handbag and produced a mirror and proceeded, between sobs, to adjust her eye make-up: this was an interesting example of literal "self-mirroring" in an effort to make herself feel better when faced with shame-generating, painful affect, and confirmed her negative core-belief, "I have to look after myself".

Narcissistic Rage and Shame Dynamics

Towards the end of therapy I had to cancel a session at very short notice due to a family bereavement (my mother died). Kate "forgot" to come to the next session: no message was left and no explanation or apology given - just that she "forgot". This was the only time this happened during the therapy and in the following session we explored why it felt important for her to "repay" me in this way for (in her eyes) "abandoning" her at such short notice. This session was filled with Kate's shame.

Shame and Loss of Attachment

A final significant event was around the ending of therapy and Kate's announcement that she had been "going to stop anyway". She asked if I would be seeing private patients, and when I explored why she had asked me this at this point in time, she dismissed it as curiosity on

her part. This again exemplified Kate's dilemma of needing to feel in control, conflicting with her (shame-generating) need for love, empathy, understanding and support, which had been symbolically provided by the regularity of the therapy. Acknowledgement of this would have involved Kate giving up some measure of control, and risking exposure of her vulnerability and fears of dependency.

Summary

This case-study illustrates the contribution of childhood maternal indifference, or lack of mirroring, in the generation of a shame-prone self, and its pathological manifestation in adulthood as a narcissistically-organised personality which served to defend against the shame. It also illustrates the role of the transference in bringing about personality change and growth, rather than mere symptom relief, in the therapeutic encounter.

Chapter 7. Conclusions: the Clinical Relevance of Shame and Implications for Therapeutic Practice

"Human kind cannot bear very much reality" (T.S. Eliot, *Murder in the Cathedral*)

Shame can be an emotion rooted in powerful feelings of vulnerability to rejection that seeks to avoid, or deny, reality by the construction of a "false self". It has important implications for the ability to develop, and use, the therapeutic relationship as the self-revelation required of a patient in psychotherapy can be intrinsically shame-provoking.

Overall, the current study marks an important step in uncovering the mechanisms whereby shame contributes to psychological disorder and distress. The findings suggest an increasingly interpersonal understanding of psychological difficulties and the role of shame within them: particularly the process whereby a "shame-prone self" may be generated in childhood. The results from the current study suggest that it is other people being unable to respond to, recognise or validate the individual - rather than responding negatively - which may be particularly pathogenic.

In this sample, guilt rather than shame is linked to level of depression as measured by the BDI. This could be accounted for by the concept of "pathological" or "shame-fused guilt" (Harder, 1995; Tangney, Burggraf & Wagner, 1995) which is reported in much of the clinical literature. This is, typically, a "neurotic" or exaggerated guilt that is fused with shame (see Angyal, 1965; May & Yallom, 1984; Menninger, 1938) and is most likely to be linked with depressive symptomatology. It is true that two items in the BDI reflect this kind of "pathological guilt" rather than shame *per se* (eg. feeling excessively guilty or deserving of punishment). As discussed in Chapter 4, another explanation may be

that the measure used in this study (Gilbert et al's (1989) Shame & Guilt Scale) has a much smaller variance (5-25) than the BDI (0-63). This lack of correlation with the BDI means there is a ceiling effect with this scale, and this is confirmed by a visual inspection of the data. Also, the sample used in the current study is a moderate-to-severe depressed group, unlike other studies which have used non-clinical or mildly depressed, samples. This suggests that shame may have a more complex role in the aetiology of depression: it may be linked to mild depressive reactions, or even to vulnerability to depression, but not influence severity once a person has become clinically depressed. The empirical findings of the current study suggest guilt may play a more significant role in moderate-to-severe depressive symptomatology. And finally, the issue of guilt (or hurting others) may be particularly salient for this particular group, comprising couples where one partner was clinically depressed, and issues of hurting others or being a burden in the relationship are likely to be activated.

Unlike other studies (Gilbert et al, 1996; Gilbert & Gerlsma, in press; Richter et al, 1994), the current study shows no association of shame with parental antipathy but it does have a positive association with maternal indifference as predicted, and this remained robust when level of depression and guilt were controlled (Chapter 4). This finding gives support to the psychoanalytic literature on the importance of "mirroring" in the early development of a well-functioning and shame-free self (Jacoby, 1994; Kohut, 1971, 1977; Winnicott, 1967).

When parental indifference and antipathy are rated separately, as in the current study, it appears to be indifference, as characterised by lack of emotional availability or response towards the child, which is the most pathogenic. No other childhood adversity factor

reached significance. Indeed, it is likely this is the first study to differentiate between indifference and antipathy in this way. It is argued that there may be a different threshold for mothers and fathers since the latter usually have less responsibility for the early emotional needs of their children, and this would explain the non-significant finding for shame and *paternal* indifference. The current study suggests it is the absence of an "affirming object", more than the presence of a dis-affirming one, which may impede the child's emotional development and lead to crises of identity and subsequent shame pathology. This is not to underestimate the role which parental hostility and criticism play in contributing to problems of adult self-esteem, as the case-study in Section C attests, and as shown in other studies (Gilbert et al, 1996; Gilbert & Gerlsma, in press; Richter et al, 1994). But it is the lack of *any* kind of response to the child that, on the current findings, appears to be the most pathogenic. In the words of Broucek (1991), shame follows as a response to "having one's status as a subject ignored, disregarded, denied or negated" (p.8). The current study may also be the first to distinguish indifference from antipathy in this way.

It is likely that shame plays a significant role in shame-prone psychotherapy patients' sense of emotional isolation, separateness or unreachability (cf. the "self-ostracism" of Lewis, 1971). This has important implications for psychotherapeutic practice requiring therapist skills in identifying and working with shame; it draws attention to the provision and quality of the therapeutic alliance. As Tangney (1996) remarks, "Any clinician knows, it is much easier to change a bad behaviour than to change a bad, defective self " (p. 750).

As such, shame's focus on identity-relevant concerns *in the eyes of the other* underscores those non-specific

therapist factors of "accurate empathy", "non-possessive warmth" and "genuineness" (Rogers, 1957) which are now increasingly found to be the keystones of positive outcome in psychotherapy research, regardless of therapeutic orientation (see Clarkson, 1997; Roth & Fonagy, 1996, for recent meta-reviews of psychotherapy outcome research).

The empirical findings in the current study show that shame (but not guilt) has a first-order association with a stable attributional style for negative outcomes, general negative self-evaluation, internalised anger and childhood maternal indifference. These characteristics are also typical of a person who feels subordinate in the world with little power to control desired interpersonal needs. Shame (but not guilt) also has a positive association with negative automatic thoughts and this association remained robust when severity of depression was controlled for. Multiple regression findings show that only submissive behaviour had a positive association with shame-proneness. It is arguable that the association of shame-proneness with submissive behaviour may be explained by a maternal style of indifference, where the child's sense of self had not been validated.

The content analysis (Chapter 5) investigated those features of childhood maternal indifference which might account for the development of shame-proneness in adulthood. The results indicate that it may be the lack of external validation of the child which is most damaging, in that it throws the child back onto its own (poorly-developed) resources and cognitive structures in order to make sense of the world. This happens at a time when psychological growth is in a critical phase and in need of external mirroring and support to facilitate healthy psychic development. The child may attribute the emotional indifference of the mother to its own self and a "self-as-bad" schema may develop, along with other

dysfunctional and erroneous self- and other- beliefs, often characterised by a resentful and chronic anger at the perceived deficiency, or disinterest, of the caregiver. The gap between the child's subjective needs and the mother's empathic response to them may lead the growing child to experience the negative side of their dependency, which can elicit feelings of impotence, inadequacy and shame, in varying degrees, according to the inner resources of the child on the one hand, and the maternal capacities of the mother on the other. This, in turn, may promote a "shame-identity" which becomes part of an enduring self-image and perpetuates into adulthood.

The rationale for carrying out a content analysis of the CECA interview material was to tease out, and explore in finer detail, those components of childhood maternal indifference which may contribute to shame-proneness in the adult, and to explore by what mechanisms they may operate. Therefore, comprehensive content analysis of recorded transcripts of the CECA interview data of a high-shame/high-indifference subsample, showed that it was maternal indifference, as characterised by emotional unavailability, which emerged as the most frequent theme. It is salutary to consider the following definition by Jon Allen (1995) of the origins of self-esteem:

> "Looking at others is like looking into a mirror. You see the "me" in reflection. How you see yourself reflects how you are seen by others, how you are treated by them and how you feel in relation to them. Many persons have been told they are bad in a myriad ways. But you need not be told directly; when you are mistreated you naturally conclude you are bad in some way" (p.21).

What is noteworthy about this statement is the comment "you need not be told directly". Indifference often involves *rejection by implication* through lack of recognition, validation and personal acknowledgement. Indifference is also a powerful indicator that one has no control over interpersonal relationships - literally, no matter what you do, no-one cares that much, not even enough to dislike you.

Because of these combined research findings, an exploration of the analytic and self-psychological literature was made and investigated the ideas of Winnicott and Kohut in their respective contributions to the role of the "failing maternal environment" (Winnicott, 1958) and its part in the generation of an unintegrated and shame-prone self. Implications for later psychopathology and for therapeutic practice were discussed.

The results of the current study suggest that "bypassed shame", possibly originating in childhood, is an under-recognised phenomenon in psychotherapy, and a clinical example was presented to illustrate how the use and interpretation of the transference can be helpful in understanding the pathway from maternal emotional unavailability to the generation of a "shame identity" in adulthood - in this case, denied and displayed within a narcissistic personality structure. By identifying and exploring the patient's shame-generating material within the therapeutic context, it was illustrated that the way can be prepared for some kind of psychological understanding and hence resolution, or relief, of current symptoms, in addition to longer-lasting personality change.

It was shown that the shame-prone patient in the therapeutic encounter uses many defences to cover this uncomfortable and distressing affect, such as silence, superficial ease, shallow conversation, grandiosity, anger, denial, contempt, evasion, trivialisation, digression and projection. At other times, relief may be sought by "acting out" ie. discharging anxiety through action and movement outside of the session. In any case, it is generally agreed that shame is an affect which seeks to remove material from therapy, while guilt, conversely, adds to it.

Research evidence is beginning to show that shame is generally more difficult to disclose than other emotions, and this is especially true in the therapeutic encounter (Macdonald, 1998). Macdonald shows that social considerations play a central role in "disclosure" decisions and "disclosure" outcomes. In Macdonald's study it was found that "non-disclosing" clients sought to conceal "destructive information" (Goffman, 1963) from people they thought would respond negatively. Helpful disclosure, on the other hand, took place in a context where the client felt "accepted and validated" by the recipient. Given this concern with how other people respond to them, it seems likely that the quality of *interpersonal support* constitutes a major non-specific factor in the effectiveness of psychotherapy. Wurmser (1981) refers to the powerful, relentless, self-attacking and masochistic elements in shame which can make therapy difficult.

Riikonen and Smith (1997) emphasise the importance of clients feeling "understood" and, by implication, they argue the function of psychotherapy is to help clients "find a narrative" that re-connects them to other people, by making their experiences identifiable and understandable to others (and often) to themselves. If earlier "containing" had not been good enough, the result may be that a client has blocked off large areas of emotional experience, or emotions may be felt but remain inexpressible in verbal form. In the view of Madill and Barkham (1997) therapeutic change results from the therapist's "legitimation of a morally defensible account of the client's actions" (p.232). In Beck's (1997) words, the client must experience the therapist as being "on their side of the fence".

To provide opportunities for patients to realise that what they do feel and think can impact on someone (the therapist), the therapist must be prepared to be highly reactive to the patient and not a "passive interpreter of

material". After all, the patient is struggling to find ways to control interpersonal needs and therapist passivity can easily be read as indifference.

A Therapeutic Model of Working with Shame

Implications of these findings for psychotherapeutic practice having been discussed, a model is now proposed for identifying, responding to and working with shame in the therapeutic encounter. According to Gilbert (1997bc) working with shame requires more than a rational "look at the evidence" or cognitive approach; it also requires the development of *compassion to the self* and others.

Such properties of "compassionate thinking" (Gilbert, 1997b) postulate that: 1. The compassionate mind is concerned with growth and helping people reach their potential 2. It is concerned with supporting, healing and listening to what we and others need 3. It listens and enquires about problems in a kind and friendly *way* and speaks with warmth 4. It is quick to forgive and slow to condemn 5. It does not attack but seeks to bring healing, repair and reunion 6. It recognises that life can be painful and we are all imperfect. It is encapsulated in the therapeutic intervention, "What would you say to a friend in your situation?".

The compassionate mind does not treat self or others as objects with a market value. Self-worth and self-acceptance are not "things" that can be earned; it is not conditional or based on fulfilling contracts.

This concept of "compassionate thinking" is very similar to humanistic psychology's philosophy of treating clients with empathy, non-possessive warmth and genuineness (Rogers' "core conditions", 1957). It is particularly relevant when working with the shame-prone and is essential for challenging clients presenting with internal shame, which may often be of long duration (see Andrews, 1995 in Chapter 3).

Shame issues in therapy often involve a sense of badness being "taken in" from outside: the resultant cognitive-affective complex is close to Klein's "bad self" (1957), and each experience of shame is associated with an image of the self as weak, inadequate or deficient. There is often an experience of being damaged or scarred by others, being robbed of a "good self", early experiences of powerlessness and rage or fear. This is often associated with fear of intimacy or exposure in the therapeutic situation - fear of trusting, and *even fear of being understood*. As the clinical example described in Chapter 6 shows, the therapist and therapeutic encounter may, in itself, engender feelings of shame, rage and envy in the client. Resolution and working through may involve grief, and the closeness necessary to work with it may ignite further fears of shame, for example, of weakness and feared dependency on the therapist.

Based on these reported research findings, I have constructed a therapeutic model of "working with shame" which essentially involves four stages:

Recognition of Shame

(links with empathy): involves "active listening" and notes "state shifts" (Luborsky 1984, 1990) denoting shameful affect. This can be verbal or non-verbal, such as sighs, silences or digressions; use of self-mirroring to "hide" or "shore up" self during experiencing of painful affect (eg. the "mirror" example referred to in Chapter 6); recognises "by-passed shame".

Responding to Shame

(links with non-possessive warmth): involves "permission-giving" in therapy to facilitate risk-taking; allows patient to talk about shame and meta-shame which involves recognising and responding to various levels of shame; pays attention and responds to signs of shame

avoidance. Therapist must be "active" and "reactive" as well as "containing" and "safe".

Working through Shame

(links with authenticity/genuineness/congruence): involves the concept of "compassionate thinking" to facilitate alliance; to counter patient's sense of emotional isolation; takes care not to repeat or reinforce the original pathogenic pattern, such as perceived indifference, lack of care, unconcern or inauthenticity. It presupposes an ability to help the patient accept, and work through, the challenge posed by the discovery of "multiple versions of one's self-image" (Anastasopoulos, 1997).

Coming out of Shame

(links with above three "core conditions"): involves encouraging the patient in the revelation and acknowledgement of shame; encourages "coming out of hiding" and acknowledges use of defences; helps patient accept and tolerate painful affect, including confusion; helps patient accept the role of disappointment in life; helps identify and change "voices from the past" ie. facilitates re-scripting of the past and re-connecting with the present; facilitates the growth of forgiveness and acceptance to self and others, such as learning it's acceptable to cry or feel pain and *not* be shameful.

Metashame

Brown and Pedder (1991) remark that the Self is "a consistent collection of images the individual has of himself and their relation to the images of others" (p. 164). This is particularly true when working with shame, where the patient constantly evaluates their image in the eyes of the therapist. Similarly, behaviour is constantly being evaluated by the patient as a result of "meta-shame" or shame about shame (see Scheff, 1988) of how they perceive the therapist is experiencing them or

imagine the therapist would like them to be (Gilbert, 1997c, refers to this as the "shame triad"). It embraces the fear of "not being a good patient", or being an "odd" or "unlikeable" patient and can engender strong feelings of shame, envy and fear.

According to Miller (1989) the original emotion of helplessness towards the parents revives during psychotherapy. Morrison (1984) asserts that patients may feel they have been "shamed" by requesting or being referred for treatment, and they may feel shame over their dependence on the therapist. The threat of violation or annihilation of the patient's psychic reality by the parent, which created the original feeling of shame, may be revived in the therapeutic encounter (Miller, 1985).

According to Lewis (1987b) the patient's shame over being in psychotherapy is inevitable. Worry over the loss of approval and acceptance, which has to be hidden because of anxiety about passivity and feared dependence, can often be acute. Moreover, the shame which causes the patient to feel ashamed also calls for further efforts to cover it up.

Patients find themselves literally "face-to-face" with the therapist, and the truth, and this stimulates further feelings of shame, when often the wish is to "save face" ie. avoid or deny their shame. Wurmser (1987) argues that in cases where psychotherapy, or a visit to a mental health professional, is socially stigmatising, the situation will clearly become more difficult. According to Wurmser (1987), there is greater awareness of the body, and the self is depicted visually and verbally *from the point of view of the other*.

The position of relative omnipotence in which the therapist finds themself, and the power of their position, can make them forget how easy it is to wound

through any "expertise", "knowledge" or "dogmatism" which may be displayed, or by the absence of active listening or sufficient empathy. According to Miller (1985) the escalation from shame to rage may often take place unconsciously, and if not recognised and worked through, can endanger the therapeutic process.

Jacoby (1994) encapsulates the relevance of shame for psychotherapy when he remarks:

> "Often, the people from the patient's childhood who contributed to the formation of these [interactions] ie. primary caregivers, failed to create a facilitating environment for processes intended by the Self, creating one of obstruction or disinterest instead. As a result, the person grew up not being able to rely on his or her feelings, especially when called on to evaluate his or her own self with its impulses, fantasies, and actions. According to Asper (1993) it is as if the Self were "overshadowed" ie. the tendencies originating in the Self were experienced as negative and shameful, when actually they would have been crucial for the development of adequate self-esteem, and ultimately, for individuation. Here the task of analysis or therapy is *to help the patient re-evaluate his or her values*" (p. 106).

Aims of Therapy

The above observation raises the following interesting points relating to the special nature of the therapeutic process when working with patients presenting with shame. Firstly, how individuation can emerge from shame in the creation of a "new self". Secondly, the importance of *the patient's re-evaluation of values* during therapy in the construction of a less shame-full self. Thirdly, defining the task of therapy in "uncovering shame" and facilitating the process of what it means for the patient to be "true to their self", such as being able to feel less shamed, beginning positive affirmations, re-scripting the past and realising the future. This therapeutic task will involve helping the patient forge a new identity based on new values, once the shame has been "worked through" in the sessions.

These points are crucial because a self that was constructed in childhood (almost by default) owing to lack of acknowledgement, external validation or emotional indifference, can be modulated in the therapeutic process to achieve individuation. The focus in therapy then becomes "how the patient would like to be" rather than how the patient thinks he/she is, should be, or is perceived by the therapist to be.

Shame as Motivator

Once shame is uncovered, addressed, and worked through in the therapy, it can act as a powerful motivator for change (see Chapter 1's opening quotation). Therefore, something historically perceived as "bad" can be transmuted into its opposite and become a catalyst for positive change in the therapeutic encounter. Although shame may have often functioned as a defence, or initiated psychopathological states in the past, it can also act as a motivation for achievements and social adaptation in the future. In the words of Anastasopoulos (1997), shame can "protect an individual's integrity and can be a modulator of interpersonal relatedness" (p. 103).

Similarly, Gilbert (1998b) points out that shamelessness is not necessarily an advantage. Lacking a capacity for shame may make it hard for people to be self-correcting in their behaviours and to set realistic aspirations. In the face of wrongdoing a shame display may reduce the anger of others compared to a defiant display (cf. President Clinton's recent public disavowal of his "inappropriate relationship", experienced by many as lacking in shame and therefore inauthentic).

Conclusion

In the current study, against prediction, guilt rather than shame had a positive association with depression severity. Reasons for this have been discussed and explored and it seems likely that a different pattern of

results may have emerged had a more sophisticated measure of shame been used. However, the association of shame with a range of other depression-related variables (Chapter 4 refers) shows that the affect of shame plays a significant role in intrapsychic and interpersonal processes which can lead to psychopathology. The current findings suggest that this is particularly true where there has been a maternal style characterised by indifference.

Gilbert et al's Shame and Guilt Scale was developed in 1989 and has now been superseded by more sophisticated measures which tap into more complex aspects of shame. However, the shame subscale's positive correlation with other shame-related phenomena in this study, such as submissive behaviour, social anxiety and internalised anger, demonstrates its usefulness as an indirect indicator of this important affect. As noted in Chapter 3, self-report scales inevitably measure expressions of how people *believe* they would feel in certain situations and cannot represent their lived experience. Measures such as Andrews' semi-structured interview to assess chronic shame of personal characteristics or behaviour (Andrews & Hunter 1997) may have been more appropriate, although not developed at the time of this study's inception in 1990.

With reference to the content analysis of the CECA data, Gottschalk et al's (1986) criterion (Chapter 5 refers) that for effective analysis the primary witness should be "able and willing" to tell the truth has obvious implications for the concept of "bypassed shame" (Lewis, 1971) introduced in Chapter 2. This, too, may well be addressed by using a more sophisticated instrument such as Andrews and Hunter's (1997) semi-structured interview, where probes are used to distinguish between bodily shame, behavioural shame and characterological shame, all of which are independent and likely to elicit a wider range of shame feelings at different levels of complexity

and are multidetermined. This is in contradistinction to Gilbert et al's (1989) Shame and Guilt Scale which operates at a single level of scenario-based shame-proneness.

These points are useful for further research in that although the Shame and Guilt Scale, with hindsight, may not be the most appropriate measure to use for a study of this kind, it has led to some exciting findings which have generated interesting questions for future research. The most important of these are the cognitive and affective mechanisms whereby maternal indifference may encourage the development of a shame-prone self. An aspect of the helplessness and fear of some patients is that they often feel helpless in the face of their emotions, or ashamed that they cannot control them. One of the mother's primary functions is to contain and transform the (otherwise overwhelming) emotions that a baby or young child experiences. This has significant implications for psychotherapy and the nature of the therapeutic relationship.

Recognising and understanding shame is the future challenge for psychotherapy when working with patients presenting with shame, and one which undoubtedly highlights the importance of the therapeutic relationship - beginning in the first session. The combined findings of this study suggest that, in a very real sense, the therapist may often have only "one (therapeutic) shot" at getting it right, in order to avoid repetition or reinforcement of the original pathogenic situation, which may result in shame avoidance and the potential loss of the patient to therapy.

To summarise, the recognition of shame in its various guises, and the quality of the therapist's response to it, is crucial when working with this particular client group and opens up a wide and challenging field for future research.

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Appendix 1: The Shame and Guilt Scale

Below are listed a number of situations that may cause you to feel bothered or upset. Circle the number that best describes the degree of upset you may experience in each situation. The numbers relate to the following degrees of discomfort.

1. Not bothered at all
2. A little bothered
3. A fair degree of upset
4. Quite upset
5. Very upset indeed

1.	To do something embarrassing in public (S)	1	2	3	4	5
2.	Secretly cheating on something that you know will not be found out (G)	1	2	3	4	5
3.	To hurt someones feelings (G)	1	2	3	4	5
4.	To be the centre of attention (S)	1	2	3	4	5
5.	To appear inadequate to other people (S)	1	2	3	4	5
6.	To behave in an uncaring way to others (G)	1	2	3	4	5
7.	To have something unfavourable revealed about you (S)	1	2	3	4	5
8.	To feel self-conscious in front of others (S)	1	2	3	4	5
9.	To behave unkindly (G)	1	2	3	4	5
10.	Not saying anything when a shop assistant gives you too much change (G)	1	2	3	4	5

Appendix 2: Background to the London Depression Intervention Trial (LDIT)

About the Therapists

The most experienced therapists were recruited for each intervention, as efficacy rather then effectiveness was being evaluated at this stage.

The antidepressants plus psycho-education condition was clinically managed by an experienced senior psychiatrist. He formulated a protocol for the drug regime which began with a tricyclic antidepressant, desipramine (Amitripytiline) which could be changed to an SSRI (a specific serotonin reuptake inhibitor) if, despite having a full six weeks on a therapeutic dose (ie. 125mg/ml.), there was no response or intolerable side-effects developed. Such a second-line choice would be trazodone (Molipaxin) if agitation was a major feature or fluvoxamine/fluoxetine (Faverin/Prozac) if retardation was a major feature. Additionally, if on initial assessment there were medical contraindications to using a tricyclic antidepressant, one of the two second-line drugs would be used. Serum anti-depressant levels were taken routinely to check compliance at 4 and 8 weeks and at 6-monthly intervals.

An educational programme about depression and antidepressant medication was given to the subject and, initially, their partner (two sessions only) to maximise compliance. The therapy sessions were conducted according to the previous work of the NIMH treatment of depression Collaborative Research Program (Elkin, 1989; Fawcett et al, 1987). Although the main focus of therapy was on medicating the patient, the drug was administered in a context of minimal supportive psychotherapy alongside an educative programme relating to taking anti-depressants on a long-term basis. Once an effective dose had been achieved and symptoms had remitted, the full dose was continued for four months before being gradually reduced to about one-half or two-thirds of the effective dose, as laid down in the MRC guidelines for clinical trials. Subjects were then maintained on antidepressants for a further six months before finally reducing the dose over two weeks and stopping altogether. This regime (ie. six months active treatment followed by six months prophylaxis) mirrors good clinical practice. The therapist saw subjects for approximately 12-20 sessions, averaging 30 minutes per treatment.

Cognitive therapy was conducted as described by Beck and his colleagues (Beck et al, 1979). The general principles used included a range of techniques and strategies designed to help depressed subjects correct negative and distorted views of themselves, their world and their future, and to focus on the underlying maladaptive beliefs that gave rise to such views and cognitions. The therapy was provided by a number of experienced therapists, all of whom had undertaken at least six months training under Professor

Aaron T. Beck in Philadelphia. Approximately 12-20 sessions were provided, in line with the pharmacotherapy group, but each session lasted for approximately 50 minutes. Subjects were given homework assignments which would be completed between appointments and discussed at future sessions with a view to the self-monitoring of cognitions, feelings and behaviour during the previous week. The rationale for this was to practice skills learnt in the sessions, encourage self-help and maximise compliance.

Systemic marital therapy, approximately 12-20 sessions, was provided by two senior couple and family therapists, one male and one female. During the pilot phase of the study, a manual was developed based on the therapists' experience with six couples who met the initial entry criteria for the study but were not randomised into treatment (Asen & Jones, 1992). The main focus of the therapy was the elicitation by the therapists of the partners' attitudes and emotions, and on the joint exploration and negotiation around issues of conflict. The focus was on the interaction between partners in the here-and-now and the acceptance of their joint responsibility for the creation, maintenance and resolution of problems. Little time was spent on exploration and interpretation of individual cognitions and feelings.

Therapists' Adherence

A concern of a major outcome trial of this type was to establish whether therapists adhered to their treatment manuals. Therefore, a treatment adherence study (piloted by the author and a final year psychology undergraduate) was carried out. Further work was done on this by an attached researcher (Schwarzenbach, 1993) whose aim was to monitor treatment integrity across all three interventions. A method adapted from cognitive therapy to assess treatment adherence was utilised, and specific interventions for each therapy were identified. Their use was assessed in a representative sample of videotaped sessions and results showed that, in general, therapists from all three approaches adhered to their respective manuals, although some techniques from other therapeutic orientations were implemented and there was some degree of overlap. Non-specific therapist variables were also investigated and recorded.

APPENDIX 3: SUMMARY TABLE OF MATERIAL FROM CECA INTERVIEWS (N=24)

Subject	Category	Interview Material
28	Academic Attitude	Mother wasn't interested in school work - she wouldn't go to school functions.
39	Academic Attitude	Neither went to school meetings although I wanted to stay on.
49	Academic Attitude	In fact I annoyed her 'cos I did well at school.
95	Academic Attitude	a) Both would go to Parents' Meetings but Mum for the attention rather than because she was interested. b) Mum didn't help when I was having problems.
143	Academic Attitude	She was only interested in school as far as getting good results went.
147	Academic Attitude	a) She wasn't interested in school functions. She didn't go. b) If I got a clump at school she'd say, 'it serves you right'.
158	Academic Attitude	She had no interest in school.
161	Academic Attitude	Mother didn't encourage me academically.
166	Academic Attitude	Only Dad was interested in my school performance.
191	Academic Attitude	(Of Mother re: smoking and bunking off school): She just said 'Don't let your father find out'. She would let me go shopping when off school. Everything was OK as long as Dad didn't know; I helped Mother out.
201	Academic Attitude	They went to Parents' Meetings out of duty but only in a halfhearted sort of way.
221	Academic Attitude	I don't know. I don't remember. If she was (interested in school) she didn't show me.
223	Academic Attitude	a) I never remember them going to my Parent-Teacher Meetings: they were never there. If you had homework to do you did it. They didn't help you - you did it. b) Mum never went to meetings at school.
248	Academic Attitude	I had to get on with my homework alone.

Subject	Category	Interview Material
28	Acceptance & Need to Please	I was always trying to please her.

Subject	Category	Interview Material
49	Child as Reminder of Parent	I was a great problem (to my grandmother). She hated my Mother for bringing shame on the family. I was a constant reminder of it.
147	Child as Reminder of Parent	a) Mum said I reminded her of my Father. I felt unloved 'cos my Mum hated my Dad. I got the hate. b) All through my life I was made to feel like my Father, who was a 'rotten man', so I started eating a lot and got fat.

Subject	Category	Interview Material
28	Emotional Availability	a) I couldn't go to her if I was upset. b) I didn't confide in her.
36	Emotional Availability	I wasn't close to either; both were distant. I couldn't go to my Mother if I was upset - she was too busy *running* the hotel.
39	Emotional Availability	I couldn't go to her because it was like a brick wall.
46	Emotional Availability	a) (Of Father): He'd take us everywhere, beaches and trips. He'd say, 'I'll-take-you-here, you-do-what-you've-got-to-do, you-get-on-with-it-and-leave-me- and-Mum-alone' sort of thing (S reported that Mother implicitly concurred with his attitude towards the children). b) There was not much time for me; she'd be the last person I'd confide in.
95	Emotional Availability	Mum was distant. There was no love, I don't think. I wouldn't go to her.
118	Emotional Availability	Mother was caught up in her own needs too much. She wanted to keep us 'young' when we were growing up.
130	Emotional Availability	If I had a problem I couldn't go to Mum or Dad; I was petrified of them.
136	Emotional Availability	My parents would come in late; I didn't know what was going on in my life.
147	Emotional Availability	a) Mum was always working - there was never time. b) I couldn't explain how I felt to my Mother.
161	Emotional Availability	I couldn't go to her if I was upset.
164	Emotional Availability	I wouldn't even go to my Mother if I was upset. I couldn't kiss her. Raymond, the eldest, could kiss her easily.
166	Emotional Availability	She didn't understand me.
175	Emotional Availability	She was leading her own life in Jamaica - she was a stranger really.
191	Emotional Availability	a) Mother couldn't protect us. She didn't have anything in her to protect us. She was over compliant, doing anything to 'keep the peace' and avoid conflicts with Dad. b) I feel they shouldn't really have had children. c) I don't remember going to her with problems. I'd go to friends at school. I ran away twice.
201	Emotional Availability	I couldn't go to either of them if I was upset.

Subject	Category	Interview Material
221	Emotional Availability	I couldn't go to her with my problems. She was indifferent.
223	Emotional Availability	a) I couldn't go to them ever. I just kept it to myself. b) I was scared to speak to my Mother. c) The way she behaved was, it didn't matter what I wanted in life, I would go and get it. I was seen as the strong one. (S saw this as an unrealistic and an unhelpful attitude).
243	Emotional Availability	I was not close to either (parent) and had no expectations of them as they always assumed the kids would 'look after themselves' as they were often not around. (There were six children in the family and both parents were working).
248	Emotional Availability	a) I've never been able to talk to my Mother as I'd like to. b) I felt she'd provide the bare necessities, but emotionally she wasn't there for me really throughout.

Subject	Category	Interview Material
39	Favouritism	a) My sister was her favourite. b) Mother would compare me unfavourably with my sister.
46	Favouritism	I wasn't - not Mum or Dad's favourite - my brothers were closer to Mother.
49	Favouritism	a) She looked to my sister's interests rather than mine b) (Of Mother): I was always punished - my sister wasn't.
118	Favouritism	I felt they favoured my sister because she was a very quiet child - I was outgoing and energetic. (They told S they preferred her sister).
130	Favouritism	I always felt Mum was for my younger brother instead of me and I was jealous of him. She always thought of him as 'the baby'. I always felt she took his side.
143	Favouritism	The eldest (boy) was favoured by Mother.
147	Favouritism	(Of siblings): I grew up feeling, well, ... they were better looking than me.
161	Favouritism	My eldest sister, Muriel, was favoured by Mother as she helped her with the children. Also, the other elder sister, Pat, was favoured by her for some reason. She used to get more than I did.
164	Favouritism	My sister Dolly who died was undoubtedly the favourite; then Cicely (other sister). Dolly who died, and Cicely - she (Mother) remembered their birthdays. I'm not sure if Mother remembered mine.
166	Favouritism	a) Mother's favourite was her firstborn son, who was a slow learner. Also, my younger sister who had curvature of the spine and needed special treatment. b) My Mother's favourite was the other two (sisters) and I was my Father's. I always felt safer there, 'cos he didn't shout like her.
175	Favouritism	My eldest brother who died in this country - he was the favourite really. (S is Jamaican).
221	Favouritism	a) She (Mother) had more contact with my younger sister - she was the favourite. I had a Nanny; (Nanny left when S's father died). b) She would say 'You're old enough and ugly enough to look after yourself', as long as I can remember. (Not said of younger sister).

Subject	Category	Interview Material
223	Favouritism	I had to do most of the work as the middle child - the first and last were favourites.
248	Favouritism	My sister was regarded very highly (ie. in educational achievement terms). I always felt that I was compared to my sister educationally. She was regarded higher than me 'cos she took her education seriously. Mother, in front of me, would say I didn't have the ability. She was always comparing me to Jennifer.

Subject	Category	Interview Material
28	Interest	Mother didn't take much interest in my life and Father was often at sea.
36	Interest	Parents had no time - they were too busy running the hotel. Mum had no interest in who I was or when I came back after going out with boys. (As teenager).
39	Interest	Mum took no interest.
95	Interest	Mum didn't have time or take an interest.
118	Interest	She took not interest in my life.
136	Interest	The interest wasn't there, especially after my sister was born (When S aged 9).
143	Interest	They had no interest in my life. They were too busy working and saving for the future - theirs.
166	Interest	She had no interest in my life. She was too stressed and depressed.
175	Interest	They were preoccupied with other things and, with my Mum, with so many other children who made demands. (There were 21 brothers and sisters in S's extended Jamaican family).
191	Interest	Mother provided no guidance and showed no interest in my aspirations. I had to get a job before I left school.
221	Interest	My parents had no interest at all in my life. (S's care was the responsibility of the maid and was erratic. Mother lived in the same house as S but was frequently away. Maternal grandmother moved into top flat of house when S aged 8, to help look after her. Friends of Father moved into bottom flat of house for the same reason. S had more contact with her nanny than with her Mother. Both parents permanently left family home when S aged 15, leaving her alone).

Subject	Category	Interview Material
39	Isolation	I felt left out when I saw friends with their mothers.
132	Isolation	I felt isolated, 'on my own', although I was told I was sent away 'for my own good', aged 12, to boarding-school, 'to develop myself' (S and siblings lived in separate cottage from parents who lived in a farmhouse nearby).
147	Isolation	As I got older I always felt left out. I was 'little fat Jackie' the ugly one. I always felt very alone. I sorted problems out myself.
164	Isolation	If there were problems, or any conflict, I'd suffer in silence.
175	Isolation	I felt as if I was on my own. I was left to get on with it.
221	Isolation	I always felt very alone. I sorted problems out myself.

Subject	Category	Interview Material
28	Love & Approval	a) (Of Mother): There was no warmth - it wasn't a normal family life. b) Mother never acknowledged it when I brought her gifts.
36	Love & Approval	(Of Mother): There was no praise, despite good attainment.
46	Love & Approval	Although she loves me very, very much, she didn't never show it.
49	Love & Approval	There was no love there.
191	Love & Approval	a) Mother was neutral in a way. She wasn't positive - but not negative either. b) (Of Mother): There was never any encouragement. I don't really remember those sort of things.
201	Love & Approval	a) She never said 'Well done!'. b) She never told us she loved us - she did but never said it.
221	Love & Approval	She was totally indifferent .... was always distant.
223	Love & Approval	I can't remember being kissed and cuddled. I felt indifferent to Mother.

Subject	Category	Interview Material
28	Material Affirmation & Celebration	Mother didn't always remember my birthday.
51	Material Affirmation & Celebration	Mother didn't write, remember my birthday or send money.
118	Material Affirmation & Celebration	My birthday was never celebrated. I was never allowed a party. I was told because it fell during the summer holiday.
166	Material Affirmation & Celebration	I had to share my birthday with everyone else - that is, share my treats with the others as they 'weren't well'. (Brother, slow learner; sister, curvature of the spine). There was no card. It was always 'sensible presents' like hats or scarves, but no toys. I felt very resentful about that.
175	Material Affirmation & Celebration	My birthday was only celebrated in the childrens' home. It was first celebrated when I was 9, in this country. Before that, I didn't even know it was my birthday.

Subject	Category	Interview Material
49	Maternal Jealousy	(Of Mother:) Maybe I took grandfather away from her.
118	Maternal Jealousy	Mother was terribly jealous 'cos I went to grammar school. She was deeply resentful of spending money on school uniform for the school. She would say ' If you'd gone to secondary school we wouldn't have spent so much'.

Subject	Category	Interview Material
51	Maternal Loss	I can't remember what she was like; I lost contact after she left.
175	Maternal Loss	(Of Mother): She was like a stranger really - the only memory I have of my Mother is her sitting down and then start shouting and we'd say she 'had the ghost' in her. (S is Jamaican and came to UK with Father when aged 9, leaving Mother in Jamaica).

Subject	Category	Interview Material
28	Physical Affection	a) Of the two of them, Father was more sympathetic. I think he was frightened to show too much affection because my Mother wouldn't like it. (S reported that Mother was not affectionate). b) I don't think Mother could show affection - she was very distant.
36	Physical Affection	There was little physical affection from Mother.
39	Physical Affection	Mother was not affectionate physically, ever.
46	Physical Affection	No physical affection - she wasn't that kind of person.
158	Physical Affection	I can't remember being hugged - she'd go into 'mood changes' and became a different person every day.
161	Physical Affection	There was not much love and affection. Mother was very distant, and grew more so as I grew older.
164	Physical Affection	I felt emotionally neglected. Seeing parents give affection to their children made me realise.
166	Physical Affection	Neither (parent) was affectionate.
175	Physical Affection	As a teenager I remember no affection from her.
191	Physical Affection	a) I felt things weren't right compared to my friends and their families. (S saw friends 'cuddled' by their parents, unlike her family). b) Mother wasn't affectionate - it was more like a sisterly thing. I was always stronger than her. There was never love or cuddles or anything like that.
201	Physical Affection	She never showed physical affection.
221	Physical Affection	I never remember a cuddle as a child.

Subject	Category	Interview Material
49	Psychological Control	a) (Of Mother): I feel it was 'put into me' to be frightened. She'd say, 'Wait 'til your father comes home'. b) (Of Mother): If he had known what she did to me she wouldn't have got her way.
147	Psychological Control	I was curious about my natural father and felt distanced from my stepfather. I could never ask her about my natural father as she disapproved and would say, 'how do you think your stepfather would feel?' (S wanted to make contact).
158	Psychological Control	I tried to buy her love by showering them with gifts, and later, sending them money. I was made to feel responsible for their state of affairs.
248	Psychological Control	a) (Of Mother): We were meant to take her side, after the break-up. b) Mum would make me feel bad for still liking Dad after the break-up. She punished him (for his affair) via the children. We had to sit on the doorstep to wait for him.

Subject	Category	Interview Material
49	Rejection & Denigration	She'd say 'You'd be in a childrens' home if I had my way'.
95	Rejection & Denigration	When I attempted suicide (aged 17) she just laughed and said, 'Go on then, do it'.
130	Rejection & Denigration	a) I always felt she didn't want me. b) Mum always said I was a very awkward child - I gave her too many problems
143	Rejection & Denigration	I felt neglected when I was sent to boarding school.
147	Rejection & Denigration	a) 'Ugly Bug' I'd be called and 'Bulls Eyes' - comments on what I ate. (S started overeating at an early age). b) (Of Mother): She'd say, 'Little fat Jackie'. c) I'd hear things like my Mother saying she didn't want to get pregnant. She did things to try and get rid of me. d) Mother used to say, 'One day somebody will love you'. e) Mum always said I was Dad's favourite. I couldn't see it myself. She used to say I was spoilt.
158	Rejection & Denigration	a) We weren't made to feel wanted; we were left to roam about. The Police would bring me back when I was 3 or 4. b) Since the age of 13, Mum used to say I was like a 'Manuel', (a Scottish serial killer). That would really hurt.
164	Rejection & Denigration	a) My brother, Bernard, and I, always felt not wanted. We felt Raymond, the eldest, was more important. b) I felt singled out. c) I cut my foot badly once and the park-keeper gave me first aid. My Mother didn't even bother to look and made me go to school the next day. I felt very angry about that. d) I suppose that by the time they'd had three children they thought that was more than enough and those that followed were just a damn nuisance. If she had a choice, I think she'd rather we hadn't been born.
166	Rejection & Denigration	(Of Parents): They endured us.
223	Rejection & Denigration	I was always a make-up freak. Mum would say, 'You look ugly' and humiliate me by making me stand in the corner. She'd say 'You'll never make anything in life'.

Subject	Category	Interview Material
28	Social Attitude	Friends had to wait on the doorstep - they weren't invited in. Mother was very cold towards them. Other families seemed warmer.
36	Social Attitude	There was little interest in my friends by either of them.
95	Social Attitude	Neither (parent) was interested in my friends.
118	Social Attitude	She never welcomed friends. They could soon outstay their welcome.
130	Social Attitude	Because of my Mum I never wanted to bring friends back - I mean, her attitude.
132	Social Attitude	I wasn't allowed to bring school friends home. She didn't take much interest in my friends - I saw them at school only.
143	Social Attitude	There was no interest in my friends. She would disapprove of me bringing friends home.
147	Social Attitude	I was never allowed to have friends in.
158	Social Attitude	There was no interest in my friends.
164	Social Attitude	I had few friends calling round - there was no interest.
166	Social Attitude	(Of Friends): Mum would reprimand us if we got into mischief, but there was no real interest. She didn't take much notice.
191	Social Attitude	We wasn't allowed to have friends round the house.
201	Social Attitude	a) Friends were never allowed in. She'd say, 'Go to their house'. b) She had no interest in my friends or who they were. She was only interested in my boyfriends if she didn't like them.
221	Social Attitude	She took no interest - I don't remember any. I rarely took friends home. She would tell them what a cow I was.
223	Social Attitude	All my friends came to the house. She had to 'know everybody' for safety reasons, but she had no personal interest in them.

APPENDIX 4: NEGATIVE CASE ANALYSIS (N=6)

Subject	Category	Interview Material
95	Material Affirmation & Celebration	Mother remembered birthdays
147	Material Affirmation & Celebration	Mother remembered my birthday
201	Material Affirmation & Celebration	Yes - I always got presents on my birthday
36	Academic Attitude	Only Mother would go to meetings at school
147	Emotional Availability	I could go to Mother if I was upset
191	Love & Approval	Mother was frightened of showing her approval - she was frightened of Dad's reaction

Appendix 5: Childhood Experience Of Care & Abuse (CECA) Interview

CHILDHOOD

Now I'd like to ask you a few questions about your childhood.

Are both your parents still alive?
IF YES:
Where are they living now?
IF NO:

Death before 17

How old were you when s/he died?
What did s/he die of?
Was s/he ill for a long time?
Who looked after you after s/he died?

Do you have any brothers or sisters?
Older or younger than you?

When you were a child, was it your mother or father who was the main wage earner?
What did s/he do?

Have your parents ever been separated?

Loss

Were you ever separated from either parent before you were 17?
IF YES:
How old were you?
How long was it for? Why?
Who looked after you while your mother/father was away?

How old were you when you left home?

Why did you leave then?

Were either your mother or father ever seriously ill when you were a child?

Did either of your parents ever suffer with their nerves?
IF YES:
What age were you?
Get details of treatment and probe for suicide attempts

Did either parent have a drink problem?
IF YES:
What effect did this have on the family?

Closeness/ Antipathy

ASK OF PARENT(S) WHO LIVED AT HOME:
Were you very close to either your Mother or your Father, say up to the time that you were a teenager?
In what way?
Was s/he fairly distant or did s/he tend to hug and kiss you a lot?

Which of them did you feel closer to?
Why?

Did this change at all when you got older?
How?

IF PARENTS WERE SEPARATED, ASK OF ONE WHO LIVED AWAY:

Closeness/ Antipathy — **Did you get to see your Mother/Father a lot after s/he left?**
IF YES:
Was s/he fairly distant, or did s/he tend to hug and kiss you a lot?
Did you still feel quite close to her/him, after s/he left?
Did this change at all when you got older? How?

IF NO:
Why not?
Did s/he write to you, or phone you quite often?
Did you feel quite close to him/her?
Did this change at all when you got older?

IF S HAD SIBLINGS ASK:

Indiff/Antip — **Did your parents have their favourites?**

" — **Up to the time you left home do you feel your parents always had time for and took an interest in your life?**

" — **Did you feel you could go to them if you were upset or unhappy?**

" — **Did they always remember your birthday?**

Neglect — **Did you ever feel neglected?**
IF YES:
In what way?

" — **Were you well looked after materially as far as food, clothes etc were concerned?**

FOR PARENT LIVING AWAY:
Did s/he send you or your mother/father money for your keep?

Indiff/Antip. — **Did your parents take an interest in who your friends were?**

" — **Were they interested in how you did at school?**

Antipathy — **Do you think your parents approved of you up to the time when you were a teenager?**

What about your Mother, did she think highly of you?
Did she praise you?
Was she hard or easy to please?

What about your Father, do you think he approved of you?
Would he praise you?
Was he hard or easy to please?

Were either of them disapproving?

Would your Mother or Father make critical or hurtful comments?
About what?
How often would this happen?

Did any of this change when you were a teenager?

Parental Control

Were your parents very strict?
About what?
About who your friends were?
About clothes and make-up?

When you were older were they strict about you going out with boys?

Did your parents ever get cross if you came home late?

Physical Abuse

Did your parents ever punish you in any way?
IF YES:
When would they do this?
Which parent did the punishing?

In what ways were you punished?

Did they ever hit you or hurt you in any way?
IF YES:
Was it your mother or father that hit you?

What did s/he actually do?
ESTABLISH THE EXTENT OF THE VIOLENCE:
Did s/he throw something at you?
Did s/he push or shove you?
Did s/he slap you?
IF YES: Where?
Did s/he hit you with something?
IF YES: What with? Where?
Did s/he kick or punch you?
Did s/he burn or choke you?
Did s/he use, or threaten to use a weapon on you?

Were you ever injured in any way?
How badly?
eg. bruised? IF YES: How badly?
Were you cut or burnt?
Did you have any broken bones?

How old were you when this happened?

Are you ever worried that s/he might be violent towards you now?
Why?

Did anyone else ever hit you or hurt you in any way?
IF YES:
Who was that?
When did this happen?
How often would it happen?

What did s/he actually do?
ESTABLISH THE EXTENT OF THE VIOLENCE:
Did s/he throw something at you?
Did s/he push or shove you?
Did s/he slap you?
IF YES: Where?
Did s/he hit you with something?
IF YES: What with? Where?
Did s/he kick or punch you?
Did s/he burn or choke you?
Did s/he use, or threaten to use a weapon on you?

Were you ever injured in any way?
How badly?
eg. bruised? IF YES: How badly?
Were you cut or burnt?
Did you have any broken bones?

How old were you when this happened?

Are you ever worried that s/he might be violent towards you now?
Why?

Discord/ Tension

How did your parents get on together?
Did they argue much?
How often was that? What was it like?
Raised voices? Throwing things?
Was that in front of you?
Did you or your brothers or sisters get involved in family arguments?

Was there a lot of tension in the house?
Did they stop talking for periods of time?

Was there any violence in the house?
How often?
What happened?
Who was involved? Any serious injuries? Police called?

Sexual Abuse

At what age did you have your first sexual experience?
Who was it with?

At any time in your life have you ever had any unpleasant or threatening sexual experiences?

Have you ever been sexually approached against your wishes, or interfered with?
IF YES:
How old were you?
Who was it?

Can I ask you exactly what happened?
Probe for details, but use discretion

Did it involve actual intercourse or was it just touching?
If latter:
Where did he touch you?
Did he make you touch him?
Did he make you watch while he touched himself?

If no touching:
Did he make rude suggestions?
Did he ask you for sex?

Did he threaten you at all or use violence?
What did he do/say?

IF APPROPRIATE:
Did he say he wouldn't love you any more if you didn't?
Did he reward you in some way?

Did anybody else know that it happened?
Who? Did they do anything about it?

IF ABUSE UNDER THE AGE OF 18:
Do you know anyone else who had the same thing happen to them?
When was that? How did you find out about it?

IF RELEVANT:
Do you think it happened to anyone else in your family?
Was it by the same person?
How did you find out about it?

Did you tell anybody about it at the time?
Who was that/Why not?
Were they very helpful or not really?

Did you tell anybody about it much later?
Who was that?
Were they sympathetic? Did they make you feel worse in any way?

Was anyone like a doctor or social worker involved?
Were they very helpful or sympathetic?
Police? Court case?
How did it go?

Appendix 6: Self - Evaluation & Social Support (SESS) Interview

SELF SECTION

I'd like to ask a few questions about how you see yourself as a person and the things that are important to you.

Self acceptance	**Is there anybody you know that you would like to change places with ?** IF YES: Who is it ? Why would you like to change places with them ? Because of the kind of life they have ? The kinds of things they do ? Because of the kind of people they are ?
	How happy are you with yourself the way you are ?
	Do you think anybody might like to change places with you ? IF YES: Why ? IF NO: Why not ? (PROBE: Because of the kind of life you have, the kind of things you do? Because of the kind of person you are ?)
Self evaluation Commitment	**Thinking of your own life now - what do you think matters most to you ?** Why do you say that ? (PROBE:For some women, a husband and children are their whole world -while for others they are only a part of it. What about you ? IF A PART: What else is part of your world ?)
Personal attributes	**What kind of person do you like to think you are ?** (How would you describe yourself?) **Do you think you are better or worse than other people?** (In what ways?)
Self acceptance	**Is there anything about yourself that you would like to be different?** (What sort of things?)
Personal attributes	**Do you feel you are a sympathetic person/or do you tend to be a bit hard ?** (Do you feel this is a good way to be?)
Personal attributes	**Do you think you are an efficient person or do you just seem to muddle through ?** (Are you glad to be that way?)
Personal attributes	**Do you put yourself first or do you give way to other people ?** (Are you glad to be that way?)
Personal attributes	**Are you the sort of person who says what you think?** (Is this a good way to be, do you think?)
Personal attributes	**Do you feel you are an intelligent person or not particularly ?** (Would you like to change this ?)
Personal attributes	**Do you think you are attractive or not particularly ?** IF NO: Do you wish you were ? How do you feel when you're dressed up to go out ?

MARRIAGE

I would now like to ask you some questions about marriage and about how you and your husband/partner get along.

IF S IS MARRIED ASK:

Commitment + eval. role performance

Is being a wife important to the way you see yourself?
(Do you like to think of yourself as married?)

Can you imagine not having married ?
(Why/why not ?) (How would you feel - left on the shelf?)

Would you want to be single again?
(Why/why not?)

Compared to married people, do you think that single people miss out on anything important?
(In what way/why?) (A family? Companionship? Security?)

IF S IS COHABITING ASK:

Commit + eval. role performance

Is being in a long-term relationship important to the way you see yourself?

Do you like to think of yourself as married? (Why/why not?)

Would you want to be single again? (Why/why not?)

Would you like to get married ?
(Why/why not?) (Is this something you ever talk about with your partner?)

Compared to people in long-term relationships, do you think that single people miss out on anything important?
(In what way/why?) (A family? Companionship? Security?)

Can you imagine not living with someone?
(How would you feel?)

ASK ALL:

Confiding

Do you find that you can confide in your husband/partner ?
IF YES: Easily or with difficulty?
IF NO: Why do you think this is?

Have you confided in him recently about anything? (What was that?)

Do you tell him about things that worry you or get you down?
(Do you just touch on it or go into detail?)

Do you tell him about your most personal feelings?
(Is there anything you wouldn't tell him?)
(What? Why not?)
(Because of what he would say or do? Or think of you?)

Active emotional support	**Do you think he is interested when you confide, or not particularly?**
	What does he say or do when you confide? (Does he listen? Comfort you? Does he take your side, or is he a bit critical? Does he offer any advice?)
	Do you think he worries about you if you are not feeling well or having problems? (How does he show it?)
	In some relationships it seems like one person is trying more often that the other to get their partner talking. Would you say this is the case in your relationship? (Does one of you seem to hold back on your feelings ? Why is this?)
Overall satis.	**Do you ever wish that your partner discussed his feelings more or showed them in different ways?** (If yes, when was the last time you felt like this ?)
Overall satis.	**Do you think that your needs for confiding, sharing and talking about things are met by your current relationships?** (Do you ever feel that something is missing?)
Security chars.	**Does he ever go out on his own in the evening or at the weekend? How do/would you feel about this?** (A bit anxious on your own? Wish he didn't go?)
Security chars.	**Is your husband/partner a worry to you in any way?**
Security chars.	**Do you feel you can rely on your husband to be there when you need him** IF YES: Always ?
	Has he ever let you down when you needed him ? (When was that? How often does that happen? Does this make you feel that you can't depend upon him?)
	Does he come and go at a regular time so you know when to expect him
Involvement	**To what extent do you take an interest in each other's lives ?** (Such as work, hobbies or interests, or what sort of day each has had.)
	To what extent do you make a point of talking to your husband/partner if you feel that there is something on his mind?
Commitment	**To what extent do either of you do what you want, irrespective of what the other's feelings about it might be?** (Like going out with your friends when you know your husband/partner would like you to stay in?)
Quality of interaction	**Do you and your partner manage to spend any time alone together?**
	What is it like when you are alone together ?

(PROBE: Relaxed ? Quiet ? A bit boring ? Tense ? Fun ? Cosy ?)

Do you do anything together, or just sit?
(Do you enjoy this? Does he?
Do you have much to say to each other?

Affection

In general, is your partner affectionate towards you?
eg. holding hands, hugging, kissing.
IF YES:
How often is that? Is it just at certain times?

How about when you're feeling upset or down?
Is he affectionate then?
In what way?

Pleasure of sex

Would you say that sex is an important part of your relationship now or not really ?

Would you say you enjoy sex generally or not particularly ?
(Do you ever feel that its a bit of a chore or obligation?)

Is it more important to one of you than the other?

Unwanted sexual experiences

In many relationships there are conflicts about sex. Have you had any unwanted sexual experiences with your partner?

Do you ever find that you have to give some extra persuasion to your partner to make love to you?

TO BOTH QUESTIONS, IF "YES":
What happened?
How did you feel about it at the time?
How did you feel about it afterwards?
How often does it tend to happen?
Was it a one-off, or does it happen quite frequently?
How does it/did it affect your feelings towards your partner?
How does it/did it affect your feelings towards yourself?

Competence + role perf.

Thinking of other women you know, how do you think you compare as a wife/partner?
(Are you better in any ways or worse ?)

Do you think you pull your weight in the relationship?

How does this compare with other women you know?

What sort of person would you say you are to live with ?
(Easy-going/moody ? quick tempered ? considerate/a bit selfish ? Affectionate/a bit cold ?)

Partners evaluation

What about your husband/partner, what sort of a wife/partner does he think you are ?
(Is there anything he admires about you, anything he'd like to be different?)
(What does he say?)

Does he ever make any critical or hurtful comments about the sort of person you are or what you look like ?
(Does he ever make any hurtful or critical comments about the way you look ? Comment on your size or shape ?)

Quality of interaction

What kinds of things make you irritable with each other ?
(Do you have a go at each other when you are niggled or do you bottle it up?)
(What about your last quarrel? What happened?)

IF EVIDENCE OF ARGUMENTS: How often does this happen - say over the last month?

Quality of interaction + security chars.)

Do arguments ever become violent where one of you throws things or hits the other?
(Has this happened in the past? How often?)
(What happens?)
(How do these arguments usually end?)

Physical Abuse **Has he ever hit you, or hurt you in any way?**

IF NO VIOLENCE REPORTED:
Have you ever thought that he might hit you even though that has never happened ?
(Why did you feel like that ?)

IF YES: When did that happen? What did he actually do?
ESTABLISH THE EXTENT OF THE VIOLENCE:
Did he throw something at you?
Did he push or shove you?
Did he slap you? IF YES: Where?
Did he hit you with something? IF YES: What with? Where?
Did he kick or punch you?
Did he burn or choke you?
Did he use, or threaten to use a weapon on you?

Were you ever injured in any way?
How badly?
eg. bruised? IF YES: How badly?
Were you cut or burnt?
Did you have any broken bones?

Does he still hurt you sometimes?
IF NO: Are you ever worried that he might be violent towards you again?
Why?

Security chars.

What kind of person would you say your partner is ?
(What kind of man is he like to live with ? Easy-going? Moody? Hot tempered ? Considerate ? A bit selfish ?)

What kind of provider would you say your partner is ?
(Is he a steady worker? Has he often had times out of work?)
(Do you think he could have done better job-wise?)

Is he dependable about money, or can he be a bit careless?
(Does he ever leave you short? Is this often?)

Security chars.

Most relationships have bad patches from time to time when they are not getting on or where one partner considers leaving - have you had times like this?

IF YES: (When ? How serious was it ? What stopped you ?
Have either of you left the other ? For how long ?)

Security characters.

As you know in some marriages one partner gets involved with someone else of either sex, has anything like this happened to you?
To your partner?
(Have you ever been suspicious ?)
IF YES: When was this ?
Did you consider ending your marriage?
What happened ?

Overall quality

Overall, how would you say you feel about your husband/partner and your marriage ?
(Happy? Good? It could be better?
It's not what you thought marriage was about?)
What do you think it is that keeps you together?

FINANCIAL PROVISION/WORK

I'd now like to ask you about work

FOR THOSE CURRENTLY WORKING:

Commitment

How do you feel about having a job ?
(Like/not like it ? In what way ?)

Some people we speak to feel that it is important for a woman have a job, while others feel that her real place is in the home, what do you think ?
(Do you think it's alright ? A good idea ?

What is the best thing about having a job ?
(Being with other people ? Getting out of the house ? Having a bit of independence ? Having a routine ? Having money of your own ? Being able to support your family/help out with extras ?)

What's the worst thing about having a job ?
(Having to be at work at a certain time ? Never having time to relax ? Or do anything properly ? Having to let things slide in the house ? Feeling that you are missing out on things with the children or with your husband/partner ?)

Eval. role perf

Do you see yourself as a worker?
(Can you imagine not being one? Not having a job?)

Commitment + Felt security

How would you feel if you didn't have a job?
(A bit lost/relieved? Disorientated?)

Do you expect to continue working over the next 10 years?
(How do you feel about that? Have you thought about stopping?)
(Would you work if you didn't need the money?)

Does having a job make any difference to your feelings about yourself?

Eval. role perf. +

How good or bad do you think you are at your job ?
(Are you able to keep up with the work each day ? Or not really?

Competence

Do you ever feel proud of your day's work?
(When was the last time you felt this way ?)

FOR THOSE WHO ARE UNEMPLOYED:

Commitment + Felt security

How do you feel about not having a job?
(Like it? Dislike it? In what way?)
Have you thought about taking a job?
(How do you feel about that?)
What's the best thing about not having a job?
What's the worst thing about not having a job?

FOR THOSE WHO HAVE BEEN MADE REDUNDANT:

Self accept	**How do you feel about having been made redundant?** (Is there anything good about not having a job at the moment?) (What's the worst thing about not having a job?)
	Has it made any difference to your feelings about yourself? (In what way?)
Commitment	**Are you now looking for another job, or not?** (Why is this?)

FOR THOSE ON SICK LEAVE:

Commitment	**How do you feel about being on sick leave?** (Does it make any difference to your feelings about yourself?)
	Are you looking forward to going back to work? (When do you think that will be?) (How well do you think you'll be able to cope?)

IF S IS IN FULL-TIME EDUCATION, ASK QUESTIONS AS FOR THOSE IN WORK

HOUSING/HOMEMAKING

I'm now going to ask you some questions about the house and housework.

Commitment + eval. role perf.

To what extent do you see yourself as being a homemaker ?
(Do you enjoy making the home cosy?)
(Do you like buying things for the home? Decorating?)

Is it important for you to have the house/flat looking clean and tidy ?
(Are there things that would make you change your household standards? eg. a chance to go out with family and friends? How about if you weren't feeling well?)

Would you pay someone else to do it if you could ?

Eval. role

In general what kind of housewife/homemaker do you think you are?
(With regard to the tasks that you actually do - Cooking? . Cleaning ? Tidying ? Washing and ironing ? Shopping and budgeting, repairs; maintenance etc. ?)

Competence

How about compared to other people ?
(PROBE: What about other women that you know, are there any ways you are better. Any ways worse ?)

Competence

Do you ever find that what you have to do around the house gets on top of you, so that you have too much to do ?
IF YES: When is this? How often does it happen? How do you feel?
(Disorganised or inefficient? Or do you feel that it's not your fault?)
IF NO: How do you manage to keep on top of it?
(Is it because you organise the work efficiently?)

Partners evaluation of S

In general does your husband/partner approve or disapprove of the way you run the home ?
(What is his opinion about your cooking ? Does he comment on how tidy and clean the house is kept ?)
(How well does he think you manage?)
(What does he say?)

PARENTHOOD

Now I'd like to ask you a few questions about your feelings about children and becoming a parent.

QUESTIONS FOR NON-PARENTS:

Commitment	**In your ideal world, how many children would you like to have?** (How would you feel if you were unable to have children for some reason?)
	Is having children in the future something you think about or do you feel it doesn't concern you at the moment? (IF RELEVANT: Do you think you are too young to think about it?)

QUESTIONS FOR PARENTS:

Commitment	**How far do you see yourself as being a mother ?**
Self evaluation	**Do you prefer to think of yourself as a mother or a wife ?**
Commitment	**Do you like talking to people about your children ?**
	Can you imagine not being a mother ? (Can you imagine never having had children?) **How would you have felt if you and your husband/partner had been unable to have any children ?**
	Do you think that people who don't have children miss out ?
Felt security + security chars.	**Are the children a worry to you for any reason?** (Have there been any problems at school? Trouble with the police?) (Health worries?) (Do they come home at a reasonable time? Generally helpful?) (Do you always know where they are?)
Competence	**Would you say that looking after children is something that takes a lot of skill or ability of any kind, or not really?**
+ role perf.	**Overall how good would you say you are as a mother ?** (Do you think you are good at looking after the children?) **Do you think you could be a better mother?** (How?) (Compared with your own mother, are you better in any ways or not as good?)
+ quality of interact.	**How patient would you say you are with the children ?** (Do you feel you are too sharp or irritable with them ? Or that you smack them even when they don't deserve it ?) **How about in comparison to other mothers ?** **Do you ever find yourself unable to cope with all the demands of being a mother - when it's just too much for you?** (How often is this?)

	How well do you think you manage to keep the children in check ? (Are the children well-behaved or do they play you up?) (Can you influence them when they are like this?) (Do you think this has anything to do with the way they have been brought up?)
Competence	**Do you feel you give the children enough time and affection - or do you find this difficult ?**
Partners evaluation	**Does anyone, such as your husband/partner notice the kind of mother you are ?** (What does he think? What does he say?) (That you're too soft, strict? Patient/too irritable with them?) (Is that often?)
Self - acceptance	**Many people would like their children to be different from themselves in some ways, do you feel this way at all ?** (In what ways ?) **Are there any ways you would like them to be the same as you ?** (In what ways ?)
Quality of interact.	**What is it like when you are with the children/baby, what sort of atmosphere is there ?** (A bit boring ? Tense ? Fun ? Do you talk much or have a laugh? Is there much fighting or arguing ?) (Do you enjoy these times or do you find them a bit of a drag?
Quality of interact.	**Is it any different when your husband is around ?** (More/less fun ? Do they get on your nerves more/less ?)

CONFIDENTIALITY

Everything that you have told us is completely confidential and will not be discussed with anyone outside the research team. However, we are interested in how your husband felt about some of these things that have been going on. We won't, of course, discuss what you have said about what happened or any of your feelings about what went on, but is there anything that has happened that you wouldn't want us to raise with you husband if he doesn't mention them himself ?

Section C

CASE-STUDY: AN EVALUATION OF THERAPEUTIC PRACTICE USING A COGNITIVE ANALYTIC APPROACH

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Frontispiece

This case-study is an example of a client who presented with chronic internalised shame originating in childhood. She experienced her father as overtly bullying and shaming, and her mother as hostile and indifferent. From early on, the client developed a defective core self which was characterised primarily by feelings of shame, inappropriate guilt and repressed and impotent anger. These feelings became introjected over time and manifested in adulthood as depression (see Section B, Chapter 2, for a literature overview of shame and shame-related phenomena).

The therapeutic intervention was aimed at helping the client re-evaluate and reconstrue her sense of self by identifying and reframing unhelpful core beliefs and their role in repetitive and maladaptive cycles of behaviour.

This was achieved within the framework of the Cognitive Analytic Model based on the work of Ryle (1975, 1979, 1985, 1990, 1995, 1997).

Background Information and Referral

The patient, whom I shall call Pat, was first seen by the author in my role of General Practice Counsellor in a busy Kent Group Practice. I was working at the Practice one day per week in addition to my duties as a research psychologist, engaged on a major treatment outcome study on depression. Names have been changed to preserve confidentiality and permission has been granted to use this material in a case-study.

At the time of our first meeting, Pat was aged 58 and was working as a receptionist in the Practice I was attached to. She was newly-separated from her husband of many years and asked to see me after an initial confidential talk with one of the female GPs at the Practice who advised her she might benefit from counselling.

Pat's presenting problems appeared to be agitated depression characterised by much residual anger, shame and guilt, originating in childhood and exacerbated and reinforced in the course of her long and unhappy marriage. Her symptoms included frequent tearfulness, agitation, feelings of entrapment and a sense of over-responsibility. She also suffered from bouts of irritability, sleep disturbance, low self-esteem, free-floating anger, much ruminative guilt and self-blame (especially over the recent death of her grandson for which she felt responsible), problems in structuring her time, and a pervasive sense of disappointment and of life being "a waste".

In her initial talk with the GP she told her how bad she had been feeling and how fearful she was for the future. Pat was very vague about the nature of these feelings and what might be triggering or maintaining them. However, despite her confusion and uncertainty, she agreed it would be helpful to see a female counsellor. I had been at the Practice about two months at the point of the referral, so had built up a 'friendly' relationship with Pat in her role as receptionist. I had often sensed a feeling of tension or restraint in her presence which, with hindsight, I realised was due to her ambivalence and anxieties about becoming a "patient". I also noticed that Pat was often a little emotionally apart from the other staff, with whom she interacted in either an aloof or overly deferential manner.

I was approached by the GP who asked me if I would be willing to see Pat for counselling and I agreed. After the doctor "paving the way" in this respect I spoke to Pat, who was concerned about confidentiality. We agreed that professional notes would be held at my place of work (the Medical Research Council, Institute of Psychiatry in London) and that she could see me there if she preferred. She asked if she could see me early evenings at the Practice, after the other staff had left and I agreed. This arrangement gave Pat a clear degree of relief from her anxiety (and shame) about colleagues finding out she was seeing a counsellor.

Our initial agreement was for 12 weekly sessions, as a predetermined limit is required in line with the Cognitive Analytic Model (Ryle 1990, 1995, 1997) although this was left open to review at a later stage if necessary. I explained to her about the supervision process and how this worked, and that all information that emerged in our sessions would be confidential to myself and my supervisor except in certain circumstances, such as potential harm to others or to herself. I also explained that I would be writing a brief report to her GP, as this was common practice in the setting where I worked.

Pat clearly related to me as a "person in authority" and a "professional" and this was manifested in her deferential and overly respectful attitude towards me, as well as an anxiety about being pathologised which was shown in remarks such as "I know you'll think I'm mad ...", "I know I shouldn't feel like this but ..." and "I know it's silly to feel this way ...". It transpired that Pat had left her husband about 18 months previously and had decided shortly after that time that she would give up smoking. She told me this was a very important decision in her life as it was "something I can do for

myself", although she believed her stopping smoking was at least partly responsible for her current anxiety and depression.

It seemed she had experienced a long and unsatisfying marriage with a husband who was very domineering and shaming, but she became so overwhelmed with deep feelings of guilt if she even fleetingly considered leaving him, that the decision was always deferred. They had a daughter whose baby son, one of twins, had recently died of a "cot death" (aged one week) and this was clearly a source of great pain and loss for Pat, who tended his grave regularly. Pat also had a son who took drugs and this too was a constant source of distress and worry. At the time of our first meeting her son was living at home, but Pat wanted him to go and live with his girlfriend, by whom he had a child. Now she had finally left her husband Pat found her new "free" life brought unexpected disadvantages, namely that she had plenty of time on her hands and "space that I don't know how to fill". She told me she had spent so many years of her marriage in planning to leave it that she was surprised how she now felt faced with an "emotional vacuum".

Very little of Pat's childhood was spontaneously elicited during the sessions. I think she found this topic quite painful and I was aware that, as I was not in a position to offer long-term psychotherapy, it did not seem appropriate to explore it in depth. But she described her father as "controlling" and "sadistic", and she reported her mother had been openly antagonistic and hostile to her with frequent denigratory outbursts, referring to her as "you cow" for no apparent reason.

Initial Session

In the first session, certain core factors emerged in the way Pat told her story. Firstly, her world had been characterised by pervasive anger and guilt (associated with her husband but also self-directed) and this had been internalised and experienced as chronic emptiness and disappointment. It transpired that she spent a lot of time worrying about her small dog, wondering if he was "having a bad life" when she was at work and away from him. She felt she couldn't leave him or he would suffer. The significance of this early remark for her marriage was to become apparent in subsequent sessions.

At a practical level, we identified and explored various options for increasing her social networks - such as evening classes, hobbies and social support from neighbours and children. We discussed how she had suffered many recent losses and how her sadness and sense of disappointment were understandable, and a "normal" mourning reaction, although hers was mixed with feelings of anxiety concerning the future and guilt relating to the past. It was agreed that Pat would make a list of "good things" in her relationship with her husband and so challenge her beliefs that it had all been "a waste", which was fuelling her negative thinking. I told her I thought the sadness belonged to the past, and that her anger and guilt often resurfaced in the present because of this. For some reason, this remark stayed with her and she told me at a later point in the therapy that it had given her an immense sense of relief and reassurance.This session culminated in the joint production of the Psychotherapy File (attached as Appendix A) which helped to consolidate the working alliance and demonstrated the unproductive circularity involved in Pat's characteristic ways of thinking and behaviour.

Session Two

At the next session, Pat announced she had not done a list of "good things" about her estranged husband as there was basically "nothing good" about him and he was essentially "a bully". She reported that she was pleased because her son would shortly be leaving home, had arranged evening classes for herself, and for her dog to be minded. The weekend had been bad however because she'd had so much unstructured time, and didn't know what to do with it. When at home she wanted to be out, and when out she wanted to be at home. Pat became very animated, then angry, while telling me this. When this was pointed out to her, she said she was feeling guilty over her grandson's recent death and realised, too, that she still feels a lot of anger towards her husband, John, but had never been able to express it in the past. Historically, this anger would result in her feeling sorry for him, and then she would feel guilty. So, in her internal world, anger and guilt were often inextricably linked.

She reported that John would often snap at her, "Who do you think you are? You're useless", and so decimate her already-fragile sense of self. This made her feel that she "didn't deserve to be happy" as she had no real self-worth or sense of value in relationships. We explored this neurotic feedback-loop of anger, guilt and low self-esteem, and how this was related to her deep fears of being unloveable as a child and, possibly, to an unconscious wish to suffer. Pat connected with this by saying she'd never felt good about herself and that even John's gifts to her were a gesture of ownership and status, like expensive jewellery (that she didn't like). It was at this point that she told me how similar to her father he was, but she'd never recognised it before. She wondered whether she'd unconsciously chosen a husband who would "invalidate [her] sense of self".

She then described how she had always felt "something would happen" to her grandson and how she had given him special care when he was born because "my unconscious must have known". She found this thought deeply disturbing. We explored her belief that if she sensed her grandson's vulnerability then she must be guilty of his death - and therefore deserved punishment. The fact that she didn't have this feeling with her other grandchildren (or the other surviving twin) confirmed the validity of her belief. This incident illustrated a characteristic process by which Pat's feelings were confirmed by events, thereby reinforcing and perpetuating the original belief.

I suggested that she keep a Personal Diary over the next few weeks to monitor these frequently-recurring thoughts, feelings and beliefs, as they seemed to suggest an inherent tendency in her to feel both over-responsible and to blame for external events.

Session Three

The third session explored how Pat had never been able to acknowledge her anger, either with herself or towards others. At the beginning of this session she became very tearful, then angry, saying that she had always experienced difficulty in putting her needs first, and how she believed her low self-esteem had originated in childhood. Her mother would often refer to her as "that cow" and, in her marriage, John would call her a "slut". Her definition of herself had therefore derived largely from others' views of her, and was often denigratory. When she couldn't find a way of expressing her (justifiable) anger at others' responses she felt guilty, and this, in turn, made her depressed and reinforced her low self-worth. We discussed the implications of her pending divorce and how it might be helpful to redefine

herself as a "single woman again" rather than a divorcee (or, in her terms, a "cast-off possession").

Assessment and Case Formulation: Session Four

In line with the Cognitive Analytic Model (Ryle 1990, 1995, 1997), at the fourth session I provided Pat with a Reformulation Statement written in the first person (attached as Appendix B), which identified some of the problems and "double-binds" she had experienced in her life, and her characteristic ways of dealing with them. It is important to emphasise that the objective here was to provide "accurate description" rather than "interpretation" in the analytic sense, in an attempt to increase empathy and strengthen the therapeutic alliance.

The Reformulation Statement was based on Pat's clinical history and the ideas contained in the Psychotherapy File which had been jointly worked on and agreed in the first session. The Reformulation Statement provided a basis for further discussion and set the agenda for the therapy. It was supplemented by an exploration of Pat's Diary in which she had been regularly monitoring the links between her thoughts and beliefs, feelings and behaviour, especially at times of distress. In fact, Pat had found this diary-keeping so useful that she decided to continue with it after the therapy had ended.

By the fifth session, Pat's mood had improved remarkably although she had reported feeling very angry at times, especially with a friend who'd had her unfaithful husband back. She was angry too with her friend's husband when she had seen him on his way to the pub while she was coming to our session. We talked about how this anger could be explained by her identification with her friend as "the mistreated woman", and how she had

displaced this anger onto others, particularly her friend's husband, who reminded her of John. She expressed surprise that she had actually been "strong enough" to leave John and escape from the marriage in the first place, having always seen herself as "weak". Together we explored her "inner strengths" and she identified these as being "not immediately obvious" (this being a shame characteristic in Pat to under-report or deny her good points), but that she had always had a "firm moral sense".

She went on to say how John had been "sadistic" and "publicly shaming" to the children in that he would punish them out of all proportion to their misdemeanours, often when they had company. He would punish and attempt to shame her, too, by staying out late and denigrating her if she refused him sex. It became clearer to her during the therapy how John had kept most of the control in their relationship and how she had retained very little, which was exacerbated by her pre-existing (childhood) sense of a "bad self", where she had also had very little power to control relationships or outcomes in her life. This meant she had felt forced to "live a lie" in her marriage and had feigned sexual enjoyment, which had resulted in her losing touch with her own needs and desires. She realised now how angry this made her feel, and how angry she had always felt, although she'd experienced this as a mixture of depression, helplessness and hopelessness (Abramson et al., 1989; Alloy & Abramson, 1982; Seligman, 1975).

Subsequent Sessions

Over the remaining sessions (which emphasised the three 'R's of CAT - Reformulation, Recognition, Revision), Pat came to see how her anger was quite rational because it had been impossible to express it as a child, against an overbearing and shaming father, for fear of the consequences. We looked at the role of disappointment in her life and how she couldn't plan ahead or look forward to things incase they got spoilt, and the implications of this for her future.

It became clearer over the next few sessions that John and her anger towards him had become less important. In the penultimate session (number 11) Pat reported having had a good week, had joined a "cot death" society, had taken part in other social events and had started knitting again. She also looked well in a new bright red blouse! She told me she had been able to ignore her husband on the 'phone and just speak to the children now without feeling guilty or that she was "bad". Even an altercation at work, when a colleague called her "bossy" (although threatening to re-awaken all the old feelings of guilt and overcompliance) no longer did so. She was very talkative in the session, defending her position by saying she now felt she had a "right" to say what she feels and didn't put so many things on her "guilty list" as she used to!

In summary, Pat reported she was enjoying her new-found sense of singularity, while at the same time realising how much John had needed to control her, and the children, throughout their marriage. His legacy to her had been years of unmet needs - for love, warmth and companionship. She said she felt she was ready to end therapy and we arranged a final session, with built-in time for review at three months if she felt she needed

it. This is in line with the CAT model of setting a follow-up date to see how termination has weathered and to assess further needs. We also agreed to exchange "Goodbye letters" (attached as Appendix C).

Final Session

In the last session (number 12) our letters were exchanged. Pat wanted to read hers in private so I handed it to her to take away. She looked very happy, saying she had written a letter to John telling him how miserable he had made her over the years - but she'd lost it! She remarked that it didn't seem so important now.

She also told me of an affair she had once had and how she had wanted to tell John to "get her own back" but had decided not to, incase it hurt him. We explored how, in the past, her feelings of anger, guilt and shame had spiralled into depression and how a more balanced view of herself, and others, was now emerging. With regard to her affair, she now saw it as representing *herself in control*, with John as the victim - a complete role reversal. She also felt she wanted to "keep it her secret" ie. something she could keep for herself. Finally, she said she still had difficulty in saying "no", and showing anger to others, but realised how much this feeling came from her past, especially from her relationship with her controlling and shaming father, and how these feelings were no longer appropriate now she was grown up. But she felt that the balance had shifted, and that she was building up real inner confidence, as well as making outer changes in her home, in her life, and in herself. One problem she still had was the inability to look forward to things incase they got spoilt, but she now understood why she felt this way and was ready to take more risks.

We ended the session by Pat handing me her "Goodbye letter", with some embarrassment (and, I suspect, some shame) saying she was pleased she could contact me again if she needed to and that, although she knew the future wouldn't be easy, I had "shown her the way" and she was grateful.

Because termination had been kept on the agenda throughout the therapy, in line with the Cognitive Analytic Model, Pat approached the last session with a mixture of sadness yet relief that she had gained some control over her emotions and insight into her unhelpful patterns of behaviour.

Active Treatment

The treatment was Cognitive Analytic Therapy (known as CAT) based on the work of Ryle (1975, 1979, 1985, 1990, 1995, 1997). My rationale for choosing this particular approach was that it is time-limited, usually 16 sessions, and requires a degree of "psychological mindedness" which Pat possessed, as she was easily able to articulate and reflect upon her feelings and behaviour with very little defensiveness. I also felt this choice would minimise the transference, which I viewed as desirable, given the setting of a G.P. practice and time-limited work. Our predetermined contract for 12 sessions provided a clear and focused structure for a joint exploration of the way in which Pat's past had influenced, and contributed to, her present difficulties.

According to psychoanalytic theory, and the developmental psychology of Vygotsky (Wertsch 1985), learning takes place through the process of internalisation, whereby what is first experienced and enacted in an interpersonal relationship (initially with parents and significant

others), generates intrapsychic functioning in the developing child. This idea has some correspondence with Luborsky's "Core Conflictual Relationship Theme" or CCRT (Luborsky 1984), where he postulates that maladaptive scripts or schemas learnt early in life have profound consequences for the future adult's internal world and way of relating to others. Through this process, an "internal conversation" is acquired as the capacity for self-observation, self-protection and self-control is gained. Internalisation is the key to personality development, and problems arising during this can lead to emotional conflicts which become the concern of psychotherapy. With Pat, I felt that this internalisation process had become quite distorted, largely owing to her early experiences in her relationship with her parents. The underlying theory of CAT, the Procedural Sequences Model (PSM), postulates that neurosis is best understood as the persistent use of, or failure to change, damaging or ineffective procedures. Such coping strategies which were useful (or even essential) for the child, become a permanent way of dealing with the world as an adult, even though they are no longer appropriate or effective. Pat's primary "reciprocal role procedure" or RRP (Ryle, 1985) was of "submissive child/shaming parent" which perpetuated into adulthood and became the major dynamic in her interpersonal relationships.

In his key work, Ryle (1985) introduced RRPs as a relational variant of the Target Problem Procedure, which develop from early infancy via interaction with caregivers. By way of the "reciprocal role procedure" Ryle argued that personality development occurred in an interpersonal context, and that these self-to-other procedures become internalised to form the basis of the child's sense of self.

Cognitive Analytic Therapy synthesises cognitive (Kellian, information-processing) and psychoanalytic elements (principally object relations) both in its theory and in its therapeutic interventions. Key accounts of CAT and its developments can be found in Ryle (1979, 1982, 1985, 1990, 1995, 1997); Beard et al. (1990) and Leiman (1992, 1994ab, 1997).

Because Ryle's interest in psychotherapy outcome research involved the use of Kelly's Repertory Grid technique in Personal Construct Theory (Kelly, 1955) Ryle believed that there were two types of therapeutic language, one primarily psychoanalytic and the plainer, cognitive language derived from the Grid. Moreover, he felt there was a need to be clear about the aims of therapy which led to an increasingly direct involvement of patients in defining their problems. Ryle (1979) identified three main ways in which people fail to modify ineffective procedures which he called "traps", "dilemmas" and "snags". These would initially be described by the therapist and then become a focus of therapy in which the goal is "to achieve a change in the terms through which experience is construed" (p.50).

"Traps" are circular negative beliefs or assumptions which generate action, the results of which confirm the original belief. "Dilemmas" are false choices and represent restrictions of choices or acts to polarised alternatives - often one pole is repeated for fear of the consequences of enacting its opposite (similar to Kelly's concept of "bipolar constructs"). In "snags", aims are abandoned owing to the prediction of negative consequences or outcomes, either the reactions of others (truly or falsely predicted), or internally predicted, and are not always recognised. For example, in a relationship the choice might seem to be between being compliant and ensuring love, or being independent and

risking rejection. Such a difficulty, in Ryle's terms, would be listed as a "Target Problem Procedure" when the Reformulation (usually in Session 4) is given to the patient. This concept of a feared or imagined response is similar to Luborsky's (1984) model of the "Core Conflictual Relationship Theme" cited above. In this, the patient's original wish or need (W) leads to a feared or imagined response from the other (RO) and a response from the self (RS) to that response, again emphasising the complex interplay between interpersonal and intrapsychic processes. Examples of Pat's "traps", "dilemmas" and "snags" are contained in the Psychotherapy File (attached as Appendix A).

The strength of Ryle's model lies in its incorporation of the essentials of cognitive behavioural therapy (CBT) with selected ideas from psychoanalysis. For example, it can identify and challenge erroneous or unhelpful beliefs, negative self-evaluations and distorted predictions of consequences (the "dysfunctional attitudes" of Weissman & Beck, 1978). It can aid more realistic evaluations of outcome and the therapist can help to model action that is more appropriate, adaptive or less self-sabotaging to the patient. From the psychoanalytic model, it incorporates the "ego defences" (CBT's "cognitive editing") of denial, repression, dissociation, reaction formation, symptom formation or substitution, and splitting. Such processes derive from the infant's interactions with adult caregivers and reflect significant early experiences (cf. object relations theory, Fairbairn, 1952) and the developmental psychology of Piaget and Vygotsky (see Wertsch, 1985).

In this case, the Reformulation was completed in session 4, based on Pat's clinical history, her relation to me in the early sessions and her Personal Diary, supplemented by the Psychotherapy File. The Reformulation was in the

form of a Statement written by the therapist in the first person and aimed to provide "accurate empathy" (Rogers, 1951, 1957) so that Pat might feel her internal world had been understood, accepted and validated. It targeted the "procedures" Pat used which needed to be changed and how they were being maintained, often unconsciously, thereby demonstrating their circularity and self-perpetuation. I gave the Reformulation Statement to Pat to read as a basis for further discussion in the sessions, and the emotional impact of this on her was profound. She sobbed uncontrollably and said she'd "never felt so understood" before. Its effect was to strengthen her sense of purpose and self-efficacy (an area of key importance to Pat where shame had played a central part in her inner world) and recruited her to an active, co-operative role in the therapy: she became "co-author" of her own story. It also strengthened the therapeutic alliance. Indeed, this may have paved the way for the remarkable improvement I saw in her in the following (fifth) session.

Termination

At the twelfth and final session it was necessary to balance the reality of termination with reminders of what had been learnt and could be taken away. So it was at this point that "Goodbye letters" were exchanged, attached as Appendix C. These provided a tangible form of internalisation and consolidation of the gains of therapy. Insofar as the therapist is internalised as a more caring and coping figure than the patient's own (internal) parents may be, s/he will be internalised as the "bearer of understanding and initiator of change" (Ryle 1995), not as the omnipotent or shaming caretaker of the submissive and shamed child. In reality, if the shamed and needy part of the patient has been adequately contained by the therapist, then the subsequent capacity to self-nurture and value the self can develop.

Critical Evaluation of CAT Therapy

Cognitive Analytic Therapy (CAT) is a brief, focal and integrative psychotherapy which is fast growing in the UK and Europe. It is practised in many settings such as NHS psychotherapy departments, community mental health teams, psychiatric outpatients' clinics, primary care, day hospitals and forensic settings. There is now a national association which regulates training and practice, and the demand for CAT courses is growing. Research, service evaluation and audit are currently being carried out and more formal research trials are planned.

CAT's growing popularity lies in its theoretical flexibility: the model summarised in the Procedural Sequences Model (PSM) provides a basis for understanding a wide range of problems. Although it is essentially a cognitive model, many psychoanalytic ideas can be represented in its terms. CAT differs most markedly in its focus on sequences and non-revision, rather than conflict, as in the Freudian dynamic model. The unconscious-conscious division is not emphasised, for most procedures are seen to operate automatically. Although mental processes are largely unconscious, it is argued by Ryle (1995, 1997) that their effects are open to reflection, and that both conscious and unconscious processes derive from the early interactions of the child with its caregivers. The psychoanalytic "dynamic unconscious" is only known or hypothesised on the basis of the patient's acts, or in the manifestations of assumed conflicts in the form of "compromise formations".

In CAT, all procedures correspond to these "compromise formations" in analytic terms. The procedures of a patient may show those distortions or restrictions which would, in analytic terms, be described as the results of repression or denial. Offering possible explanations in

terms of intrapsychic conflict (interpretations) would be secondary in CAT. For example, submissive behaviour might be attributed to "castration anxiety" in psychoanalysis, but would, in CAT, be described as a procedure leading to negative outcomes often associated with shame, guilt or depression (see Alexander et al, 1999 and Section B, Chapter 2). For example, the source of the patient's perception of the reciprocal role patterns of others as shaming or threatening, would be discussed within a cognitive analytic framework.

The joint production of the Reformulation Statement, the use of it by the patient to develop more accurate, relevant self-reflection, and the use of it by the therapist to guard against any collusion with the patient's negative procedures, are seen as the main therapeutic factors eliciting change (or revision). The Reformulation Model combines the two modes of learning identified by Bruner, the "narrative" (the retelling and linking of the patient's life story) and the "paradigmatic" in the provision of focused descriptions of the ongoing processes (Bruner, 1986; Ryle, 1994). The method combines accurate, detailed, empathic understanding with the "corrective emotional experience" (Alexander & French, 1946) of an honest, thoughtful, relationship which involves respect, joint work and non-collusion, enabling patients to learn new ways of reflecting upon, understanding, and valuing themselves.

Research has shown that cognitive analytic therapy has been applied to a very wide, and often severely disturbed, range of patients (Ryle, 1997) and seems a safe first intervention: there is no reported evidence of dangerous negative effects in terms of breakdown or suicide. In 1987, a comparative study by Brockman and colleagues had demonstrated that CAT effected more cognitive change than did a similar psychodynamic brief

therapy. More recently, other outcome studies are under way and suggest a promising future for this form of time-limited therapy (Ryle 1995, 1997).

Ryle (1997) states that the results of ongoing research, whose aim is to describe the scope and limits of CAT, are yet to be published. As these are not available at the time of writing, this makes a definitive assessment of CAT difficult at this stage. However, process studies have defined measures of "CAT delivery" and prepared the way for controlled comparisons with alternative treatments. So far, the results are considered by Ryle to be encouraging enough to justify the use of CAT with borderline personality disorder patients (Ryle, 1997). This development is contemporaneous with similar developments in schema-focused cognitive therapy (Young, 1990).

Ryle states that one source of CAT was the evaluation of dynamic psychotherapy and that CAT has some claim to the current, popular call for "evidence-based practice" in the NHS. CAT-associated research is summarised in Ryle (1995) and Ryle concedes that its scale and design is not as comprehensive as he would have liked (the work having largely been done in the course of clinical practice). But he argues that the accumulating evidence supports his claim for the general efficacy of time-limited CAT with a wide range of patients (Ryle 1995, 1997). Brockman and colleagues (1987) had randomly assigned 48 outpatients to 12 sessions of CAT or 12 sessions of treatment following the model of Mann (Mann & Goldman, 1982). Mann's model was chosen as it resembled CAT in its time-limit and explicit sharing with the patient of a focal issue. There were significantly better outcomes for the CAT sample on the "Target Problem" and "Target Problem Procedures" ratings, but these disappeared when initial score levels were allowed for.

More recently, ongoing research into treatment of borderline patients using CAT (yet to be published) is encouraging, although a more sustained research base is needed. Ryle argues that the reciprocal influence of using repertory grid measurements in CAT research, and developing cognitive analytic methods in practice, has been fruitful and, over time, has generated many interesting developments, such as the use of the self-states sequential diagram (SSSD) as a diagrammatic alternative to the written Reformulation Statement (Beard, Marlowe & Ryle, 1990; Ryle 1990).

With regard to process studies, Evans and Parry (1996) looked at the impact of reformulation in CAT with "difficult-to-help clients" using a multiple base design to evaluate the short-term impact of reformulation on the therapies of four clients who had previously been difficult to help. Results showed that reformulation did not have a systematic short-term impact upon measures of the clients' perceived helpfulness of the sessions, the therapeutic alliance or individual problems. However, in semi-structured interviews clients reported that the reformulation had considerable impact upon them. A further process study by Bennett and Parry (1998) supported the view that, in CAT, it is possible for the therapist to create a descriptive diagram (SSSD) which is a valid representation of recurrent relationship patterns.

Another question relating to CAT is the extent to which it is an integrative psychotherapy. Ryle believes it is (see Ryle 1995, 1997) and although it receives only a footnote in Roth and Fonagy's (1996) recent review of psychotherapy outcome research, the authors clearly view it as a theoretically sound and useful integration of cognitive and analytic ideas:

> "It is worth noting that over the past 20 years considerable efforts have been made to systematically integrate differing components of psychotherapies within a coherent theoretical framework; in the United Kingdom the most notable such development is that of cognitive analytic therapy (CAT; Ryle, 1990). Practitioners of CAT are likely to use intervention techniques belonging to, for example, psychodynamic or cognitive-behavioral therapies. However, intervention strategies follow from a formulation of the patient's difficulties. This coherent and planned eclecticism is distinct from therapies in which techniques are "borrowed" in the absence of a guiding theoretical framework" (p.4, footnote).

CAT is a cognitive therapy insofar as it is concerned with information-processing, and explores the link between appraisal, beliefs and action. It focuses on emotional and behavioural sequences which become self-maintaining. But it differs from Beck's model of cognitive therapy, not so much in incorporating emotion or highlighting the childhood origins of self-defeating beliefs, but in positing a more complete account of cognitive processing, and in drawing attention to the relationship between the therapist and patient.

Further concerns relate to the wider social and cultural context in which therapy takes place. Hagan and Smail (1997), whilst acknowledging the reformulation as a "sympathetic and respectful statement" of how the client has learned to cope in life (p.272), argue that such approaches run the risk of "psychologizing the materiality of social power". By this they mean that there is an inherent power imbalance in the world. CAT's assertion that a person's situation in the world has (fundamentally) changed since childhood, and therefore the "procedures" which were adaptive in the past may have become problematic and in need of revision, does not take into account the *actuality* of material power. In other words, simply becoming adult does not necessarily result in significant increases in power, nor neutralise the

experience of power in the past. The authors argue that it may be more important for an abuse survivor to confront their abuser(s) in the real world outside the consulting-room, than to confront their painful "inner" memories as part of the "therapeutic" process. Ryle (1997) unconsciously acknowledges this imbalance when he states, "Referral patterns, unfortunately, result in the fact that more educated patients are over-represented in the [Munro] clinic" (p.xiii). This concern with inequity has been echoed by Bell (1995) and Masson (1990).

Finally, Bell (1995) argues that CAT is still a relatively "young" psychotherapy and that some elements in the Psychotherapy File (see Appendix A), such as the final section on state shifts, are crude and need further refinement. Bell also argues that CAT is in danger of "blaming the parents rather than blaming the victim" (p.29) and, like Hagan and Smail (1997), claims that it ignores the wider social and cultural context of clients' lives. On a more practical level, the Reformulation Statement (or SDR if used) can, according to Bell, take 5 to 6 hours of therapist time, in addition to the usual administrative tasks. Because of this, in a busy NHS psychological therapy department, CAT is most likely to be reserved for identified clients with unresolved issues relating to their past.

Conclusion

CAT is clearly a valuable and potentially powerful time-limited psychotherapy which offers much to the practice of counselling and clinical psychology. It has unique strengths in addressing the origins and meanings of peoples' problems, whilst encouraging their self-efficacy. Main criticisms centre on CAT's focus on the inner world of the client, or the early dynamic between client-as-child and caregiver, whilst neglecting the role

of power inequities in shaping peoples' views of self, world and future.

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Appendix A: The Psychotherapy File

Monitor familiar ways of feeling and acting - these can often be "self-sabotaging" and are often automatic. Recognising them is an important step to changing them.

Keep a "Personal Diary" of moods and behaviour.

- Symptoms, moods, uncomfortable thoughts or behaviour
- What triggers them? How often? In what context?

Keep a running record of any particular mood, thought, symptom or behaviour (daily if possible).

1. How were you feeling about yourself before the problem started?

2. Any external event, thought or image in your mind when the trouble came on?

3. Once started, what were the thoughts, images or feelings you experienced?

Writing these down will help you recognise and eventually help you control how you feel or act at the time. Often bad feelings like resentment, anger or depression are the result of ways of thinking and acting that are unhelpful. Keeping a Personal Diary will help you learn different ways of coping with things.

Keep this for 2 weeks and then we will discuss it in the following session.

Traps, Dilemmas and Snags in Your Life

Traps

Traps are things we cannot escape from and certain characteristic ways of responding can escalate, so making things worse. In an attempt to deal with feeling bad about ourselves, we often think and act in certain ways that "confirm" our badness or sense of shame.

For example:

1. For a long time now it has been important for you to please others - this is because your own sense of self has been largely derived from what others think of you, starting with your father and mother, and ending with your husband. As a result, you often end up being taken advantage of by others (as in your marriage) which makes you feel guilty, ashamed, angry or depressed.

2. Because of the difficulty you have in showing your true feelings, especially anger, and at the same time wanting to please others, you prefer to "take the line of least resistance" ie. put things off or hide how you really feel, in an attempt to keep the peace. People sense this compliance in you and it can make them angry or critical, thus confirming your fears that you are weak and unloveable.

Both of these examples can be seen as dual "traps" of "trying to please" and "avoidance" and show in the way you often think, feel and behave. Because you had shaming parents who were unkind and invalidating of you, you felt you "didn't deserve" happiness. Your disappointments in life confirmed your expectations about yourself which, in turn, confirmed your feelings of worthlessness and shame. Such an idea has been reactivated by the death of your grandson. Because you knew he needed "special care" you "must have known" he would die and blamed yourself for not preventing it. This confirmed that you are therefore "guilty" of his death and consequently, "deserve to suffer".

Dilemmas

These are forms of "false choices" with either/or options that seem right to us - indeed, often they seem to be the *only* way of thinking and behaving. They are not consciously recognised but we often act "as if" these choices are true.

For example:

1. If I express my feelings I risk being out of control and rejection by others, but if I don't express them, or deny them, I feel angry and risk being exploited by others.

2. Either I give up control in a relationship and have material security, or I keep the control and risk emotional insecurity.

3. Either I ignore my own needs and give to others, or I put my own needs first and risk alienating others.

4. Either I look forward to something and risk being disappointed, or I don't look forward to it and avoid being let down.

5. Either I keep something to myself and it stays safe, or I share it and risk disapproval or hurting others.

Snags

What happens when we say "I want to ... but" (cf. the game *"Why don't you? - Yes but"*, Berne, 1964). Sometimes *this comes from how* we or our families thought about us when we were children (*eg. Pat as "difficult"*). Sometimes "snags" come from other people in our *lives not wanting* us to change (Pat as "submissive") or not able to tolerate what our changing means to them, as in your new-found sense of independence from your controlling husband, and his response to that. At other times, we "arrange" to avoid pleasure or enjoyment or, if they come our way, we "pay" by feeling guilty, ashamed or depressed, convincing ourselves we are "undeserving" by spoiling things in advance. It is helpful to learn to recognise these patterns and how they affect your life because only then can you start changing them.

1. Notice that: you do things now because this is how you learned to manage best when you were younger, eg. not showing you were angry with your father to avoid the consequences of being shamed and humiliated by him.

2. Realise that: you don't have to go on doing them. What was appropriate then (as a child) is no longer appropriate now (as an adult).

3. Understand that: by changing your behaviour, you not only control it but you change the way people behave towards you. For example, your recent "altercation" at work when you didn't feel *you* were in the wrong, and demonstrated that belief by your behaviour.

4. Believe that: by really being firm about your right to change, those who really care for you will accept and respect it.

5. Learn to: avoid "snags" by staying true to your self.

You feel limited by:

1. The fear of others' responses
2. The fear of your own responses to their responses

Learn to monitor how some states are accompanied by:

- intense and uncontrollable emotions
- feelings of "emotional blankness" or cutting off
- feelings of shame, guilt and anger
- fears that others might hurt you
- wanting to retaliate
- swift mood changes that seem to emerge from nowhere

Appendix B Reformulation Statement

I have felt bad about myself for as long as I can remember. I never felt loved or wanted by my parents and they both used to put me down although I've never understood the reason for this. I suppose I must have been a bad child in some way and a disappointment to them. They must have felt ashamed of me. I soon learnt to "be a good girl" in order to please them, or at least, to avoid the consequences of showing them how unhappy and ashamed they made me feel. I didn't feel happy inside at all. In fact, I often felt angry and resentful. As I grew up, I thought that by caring for others more than myself it would make other people come to love me and value the sort of person I was - and in that way I would find happiness. But I couldn't get rid of this feeling that maybe I "deserved" unhappiness because I *was* really bad -otherwise why did my parents dislike me so much? And so I began to believe that other peoples' views and opinions about me were the only ones that mattered - and that they were probably true. It was all so confusing ...

Because I had never felt loved as a child, when I met my husband I felt safe with him. He looked after me in a material way and it was a familiar feeling, being around this man "in authority" who always knew what to do and how to cope. Now I realise how like my father he is. As a child, when I got angry with my father I would hide it, because I was scared of what he'd do to me if I "rebelled". When I got angry with John I did the same: although I wasn't happy with him I was still frightened of the consequences of losing the only security I had and I "lived a lie". He was unkind to the children out of all proportion to their misdemeanours. What I thought was his setting them firm boundaries, I now realise was bullying and shaming behaviour. Yes, that's how he reminds me of my father. I'd never realised it before, but they both had to be in control in order to feel good about themselves. And they could only do that at someone else's expense, by making sarcastic remarks or threats.

But these things have been very difficult to sort out. I often have times when I think I am to blame for everything that goes wrong in my life - as well as other peoples'. When my little grandson died recently of a cot death, just one week old, I felt it was my fault. I knew he needed special care. I felt it intuitively and so my unconscious must have known. That means that I let him

die: in other words, I was responsible for his death. I let him die so therefore I must be bad and am being punished. That's why I go to his grave so often, to make up for the wrong I've done him in not acting, not warning anyone, not taking extra care. But is that really true? Maybe there are some things in life that just happen and that are nothing to do with me at all. It's getting a bit easier to believe that now, although I often lapse into my old ways of thinking.

I'm very confused about who I am and what I want from life. When I'm at work I want to be at home, and when I'm at home I want to be at work. I don't know what to do with my time - I've nothing and no-one to fill it. I would like to meet people and start some new things, but I know what I'm like. I soon feel disappointed or get bored and want to withdraw. I wonder, will you get fed up with me? Am I worth all this help? I've always felt like that - not feeling I belong anywhere, not feeling I'm worth the effort. Disconnected. I want to make changes in my world but I think I'm afraid.

Note

It is the therapist's view that, historically, both parents have chronically shamed this patient who has internalised the shame and, in analytic terms, come to see herself as a "bad object". This dynamic was maintained when the "shaming father" was replaced by the "shaming husband". The "self-as-bad-object" schema is automatically reactivated by a traumatic event (her grandson's death) which calls into question the patient's self-worth and exacerbates her pre-existing negative self-beliefs. The patient's sense of over-responsibility perpetuates the self-blame, which fuels further the schema of "self-as-bad-object" and confirms her underlying core beliefs that she is bad and undeserving, both being fundamental concomitants of shame.

Appendix C: Goodbye Letters

Dear Pat,

Over the past few weeks of therapy you have gained some awareness of how difficult it has been for you to show your true feelings, both with your parents and later, with your husband.

You have connected the way in which John resembles your father - both strict and shaming men who had to be in control, so that you never really felt good about yourself. You experienced your mother as hostile and critical, which undermined your self-worth even further. Understandably, you were unable to make sense of their behaviour towards you, which confirmed your beliefs that you were different from, and inferior to, others. This left you feeling unloveable, lonely, and of little value in the world. In order to please people, in the hope that they would like or love you, you developed a compliant and submissive self. This denial of your own needs often made you feel angry, which then led to guilt, thus driving the anger even further underground.

Attempts to express your real feelings have always made you feel ashamed and guilty, which then became internalised as depression. Sometimes you've found it hard to know what your true feelings are, having learnt so young to consider everybody elses'.

I said at our first meeting that the sadness and shame you feel belong to the past - I think they do - and that's where they belong. We talked about the role that disappointment has played in your life, stemming from childhood feelings of not being wanted and of being actively disliked, and how this has implications for you now, in that you find it hard to plan, or look forward to things, incase they get spoilt. By not anticipating pleasure or enjoyment, you are able to avoid the pain of disappointment that you were unable to express as a child.

We saw how your shame and self-doubt during the sessions have given way to anger, with yourself and others, but

particularly John, and how you can now accept this without feeling guilty.

Finally, we talked about how you feel able to put the sad part of your life on one side, and how "the anger seems less important now" (your words). You can enjoy being on your own and living life how you want, learning it's O.K. to put your needs first and that you no longer have to accept other peoples' definitions of how you should be.

It seems you were caught in a basic dilemma concerning your relationship with others. It is as if you either expressed your feelings, got hurt, felt helpless, rejected and powerless, or denied your feelings, so avoiding disappointment and rejection. But this was not helpful because it left you feeling alone and isolated with no sense of belonging or intimacy in your life. However, you realise now that there are alternatives. You can be in control of your life, be more assertive about your needs and be involved with others in mutually caring, sharing relationships - using that "inner strength" you referred to. You have also learnt to be more positive and less shame-full in the knowledge that you were not to blame for your parents' attitude towards you.

We are saying "Goodbye" and you can see this time as an important testing-out period for your new strengths and identified weaknesses. Alone, but not completely, as we can always arrange more time together if you'd like it.

So "Goodbye Pat" and good luck - for a future of your own making.

With warm regards

Barbara

P.S. I hope there won't be so many things for your guilty list now - perhaps you may even tear it up one day?

Dear Barbara,

I'm not very good at writing letters, but here goes.

I would like to say how much I have got from our weekly sessions. You have helped me understand myself and to realise that I am as good as others.

I know that my life isn't going to change overnight, nor is it going to be easy. But you have shown me the way and I thank you for that.

It is also comforting to know that if things get too difficult I can contact you again.

Yours sincerely

Pat

Section D

A CRITICAL REVIEW OF THE RELEVANCE OF DREAMS IN THERAPEUTIC PRACTICE

Table of Contents

"It is is certainly true that there are dreams which embody suppressed wishes and fears, but what is there which the dream cannot, on occasion, embody? Dreams may give expression to ineluctable truths, to philosophical pronouncement, illusions, wild fantasies, memories, plans, anticipations, irrational experiences, even telepathic visions, and heaven knows what besides." C.G. Jung, 1963, *Memories, Dreams, Reflections.*

Frontispiece

Because shame is becoming increasingly acknowledged as such an important affect, which is often unconscious or defended against (Section B refers), its recognition has particular significance for the handling of the therapeutic relationship and therapeutic outcome. The "pain of shame", which is often denied or repressed by the patient, has far-reaching implications for the place of dreamwork in psychotherapy. Dreams often provide clinically useful information which can alert the practitioner to the patient's shame-generative material, which the patient may disown, or be unaware of, in conscious life.

The aim of this review is to critically evaluate the role of dreams within the psychotherapeutic context. By her notion of "bypassed shame" (Section B, Chapter 2), Lewis (1971) makes implicit reference to the role of the unconscious in the repression, or avoidance, of shameful affect. Lewis suggests that the "pain of shame" may be actively avoided by the patient and can remain unrecognised by, and inaccessible to, the conscious mind.

Lewis (1971) described shame in its two main variants: overt, undifferentiated shame and bypassed shame. Whereas overt shame is analogous to being ashamed, bypassed shame is a state of shame that is largely unconscious. Bypassed shame is a low-visibility state which is difficult to

detect. Bypassed shame cannot be detected in bodily arousal; it is primarily observed in thought processes and interpersonal relationships. Sometimes it may be confused with guilt. The concept of bypassed shame is critical for understanding the therapeutic process and can have a dramatic effect on outcome. Lewis also discovered that "shame in the patient-therapist relationship was a special contributor to the negative therapeutic reaction" (p. 11). She showed that, because one unresolved aspect of transference is bypassed, or unconscious, shame, it could easily be overlooked.

Dreams, therefore, make a significant contribution to identifying and understanding bypassed shame. It is the unconscious aspect of dreams, and in particular the role of dream interpretation as postulated by Freud, that can play a crucial role in making sense of a patient's shame-generating material. This review will therefore begin with an assessment of Freud's conceptualisation of the function of dreams and the role they play in expressing repressed psychic material.

Freud: Dreams and The Unconscious

Freud (1900) originally used the term "dreamwork" to denote the complex process by which the dream "censor" (ie. the theoretical ancestor of the superego) converts the "latent" content of the dream into its "manifest" content, thereby giving the dream its often succinct and surreal quality. In the therapeutic situation, the process of dream interpretation requires that the therapist "unravel" the dreamwork by methods such as the patient "free associating" to dream components, in order to uncover their deeper meaning. Due to the "dreamwork", which involves such complex processes as condensation, overdetermination, displacement and symbolisation, the

wide-ranging nebulous quality of the dream-thoughts is replaced by a brief and often meagre dream fragment - rich in underlying content but often extremely sparse in its dreamed state.

In this way, two aspects of dream function become apparent: the representation and symbolisation by which the dream thoughts are replaced by visual images, and the process of "secondary revision" whereby the dream is dramatised and given a sense of coherence or a "storyline". Because Freud originally maintained that the underlying function of the dream was "wish fulfilment", it followed that there was no such thing as an inconsequential dream or gratuitous dream material, because its aim was to establish connections and fuse them into a complex and unified whole, despite its seemingly fragmentary, often archaic, quality. Freud (1920) extended his notion of dreams as wish fulfilments by suggesting that dreams could also function as a form of "active mastery" over events that had previously been suffered passively. A contemporary example of this was in the recurrent traumatic dreams of shell-shocked soldiers which Freud called the "repetition compulsion". Even so, the central concept of a disguised and repressed wish (often sexual and originating in childhood) still remained.

To illustrate this notion of "reworking" I present an example of a dream which a patient, whom I shall call Kate, described and which had stayed with her over the years (Section B, Chapter 6 refers). Her younger sister by two years, named Barbara, had died of meningitis at the age of seven, when my patient was nine years old. The death was "hushed up" by her mother and my patient was told that her sister had "gone": no explanation was ever given. It came as a shock to her when, over a year later, she found out Barbara had died. Around this time, as the

eldest child, she was caretaker to her two younger siblings (a younger sister and a brother born in the year following Barbara's death), as her mother was depressed and unable to resume this role. She felt prematurely forced into taking on an "adult" role, which left her feeling resentful and neglected - not able to join her friends in normal childhood games.

During therapy, it soon emerged that the issue of "secrecy", understandably, caused her great anxiety and psychological distress. This had been compounded in her marriage as she felt her husband had a "secretive side" and was not always as open with her as she would have liked him to be. This made her feel angry and resentful, which became internalised as depression, her presenting symptom.

She spoke of a recurring dream which she would have as a child, especially when she was unhappy, and this was of being in an exotic, warm and foreign land, where she felt free and unrestrained. The few days prior to the (dream) session had been particularly painful for her, as she'd arrived at her husband's office unannounced, and discovered his accountant (whom she did not expect to see) sitting on a swivel-chair in the middle of the room, mini-skirted and animatedly gesticulating and chatting to Kate's husband. Her description of her was "all gestures - like she does", flamboyantly extending her arm in a re-enactment of her painful "discovery" a few days earlier. This event had profoundly disturbed her as it resonated with her worst fears and anxieties around secrecy. That night Kate woke up crying in the middle of a dream, set in Spain, and depicting a flamenco dancer "performing" to an applauding and enthusiastic audience. Kate thought she was there in the dream *both as a spectator and, at times, the dancer* but couldn't be sure.

In Freudian terms, the dream could be understood as the flaunting, discharged energy of an exhibitionistic and grandiose self wishing to be seen and admired. At the same time, with the dreamer as onlooker, it could imply the longed-for wish of the voyeuristic self observing exhibited sexual impulses (and therefore shameful) depicted here in the form of flamboyant dancing. According to Freud's (1920) later view, which embraced the "repetition compulsion", the dream could also be seen as a "reworking", or attempt at mastery, of past traumatic events: in this case Kate is no longer merely a "spectator" of life, as childhood events had made her.

The dream is also very interesting clinically in that it expresses Kate's ambivalence about the desirability of being "centre-stage", hence her slipping in and out of the spectator/dancer role (another example of affective and cognitive "reworking"). The dream clearly made use of the "day residue" (Freud 1900) with the flamboyant "other woman", as well as connecting with Kate's recurring childhood dream of freedom and warmth, symbolising escape from a household in which she had been forced to take on premature responsibilities. It is of note that her earliest memory was of escaping from her harness when in the garden and she recalled the enormous sense of pleasure and relief that such "illicit" freedom gave her. At a more cognitive level, the dream also served to bolster up her flagging self-esteem at a time when she was feeling jealous and vulnerable, believing that she compared unfavourably (in her husband's eyes) to "the other woman." Such feelings of jealousy were inevitably accompanied by shame.

It is Freud's concept of dream material providing a "working through" of traumatic events that can bring significant benefit in the therapeutic encounter as such painful, and shame-generating, reminders are often

avoided in the patient's conscious life (cf. Lewis' (1971) "bypassed shame"). However, Freud's view of the role of dreams as providing access to unconscious and repressed material has attracted much criticism (Fairbairn 1952; Jung 1963; Meltzer 1984; Segal, 1983) and various theorists have extended the whole concept of "dreamwork" to include the totality of the patient's emotional and cognitive experiences, in addition to the unconscious meanings attached to them.

Because the concept of dreamwork, since Freud, has been extended to cover all aspects of working therapeutically with dreams, this review will examine the use and function of dreamwork across a range of therapeutic orientations. Because dream analysis has also evolved as such a central feature of Jungian "analytical psychology" Jung will be considered first.

Jung: The Healing Function of Dreams

Despite the importance of dream analysis for Jung, he intentionally did not develop a general theory of dreams, believing as he did that the aim of the therapist is to increase the patient's capacity to "conduct his own therapy" (Jung, 1963). Jung, in fact, stressed how important it is to abandon any preconceived opinions and theoretical predilections in working with dreams. He urged the therapist to "stand ready in every single case to construct a totally new theory of dreams" (Jung, 1963). However, Jung did hold a number of basic assumptions: firstly, that dreams did express unconscious structures and processes both personal and archetypal (ie. universal); secondly, that they contained a meaning that could be understood if the "dream context" could be established; thirdly, dreams revealed a compensatory

process in the unconscious; and fourthly, they showed a "purposive trend" towards individuation in the psyche.

Freud and Jung: A Comparison

Unlike Freud, Jung did not endeavour to dismantle the dream into its component parts, and only pursued the patient's associations insofar as they provided a clue to the dream's meaning. He did not urge the patient to pursue them because, he claimed, dreams lead to *parts* of the self only, and can cause disintegration in the person as a whole. In Jungian therapy, the patient is often advised to write down his dreams in a "dream book" or "dream journal" and, in this way, a whole "dream series" can be constructed. The patient is inducted into an ongoing therapeutic but *self-healing* process, minimising regression and dependence on the therapist.

Whilst Jung agreed with Freud that dreams were "the royal road to the unconscious" (Freud, 1900), his understanding of their meaning and function differed radically from Freud's. As Freud considered the "manifest" content of dreams to be the disguised fulfilment of a repressed wish which had its origins in infantile sexuality, Jung believed dreams had much wider and deeper significance. Jung rejected the idea that the dream is a facade concealing the "true" meaning: "the so-called facade of most houses is by no means a fake or a deceptive distortion; on the contrary, *it follows* the plan of the building and often betrays the interior arrangement" (Jung, *Collected Works* 7, p.295). He believed that dreams were the direct expression of unconscious psychic

activity and acted as symbolic communications or "a message from the soul".

As such, Jung believed dreams provide a view of the dreamer's situation, and mobilise the potential of the personality to meet it. Since dreams can introduce new and unexpected factors into the total situation, they enable the patient to view things differently, and through their "compensatory action" can support and strengthen the Self, promoting development of the personality. One could see this process as similar to "reattribution" in the cognitive therapy literature (Beck et al., 1979) or as "reframing" within the systems paradigm (Epston, 1989; White, 1989; Woolfe & Dryden, 1996).

Jung believed that, as an efficient homeostatic system (cf. Freud) the psyche possesses the capacity to heal itself, and it is in the "compensatory function" of the unconscious that this power for self-healing resides. A vital expression of the propensity with which the unconscious gives rise to symbols, and is capable of reuniting conflicting tendencies which are seemingly irreconcilable at the conscious level, Jung referred to as "the transcendent function". His view was that individuals are never able to "solve" the most crucial problems in life - only "transcend" them.

According to Jung, it is only by the awareness of both "poles" of every conflict, and one's endurance of the "tension" created between them, that radical shifts can occur in personality change. This comes about, he argued, through the power of the unconscious to create a new symbolic synthesis out of the existing conflicting propensities, reflecting Kohut's (1977) ideas on the "matrix of tension arcs in the bipolar self" (referred to in Section B, Chapter 5).

Therefore, to Jung, dreams were seen to be extremely therapeutic and this is emphasised repeatedly in his (1963) autobiography, *Memories, Dreams, Reflections*. At every crisis period in his life, a dream or a vision provided Jung with an essential source for developing a solution. Jung also realised the importance of "waking consciousness" as well as dreams, and found ways of bridging the gap between the two by inducing from them "active imaginations". In these ways, the whole concept of the dream was extended to include both the dream experience as dreamed *and* its waking memory ie. it included both waking and dreaming elements. Jung was therefore influential in recognising the multi-faceted nature of "dreaming", with his inclusion of the patient's visions, fantasies and "active imaginations" as part of the overall dreaming process.

By such means, according to Jung, the "transcendent function" can find expression and so lead to personal growth and individuation. But Jung also warned that the use of a "dream book" or "dream journal" in the sessions could be used defensively (often by intellectualisation) and so impede the progress of therapy. He commented:

> "However much people underestimate the psychological significance of dreams, there is an equally great danger that anyone who is constantly preoccupied with dream analysis will overestimate the significance of the unconscious for real life" (Jung, *Collected Works 8*, p.256).

In the Jungian view, Kate's dream could be seen as an example of the "transcendent function" in which a "transitional self" attempts to reunite conflicting tendencies which may seem irreconcilable at the conscious level, capturing the tension between a desired (shame-free) and an existing (shame-full) self: hence her slipping in and out of the dancer/spectator roles. It

portrays the dreamer in touch with previously-disowned aspects of her personality in order to achieve a fuller integration, and embraces the Jungian concepts of "dualities" and "psychic compensators".

Perls and the Gestalt View of Dreams: Dreams and Individuation

Such ideas of individuation and potentiation of the "missing links" of the self are also central to the Gestalt way of working with dreams. The founder of Gestalt therapy, Fritz Perls (1951), conceptualised the dream as providing a means of exploring unrealised parts *of the personality. Dreams were* not seen as "disguised wishes" as in the Freudian view, but as *"existential* messages" from the dreamer, anchored in the here-and-now, which function as a form of creative, dynamic expression.

The Gestalt way of working with dreams suggests the dreamer must re-own, re-integrate and "take responsibility for" the sum of his or her existence, which, through the dream process, can finally be assimilated into the Self. Because of this, Gestalt "dreamwork" encourages the dreamer to speak as all parts of the dream, and to identify with each in turn. This concept of differentiation and integration, and of working with polarities and dualities of the Self, is very close to Jung's notion of dreams as "psychic compensators". The aim of therapy then becomes to "unblock" repressed dreams, and dreamwork is seen, essentially, as a continuous process towards self-actualisation by "entering into a dialogue with the exposed aspects of the dream" (Fantz 1975, p.80).

Perls and Jung: A Comparison

For both Perls and Jung, the "message" was in the dream and both used dreamwork extensively. Within the Jungian approach, the dream is supremely valued for its healing and balancing function; in the Gestalt view it contains the "existential difficulty" ie. the missing part of the potentially integrated self. Both Perls and Jung looked on dreams as the primary therapeutic vehicle which had direct relevance to the patient's present life situation as well as his or her basic personality structure, informed by early experience. Both theorists agreed that the dream is a revelatory process and not a mechanism for disguise and distortion, as did Freud. They saw working with dreams as conducive to growth and self-knowledge and, in this sense, to be dynamic, rather than providing an outlet for repressed or unacceptable (shameful) wishes.

Perls believed that any particular dream has reference to the dreamer's present life situation and should be interpreted in whatever way the dreamer finds most useful. For example, if the dream generates an infantile wish, this should be explored to see how it is affecting the dreamer's life in the present. Perls, like Jung, believed that such a method could be used by ordinary people at home to gain insight into personal problems and conflicts - and was not to be regarded as a "specialised" (and often "mystified") approach to be used only by "experts" in the consulting-room. Perls was even reluctant to use the word "interpretation", just as Jung was reluctant to develop a general theory of dreams.

A Gestalt therapist might ask the dreamer to identify with (and possibly actively play out) each of the

different dream parts or components. In the clinical example described here, the dreamer might be asked to become the dancer's skirt, the staccato'd rhythm of the music, or the cheer of the applauding crowd.

Two concepts central to the understanding of Gestalt formulations are "need fulfilment" and the processes of "differentiation" and "integration". Perls saw needs as being patterned in a constant flux or movement, and he regarded them as a "function of shifts" in a figure-ground relationship. In Kate's dream, the shifting nature of the figure-ground relationship is clearly portrayed, in the fusing of dancer and spectator, and it is by the process of identification with the changing dream-components, and actually taking them into the Self, that the dreamer can come to a fuller and more integrated awareness. As such, the dream is a means of dynamic, creative expression, allowing the dreamer to experience, and be aware of, their self at various levels. This may often involve "re-owning", or taking responsibility for, shame-generative material.

Kelly and Personal Construct Theory: Dreams and Construct Loosening

Interestingly, this idea is reflected in the personal construct approach, where one of the therapist's first concerns is often a continuation of the process of elaboration of the patient's construct system, which is likely to have already commenced during the assessment process. The personal construct therapist is concerned to either "loosen" or "tighten" a patient's construing. "Loosening" may serve several functions, such as setting the stage for a re-alignment of constructs or facilitating the attachment of a verbal label to a

preverbal construct. It may be done in various ways, including relaxation, free association or uncritical acceptance of the patient's construing. Such methods minimise patient shame and encourage authenticity in the therapeutic relationship (cf. Roger's "core conditions", 1957); they also encourage the reporting and exploration of dreams within the sessions (Woolfe & Dryden, 1996).

Klein and Object-Relations: Dreams and Phantasy

The Object-Relations position on dreams is, in practice, not essentially different in its principles from the Freudian one. But it recognises and interprets features of the transference more readily. It is seen as the therapist's task to get the patient working, or playing, with the ideas (from dreams or other sources) that preoccupy him or her. The repressed wish underlying the train of associations in the dream is, according to the Kleinian view (Klein, 1952), secondary to the attempt to deal with bad or threatening "object relationships" and to "put right what once went wrong" (p.48). Winnicott's personal contribution to therapeutic technique was to get therapists to conceptualise their patients as people who, in childhood or adolescence forgot (or never developed) the capacity to play, and who now need to experience this as a key component in the therapeutic process (Winnicott, 1951).

For Klein (1975) the unconscious is viewed as a "container" full of contents with no clear distinction between pre-consciousness and consciousness. The aim of the Kleinian therapist is to find the "unconscious content of the phantasies" and the workings of the unconscious ego. As Susan Isaacs (1958) notes, the

primary content of all mental processes is unconscious phantasies, and such phantasies are the basis of all unconscious and conscious thought processes. As such, Klein is not concerned with the unconscious as a system of thought. It is the *content*, not the dreamwork, which is central to a Kleinian therapist's interpretation of dreams.

Such a view, along with Klein's observations of children, resulted in her orientation towards the "phantasy" content of symbolic play, which she saw as representative of the same archaic mode of expression which occurs in the dreams of adults. Klein (1926) states:

> "symbolism is only a part of it ... we must take into account not only the symbolism which often appears so clearly in their games, but also all the means of representation and the mechanisms employed in dream work, and we must bear in mind the necessity of examining the whole nexus of phenomena" (q. Mitchell (1986) pp. 64-65).

Klein (1926) maintained that symbolic play can only be fully understood if approached by the method that Freud used for dreams, because "children produce no fewer associations to the separate features of their games than do adults to the fragments of their dreams". Moreover, Klein (1926) argued that, in their play, children often represent the same thing that has appeared in some dream which they have narrated before, and often produce associations to a dream by means of the play which follows. She maintains that play provides childrens' most important mode of expressing themselves. In this way, Klein believed that children substituted actions, the original precursors of thoughts, for words. Symbolic play-acting was seen by Klein as both an extension and representation of the dream process.

In Klein's view, the concepts of symbolism and phantasy (ie. how the baby relates psychically to the conjunction of its inner and outer worlds) are central to her therapeutic work. The affinity of the child's world of play to the dream world of the adult is self-evident. Therefore Klein, whilst accepting the importance of the Freudian process of "unravelling" dreams through "dreamwork", modified its use to encompass the "unravelling" and interpretations of a child's symbolic play. In this way, she developed and extended the dream's function, but did not focus on it exclusively as a therapeutic tool. The dream was seen as indicative of the *contents* of the current transference relationship, and was therefore located in the "here-and-now" of the therapeutic sessions. However, the association of shame with self-consciousness reported in the literature (Section B, Chapter 2 refers) suggests that shame would be less problematic for children than for adults.

Moreover, the actual "reality" of the patient's historic life-events would be seen by Klein as of secondary importance to the internal, psychic, and primitive interplay of life and death instincts and those infantile phantasies, and adult dreams, that are generated by this interplay.

It is interesting that, in the example described above, the patient reported "waking up crying" in the middle of her dream, illustrating the pain that such psychic conflict can evoke. In her dream, the primacy of the "life-depleting" (and shaming) forces of rage, persecutory anxiety and envy, are portrayed in opposition to the "life-enhancing" instincts of love, gratitude, and freedom, where these forces embody a self that is "shame-prone" or "shame-free" respectively. In Kleinian terms, the dream demonstrates the "paranoid-schizoid" position of a patient whose feelings are "split" into

envy on the one hand, and gratitude for life on the other, denoted by the tension between (envious) onlooker and (envied) dancer.

Segal: Dreams and "Psychic Evacuation"

In contradistinction to Klein's focus on the importance of the unconscious content, Segal (1983) made the point that the form and function of a dream could be more important than its content and, in her view, dreams frequently function as a means of "evacuating psychic material" which the dreamer is currently unable to deal with at a conscious level (again, reflecting Lewis' (1971) concept of "bypassed shame" referred to in Section B, Chapter 2). It is also similar to Freud's notion of the "repetition compulsion" - a reworking of disturbing material in order to achieve mastery over it. The dream is seen as a kind of "psychic holding exercise" with a view to regaining some measure of emotional equilibrium.

Piaget: Childrens' Dreams

Piaget (1953) considered dreams in the context of the processes of childhood, and believed that conscious thinking was pre-dated by a more primitive form of thinking which occurred "through the articulation of imagery". He saw this as the process which occurs in dreaming ie. an active but primitive process. He also believed that children are often unaware of things because they simply take them for granted. He argued that childrens' assumptions are unconscious because they are so familiar that they elude awareness. Interestingly,

Symington (1986) refers to a similar process in psychotherapy, stating that often the deepest clinical observations are the ones that have "stared you in the face" from the first meeting with the patient, but which may take a long time for the therapist to notice.

Winnicott: Dreams as "Transitional Becoming"

Similarly, Winnicott (1951) in his clinical use of dreams, always looked for that element which contained the "transitional" ie. an ambiguous quality or an ambiguity in the state of existence: one moment part of the self, and at another, a part of the central figure in the world beyond the self (such as the mother's breast during feeding). As such, Winnicott argued, the dream represents a state of constant "becoming", similar to Khan's (1972) idea of the "dream space", which can also be used transitionally in this way.

Meltzer: Dreams and the Primacy of Feeling

Meltzer (1984) took the view that every dream is an attempt to solve an emotional conflict and that the process of dreaming, "the generative theatre of meaning", enables internal and external objects to take on new emotional significance which can then be utilised in the dreamer's current life situation.

This has important implications for the therapist, as Meltzer believes that the "occupational hazard" of dream analysis is the "exposure to radioactive material". In other words, the "charged" material of the dream, and its ability to evoke projective identifications, can result

in the therapist's fear of being invaded, taken over or confused by the patient. Meltzer, like Bion (1967), saw dreamwork as concerned with how to translate painful emotional experience which is often shame-generative, into some *symbolic form* so that it can be reflected on and communicated to others, thereby acknowledging the primacy of feeling over thought.

Fairbairn: The "Symbolic Narrative" in Dreams

Fairbairn (1952) believed that, in therapy, the dream functions as a "symbolic narrative" which reflects on the individual's psychic state, and most importantly, on the state of his or her "internal objects". In the analytic literature, objects are nearly always people, parts of people, or symbols of one or the other. An "internal object" is an object-representation which has acquired the significance of an external object ie. it is an image occurring in phantasy which is reacted to as "real". As such, the dream becomes a "dramatisation" of situations existing in the person's inner reality and the *dramatis personae* are drawn from parts of the dreamer's own self and/or internalised objects. As such, according to Fairbairn, dreams reflect not only a current self in relation to the therapist, but also show part- and whole- object experiences from the patient's most archaic developmental levels. On this view, the dream directly illustrates, in symbolic form, the unfolding dynamics of the interactive psychotherapeutic process.

Kohut: Self-State Dreams

Kohut's "Self-Psychology" (1971, 1977) provides a theoretical framework which postulates the organisation of the "bipolar self" in the midst of change, and in relation to its "self-object" experiences ie. important experiences with significant and internalised others (Kohut 1971, 1977, referred to in Section B, Chapter 5). Kohut describes two types of dream: "those expressing verbalizable latent contents (ie. drives, wishes, conflicts and attempted conflict solutions), and those attempting, with the aid of verbalizable dream-imagery, to bind the nonverbal tensions of traumatic states". The latter, which Kohut referred to as "self-state dreams", attempt to "deal with the psychological danger by covering nameless processes with nameable visual imagery" (p.108).

In this type of dream, an exploration of the patient's "associative elaborations" provides clues to the fact that "the healthy sectors of the patient's psyche are reacting with anxiety to a disturbing change in the condition of the self" (p.109). This could range from manic stimulation to a depressive drop in self-esteem, as experienced in shame, or even to a threat of total disintegration. Such "self-state dreams" are not dissimilar to the dreams of childhood, or those experienced in traumatic neuroses. The state of the self is observed by an observing sector of the self, and that *observation* is represented in the dream.

Tolpin: Selfself-object Dreams

According to Tolpin (1983), Kohut's writings contain other types of dream about the trials of the self and its

experiences with self-objects, although he maintains Kohut did not provide them with a name or function. Tolpin refers to such dreams as "selfself-object dreams", indicating the crucial role of the relationship of the self to the self-object, regardless of how archaic or mature the (dream) self is found to be.

Such dreams cannot be understood from their "manifest" content alone, but only from a combination of present-day associations, the "day-residue", and an understanding of the patient's transference, dynamics, personality and defensive tendencies, "grasped empathically together." Tolpin (1983) argues that there are "mixed" dreams, whose interpretation is derived from an understanding of the self-state elements, as well as the more concealed symbolic components. Kohut (1971) referred to these as "transitional" forms of dreams, in which aspects of the "archaic self" are present, possibly as a total setting or background atmosphere of the dream, while other elements represent varieties of "structural conflict". In all these dreams are found the usual psychological devices of dreamwork: symbolisation, condensation, displacement and secondary revision. However, the interesting forces are not seen as the structural ones of id, ego and superego (as in the Freudian view) but in the "vicissitudes of the self" in the midst of change.

To place the dream described above within a self-psychological framework, one can see it as an interesting example of a "mixed dream", containing elements of both "self-state" and "selfself-object" associative experiences.

As a "self-state" dream it expresses ambivalence, because the ideal self is represented as the observed flamenco dancer, and also as "the other woman" of the "day-residue". It graphically portrays both the desired-yet-

envied self, the dilemma being that the ideal self produces envy and the wish to spoil in the dreamer, which is shame-generating. It also provides an example of a structural conflict between the ego and the id. It describes a "crystallization point" around which a depleted "self-state" takes a specific visualisable form.

Interestingly, as a "selfself-object" dream, it portrays the state of the self in its struggle to maintain an emerging (but fragile) sense of confidence and independence. It shows a particular configuration of self-development and represents the patient's use of an idealising transference with the therapist. In a display of oscillating self-confidence, the dancer is both her ideal self *and* the envied "other woman". It is true that, during the therapy, Kate did develop a degree of self-reliance and increasing self-esteem. However, historically, once given the attention she craved, she had never been sure she really wanted it, and this led to her ambivalence about being the "desired object" and of being "centre-stage". Therefore, the dream leads not just to an understanding of the patient's current self-state, but also to an understanding of her current selfself-object transference and, beyond that, to its origins in her early childhood relationship with her mother *(Section B, Chapter 6 refers)*.

Therefore, as well as *being a "self-state" dream, it is* also a dream about "selfself-object" experiences *and* about the overall functioning of the self at a particular moment in time. In self-psychological terms, the dream's organisation can be seen as representing the fluctuating state of the dreamer's emotional world, in its quest for resolution and harmony, and the re-owning of shameful affect, such as envy.

Therefore, the self-psychological perspective emphasises the importance of a "holistic" approach to understanding dreams, involving an overall "empathic grasp" of the dreamer's current life-situation, childhood experiences, and everchanging emotional associations, before it can be understood or interpreted.

Dreams: Evaluation of Therapeutic Differences

In the view of Fosshage and Loew (1978), dreamwork is a technique which is as productive as transference interpretation, and as essential, if the aim is to maintain an equal relationship, and they see it as providing an "objective third term" which is equally available to patient and to analyst. By providing a spontaneous check from compliance to the "wise and powerful analyst", they argue that dreamwork can play an important role in countering an unrecognised or unrelieved transference, whilst minimising the effects of repression, and hence shame-generating material.

In summary, although differences emerge in the emphases which various theorists and practitioners place on the value of dreamwork in psychotherapeutic practice, it has clearly been modified and extended since Freud's (1900) original exposition on dreams. According to theorists such as Garma (1974), the dream is more valuable than any other product which the dreamer could invent while awake, and he asserts that it is only when deep dream interpretations are realised that treatment progresses well.

As such, in contrast to other clinical material, dreams are generally seen to provide a direct inroad into unconscious, or unrecognised, conflicts in the "here-and-

now" and are used as a therapeutic tool by practitioners across a wide range of theoretical orientations.

It is of note that many Freudians themselves disagree as to the significance and usefulness of dream material in therapy. While many Freudian analysts (Altman, 1969; Garma 1974; Greenson 1970) continue, in the tradition of Freud, to regard the dream as different from other clinical material (in that it provides ready access to the workings of the unconscious), other Freudians argue that a dream is no different from, and clinically no more important than, any other piece of verbal or nonverbal behaviour.

According to Freud's topographical model, dreams were seen as the "uncontaminated product" of the unconscious and were highly esteemed in the primary therapeutic task of "making the unconscious conscious". Later, in his structural model, Freud shifted the therapeutic focus from making the unconscious conscious to "intersystemic conflict" and to the analysis of defence-mechanisms. Such conflicts (either conscious or unconscious) are, on this view, readily accessible in *any* of the patient's behaviours, including dreams: hence dreams are seen as neither more nor less important than any other piece of clinical material.

Within the Jungian approach, the dream is valued for its healing and balancing function because of its power to confront - and reveal - important aspects of the Self that are not heeded when awake. The dream serves as "director" of the therapeutic process and so has an equalising effect on patient and therapist alike, indicating what needs to be focused on and what changes need to be made.

In Jungian therapy, "dream journals" are part of routine treatment procedure because of the clinical significance ascribed to the dream. It is here that the approaches of Jung and Perls converge, for Perls saw the dream as containing the "missing part" of the self and as providing an "existential message", whereas for Jung it was a "message from the soul". But in spite of the centrality of dreams for both theorists, neither dwell on them exclusively, or as extensively as Freud, but take into account the significance of the dream in relation to the totality of the dreamer's current life situation and existing emotional associations.

Klein, whilst accepting the importance of dreamwork in the Freudian sense of "unravelling meaning", modified and extended its use to include the concept of "phantasy" (the "ph" denoting it as an unconscious process), which became so central to her therapeutic work. Within the Kleinian framework, the dream is seen as a catalyst to the process of understanding the transference, and its emphasis is very much on the "here-and-now". As such, it is not seen as the primary therapeutic vehicle, but as a useful adjunct to therapy.

Within the self-psychological approach of Kohut (1971, 1977), the organisation of the "bipolar" or changing self is the orienting principle in therapy, and dreamwork is but one part of a far more complex, all-embracing process in which the totality of the patient's world is taken into account and explored.

A Critical Evaluation of Dreams in Therapy

One important issue in evaluating the use of dreams in therapy is that of dream interpretation, which has remained a neglected technique in most contemporary counselling and psychotherapies (see Means et al, 1986).

Firstly, because the process of dream interpretation has been considered a complex and somewhat mysterious art; secondly, because it has often been linked to particular theoretical orientations, and methods of interpretation are infrequently applied outside of these. The use of dreams in therapy was, for many years, thought to be the prerogative of psychoanalysts, or psychodynamically oriented therapists, since dream material was seen as a product of the unconscious mind and was thus, by definition, not readily available for inspection. Even some therapists trained in a psychodynamic perspective, although seeing dreams as valuable, often felt they had insufficient training to interpret them.

Those belonging to other orientations often avoid dream material: cognitive and cognitive-behavioural therapists for example, often leave dreams alone, although in treating chronic nightmare sufferers, they will use techniques such as imagery rehearsal to help reduce or eliminate them (see Krakow et al, 1996). In the treatment of a patient with night terrors, Friedman (1993) believed it was the replaying to the patient of a recorded video of her taken during the terror that finally extinguished it.

Excepting Gestalt therapists, who are trained to use dream material, many practitioners working in a humanistic, experiential way with "here-and-now" material have not wished to interpret dreams. As a consequence, only those patients in analysis and Gestalt therapy have been encouraged to present dream material in the sessions.

Haskell (1986) argued that one reason dream data have not been considered scientifically significant is that they are viewed as sensory and visual phenomena, and are seen as perceptual rather than cognitive events. Also, dreams

are considered to be irrational and bizarre, ie. lacking in logic and reason. This may help explain why, until recently, cognitive psychology has largely ignored dreams, although it does not explain why information-processing models of psychology have done so. Haskell also argues that, as a result of the Freudian legacy, dreams are often seen as "pathological phenomena" and relegated to the status of "interpretive" case-studies which cannot be methodologically controlled. This reinforces the view that dream data are unreliable and therefore invalid as cognitive data. Waking thoughts and feelings are viewed as qualitatively different from dreams, so the latter are seen to have little to contribute to cognitive psychology. Webb and Cartwright (1978) believe that the status of dream research is such because dreams are unobservable by others and cannot be studied by the intersubjective methods proper to scientific study. Also, the working conditions under which dream data are collected are difficult: experimenters must gather data at night while participants are asleep, and expensive sleep laboratory equipment is needed.Thus, most studies have had few participants and most have not been replicated. Moreover, the nature of dreams makes it difficult to conduct some kinds of studies: nightmares, for example, do not seem to occur under sleep laboratory conditions. Therefore, there are many reasons why the study of dreams and dreaming has not been accepted into the mainstream of academic research. It is of interest that neither Roth and Fonagy (1996) nor Bergin and Garfield (1994), in their recent reviews of psychotherapy outcome research, refer to the therapeutic use of dreams.

A further important consideration is that of patients' dream beliefs, as these will significantly influence how (or if) dreams are used in therapy. In an ongoing study by Parker et al. (1999) an exploration was made of

beliefs about dreams by means of a questionnaire that was circulated to 300 participants. Against the prediction that Freudian beliefs such as "dreams are the products of the unconscious mind" would predominate, it was the information-processing (or cognitive) model of dreams that was the most popular. Other beliefs were parapsychological ("spirits visit me during the night") or neuro-physiological (eating wrong foods and/or random firing of neurons in the brain). These four models can be conceptualised as follows: analytic (based on intrapsychic conflict ie. Freud's structural model of the mind: treatment, interpretive therapy); information-processing (based on the computer model of the mind: treatment, problem-solving/increased self-awareness); parapsychological (based on spiritual beliefs: needs treatment only if malevolent, such as exorcism); neuro-physiological (based on random firing of synapses: treatment, medication).

The information-processing or "computer" model of dreams postulated by Evans (1983) suggested that, in dreams, the day's events and experiences are organised and integrated with other memories and stored in longer-term memory. Evans' computer theory has common ground with some other psychological theories of dreaming, since Evans considers dreams important for the problem-solving and creative functions.

One major neuro-physiological theory of dreams, called the activation-synthesis hypothesis (Hobson & McCarley, 1977), suggests that purely physiological processes cause dreams. They argue that, in REM sleep, the brain generates random signals which the cortex attempts to make sense of, in the same way that it tries to make sense of memory input during waking hours. Critics of this theory have suggested that, although a description of the dreaming process may give an account of the

brain's activity, it does not explain the *psychological* reason for the process. Also, a purely physiological explanation of dreaming does not account for the creative functions of dreams that have been documented by many writers, poets and artists. Another unanswered question is, if dreams are caused by the random firing of neurones, why "dream logic" appears to follow such consistent rules. Additionally, this theory cannot account for repeated or recurring dreams which are widely reported in the literature, especially those related to trauma. As yet, the links have not been made to connect the neuro-physiological evidence with psychological theories, and the question of why we dream still remains unanswered.

It is true that, whatever one's dream beliefs, some people remember dreams better than others. Clearly, no-one remembers all (or even most of) their dreams and people who claim to remember all their dreams are mistaken. With an effort, selected dreams can be remembered and recall improved with practice. The dreams that patients take to their analysts, for example, are only a selected sample and psychoanalytic theories cannot provide a comprehensive theory for the totality of dreaming, although may be valid for some dreams. Studies of sleep show that those who do not remember their dreams, or even claim never to have dreamt, spend a fifth or more of their sleep in dream activity; if woken during periods of rapid eye movement (REM) sleep, they are usually able to describe dreams (Berger, 1969). Those who do not may show characteristics of alexithymia (Kalucy et al, 1976). It is striking how often people in therapy start remembering dreams for the first time and it is well-known that Jungian patients will present Jungian dreams to their therapist, and Freudian patients will bring Freudian dreams.

Rycroft (1979) emphasises the creative and imaginative aspects of dreaming, rather than just the conflictual and neurotic, and regards dreaming as the mode of communication of the non-dominant cerebral hemisphere.
To summarise, all of us, if we choose, can make sense of our dreams in a way that is helpful and meaningful. We should all be able to incorporate our dream material into our waking lives, both to increase self-awareness and extend creativity. How much dreams are made use of in the consulting-room however, are very much a negotiated choice between patient and therapist.

Conclusion

In conclusion, the existence of such diversity in the literature relating to the role of dreamwork and its place in therapeutic theory and practice, suggests that it is generally seen as of significant clinical relevance regardless of practitioner orientation, although it is important that patients' beliefs about dreams be taken into account and respected by the therapist. The ability to work with a dream hinges not on the therapist's particular knowledge of dream symbolism, but rather on therapeutic skill in detecting the various ways *in which the dreamer awake evades the message from the dreamer asleep*. From this vantage-point, the concept of dreamwork can make a significant and far-reaching contribution to psychotherapeutic practice especially when working with the shame-prone patient. It is in this group that shame-generative material may often be denied or repressed, but may emerge in disguised form in the dream material.

In conclusion, it is clearly the psychoanalytic emphasis on the role of the unconscious and the mechanisms of repression and distortion in dreamwork, as espoused by the psychoanalytic therapists, that is most relevant to

Lewis' (1971) concept of "bypassed" or unconscious shame and the avoidance of painful affect.

According to Hobson (1985):

> "the dream ... carries a multiplicity of meaning. It is an event which denotes progress within the therapeutic encounter, changes taking place over time within the dreamer's internal object relationship, and the state of transference and countertransference. It may also represent itself and its place within the work of the session" (p. 3).

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