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Shame and Guilt: Psychodynamic Foundations and Clinical Manifestations in Outpatient Practice

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ABSTRACT – This psychodynamic paper examines the metapsychological differentiation and early childhood genesis of shame and guilt. While a mature sense of guilt represents a conflict between the Ego and the Superego, shame affects the global self-image, often arising from a painful discrepancy between the real self and the perfectionistic demands of the Ego-Ideal. This theoretical paper utilizes a clinical case vignette of a 53-year-old patient to illustrate how these dense intrapsychic dynamics can manifest in outpatient practice through psychosomatic somatization and delinquent behavior. Modified treatment techniques for the outpatient setting are discussed, highlighting a holding, non-judgmental therapeutic relationship. Furthermore, it is demonstrated how these phenomena can be understood complementarily from the secondary conceptual lens of Alfred Adler's individual psychology as goal-directed arrangements.

Keywords:
Shame; Guilt; Metapsychology; Psychosomatics; Outpatient Psychodynamic Psychotherapy; Individual Psychology

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Introduction

Background of the Problem

In clinical practice, shame and guilt present themselves as deeply rooted affect constellations that can impair self-esteem and relational patterns. While functional shame protects intimate boundaries and healthy guilt regulates social interaction, their dysfunctional variants tend to deeply affect the experience of one's own identity. Affected individuals often no longer perceive themselves as guilty only in relation to a specific action but tend to view their entire existence as fundamentally inadequate or flawed. Although these differences are clinically evident, shame and guilt are frequently not sufficiently differentiated from one another in the literature and traditional diagnostics (Lewis, 1971; Wurmser, 2011).

Research Interest

The aim of this paper is to first differentiate the two affect structures from a metapsychological perspective and investigate their origins in early childhood. Building on this, a detailed, theory-guided

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psychodynamic clinical vignette of a 53-year-old patient is integrated to illustrate how the chronification of these dynamics in adulthood may contribute to permanent structural deficits. By shifting the focus away from an empirical-qualitative framework, this paper aims to provide a dense theoretical discussion on how these pathogenic patterns can potentially manifest through psychosomatic somatization and delinquent behavior. Finally, the specific therapeutic stance required in an outpatient setting to resolve the pathological shame-guilt cycle within the therapeutic process is examined, using the individual psychology of Alfred Adler as a secondary, complementary conceptual lens.

Theoretical Framework: The Metapsychology of Shame and Guilt

Structural and Conflict Differentiation

Guilt

Metapsychologically, guilt arises from a structural tension between the Ego and the Superego (Freud, 1923; Hirsch, 2022). It reflects the inner conflict that occurs when a behavior or an unconscious instinctual wish violates the moral prohibitions internalized from early caregivers. According to classical psychoanalytic theory (Freud, 1923), neurotic feelings of guilt result from aggressive or libidinal impulses during early childhood drive development. These impulses are internalized and directed against the subject as soon as the Ego violates the boundaries of the Superego.

Phenomenologically, the focus of guilt remains fixed on a concrete act or cognition (Lewis, 1971). The individual experiences themselves as flawed because of what they have done or intend to do ("I have failed"). On an intersubjective level, a mature feeling of guilt fulfills a vital relational function: it generates a psychological urge to make amends in order to protect the inner balance and the relationship with the real object (Piers & Singer, 1953; Tiedemann, 2007).

Shame

While guilt relates to a concrete action, shame affects the entire person; it evaluates self-worth rather than behavior (Lewis, 1971; Nathanson, 1992). Shame is shaped by the painful gap between the real self and the perfectionistic demands of the Ego-Ideal (Seidler, 1995; Wurmser, 2011). Although the Ego-Ideal forms an integral part of the Superego, its dynamic differs fundamentally from its punishing function: while the purely moral authority of the Superego primarily operates through condemnation and repressive threats of punishment, the function of the Ego-Ideal responds to the failure of its claims to omnipotence and perfection with withdrawal of love, existential contempt, and the threat of social isolation.

Shame resembles an acute narcissistic crisis (Kohut, 1971). In the presence of a real or internalized observer, the individual feels fundamentally deficient and exposed (Tiedemann, 2010). This conflict moves dialectically between the desire for visibility and recognition on the one hand, and the traumatic experience of being exposed on the other (Wurmser, 2011). To prevent an impending fragmentation of the Ego, the psyche resorts to more primitive forms of defense: these manifest as hiding, social flight, shame-rage, or the transformation of psychological pain into somatic symptoms (Nathanson, 1992).

In summary, the metapsychological model conceptualized in this paper strictly relies on structural psychoanalytic drive and ego psychology, fundamentally operating on a vertical intrapsychic axis (Freud, 1923; Hartmann, 1939). It differentiates structural tensions within the tripartite psychic apparatus: guilt is modeled as a direct conflict between the Ego and the moral, punitive authority of the Superego, whereas shame is defined as a narcissistic crisis stemming from the painful discrepancy between the real Self and the perfectionistic, omnipotent demands of the Ego-Ideal (Freud, 1923; Kohut, 1971; Wurmser, 2011). This framework consciously avoids broader, popularized interpersonal definitions of these affect structures by anchoring them strictly within structural deficits of self-regulation and internalized object relations.

Intersubjective Genesis in Childhood

The Development of Shame Dynamics

Early childhood interaction experiences form the foundation of psychological structuring. If parental resonance is lacking, blocked emotional impulses can progressively solidify into permanent structural deficits (Bradshaw, 1988). At the center of pathogenic shame conflicts is a chronic lack of emotional mirroring. When primary caregivers react to the infant's archaic narcissistic needs and basic affects with emotional withdrawal, devaluation, or open rejection, the child internalizes these dysfunctional reactions (Heller & LaPierre, 2012). As a result, the affected affect loses its inherent regulatory function and manifests as chronic shame symptomatology. This permanently impairs the fragile self-esteem and can lead to profound structural disorders, such as the formation of a False Self (Winnicott, 1960).

The Genesis of Guilt

Pathological feelings of guilt tend to evade functional, relieving reparation (Hirsch, 2022). In psychodynamic literature, this is frequently linked to an unconscious transgenerational delegation. Only in the context of parental parentification, the child may assume co-responsibility for the psychological stability of dysfunctional caregivers. The inevitable failure to cope with this structural overtaxing can foster the development of a deep guilt structure, which can persist into adulthood as an unconscious tendency toward self-punishment.

Clinical Case Vignette: Between Existential Exposure and Unconscious Enactment of Punishment

Anamnesis and Relational Dynamics

The 53-year-old patient, Mr. S., has worked for 15 years as a trained industrial clerk in the billing department of a medium-sized logistics company. The reason for therapeutic treatment was an acute conflict with his new department head (“bossing” or “bullying”), which severely worsened latent depressive symptoms and diffuse anxiety states. The patient suffers from urinary incontinence and therefore has to visit the restroom more frequently during the office routine. These restroom visits were meticulously documented and clearly criticized in frequency and duration by the new department head. Mr. S. felt highly pressured and humiliated by his superior as a result.

After a particularly sharp reprimand, he used the central department printer to print out a comprehensive, private manuscript in large quantities. Since Mr. S. carried out the act in a highly dilettantish manner, over hours, and within the direct line of sight of his supervisor, the internalized maternal introject—viewed psychodynamically—appears to have influenced the real external sanction. Consequently, he was caught and summarily dismissed due to the unauthorized misuse of company resources and intentional time fraud. According to the patient, the act did not stem primarily from economic benefit but was presumably based more on an unconscious dynamic of revenge and retaliation shifted onto a substitute object. The offense seemingly activated an already existing, introjected guilt structure. The real act can be interpreted as having transferred the previously diffuse, unconscious guilt into a concrete, factual situation, which may have temporarily relieved the Superego. The Superego is relieved because a real, tangible punishment is psychologically easier to bear than an unconscious, unendurable guilt.

Biographically, the patient grew up in a rigid, religiously and morally heavily determined family system. Variations from maternal norms regarding order and "absolute honesty" were frequently punished with several days of maternal withdrawal of love and icy silence. Early on, Mr. S. assumed the role of the family scapegoat to stabilize the unstable, depressively dominant state of his mother and to secure the vital object tie. This dynamic continued into adulthood: for years, he cared for his chronically ill life partner against the devaluing protest of his mother. The sudden death of his partner three years ago left a traumatic void and reactivated his introjected guilt structure through severe self-reproach.

Psychodynamic Diagnostics (according to OPD-3)

To provide a relatively objective assessment of the patient's intrapsychic functioning, psychodynamic diagnostics were structured using the Operationalized Psychodynamic Diagnostics manual (OPD-3 Task Force, 2023). The OPD-3 represents a multiaxial diagnostic system widely utilized in academic and clinical circles to operationalize psychodynamic constructs. For this single-case illustration, the diagnoses across the axes were derived retrospectively via comprehensive clinician impressions and a structural evaluation of the extensive clinical material from the outpatient therapy sessions, rather than conducting a standardized semi-structured diagnostic interview.

Axis I (Experience of Illness and Prerequisites for Treatment)

High subjective suffering, accompanied by a pronounced ambivalence toward therapeutic closeness. Dependency is directly linked to the fear of emotional submission and exposure.

Axis II (Relationship)

Patient's Perspective. Due to his biographical shaping, Mr. S. primarily anticipates a devaluing, controlling, and morally judging stance from the therapist. This negative expectation reflects a classic transference occurrence, in which the maternal introject is projected onto the current treatment situation.

Therapist's Countertransference. Within the therapeutic interaction, this constellation induces a pronounced countertransference tension containing both concordant and complementary features. In the transference process, the therapist experiences massive projective pressure to assume the role of a punishing, judging authority. Simultaneously, this dynamic is overlaid by a defensive counter-impulse, which manifests in excessive clinical caution and a tendency toward overprotection.

Therapeutic Resolution. This dynamic requires consistent containment, the preservation of careful neutrality, and strict avoidance of complementary acting out. By consciously holding these impulses and utilizing targeted metacommunication, the therapist signals a refusal to engage in the reenacted perpetrator-victim role, allowing the patient a corrective relational experience within a safe framework.

Axis III (Conflict)

Predominance of the conflict between self-worth versus object-worth in the passive mode (collapse of self-worth upon disappointment by the object). Secondarily, a neurotic submission-versus-control conflict is apparent.

Axis IV (Structure)

Moderate level of integration with temporary tendencies toward disintegration during intense affect storms (especially shame-rage dilemmas). Structural vulnerabilities manifest primarily in the area of self-regulation, expressed by reduced affect tolerance and the inability to psychologically represent vital aggressive impulses without fearing an acute fragmentation of the self-image.

Psychosomatic Somatization

The structural vulnerability of Mr. S. appears to enter into a close functional alliance with recognizable physical symptoms. He suffers from mild urinary incontinence. This reportedly tends to manifest primarily in moments when the Ego is flooded by shame affects and psychological defense seems to fail. A key event illustrates this dynamic: after being forced by his department head to sign an unjustified target agreement, he suffered acute urinary incontinence in the hallway of the office building. The subsequent meticulous logging of his restroom breaks by the supervisor acted like a psychosocial trauma that reactivated childhood condemnation.

The Therapeutic Process in the Acute Crisis

Delinquent Acting Out and the Unconscious Search for Atonement

The summary dismissal of the patient occurred after he was caught by his supervisor misusing the department printer for private purposes on a large scale. Phenomenologically, the offense was characterized by a highly obvious approach, which unconsciously provoked discovery. Psychodynamically, this behavioral escalation was not driven by material gain but served as an act of revenge that primarily operationalized an unconscious need for punishment to relieve an archaic, punishing Superego (Freud, 1924; Hirsch, 2022).

By staging the execution of the act—especially through hours of tampering in the supervisor's direct line of sight—so that failure was guaranteed, the rigid maternal introject forced a real external sanction. This unconscious atonement arrangement brought about a mitigation of the unendurable feeling of guilt.

Modification of the Psychodynamic Treatment Mode

To build a stable alliance and prevent premature termination of therapy, the treatment mode was modified as follows:

- ***Preserving a careful neutrality*:** It was essential to adopt a strict but emotionally present, non-judgmental stance to avoid both moral condemnation and an overly protective, shielding attitude.
- ***Prioritizing validation over confrontation*:** The acute delinquent acting out was consciously not focused on in a moralizing way. Instead, the underlying distress was explored, and the defensive behavior was respected as a necessary defense.
- ***Focus on interpersonal affect regulation*:** Through a benevolently inquiring stance, it was signaled to the patient that his destructive impulses would not destroy the therapeutic space, facilitating the internalization of a relieving object.

Outpatient Complementary Interventions and Everyday Transfer

Since clinical group and specialized therapies were not available in the outpatient individual setting, the focus was intentionally placed on therapeutically guided social relational experiences and the utilization of external structural resources:

- ***Relational corrective experiences*:** Through a reflective opening into the real object world (e.g., participation in a guided outpatient self-help group), the patient experienced positive interpersonal feedback instead of the unconsciously anticipated projective rejection. This allowed his Ego-Ideal to gradually distance itself from the merciless demands of maternal introjects.
- ***Mentalization and integration of bodily experiences*:** In the therapeutic process, the patient was encouraged to psychologically regulate his blocked shame-rage dynamic via a flanking external sports program. Working through these bodily experiences promoted the internal representation of vital aggression and sustainably strengthened the patient's structure-related ability to set boundaries.
- ***Fostering affect tolerance and affect integration*:** In therapeutic reflection, the patient learned to reclassify vegetative warning signs. He no longer experienced the psychosomatic urge as a humiliating loss of ego-structural control but interpreted it as a somatic indicator of psychological overload.

Discussion and Limitations

Clinical Implications

The clinical presentation suggests that the patient suffers from chronic, unconscious feelings of guilt resulting from identification with an overly strict mother figure. To potentially relieve this unendurable inner pressure, it is hypothesized that he unconsciously stages his own exposure through the obvious misuse of the department copier in the direct line of sight of his supervisor. The existential damage provoked by this—the loss of employment through dismissal—appears to be unconsciously sought after. This harsh external sanction seems to function intrapsychically as atonement: by suffering this real damage, the punishing maternal introject is likely appeased, leading to a temporary and paradoxical relief from chronic feelings of guilt.

In psychosocial crises, a high functional convergence with the somatic level is also evident. When the Ego is flooded by affect and psychological defense fails, shame can lose its purely psychological signaling function. It may at times express itself conversely through the body, with urinary incontinence functioning as the physical expression of a loss of control.

Complementary Lens: Individual Psychological Perspective

While classical psychodynamic reconstruction places these pathogenic patterns primarily on a vertical, intrapsychic axis, Alfred Adler's individual psychology is integrated here as a secondary conceptual lens to add depth by shifting the focus onto a horizontal, psychosocial, and interpersonal dimension. This complementary approach overcomes the risk of conceptualizing the patient as isolated from his social environment by replacing purely causal intrapsychic drive mechanics with the teleological principle of finality (Adler, 1920, 1933). The core premise of individual psychology states that all psychic phenomena and symptoms are goal-directed maneuvers serving an unconscious, systemic purpose within a person's individual ‘lifestyle’ (Adler, 1927). By applying specific Adlerian concepts—such as the ‘unconscious arrangement’ of symptoms, the ‘private logic’ safeguarding personal worth, and the protective usage of ‘organ language’—this secondary framework helps to illustrate how the patient actively, though dysfunctionally, maneuvers to maintain social efficacy and secure a sense of systemic belonging under intense psychosocial overload (Adler, 1928, 1933).

From this teleological perspective, the restrictive maternal upbringing and the patient's early adoption of the family scapegoat role may have functioned as a prototype for a specific, unconscious lifestyle designed to secure systemic belonging. The phenomenologically somewhat clumsy delinquent acting out in the office appears to obey an unconscious “private logic” aimed at safeguarding personal worth: by provoking the summary dismissal, Mr. S. potentially stages a moral drama that allows him to settle into a passive victim role and evade responsibility for the actual conflict.

Similarly, his urinary incontinence can be interpreted as “organ language,” metaphorically expressing an inability to “hold oneself back” under permanent external control. The implemented treatment modifications—such as establishing therapeutic equality through careful neutrality, providing encouragement via validation, and fostering social and physical activation (self-help group and sports)—functionally converge with Adlerian principles. They effectively strengthen the patient's community feeling (*Gemeinschaftsgefühl*) and reactivate the creative power of the self, allowing the symptoms to lose their defensive-reactive character and become recognizable as active, albeit relatively dysfunctional, attempts to maintain social efficacy under psychosocial overload.

Methodological Limitations

The postulated changes are based on the theoretical synthesis and the interpretation of a single, illustrative clinical vignette. Because this manuscript is framed as a theoretical discussion rather than a systematic qualitative study, the generalizability of the findings to broader clinical populations is naturally limited. Furthermore, the reconstruction of family genesis relies predominantly on the patient's subjective reports, as primary objects could not be directly included.

Conclusion and Outlook

Theoretical analysis and case presentation underscore the fundamental relevance of a differentiated metapsychological perspective within psychodynamic diagnostics and therapy. While functional forms of affect fulfill adaptive roles, chronic manifestations of shame and guilt can contribute to deep structural deficits in self-experience. In clinical practice, working through these pathogenic structures requires a specific therapeutic stance: only by building a holding, non-judgmental therapeutic relationship can the power imbalance be neutralized and the destructive shame-rage cycle sustainably broken (Dearing & Tangney, 2011; Tiedemann, 2010).

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Ethical Declaration and Data Protection: The case vignette presented in this work has been profoundly and irreversibly anonymized to protect patient privacy and maintain medical confidentiality. All demographic data, job-related contexts, biographical details, as well as the concrete forms of manifestation of the symptomatology and acting out were systematically modified or replaced by functionally equivalent patterns. Through this extensive masking of data, the risk of re-identification of the real person or inferences by the social and institutional environment is minimized to the greatest possible extent. The presentation thus aligns with international ethical standards for the publication of clinical case reports (e.g., COPE guidelines).

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