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### **Class, Shame and Self-righteousness**

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Eric Berne's departure from psychoanalysis and his development of the theory of transactional analysis constituted a break from the dominant culture of psychoanalysis. The theory of transactional analysis implicitly challenges the dominance and assumption of superiority inherent in psychoanalysis. It does this in several ways; by creating a new language Berne made complex psychological theories accessible to everyone including, in particular, the poor and therefore the working classes, ethnic minorities and women: by linking humanism with a system for understanding Berne enabled the individual to be understood within their own social and historical context (Perlman 1999).

The inclusion of Physis, the 'creative force of nature which makes all things grow in an orderly and "progressive" way (Berne 1971) and the development of the Kleinian (1986) developmental positions to include 'I+U+' as symbolic of a mature integrated grown up state where it is possible to accept one's own and other's limitations without feeling the need to blame, allow for optimism in the area of human relatedness and in particular suggests the potential for human beings to come to terms with difference without interpreting diversity as pathological. So already within transactional analysis we have theoretical models which allow for diversity and health to co-exist. Paradoxically, these very strengths also point to an inherent weakness within transactional analysis and that is that I+U+ can all too easily be used to deny the significance of difference particularly in relation to social discrimination based on class, disability, gender, race and sexuality.

In making unconscious processes so accessible through script, racket and ego state theory Berne maybe unintentionally made it too easy for us to be seduced into the false security of believing that our unconscious processes can be controlled by simply declaring I+U+. In some ways this could be viewed as a type of narcissism where we cannot bear to either acknowledge the existence and certainly not the significance of difference. At worst this could reflect our "culture of narcissism" (Lasch, 1979) in which personal achievement is given an elevated status implying that social inequality is not significant since it can be transcended if we "do our personal work" and choose to make the right redecisions. If we fail to account for the impact of past and present social inequality on our clients' sense of self worth then we are perpetuating the trauma of social discrimination through a process of denial. For the significance of difference to be taken into account we suggest we need a deeper and more involved exploration of the unconscious.

In psychotherapy what we mainly do is listen and seek to understand. The language of the Child can often not be communicated verbally. Stern's (1985) identification of four domains of selves identifies three nonverbal senses of self. If we add cultural diversity to this then the plot thickens! In the following vignette both therapist and Patient (X) are both white and apparently middle class. X however was brought up in a working class background. She tells the therapist of an incident which she knows happened when she was one year old but cannot remember.

### **God Save Our Gracious Queen!**

**X:** "My parents came to collect me from hospital but I did not recognise them. I just sat between them sighing (sounds sad and a little lost)....I had lost them forever..."

**Therapist:** "That little baby, sitting there, feeling lost and hurt, sitting in the car between her mummy and daddy but not knowing that they were her mummy and daddy."

In this vignette the therapist was empathically attuned to her patient's emotional state. She used her own background to project onto X what the material circumstances would have been and so interjected the idea of a car which had not been mentioned by X. Upon hearing the word "car" X froze and felt embarrassed. Her family of origin had never owned a car and her parents could not drive. That the therapist believed they had had a car felt like a confirmation that there was something shameful and bad about them. She did not want to disabuse the therapist of her view of her as the type of person who came from a family who would have naturally owned a car: who were 'naturally' therefore of value. She felt paralysed by a sense of shame and confusion. In this way her position of feeling one down was subtly reinforced by the therapy and something authentic and true about her life history was denied; therefore something authentic and true about who she was as a person could not really come into the therapy. The therapist had tapped into X's sense of loss of self (Ao) (Hargaden & Sills 1999). However, upon hearing the word "car" in this context, X was reminded that there was something shameful about who she really was and 'froze'; there is a sense of an emotional state being put back into cold storage. X felt herself to be of value when reflecting the therapist's image of her (A1+) (Hargaden & Sills 1999) hence her confusion about feeling shame and rejection in the part of herself where she had an uncertain sense of self (Ao). These feelings probably evolved from the sense of loss and abandonment in the original hospital incident where we can imagine that she took the early developmental position of I-U+ and felt a sense of inferiority which had then been reinforced by class as she grew up and in this instance was symbolised through the word "car". She responded mutely to the therapist resuming her presentation of "I will be who you want me to be" (A1+) and let go of "who I really feel myself to be" (Ao) because it is too shameful.

We are culture bound by our own assumptions; even in an attempt to understand someone else we will translate that into our own language and understanding which then can make it into something it is not and mean that we lose contact with our patient. Why did the therapist decide that X had travelled in a car? Was it that she could not imagine difference in her patient? Did she at that moment unthinkingly project her Child onto X? Did she act out of the countertransference and collude with X's projected image of herself (A1+) through the process of projective identification as specifically developed by Ogden (1991)? This could be a possible interpretation as X had often been told that she appeared rather aloof and superior, that in the hospital as a baby she had been referred to as "the little queen" because of her propensity to stand at the end of her cot with her nose in the air ignoring people. Was the therapist unwittingly tapping into this primitive notion of assumed superiority (A1+)? After all a Queen would never travel by public transport - would she?

In this vignette the theme of class emerges as a rupture within the therapeutic relationship manifest in the clients experience of shame in relation to her working class background. Erskine (1994) summarises shame as:

"a complex process involving:

- 1) a diminished self-concept, a lowering of one's self-worth in compliance with the external humiliation and/or introjected criticism;
- 2) a defensive transposition of sadness and fear; and
- 3) a disavowal of anger."

He goes on to suggest that, "This self-protective lowering of worth is observable among wild animals when one animal crouches in the presence of another to avoid attack and to guarantee acceptance". It is not surprising that class themes emerge in the therapeutic relationship as a microcosmic reflection of class stratified culture along with its explicit and implicit hierarchy. The therapeutic

relationship then becomes a fulcrum in which the spectrum of experience related to class phenomena will be co-created (Summers and Tudor, 2000). How do we begin to acknowledge and explore these processes which are highly significant in our development of self-in-the-world?

This vignette also contains reference to "superiority" - an attitude that Erskine suggests is a defence against shame: "The person fantasises value for himself or herself, often by finding fault with others and then losing awareness of the need for the other". Snobbery and "inverted snobbery" are terms that are often used to describe self-righteous attitudes in relation to social class. How might such attitudes and associated feelings manifest in the therapy from both therapist and client? What relevance might these attitudes have in the healing process?

Given the professional status of psychotherapy and its largely middle-class origins the projection of middle-class experience onto the client in the above example is understandable. Karney (1996) suggests a number of ways in which working class experience may be relevant to the counselling situation. Working class families (including extended family) tend to be geographically closer and mother-daughter contact more frequent and practically interdependent than in middle class families. Couples tend to have more gender differentiated family roles than their middle class counterparts. People tend to speak in less elaborate ways and with a more restricted vocabulary. Poverty and poor health is more prevalent among working class people, both of which carry social stigma particularly when contrasted with our healthy and wealthy media ideals.

So what might it mean for a working class person to meet a middle class therapist? What might it mean for a therapist and client who have similar or different class backgrounds? What does this mean for the physical setting in which we practice therapy or counselling? Do we ignore class difference, minimise it, or enact it? Do we acknowledge it and explore it as a significant

aspect of our past and present sense of self? What do you think, feel or do about these themes either as a therapist or a client?

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