Chapter 8

The Shame Experiences Of the Analyst

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In a recently published paper, Fonagy and Target (1995) tell us of a patient with a congenital deformity of the spine, who, unkempt, unshaven, and dirty, declined with contempt any help from the analyst, while at the same time asking for it, and sneeringly rejected an interpretation involving his dependency on the latter. This patient started an analytic session by suddenly taking off his shirt to reveal his deformed back, leaving it exposed for the entire session. "I felt revulsion, confusion, and then shame," writes Fonagy (p. 489). His comments about the patient's attempt to preempt his anxiety of rejection "by trying to control the feelings of those around him" (p. 489) met with derision, although Fonagy sensed that his interpretation had been true; the patient, however, refused to accept the analyst's empathy with "the sense of injustice and hurt which seemed to drive his bitter hatred." But then Fonagy (1995) had the idea of telling him: "It seems that you feel safer when someone is uncomfortable" (p. 489). "To this the patient readily agreed," writes Fonagy (1995, p. 489).

This is one of the few mentions in the literature of a shame experience of the analyst, which is, however, not further discussed. I think that precisely at the moment that Fonagy sensed more directly the patient's

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different varieties of the shame experiences of the analyst are presented and discussed and illustrated with the help of clinical material: two object-related types of shame, namely resonant shame and introjected (or vicarious) shame, and two self-directed types, namely shame of lack and shame of excess, are described. It is further suggested that changes in the analyst's position make for a different relationship of the analyst to her shame in interesting ways.

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function and its links with shame. I shall then attempt to point to some reasons why the shame experience of the analyst has not been discussed until now, adumbrating the analyst's changed position as a major factor responsible for this state of affairs. In presenting some varieties of the analyst's possible shame experiences, I shall begin with two types of shame, which derive from the intersubjective interaction between the two analytic partners.

THE ANALYST'S RESONANT SHAME

There are situations where the contemporary analyst, less invisible and freer than the classical analyst, with all her lesser susceptibility to shame and with her greater freedom, as I shall try to show later, may resonate with the patient's shame so powerfully, may feel the reverberations of this particular kind of pain that wants to hide, as to consciously or unconsciously feel ashamed and embarassed herself. The contagious quality of shame may then shift the analyst's attention from containing and "metabolizing" the patient's experience, toward withdrawing into her own feelings of guilt and shame about witnessing the patient's shamed feelings and gestures. Or the analyst may unconsciously altogether block feeling any shame, with its potentially paralyzing threat and eventual spiraling into resourcelessness. The patient, on his part, may wish not to embarass his analyst, and thus both patient and analyst may collude in not recognizing or misrecognizing painful aspects of their actual, mutual experience (Lewis, 1971). In this way, shame is probably one of the principal factors contributing to the analyst–patient collusions, because in the case of shame, the comfort one usually gets from sharing feelings does not apply. This is a specific feature of shame: recognizing and resonating with the other's shame feelings can be embarrassing and painful. Sometimes silence is the most empathic route; at other times, suitable words have to be found in an effort not to withdraw in the face of the patient's shame and help him with it. Lawrence Friedman (1992) convincingly, though indirectly, touches on how the analyst's dispassionate attitude toward the patient's most painful passionate (embarrassing) feelings and acts strongly impresses the patient (p. 12). I read Friedman as saying that the analyst's calmness and her nonjudgmental attitude in the face of delicate, shameful feelings can put an end to the mutual reverberations of shame. Such an inner attitude, where the analyst is both immersed in the patient's experience and overcomes it, presupposes maturity and freedom from shame, which the patient will sense and usually experience as helpful with his own shame. It is in the context of the resonating and amplifying power of shame that we can read Freud's admission that he could not bear being looked at by his

WHY THE ANALYST'S SHAME IS NOT DISCUSSED

With recent attention to the analyst's emotional responsiveness, it is surprising that the literature on the shame of the analyst is practically nonexistent. There are no descriptions of how it feels for us analysts to really be proven wrong, of the subtle discomfort we feel when we sound off track, of the apprehension and anxiety in appearing ignorant or mistaken, and of having to grope occasionally for the right words, metaphors, and intuitions, only to be corrected by the patient. Even though there are numerous recent essays and books on shame, products of the intense interest sparked lately by this affect, shame has not found its way to metapsychology or to other nuclear psychodynamic explanations, in contrast to the affects of anxiety and guilt that have always held a basic and constitutive role in psychoanalytic theory. Kohut's theorizing is in some sense an exception, and when he could overcome his discomfort and shame when being reprimanded and chastized by Miss F, he gave birth to his groundbreaking theory. Another recent exception is Andrew Morrison's (1994) recent paper. In addition to the difficulties in grasping this complex and sometimes paradoxical affect, an affect that can arouse the desire to hide or to be angry and attack, an affect that is a central regulator of all other affects and that involves the whole self, there are the emotional dynamics of the analyst who experiences such an affect, dynamics that have impeded analytic attention from being granted to the analyst's shame.

Sandor Ferenczi wrote that "we analysts must admit to ourselves that we are much indebted to our patients for their sharply critical view of us, especially when we promote their development, which helps us gain considerable insight regarding . . . our own character" (in Dupont, 1988, p. 26). Ferenczi, writes Anthony Bass (1993), "came to realize that stalled analyses often foundered on the shoals of the analyst's own artificiality of behavior, his feigned friendliness, part of a posture or facade intended to mask or deny countertransferential feelings and responses *at odds with the analyst's preferred self-image*" (p. 155, italics added). Bass mentions Wolstein (1992), who wrote that "the psychoanalyst may . . . adopt a professional attitude of expertise—attitudinalize, so to say, a therapeutic facade . . . but . . . a patient's capacity to perceive the unconscious psychic experience of others, including the psychoanalyst, does not shut down by virtue of taking the socially defined role of patient" (pp. 185–186). Hoffman (1983) writes that the idea of patient and analyst generating plausible hypotheses about each other makes the analyst more aware not only of her actual impact on the patient, but also of the contrast between this impact and her imagined, wished-for stance—and the impressions it generates.

Case B is an example communicated to me by a colleague. From the beginning of her treatment, this patient started a kind of "exposure contest" with her therapist, where she would inquire, spy, and pry upon her analyst's whereabouts. This narcissistically disturbed woman who felt overly shamed and humiliated by the analytic procedure, reacted by intruding upon her analyst's life in the same way she felt the analyst had done to her. The analyst would at such moments feel unpleasantly surprised and invaded, and gradually she became aware of feeling increasingly embarrassed and ashamed. In the concrete words of this colleague: "It is as if such a patient were saying, "You are my analyst, therefore I am entitled to get into everything that is yours, even into your pants.'" The analyst felt, like one may typically feel in such cases, a blend of revulsion, of being coerced against her will, of helplessness, and of being titillatingly manipulated and frustrated, all of these reactions leading to shame feelings.

The countertransference to perverse enactments or even to the (always enactive) descriptions of perverse scenes is typically that of a listener or spectator who is being coerced to participantly witness a vicariously shaming scene or event and being made to feel the shame that should be normally involved. The analyst then experiences what may metaphorically be called the "missing" shame of the patient, the shame the perverse patient "should" experience but fails to when he degrades and desecrates himself, often projecting it into the analyst by his arrogant and devaluatory attitude. "Witnessing such a scene [the prototypical perverse scene in which humiliation is used for achieving control]," writes Nathanson (1992), "we tend to avert our own gaze and cry out our wish that the protagonist be shielded from our view" (p. 318). It is intriguing to note that with perverts we may be ashamed both of their excess and shamelessness, and of the image they create of us as limited, "square," ridiculously naive, lacking—in sophistication, wit, or glamor. The analyst who receives the pervert's gaze feels shame by being looked at in this way. In my experience, such enactments and feelings are particularly likely to happen with perverse patients, who characteristically tend to evince high degrees of shamelessness (Khan, 1979; Bonnet, 1981; Chasseguet-Smirgel, 1984). When we are coerced and enmeshed into an enactment of a perverse relationship, we have to bear and carry the patient who abandons shame that is felt as threatening to his self. Perversity is the refusal of differentiation, a struggle against boundaries (the pervert does not experience and use shame to maintain limits); it is the abnegating of the experience of the other person as separate and as entitled to his own privacy.

The two apparently contradictory situations, that of resonant shame and that of perverse shamelessness, point to an interesting

THE ANALYST AS SELFOBJECT, THE USE OF THE OBJECT

It is arguable that the potential for shame may provide one sort of answer when we ask ourselves what draws us as analysts to fulfill our patients' selfobject needs. What (in addition to our competence-seeking work ego and our reparative commitments) makes it so attractive, so deeply moving (at least for some types of analysts), to be prepared to steadfastly mirror some of the most "absurd" or "extravagant" needs of our narcissistic patients? Why should the analyst desire to serve and be used as a selfobject (provided it is something different than the echoes of masochistic submission, analytic grandiosity, and rescue fantasies)? Is it only to assuage our own sense of loneliness by deeply connecting, immersing ourselves and merging with another human's inner world, and identifying with the empathic reception we are giving him? May it not also be that the attracting power of this therapeutic activity for analysts lies in the fact that by following, by "shadowing," the patient with sensitive dedication, we in a sense fulfill a longing to shed our occasionally burdensome selves and identities (cf., Lichtenstein, 1977, p. 187) and, thus, to protect ourselves against the pains and errors born of our initiative and difference? May we not be nourishing the fantasy that, by being empathically immersed in the patient's experiential world, we can spare ourselves our own exposure, our coming forth and showing ourselves in our naked individuality, and that, moreover, we can enjoy the opportunity given to us of making good our strayings from the patient's inner perceptual rules by the clarification of our empathic failures with him? In this sense, being an analytic selfobject is holding on to a banister, a support; it is molding oneself according to the shape and contours of the selfobject needed by the patient.

Some take this even further (as have done Ferenczi and Winnicott, each in his own way) and have added the context of being prepared to be "used." Here we are talking of giving ourselves over, in a sense, so the patient can use those of our functions that he needs for his own growth (Bollas, 1987). There is something pleasurable as well as embarrassing in being used. Perhaps it is embarrassing because it is pleasurable, the pleasure deriving from the temptation inherent in giving oneself over and faithfully following the other's intimate movements and strivings—as if, in a sense, giving up the right to have one's embarrassment existent and active.

There are analysts who are particularly sensitive, and sometimes actually embarrassed, when the patient needs them to express happy recognition of his achievements or warm or enthusiastic reception of some of his experiences or even claims. They may feel that their

narratives, and transference fantasies. On the other hand, as shame is a means of regulating excitement when the analyst's excitement cannot be controlled and modulated "naturally"; that is, in case the analyst cannot contain disruptive affects, her (conscious or unconscious) shame might help her modulate or suppress these feelings rather than act them out and harm analytic developments. In this sense, shame in its mature and subtle forms is a powerful protection that sustains self-respect, dignity, and integrity, and the signal of shame serves these ends. Analytic competence lies in the analyst's becoming clearly aware of her shame and in analyzing and overcoming it to be creatively free to intervene therapeutically and not project it onto the patient, because only when the patient does not get back the projected shame of the analyst can he moderate and mollify his own shame and self-rejection (cf., Speziale-Bagliacca, 1991, p. 31 and Sandler, 1992, p. 196).

SHAME OF EXCESS

The shame the analyst experiences upon realizing she has been too expressive, ardent, or unrestrained; her reserve about the patient's exuberance and idealizations; but also the analyst's feelings of having passed from an intense affective state to a decidedly less intense one (for instance, the intimacy that builds within a session, which suddenly comes to an end when the hour is over) are all instances of what I call "shame of excess."

There is obviously something fearful about excitement for analysts, and we have learned to link spontaneity and excitement with an anti-analytic attitude because of its attributes of arousal, nonreflective directness, and nearness to impulsivity and notions of acting out and loss of professional control. But it is the exquisite blend of spontaneity and reflection that marks the art of analysis. It is the unique combination of deeply thinking and feeling without succumbing to the action tendencies inherent in strong affect that yields psychoanalytic understanding and wisdom.

This latter way in which shame functions, what I have called "shame of excess," is a profoundly important but ignored aspect, which is being now discovered and articulated by many researchers on shame. It has to do with the idea that shame is not necessarily caused by some fault, lack, or negative quality: one can experience searing shame at points of high expectations, excitement, or pleasurable feelings.

Thus, the more the analyst can experience and tolerate such states of excitement without becoming too aroused or anxious, the more she will be able to be in touch with her inner knowledge of herself and of her patient. Kohut (1971) beautifully describes the psychic pain of such a

self-deflation, and Schore (1991) spoke of it as a rapid reduction of interest-excitement, a sudden decrement in mounting pleasure. In Kohutian terminology, shame is related to an empathic break between the mirroring selfobject and the grandiose self. Kohut tapped a process that is ubiquitous and occurs often and mostly automatically, when he spoke of empathic failure as lack of in-tuneness (of the caretaker or analyst to the child or patient) and showed its vicissitudes within narcissistic patients, as well as within everybody. He even spoke of empathic failures as mini-traumata, which replicate, on a smaller scale, "the dedifferentiating influx of unneutralized narcissistic libido" (1971, p. 152). What I would like to add here is that the analyst, too, can at certain moments experience empathic failure of her own toward herself or of her patient toward her and feel ashamed.

Let me illustrate what I have in mind with an event that took place at a party I was attending, where I spotted an ex-patient of mine whom I liked, but whose analysis I estimated to have been not very satisfactory. At the end of this analysis, I had felt that perhaps more could and should have been done to help her. Seeing her, I felt quite interested in her and curious about how she had fared after the analysis. I greeted her and asked her how she was, but as I was addressing her, I somehow realized that my hailing was unwelcome and that she was not reciprocating my interest in her: it was all completely different from what I had expected it to be. At that very moment, I felt my interest in her and even slight enjoyment become embarassing and inappropriate manifestations, my look an unwelcome intrusion, and my greeting a flat movement, left hanging in midair. She did not say a word, but her countenance expressed what I took to be some kind of condescension through which she seemed to wordlessly signal the futility, uselessness, and worthlessness of my query, or so I thought. I did not say anything further, and I remained with this extremely unpleasant experience throughout the evening and remembered it for many weeks. Only months later, upon incidentally meeting her on the street, did we clear up this matter. As I again politely inquired about her well-being, she flippantly replied that I had not seemed so interested when I had asked her the same question last time, so why was I asking now. It soon became clear that she had felt so embarassed by my unexpected presence at the party and my open interest in her that she could not bring herself to say a word: instead, in her discomfort, her face involuntarily became a grimace of shame. It was a tremendous relief for her to learn that my withdrawal after addressing her was not out of indifference to her, but because of the way I had interpreted her wordless answer to my question. With myself, I then wondered what it had been that had not let me see her shame and led me instead to read her response as a shaming gesture toward me. Reflecting upon it, I realized that the part that came from within myself that had contributed to this situation was my self-criticism (partially a result of identifying with her own criticism of herself and of me and partially my own feeling of dissatisfaction with my analytic work with her). As to her part, I realized that what had been misleading me was that the expression of her face did not look like that of an embarrassed adult. It was the face of an openly ashamed child, with one shoulder lifted, eyebrows raised, the mouth pulled down at the corners, the head a little tilted aside, all a blatant and childish expression of shame. Aided by knowledge of my self-doubt about her, I understood it as referring to the same aspect of our past enterprise, the analysis, as the one I had been worried about. I did not realize that the clues of worthlessness her face emitted were directed toward herself. She had been unable to contain her excitement on seeing me, and her facial signs of shame, unexpectedly intense and uncontrolled, were read by me as a gesture of a put-down, as her attempt to communicate that our connection was without value and even contemptible in her eyes. I could not see that this expression referred to her own inner state, to her self-perception and self-image. I could not see that her drooped head (Tomkins [1963] ascribes it to sudden loss of tonus in the neck that is a physiological accompaniment of shame) and the contours of her lips were not signs of dislike, but a sign of the utter shock of her shame of me, who represented for her at that moment, transferentially perhaps, the shaming other. Rather symmetrically, she was for me at the same moment the shaming other, and I felt ashamed by her wordless affect display and ashamed of my unsuspecting directness (and shamelessness). This encounter, brief, but under very loaded circumstances, was enough for both of us to put us into months of unpleasant feelings of being rejected; each of us privately felt, with the sure knowledge of the flash of recognition of a face, a similar feeling that could be dissipated only at a later encounter. A short time afterwards, this woman resumed analysis with me, which this time reached parts of her that had not been accessible in the past.

Thus, we have come a long way from the common-sense, familiar connotation of shame as the reaction to the exposure of something faulty or lacking in oneself. In addition to such "shame of lack" and in addition to shame or lack of shame that is transmitted the way affects are transmitted, through resonance (and attunement) from one person to another, or through projective identification there is shame as shock about exuberance and excess. These different varieties imply different kinds of subtle, delicate balances of intimacy and distance. All interweave with various inner states in the analyst and patient and produce blends of restraint with varying degrees of comfort.

phenomenon, namely that *the danger of collusion, falseness, or impasse is averted if one of the analytic partners experiences shame*: either the patient experiences shame with the analyst managing not to resonate too closely with his shame, or the analyst feels shame, by having to temporarily carry the perverse patient's shame. If both partners feel too ashamed, painful themes will be bypassed, whereas if both partners have no shame, various perverse or narcissistic enactments are likely to happen. Thus, shame is an exquisitely subtle and complex marker of the boundaries between normal and abnormal curiosity and exposure.

In addition to resonant shame and projected shame, which are varieties of the analyst's experience of reverberating, projectively identifying, or containing mental contents of the patient, there are two other, rather self-directed, types of shame experiences of the analyst, namely, shame of lack and shame of excess.

SHAME OF LACK

Shame is usually regarded as awareness of one's lack, failure, or defect. The classical examples are those of the analyst being made to feel aware of her shortcomings, mistakes, or inefficiency.

Since these cases are the most familiar and thought about, I shall go into a more subtle, less articulate, but no less important, phenomenon of shame: shame that regulates surplus of excitement, which has a tendency to be perceived and experienced by the excited person as loss or lack of control. Freud (1905) conceptualized shame as a superego counterforce or reaction formation against overstimulation of the exhibitionistic drives, which has potential ego-disruptive effects. Schore (1991) writes that "shame signals the self system to terminate interest-excitement in whatever has come to its attention" (p. 194). Excitement, as Kohut and contemporary relational theorists say, is not necessarily sexual or sexually derived but is a much broader affect. Spezzano (1993), for instance, says that, given the inevitable uncertainty about the future and the lack of any absolute (foundational) knowledge nowadays, one should regard excitement as the best guide to our actions (p. 157). This broadened psychoanalytic view of excitement makes the affect that deals with excitement, namely shame, a central phenomenon of self-experience. Indeed, Kohut (1971) speaks of defenses against dangerous excitement: excitement that cannot be contained arouses shame to block it. However, if the analyst is inhibited by shame (about the patient's excited erotic transference, for example), she will unconsciously repudiate it and thus be unable to empathically attune to the patient's excitement, fear, and desire and to help put these feelings into words,

balance is threatened. They may feel ashamed either through projective identification (identification with the praise-dependent patient's projections) or because of the feeling that, by expressing recognition of the patient's narcissistic strivings or feelings, they will seem awkward or foolish or become diminished in their own or in their patient's eyes. This, in my experience, accounts for mistakes by omission made by the analyst who lacks the inner freedom to "celebrate" the patient (Bollas, 1989) when it is analytically or therapeutically needed. Such an analyst will instead feel pressured and will unwittingly use her interpretations to ward off this felt pressure. What I am saying is that serving as a selfobject may potentially defend against the analyst's (effortful) responsibility for her individuality and the shame that is liable to follow, but I am also saying that evading functioning as a selfobject for the patient may likewise be a defense and for the same reasons. From the patient's perspective, the analyst's avoidance of "celebrating" him, of recognizing his achievements or qualities, is experienced as a much needed affirmation that is not forthcoming at vulnerable moments. The analyst, who is ashamed to happily or calmly recognize or "celebrate" the patient, is then experienced as censuring and condemningly judgmental, and the outcome of the analyst's withdrawal is that, rather than valuing the differences between self and other and remaining confident and proud, the patient then feels obliged to wipe out this difference by various means (such as narcissistic withdrawal, devaluation, or some of the defensive self states described by Kohut).

Another difficulty analysts may have, as Kohut observed (e.g., 1971, p. 266), is to let the patient admire and idealize them when he needs it, without attempting to interpret it as a defense. Kohut explains it as the analyst's fear of his own grandiosity getting out of hand when stimulated by the patient's idealization of him. I read it as the analyst's fear that the patient's idealization might break through her protective shame barrier. She may consequently redouble her efforts to hold it in check, at the same time reinforcing her shame-rooted avoidance of such interventions. It is as if the analyst feared the danger of believing the patient and forgetting all shame. In other words, the analyst's counterresistance to being idealized may stem from her fear of accepting (introjectively identifying with) and believing both in her aggrandized size and the patient's feeling himself as small, and thereby indeed perceiving him as small and shameful. This is another instance of how the unworked-through, excessive shame of the analyst, resulting from insufficiently integrated grandiosity and narcissistic devaluatory tendencies, tendencies that need and "absorb" shame for their regulation and control, may interfere with therapeutic work.

patients 8 hours a day (in Schneider, 1987, p. 207). Freud (1915) also said that transference love functions as a resistance to treatment and serves to put the analyst "in painful embarassment" ("*peinliche Verlegenheit*," p. 124). Let me give an example of what I mean by that.

Case A

I had a patient who, at the beginning of his treatment, would come in, sit down, and fix me with a direct, wordless, frozen stare, which lasted for what seemed to me unending moments. I felt extremely uncomfortable and self-conscious, yet I tried not to look away because I had the feeling he needed me to be there for him by looking back at him with a steady, friendly, yet unsmiling look and to sustain my discomfort and embarrassment at being looked at in such a way. All this time, I was trying to figure out, first to myself, and later with him, what his stare meant. I felt like I was being swallowed up by his eyes, almost made into a senseless object, and I was alarmed by his lack of reserve or compunction or feeling of proportion about his rather bizarre stare. After some weeks, he felt secure enough to tell me he stared at me out of great fear, fear that made his eyes glued on to my face—his fear of therapy, of me, and of what we were about to discover in the depths of his soul. It then became clear that what he called his fear was another name for his chronic shame about himself, which he tried to counterphobically overcome by this stare. With time, the intensity of his stare lessened somewhat, and it then assumed a different function: it now expressed his intense need for contact, especially physical contact, and it was his way of feeling in deep touch with me. After much therapeutic work, this stare disappeared or, rather, was transformed into verbalizable recollections, wishes, fantasies, and new emotional experiences. I believe that by my not shying away from his gaze and hiding and by my wordless, concrete mirroring of his excited stare, he was enabled to gradually calm down from his excited fear and be able to reflect about what was happening to him.

A different variety of the analyst's shame is illustrated by Fonagy's example. This is the kind of shame the analyst experiences with perversions; we could name it "counterperverse shame."

THE ANALYST'S SHAME AND PERVERSION

Shame may be experienced by the analyst when she becomes strongly enmeshed in transference–countertransference gambits of certain patients, who may show amazing shamelessness.

SHAME AND THE ANALYST'S NEW POSITION

Now our question becomes more specific: What happens to the analyst's shame feelings in this new, less elevated, less distanced position? Does such a position entail that she will experience more, or less, shame? Apparently, the analyst now is less protected and more exposed to scrutiny, both her own and that of her patient's; she can conceal less embarrassments under so-called neutrality; she can hide less behind the mask of the blank screen; she cannot act any more like the cold, infallible surgeon, who operates upon a patient whose view is taken to be dazed by his own analytic regression. The analyst and her foibles are exposed, often taken into the midst of the analytic discourse and not always dismissed as the patient's tranference, but seen as the patient's occasionally valid perceptions of his analyst. The analyst is more aware of being grasped by the patient, while at the same time being more sharply aware of not knowing what her gesture or interpretation will mean to an individual patient at a particular moment (Schafer, 1983; Hoffman, 1996). Having become aware of this lack of certainty, a great many of us analysts become more humble—even as our experience and accumulated knowledge have increased.

But intriguingly, this humbleness goes hand in hand with more legitimation to be fallible. The analyst's fallibility is being more acknowledged than in the past (cf. Cooper, 1993). No longer occupying such an authoritarian position, the analyst assumedly tends to be more tolerant and less ashamed about exposure of her shortcomings (see Morrison's [1994] beautiful example; other examples are unforeseen events, loss of control, evident mistakes one makes, and certain countertransferential reactions, a central instance of which may be reactions to an erotic transference). When the analyst knows that she is bound to have countertransferential feelings and that it is not inappropriate to experience them, she will feel less ashamed; she will have acquired more degrees of freedom, and a greater range will open for her in the space between acceptable feelings and those she will feel she has to defend against. In short, the "new" analytic position is more revealing and thus more conducive to shame but is at the same time more permissive, even relieving, in that it encompasses the analyst's proneness to error and uncertainty as legitimate and natural aspects of her analytic attitude.

SUMMARY

This chaper addresses varieties of the shame experiences of the analyst, in the wake of the great interest recently shown in the affect of shame as a central regulator of self states and as a marker of boundaries. Four

shame and discomfort and could apprehend and interpret the patient's defense against shame (rather than his dependency or his sense of injustice), the analyst could come empathically near the patient's experience and could find ready acceptance in the patient's heart. Now a clearer picture could emerge: that of "a persecutory, cruel but damaged object (represented by [the patient's] . . . back), and a figure seen as shamed, uncomfortable and weak [which was sometimes the analyst and sometimes the patient]" (p. 489).

In this chapter, I want to discuss some manifestations and consequences of the experience of shame in the analyst. My inspiration for discussing shame came from Kohut's writings and was further supported by the intersubjective approach that takes into account the influence of the observer, the analyst. This approach suggests that the analyst in fact also turns to the patient with selfobject needs (Stolorow and Atwood, 1992, p. 247), although usually in a less archaic form. This growing mutuality of analyst and patient (Aron, 1992, 1996; Casement, 1985, 1990) enlivens our notions about the shame of the analyst, in addition to that of the patient. Recent findings and knowledge gained from developmental research on shame (Schore, 1991; Tyson and Tyson, 1990), which deeply connect with self psychology's view of shame as a response to selfobject nonresponsiveness (rather than as a simple reaction formation against drives), all contribute to an expanded, modified conception of our habitual notions of shame. The perspective of relational theory (e.g., Mitchell, 1988) powerfully informs my approach as well, providing such notions as the need of the patient to have his experience reclaimed and revitalized and his disordered subjectivity healed, and the analyst's knowledge, which is not only about the mind, but which is personal *and* not idiosyncratic. Such knowledge as the analyst has, grounds her beliefs about the patient in her own subjective experience (Mitchell, 1993). And last, the background for this chapter is my longstanding interest in affects (Stein, 1990, 1991, 1993, 1994, 1995, 1996), together with ideas that emerged during work with my patients. In this chapter, therefore, I will suggest that understanding and acknowledging moments of shame in the analyst and discerning their varieties may greatly help us become free to tap new dimensions in our clinical work.

In what follows, I shall present different varieties of the experience of shame in the analyst, which, for heuristic reasons, will be differentiated into four kinds. The first two, which I shall call "resonant shame" and "introjected shame," are the analyst's responses to the patient's shame and shamelessness, respectively, whereas the last two, "shame of lack" and "shame of excess," pertain more to the analyst's self-experience and will be followed by some of my views on the analyst's selfobject

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