Shame in the Treatment of Schizophrenia: Theoretical Considerations with Clinical Illustrations

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The phenomenology and dynamics of shame have been largely overlooked in the psychoanalytic and psychological literature. The emerging literature now suggests that shame may play a vital role in autonomy and personality development, symptom formation, character pathology, and interpersonal relationships. This paper attempts to describe shame phenomena and identify shame dynamics. The role of shame in the understanding and treatment of schizophrenic individuals is then demonstrated through reference to the writings of Frieda Fromm-Reichmann and examples from the author's clinical work.

INTRODUCTION

Shame is a universal human experience that has received little attention in the psychoanalytic and psychological literature. The role of shame in personality development, psychopathology, and psychotherapy remains to be explored. The existing literature on shame, however, suggests that it is a powerful force in all areas of concern in the theory and practice of psychotherapy. This paper will attempt to outline the current understanding of shame phenomena and then, through the work of Frieda Fromm-Reichmann and clinical examples, demonstrate the importance of shame in the treatment of schizophrenic individuals.

CURRENT CONCEPTS OF SHAME

The acute experience of shame is an abrupt and painful awareness of the self in the presence of another. It is accompanied by autonomic responses such as blushing and sweating, which heighten the self-awareness of the experience. These physical reactions are outside the control of the individual but can be perceived by the observing other, which intensifies the shame. The self experiences a feeling of shrinking and wishes to disappear or die, and a sense of helplessness and passivity are the result.

Helen Block Lewis's clinical and theoretical work, Shame and Guilt in Neurosis [1], is the first book to consider shame as a primary dynamic. She explains the neglect of shame in professional literature by describing a basic aspect of shame. Shame is a painful experience that leads the individual to attempt to hide the experience from the self and others. It is also inherent in the process of shame that a person witnessing it will ignore it. The very nature of shame, then, is thought to hide it from observation and study.

Erik Erikson in Childhood and Society [2], briefly addresses the concept of shame, equating shame with issues of autonomy and doubt. The function of shame in the formation of identity is noted by Erikson, Lewis, and Helen Merrell Lynd [3]. Shame
can function to alert the self when fantasy or misperceptions are operating. The awareness of the other can abruptly terminate these interior operations. When this perception occurs in a tolerable manner, the identity of the self is enhanced. When overwhelmed by shame the self is diminished, at least temporarily.

Certain interpersonal experiences are associated with the creation of a shame event. The rebuff or rejection of affection by another creates a shame experience. When one individual needs another and this need is refused or belittled, shame occurs. Many other synonyms for shame identify both the interpersonal interaction creating the shame event and, at the same time, define the resulting state of shame: humiliation, ridicule, embarrassment, chagrin, dishonor, mortification, disapproval, and disappointment.

Although shame events occur suddenly and are often quickly repressed, the event can cause long-lasting effects, especially for vulnerable individuals. After the acute event, the self-awareness is split between the painful, diminished self and the perceived, critical disapproval of the other. The presence of the other is important at the moment of shame and in the resulting self-experience, where continued concern about the opinion of the other further diminishes the boundaries of the self. A part of the self's experience is attributed to the other person, who is experienced as the source of the discomfort or blame. The self, simultaneously, experiences the act of blaming and the feeling of being blamed.

Lewis identifies two basic forms of managing the resulting self-experience following an acute shame event. In the first, called overt but unidentified shame, the emotions remain conscious but the identification of the cause and the recognition of the process are lost. The results are feelings of self-consciousness, low self-esteem, and feelings of badness and tension. In the second process, called bypassed shame, the individual registers a wince but does not consciously experience the emotions of shame. A vague sense of disturbance is registered, the self-esteem is diminished, and ruminative doubts about the self and the opinions of others consume much of the cognitive functions. These two processes are not mutually exclusive. In both, the self is diminished and rendered relatively passive and undifferentiated. The boundaries of the self in either of these outcomes are damaged and the concern with the presence and the opinion of the other is incorporated into the self-experience. The real and imagined attitudes of the observing other affect the self-evaluation and experience.

Another predictable outcome of the shame experience is identified by Lewis as humiliated fury, a rage marked by ideations of vindictiveness and self-justifying retaliations. This humiliated fury creates further complications for the shamed individual. First, because the self is in a diminished and passive state, action of any type is difficult and aggressive action is especially difficult. In addition, this rage is directed toward another individual who is perceived as powerful and who has already succeeded in overwhelming the self. This powerful other is often important to the self in other ways and in fact is held in some esteem and is needed. To experience retaliatory rage toward such an important, needed other inhibits the expression of the rage. Last, the self in evaluating this vindictiveness may become secondarily ashamed of these feelings and ideations or ashamed of the inability to take action.

Humiliated fury is then an outcome that further reduces the self. The diminished, blamed self finds further reason for blame. The drive to turn the tables on the shame-inducing other is overwhelmed by its own qualities of vindictiveness, lack of proportion, and having as its target another perceived as important and more powerful
than the self. This predicament serves often to perpetuate the shamed state of the self with the attendant lowered self-esteem, passivity, and decreased differentiation between self and other.

Shame can become the integrated self-experience. Beyond the difficulties of managing shame experiences in day-to-day life, the self may be maintained in a state of shame. The result of a continued state of shame is an obvious calamity for the individual. The self is constantly experienced as helpless, passive, critically evaluated by the overestimated other, vulnerable to insoluble rage that is vindictive, and retaliatory toward the more powerful other. The other is constantly contaminated by this rage and at the same time maintained as an essential source of self-evaluation.

When shame is the chronic state, the self-correcting functions of shame cannot be used effectively. Shame, as it functions to produce autonomy and self-identity, will be inverted to produce the opposites of failed differentiation, self defined through the other, and chronic self-doubting. This chronic state of internalized self will produce marked difficulties in interpersonal encounters. A self highly sensitive to the real and perceived reactions of the other is the result. Repeated experiences of shame in interpersonal encounters will reinforce the shamed self. Often these shame experiences are created by the highly sensitive self and would not be perceived as strongly shaming by relatively healthy individuals who have an intact personal autonomy and well-established identity.

THE WORK OF FRIEDA FROMM-REICHMANN
AND THE DYNAMICS OF SHAME

The work of Frieda Fromm-Reichmann [4] emphasizes interpersonal relationships both to provide a developmental understanding and a perspective from which to understand the therapeutic relationship with the schizophrenic individual. She identifies the influence of Harry Stack Sullivan on her work in accepting that no developmental period exists outside of human relatedness and that this relatedness is essential for security and development. Furthermore, she accepts that anxiety is the discomfort that the infant experiences in the presence of disapproval of a significant other and that the infant can sense such disapproval very early in life [4].

Fromm-Reichmann redefines Freud's contention that the schizophrenic is too narcissistic to develop an interpersonal relationship. She identifies the schizophrenic as a highly sensitive individual who reacts with extreme intensities of love, hate, and fear to interpersonal interactions and that the narcissistic withdrawal is an attempt to avoid this intensity and the fear of repetitional rebuffs. This profound sensitivity she attributes to early traumatic experiences in which there was a devastating blow to the infant's normal and necessary egocentricity. Because this trauma occurs early, the individual remains highly sensitive to interpersonal interactions and frustrations because the trauma occurs prior to a sense of security that underlies self-assurance and reliance.

Fromm-Reichmann frequently refers to the sensitivity of schizophrenic individuals to rejection. These individuals have been sensitized to rejection and fears of rebuff because of the early traumatic "infantile rebuff." She identifies the anxiety of these individuals as being based upon the expectation of disapproval and rejection that is consequently anticipated. This sensitivity is important in maintaining a therapeutic relationship and in understanding the behaviors and obscure communications of the schizophrenic. As a bond forms between patient and therapist and the patient begins to
experience feelings of fondness for the therapist, fear of rejection and disapproval is very high. The fear that a repeated rejection of positive feelings and needs is inevitable leads the patient to attempt to hide these positive feelings. This disguise may take on the form of haughtiness, exclusiveness, and megalomania. Another technique is the use of stereotyped, bizarre-appearing behavior and obscure verbal communications that serve to hide the feelings of affection.

The role of rage is also explored by Fromm-Reichmann. She defines this rage as retaliative hostility that is derived from the experience of the schizophrenic as a rejected child, the product of a developmental background in which he was unloved and unwanted. The schizophrenic both hates and fears his rage.

When the therapist disappoints or shames the patient, the patient responds with hatred of the therapist. He then fears that the therapist hates him for his hatred of the therapist and his hatred and fear continue. Furthermore, if he senses that the therapist is afraid of him, his sense of being a dangerous, unwanted person will be confirmed and the low self-esteem and hatred he feels will continue to be directed toward both self and therapist. She recommends that the therapist remain with the patient through rageful and disturbed periods so that the therapist’s acceptance of these reactions can assist the patient in accepting himself after such an episode.

Fromm-Reichmann does not use the term shame. However, the parallels between her descriptions of the interpersonal processes of schizophrenic patients and the previously defined dynamics of shame are clear. Rebuff, rejection, and disapproval are common causes of shame. The marked sensitivity to rejection and fear of rejection suggest an individual who is highly vulnerable to the experience of shame and who anticipates marked disruption of the self in experiences of shame. The extremes of behavior, withdrawal, and obscuring of communications that the schizophrenic uses are not only defenses but are also attempts to hide the self from the exposure in shame. The retaliatory nature of their hostility is the same as the complex rage that follows shame, i.e., humiliated fury.

SHAME IN PRIMARY PROCESS LOGIC AND SYMPTOM FORMATION

If shame is accepted as a powerful influential experience for the self, one that is often sustained in the experience of the self over time, then shame events can be taken as important causal events in the disrupted function of the self. Shame has been identified as leading to a disrupted self that is caught in experiences of passivity, diminished self-esteem, doubts, fusion with the opinion and appraisal of the other, and in vindictive rage.

Beyond these consequences, Lewis has reviewed some of Freud’s work in relation to shame. Freud did not address himself to an in-depth study of shame; however, on many occasions he does identify a shame event as preceding the psychological state that he proceeds to analyze. This sequence is true in some of the causes of hysterical symptoms. In Freud’s essay on concealed memories [5], he clearly identifies humiliations as the catalysts that lead to the process that he then describes. This raises the issue of the role of shame in the formation of symptoms and psychic phenomena that has been described by various writers.

It can be postulated that one of these psychic events that is initiated by shame is the expression of primary process thinking. It has been previously stated that, following a shame event, the boundaries of the self are weakened and that the other person takes on an unrealistic and undifferentiated perspective. The self becomes caught up in interior
processes that are not consistent with consentually validated reality. Interior concerns and ruminations begin to fill the perceptions of the self, which are confused with external reality. The retaliatory rage fantasies that result often operate outside of reality logic. This rage can also be experienced as directed toward the self. Such a reversal is a form of primary process phenomenon. Shame events can also influence dreams, a fact identified by Freud. Dreams are a defining example of primary process logic.

For the schizophrenic individual, primary process logic is not restricted to dreams and is often elaborated as the waking perceptions of reality. If the previously described origins of the schizophrenic's sensitivity in interpersonal relations is accepted, i.e., early rejection by important others, then a role of shame in creating the formation of primary process logic could be postulated. Since it is also known that schizophrenics are capable of secondary logic, then an emergence of primary process thinking might indicate that a recent shame event or fear of shaming is in operation. This point of view helps the therapist to maintain a focus on the interpersonal process rather than to become caught up in analyzing primary process productions or becoming frightened when these emerge in treatment.

CLINICAL EXAMPLES

Some clinical examples that use shame as a direct focus of treatment and understanding will follow. These examples are drawn from the clinical practice of the author at the Partial Hospital Division of the Department of Psychiatry at the University of New Mexico. Within that program two therapeutic communities provide milieu treatment and individual therapy to patients needing intensive outpatient treatment. One unit consists of a short-term, twelve-week program that serves higher-functioning patients. Approximately 20 percent of these patients have a psychotic diagnosis. The other program offers long-term treatment and approximately 80 percent of these patients have a psychotic diagnosis.

The clinical examples presented here concern schizophrenic patients treated in these two programs. Two major categories of schizophrenia will be presented: the paranoid and the catatonic. The process of shame is viewed as being different in each of these two subcategories, although both diagnostic categories obviously overlap. The paranoid patients are characterized by bypassed shame descriptors, with catatonic patients having more of the characteristics of overt unidentified shame, described by Lewis.

The overtly paranoid patient is often concerned with issues of blame and persecution. This feeling is perceived as an active process being directed at the patient by others. The role of the other is often paramount in such thinking, which is most often interpreted as a defense involving denial and projection. Another interpretation may be made using shame as the active dynamic. In bypassed shame, the self becomes concerned about the thoughts of the other and the valuation of the self by the other. A sense of loss of the self occurs with resultant feelings of being "strange" or feeling "funny." These feelings are often caught up in concerns about how the other views the self. Retaliatory rage is often more overt in bypassed shame and is often focused on the concern about the other. The retaliatory fantasies can be expressed as accusations against or from the other.

In the paranoid patient, concern about the other and the other's view of the self is often clear. Erikson emphasizes the role of exposure in shame. The self is felt to be overexposed but with an unwillingness or resistance to be exposed at all. The eyes of the
other become the instruments of exposure. It is well known that the paranoid often produces fantasies of “eyes” and speaks of a “watcher.” This presents the paranoid as an intensely self-conscious individual concerned about somehow being violently and unwillingly exposed to the overly powerful view of the other.

When the paranoid is viewed as a highly self-conscious individual, the hypothesis of projection becomes less relevant. When viewing the individual in an acute state of discomfort brought on by shameful exposure, a therapist’s responses to the patient can be more immediate and perhaps closer to the patient’s actual experience of his interpersonal contacts. His accusations come from the retaliatory response coupled with the self-conscious and painful experience of the self as significantly diminished and with autonomy disrupted.

The following clinical summary is from the treatment of a thirty-two-year-old paranoid woman who was seen individually by the author because her continual caustic accusations toward other patients threatened their security within the milieu. She spent considerable time finding fault with others and accusing them—either directly or indirectly—of somehow being inferior. In individual sessions she was obviously anxious and uncomfortable. She moved about the room from seat to seat in an abrupt, impulsive manner for no apparent reason. Discussion was directed to her feelings in the meetings rather than to her problems in the community. She was able to identify her own discomfort and to state that she thought she had been brought into the meetings to be berated for her behavior in the community. She began to reveal her fears about how she was seen by the therapist. “You are probably looking at my socks and thinking that I probably think that I am a man.” She was then asked if she felt self-conscious in the presence of others. With this she relaxed somewhat and asked the therapist to explain what self-consciousness meant. She became active in discussing this and identified her feelings of exposure that included many primary process ideations. Since that time she has continued to be accusatory toward others but has also become willing and able to stop this process and to identify her feelings with the aid of therapists, rather than to continue accusing others about that which she perceives to be making her uncomfortable. The circumstances that lead to her accusations always involved such shaming events as feeling excluded, shunned, or being sexually attracted to unavailable men. As she has become more aware of her fears of being rejected and exposed, she has become more involved in the milieu and her appearance has become less eccentric. She has received less rejection as a result.

The second case involves a twenty-four-year-old man who steadfastly refused medication because it would define him as schizophrenic. He struggled with his intense anxiety and expressed feelings that were clearly paranoid. He described a mountain retreat as the only place that he could find peace of mind. These retreats were always made alone and he talked of a dream in which he could live alone and “live off the land.” On his return from these retreats, his peaceful state was disrupted by the temptation to stop and make a purchase at a grocery store or the need to buy gasoline. He began to feel that the attendants were viewing him with hostility and were waiting to accuse him of theft. He then began to have retaliatory thoughts toward them. He described such an incident
in which he delayed stopping for gas as long as possible. When it became imperative to do so, he was in a state of near-panic. After describing this he began to make self-recriminations about how he must be either very sick or morally corrupt. Because he attempted always to be good and not impose on others he wondered how he could be the despicable person he believed himself to be.

This patient was asked to consider the possibility of his own self-consciousness. His discomfort was thought to have begun when he first thought of presenting himself to another. When he recalled his experience at this stage, he was able to speak of his feelings of exposure that seemed to him irrational and over-determined. He was helped to consider at length the reason person at the gas station and the view that person would have of a customer. Eventually the patient was able to laugh at the development of his paranoid ideations and began to label them as such. This was discouraged because paranoia was a sickness to him. He was instead directed to consider his active self-consciousness and how this allowed his thoughts of others to take over. His shamed sense of self as unworthy, ugly, and revolting always contaminated his sense of how others viewed him. He gradually became able to identify his self-consciousness before an entire process took effect.

The dilemma of the catatonic patient in relation to shame fits best with the description by Lewis of overt but unidentified shame. In this situation the painful feelings of shame are experienced as low self-regard, overt shyness, ineptness, passivity, helplessness, and worthlessness. The self is fused with what is experienced as the critical blaming attitude of the other toward the self. The self accepts this criticism without question. The humiliated fury is almost entirely directed back onto the self. The experience of rage toward the other is virtually intolerable. R.D. Laing [6] described shame as an implosion of the self. The gestures and attitude of this implosion include the head bowed, closed eyes, and the body curved in on itself. While this does not describe the classic catatonic posture, many catatonic patients who are not fully withdrawn do sit for hours in such a posture. This posture betrays their inner feelings of dejection, forlornness, and their wish to be overlooked. A variation of the above is the posture of properness, which suggests that the individual is only doing what is expected and nothing else. This posture creates the illusion for the patient that he will not be called upon nor will he be called to task. Beneath this illusion is the hope that a more painful self-experience will not be aroused and that the other will not disturb the patient with critical remarks or with scorn. The following briefly describes such a case.

A young man of twenty-three was admitted to the long-term community program after two years of untreated illness. He spent long hours sitting alone, appearing dejected, and was minimally responsive to verbal interactions. He attempted to comply with the activities of the program but remained nearly mute. He did not respond to milieu therapy, neuroleptics, or family involvement. During individual therapy, which was conducted in short, frequent, and private sessions, he was initially mute except for simple, compliant answers. This behavior began to change when he was asked if he felt ashamed. He responded to this question with his first spontaneous remarks. He explained
that he constantly felt he was guilty of a terrible but unknown sin and condemned. He felt beyond redemption. He was asked to consider that rather than being guilty of some transgression that was unknown, he felt ashamed and that this caused him to feel as if he were a sinner. He struggled with this idea and eventually was able to express more of his inner feelings. He formed a true bond with the therapist, however, only after she shared a similar experience of her own shame. This identification produced a marked excitement in the patient and the first true affectual change observed in him. The possibility that another person shared his experience produced a change and created a bond. He was no longer with a condemning other but, rather, he was with another who could identify with the shamed self.

This bonding produced an unexpected reaction that was a further expression of his constant struggle with shame. He developed an extreme facial grimace that was noted to be present much of the time in therapy and in the community. He maintained his increased energy and involvement in the program but this bizarre gesture created concern among the staff, including the therapist. It was thought that the grimace was an extrapyramidal side effect of his medication. The dynamic significance of the gesture, however, was discovered because it so clearly coincided with his change toward others. The grimace was considered from the interpretation offered by Fromm-Reichmann that such stereotyped gestures are attempts to conceal positive feelings and an interest in the other person. As this grimace was studied, it became clear that it was an exaggerated yawn. It appeared that the patient’s eyes were closed and that he was ultimately disinterested. This was a disguise for exactly the opposite attitude. From behind this facade he was carefully scrutinizing the reactions of others toward him. When this fact was recognized by the therapist, a conscious effort was made not to look at him with concern in regard to his very strange appearance. These looks were only reinforcing his fear that others were looking at him critically and with disdain. In addition, time was provided during the individual sessions when the therapist intentionally averted her eyes so that he could observe her unnoticed, thus decreasing his anxiety in his shamed state.

Over the course of a year of therapy, the patient has given up his grimace, although he refuses to wear glasses (despite a rather severe myopia) because he fears the looks of others. He has begun to relate very personal issues about his family, his sexual concerns, and his feelings about himself in treatment sessions. While he still continues to have marked problems, he is actively engaged in therapy that continues to be focused on his perpetual experience of himself as a shamed individual.

**SUMMARY**

Shame is a universal human experience. The power of shame for an individual can be overwhelming and long-lasting. In the highly sensitive schizophrenic patient, shame events are frequent and need the close attention of the therapist in the treatment of these individuals. The chronic state of shame postulated to be a major identification of the self in schizophrenics may relate to many of their symptoms and reactions.

Because shame is a universal experience, the use of a focus of shame in therapy can help to minimize the overuse of theory in relating to patients and to provide definitions of a “normal human experience” rather than pathologically defined concepts.
Shame is inevitable in interpersonal relationships. The sequelae of shame can be minimized by identifying and addressing them. For the highly sensitive patient, this technique is important so that therapy does not become an additional source of shame.

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