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Work in Progress

Relational Therapy in a Nonrelational World

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Work in Progress

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Abstract

An overemphasis on individualism and the exercise of "power over" others creates divisive tensions throughout society. This individualistic, hierarchical mode of functioning also contributes to what might be called an "anti-relational" bias in many Western cultures. Our traditional models of clinical practice reflect the prevalent emphasis on separation, autonomy, and disconnection. A relational model of therapy, on the other hand, emphasizes: relational awareness; mutual empathy and mutual empowerment; examination of strategies of disconnection; and appreciation of the centrality of context and diversity.

We are meeting at a time when the mental health field is experiencing significant challenges to its integrity, when the gains made by women in areas such as the right to control our own bodies are under fire, and when affirmative action is being actively dismantled. The individualistic mode of operating in the world which characterizes Western patriarchal culture appears to be in its ascendancy but ironically the current backlash and heightened reactionary response suggest it is a system that is being seriously challenged.

Fortunately, many are beginning to question our societal emphasis on power and an individualistic ethic. The women's movement, the ecological movement, representatives of diverse cultures, and relational models of psychology are challenging the prevailing Western "separate self" paradigm. The African worldview "*I* am because *we* are" (Comas-Diaz & Greene, 1994) stands in marked contrast to the Cartesian, Western notion of "I think therefore I am."

What I would call the anti-relational biases of the dominant culture are most clearly embodied in its highly individualistic values, its aggressive or dismissive attitude toward vulnerability, including its tendency to blame the victim, its active devaluing of empathic responsiveness and its objectification of human beings, with its creation of judgments of superiority and inferiority around difference. The way a society handles difference and vulnerability tells us a great deal about its commitment to relational values. A society that scorns, punishes, and blames its vulnerable individuals is a society that is ultimately lacking in compassion and feels unsafe for all. Many countries throughout the Western world have responded to the deep human need for compassion and respect for vulnerability by developing elaborate care systems for mothers and children, the elderly,

anyone in need of medical or psychological help. According to Marion Wright Edelman, Director of the Children's Defense Fund, American children are three times as likely to be poor as British children, and seven to 13 times as likely to be poor as Dutch and Swedish children. Marion Wright Edelman notes, "Isn't it ironic that a nation that mouths family values does so much less than its industrialized peers to protect families against poverty and its consequences." (Edelman, 1995, p. XX).

To build communities that respond with compassion to vulnerability, we must support the growth of empathic responsiveness in all people. And yet, in many ways we appear to be doing the opposite. It is noteworthy that 57% of programs on television contain some violence and most violent portrayals do not show the *consequences* of a violent act; 47% of all violent interactions show no harm to victims and 58% depict no pain (Farhi, 1996). Not only is there *over*exposure to violence but there is *under*exposure to the human consequences of violence. This undoubtedly erodes the development of our capacity to empathize with the distress of others. It reinforces the notion that we should not be concerned about the consequences of our actions on others, particularly if we hurt them. Anticipatory empathy, concern about how we affect others, distinguishes a relational from an egocentric way of being in the world. Unfortunately, in the service of developing "strength in separation," our natural empathic inclinations are constrained and discouraged.

Another form of violation of empathic connection occurs in the dominant culture's intolerance of difference and its politics of insider/outsider groups. Relating to others through stereotypes turns people into "objects," externally viewed, a profoundly hurtful and disconnecting stance. To buttress its sense of entitlement and justify its right to discriminate against the less privileged, the dominant culture has further developed the myth of "earned power" or "meritocracy" or the "culture of achievement." According to these myths, people get what they deserve. Those in positions of privilege deserve privilege; those in positions of powerlessness and vulnerability deserve what they get also. Very often this includes blame, punishment, and scorn.

Root (1992) has proposed the term "insidious trauma" for emotional abuse, racism, antisemitism, poverty, heterosexism, and ageism which activate survival behaviors that might then be mistaken for pathological responses rather than being seen as adaptive responses to traumatic situations (e.g., "adaptive vigilance" which gets interpreted as "paranoia"). Blaming the victim is a frequent response to pain and trauma.

Therapy

Western psychology has contributed to this system of objectification and disconnection in its models of the de-contextualized self that suggests "the self" is primary, internal, separate, relatively unchanging, and demarcated by boundaries that protect it from the surrounding context. Relationships are seen as secondary to separateness and as potentially distorting or dangerous to the separate self; safety is achieved in exercising "power over" others and in gaining a position of ascendancy and self-sufficiency. There is active denial of the vulnerability implied in the notion of connection and mutuality. Normative socialization teaches that we are safer and stronger, "better," if we can exist without needing relationships.

In many of these traditional models, the therapist is supposed to be the "objective" expert, there to interpret the internal organization of the patient. The movement in therapy is toward independent, autonomous functioning with increasing capacity for control and freedom from unconscious conflict. The client's desire for support is seen as a sign of the illness, something to be changed in the therapy process, rather than a sign of strength. The therapist's need for support from colleagues is often seen as a sign of personal or professional inadequacy. Vulnerability is discouraged. What we might call "defensive self-sufficiency" is the standard of psychological maturity in many of these models. Rather than creating better connection, the emphasis is on building increased and secure intrapsychic structure and self-knowledge.

Authority in most of the traditional therapeutic models is clearly hierarchical, a "power over" model which is supported by the mystification of the therapist. Unrealistic notions of human autonomy and independent functioning are fostered in a system where the therapist's own flaws, human struggles and ongoing need for support from other sources are made invisible. The myth is perpetuated of attainable independence, freedom from suffering; we therapists may give the impression: "Yes, I was once a person who suffered or faltered but having been through my

own therapy or analysis, I am now in control of my life (if not altogether free from suffering)." My own reality is that I continue to experience confusion and uncertainty both in and out of my work as a therapist, that I continue to make painful mistakes in relationships. I do not ask my clients to help me with these issues; that is not their job. I apologize for my mistakes as a therapist and I seek consultation when we fall into impasses, which are inevitably about disconnections in the therapy that neither one of us can see our way through without outside help. I am *not* a relational expert but I am deeply committed to trying to learn in relationship, perhaps because that is where I most need to learn!

In addition to some of the biases of many traditional therapies which may favor disconnection, we are currently beset by new pressures of how to practice the art of psychotherapy; the managed care delivery system is technologically driven and concerned with "fixing" problems rather than building relationships or transforming personal suffering. This system, to me, epitomizes the objectifying, unempathic stance of the dominant culture. While the notion of managed care is not intrinsically bad and its early forms were actually responsive to the spiraling medical costs of the 1970s, when the profit motive is factored into the system, the consequences for clinical care and therapeutic relationships can be disastrous. Outpatient reviews are frequent, intrusive, and they compromise confidentiality. Short-term therapies are seen as best for everyone. And those who do not appear to be good candidates for short-term interventions, are often left without coverage altogether. Most short-term therapy models, emphasizing the dominant cultural mode, focus on separation, confrontation, and getting the patient to stand on her "own two feet" as fast as possible. Most of the managed care systems are at best unappreciative of both the complexities and the healing power of relationships. At worst they blatantly discourage the kind of relationship building that is central to our work.

Relational therapy

In many ways therapists are called upon to heal the wounds caused by relational violations and lack of empathy; many of these wounding disconnections are subtly or blatantly created by our immediate and larger social contexts. Disconnection is viewed in a relational model as the primary source of human suffering.

The thrust of therapy that grows from this model is to help the client: 1) reestablish a sense of empathic possibility and mutual empathy through which growth-fostering relationships develop, 2) to increase relational awareness, especially of the patterns and dynamics of connection and disconnection, thereby enhancing one's ability to engage in mutual connection, and 3) to develop the courage to represent oneself more fully in relationship.

In relational therapy empathy is the *essence* of therapy, not the precondition for the "real" work of interpretation. It is the basis for co-creating connection and underlies the capacity to make use of supportive, growing connections in which meaning is discovered and created. It is essential that the therapist be *moved* by the client's experience. And it is essential that the client know, see, and recognize that the therapist is moved, touched, and affected. This is what we mean by mutual empathy. In the moment that the client sees the therapist being moved by her, empathic possibility is reborn and healing begins. This approach is profoundly different from many traditional models based on separation and neutrality, which suggest such responsiveness may interfere with the unfolding of the transference or could be destructive in other ways for the client.

Kate is a young woman who grew up in an extremely emotionally depriving, although materially comfortable family. In one session she was describing wandering from room to room of the family's empty rambling house, terrified that her abusive older brother was going to corner her. She couldn't get away from him and she couldn't tell anyone about his torture of her. She had learned well the family rule that was taken literally, "Children are to be seen not heard." No one wanted to hear her pain. There was no one to protect her. While she struggled with these emerging memories and images, she also doubted herself and she felt she was was probably exaggerating how bad it was. She couldn't quite believe what she knew, nor could she feel empathic with her own experience. The family denial also kept her at a distance from her real feelings. At one point when she was describing her panic as a child in looking for a place to hide, in feeling there was no way to escape, I felt myself getting goose bumps and my eyes filled with tears. I said, "You were like a small, voiceless prisoner . . . how lonely and terrifying it was

for you." She responded, "It was more like a concentration camp. It's like those dreams I have of concentration camps." She suddenly looked closely at me, "Are those tears?" I nodded. "God, that gives me a chill," she said. "It's like your witnessing and caring about my pain makes it more real. You know, I think if I'd tried to say something about this to my Mom, she would have blamed me: 'What are you doing to get your brother all riled up?' If I bumped into a piece of furniture and hurt myself, she'd say, 'Why don't you look where you're going?' It was never, 'Sweetie, are you all right?' The only thing she ever cared about was maintaining her image of the perfect family and herself as the perfect mother. Anything that hurt us was our own doing. She just couldn't respond with caring." She then turned and looked at me closely again, "I really see that my feelings matter to you. *I* matter to you. I'm not all alone with it anymore." She began to sob. "I think this is the first time, I have really let myself know this pain. It's big." I felt profound sadness for her pain but also a sense of the life-giving connection that occurs at a deep level when you know you've met someone in a place of authentic feeling. We both felt it. In retrospect this felt like a turning point in our work; as Kate later said, "You know, I felt like I came out of prison in some deep way and rejoined the human community that day. It was like coming alive."

Empathy with the particular affect state a client is experiencing in the therapy session can dramatically shift patterns of disconnection, but the therapist must also develop empathy for the whole person, for the whole fabric of the client's social and emotional world. We could call this a kind of contextual empathy which can take the form of gender empathy (e.g., how can I as a woman be empathic with your experience as a man?) or cross cultural empathy (e.g., how can I as a white woman be truly empathic with your experience as an African-American woman?). This often involves empathy across difference. "While some mutual empathy involves an acknowledgment of sameness in the other, an appreciation of the differentness of the other's experience is also vital. The movement toward the other's differentness is actually central to growth in relationship and also can provide a powerful sense of validation for both people. Growth occurs because as I stretch to match or understand your experience, something new is acknowledged or grows in me" (Jordan, 1986, p. 7). This is what makes mutual empathy and empathy across difference dramatically different from what some call "mirroring" or simple empathic resonance with similarity This process lies at the heart of growth-in-connection; through it we learn new patterns and begin to transform existing relational expectations. In order to empathize across difference, we also need to develop awareness of our own cultural and ethnic privilege and blind spots, our personal weaknesses and strengths. Then difference can be a source of connection rather than disconnection.

Therapy allows us to bring empathic awareness to many different kinds of disconnections, creating the possibility of moving back into connection. Acute disconnections are inevitable and ubiquitous in all our relationships. But chronic disconnections result when we are unable to represent our experience fully in relationship, when the other person is unresponsive to our needs or our pain (Miller, 1988). Disconnections become problematic when the other people in the relational context, do not allow us to participate in shaping the ongoing relationship. One very depressed client, who had grown up with distant and controlling parents, said: "You know what hell is? It's the terror you feel when you get no response from someone when you *really* need them to be there for you. You just can't reach them. It's terrifying. The only time I get any response from my parents is when I start to get suicidal. Then they freak out. But at least they respond."

Jean Baker Miller and Irene Stiver (1994) point out that the therapist's ability to be empathic with both the yearning for connection and the need to disconnect is central to therapy. As they note, the strategies for disconnection are usually extremely important to the client and often there is profound terror at the possibility of being left in a place of vulnerability in relationship without the ability to resort to these strategies. We see this most clearly in working with trauma, which is, after all, the result of extreme relational violation; as trust builds, as the person begins to open up and feel more vulnerable and aware of the yearning for more connection, there is often a sudden, whiplash movement into nontrust and disconnection in an effort to reestablish a sense of safety. Even a slight reminder of some unsafety or some vulnerability from the past can trigger an emotional hijacking that takes the trauma survivor into dramatic, massive disconnection. To the therapist this can feel awful, invalidating, frightening and can lead to disconnection on her part as she blames herself

for somehow having failed the client. Instead, the therapist can deal with her own tendency to disconnect at these times by staying empathic with the client's protective strategies of disconnection rather than moving into her own sense of failure or helplessness. We might say the therapist uses this strategy to stay *in* connection. In fact, it is the therapist's capacity to remain available for connection while recognizing the client's need to disconnect that allows the working through of these precipitous, painful disconnections. This is where the possibility for empathic connection is rekindled.

One client, Emily, who had suffered severe emotional abuse as a child, became very silent after she admitted that she had missed me the previous week when I was away. I could feel how hard it was for her to be aware of that and even more difficult to tell me. I made, what I thought, was an empathic comment about this. She looked very anxious, became silent, and turned her head away from me. I tried gently to think aloud with her about what might be going on. She now picked up her chair and turned it facing away from me and did not respond verbally. I felt pushed away; I thought, "I wish Irene Stiver (my former supervisor) were here, she'd know just the right thing to say or do"; and then shame entered and I thought, "Thank God Irene *isn't* here to see what a mess I'm making" and then I began to fall into a sense of inadequacy and fatigue. Emily was clearly disconnecting, but now I, too, was in the throes of a major disconnect, in the form of self-blame and withdrawal. Finally I caught myself and realized she just needed to "go away" for a bit in order to stay safe and not feel ashamed of her vulnerability; Emily needed me to simply stay there with her as best I could. We could make sense of it later.

Learning to differentiate the current relational context from the past is one of the core tasks of relational awareness. The client needs to differentiate when she is responding on the basis of old relational images and expectations and when she is able to be more fully present in the current relationship. In a relational awareness group I was co-leading recently, a client, Mary, commented "My brother said I'm the most withholding person in the world. In the past I would have either collapsed in shame and self-loathing or I might have mustered some defensive response. This time I thought, maybe I *am* withholding in this relationship. Maybe there's even a good reason I'm withholding here. I know there are many other people who find me generous and loving. Its all about context and what this particular relationship brings forth in me. In the context of my brother's abusiveness, cutting off was necessary and life saving."

While the goal of therapy is to assist the client in her personal goals, both therapist and client are affected, moved, and grow in these powerful interactions. I have often commented that I'd rather be in a good therapy session than in almost any social situation I can imagine. Some have suggested I am revealing too much of my own personal social limitation or pathology in this admission (That may be true.) but I feel that at its best therapy is about helping people come into their most real and deep places. That is true for both therapist and client. To me, therapy invites us to participate in a core human privilege: to witness, encourage, and engage in the development of a relationship that fosters personal truth and the sense of well-being that ensue from deep connection between oneself and others. I see no way of doing this without a sense of openness to change and hence vulnerability on the part of both people.

In embracing any new paradigm, one moves from behind the protective armor of accepted theory and dogma. One of the first reactions to new theory is "This is outrageous, crazy, and even dangerous." These same people, years later, will frequently attest about the very same theory, "We've known this all along. We've been doing it this way for years. It's so *obvious* that this makes sense." Ensconced in established theory, the clinician feels safer. Breaking from these traditions also means being exposed to doubt, possible criticism, and censure. There is a threat of disconnection and isolation as we fear becoming cut off from a community of colleagues. The work of therapy often feels lonely and treacherous, even without the added burden of working with a new model; so it is especially important to get consultation and support from colleagues as we try to transform the ways we do therapy (Jordan, 1995). I remember early on when I was beginning to rethink some of my own training, how uncomfortable I felt when a client brought me a small gift, a book that meant a lot to her. I had just read an article strongly suggesting that accepting gifts from clients was a questionable practice, the beginning slide down the slippery slope toward "boundary violations." I had a clear sense that accepting this gift was an important message to this young woman who

had spent years in almost complete isolation, feeling she had nothing good to give to anyone. I feared that rejecting it would confirm her worst fears about herself but (I'm somewhat embarrassed to admit) I actually experienced some internal turmoil about my decision to indeed gratefully accept and appreciate her present. I felt I had stepped outside the accepted bounds of practice that had been so thoroughly outlined in the journal article. My anxiety did not entirely go away until I later had a chance to talk about it with a colleague.

Because the relational model directly challenges the dominant culture's emphasis on separation, objectification, and nonmutuality, it really poses a threat to many established dogmas. It takes a certain kind of courage, or resistance as Carol Gilligan (Gilligan, Rogers & Tolman, 1991) uses the term, to pursue a new vision and we sometimes feel as if we are isolated or out on a limb. But we need to challenge the myths of neutrality, objectivity and a value-free context in therapy because these illusions create enormous pain and isolation for many people. When we collide with accepted practice, even when we have carefully considered the reasons for proceeding differently, we often feel vulnerable or question our own judgment. While as therapists we must be willing to be in our own vulnerability as we make these changes, we must also remain respectful of the ways we need to protect ourselves as well as our clients and keep the therapy relationship safe for all participants.

I want to present a small piece of work with a client of mine that I think will illustrate some of the issues of objectification, the yearning for connection, and need for disconnection, mutual empathy, and vulnerability, and some of the tensions we can face in working in a relational way. A young woman I was seeing in therapy, I'll call her Dee, was a veteran of the mental health system. I might add she was also one of my greatest teachers. She had seen about 15 therapists and had been hospitalized several times and was frequently treated in emergency rooms following self-destructive behavior. An abuse survivor, who began her treatment before the ravages of abuse were appreciated by the mental health field; she had been diagnosed and treated as "a borderline." She was an exceptionally bright and creative individual and when she was told her diagnosis by a previous therapist, she tracked down the DSM-IIIR and felt haunted by what she perceived as the judgmental language she found there. She knew it was not "good" to be "a borderline." She knew people didn't like "borderlines" and she knew when people saw her as "a borderline" they failed to see a lot of her. She and I had talked about the pejorative connotations of this diagnosis and I let her know I also had misgivings about it in general. She had been described by other treaters as "manipulative," "too needy," "filled with primitive rage," "too interpersonally intense," "using self-destruction to try to control her treaters." Few saw the terrified, injured girl who actually had amazing pockets of love, appeal, and wisdom; few described or noticed the terrifying vulnerability she experienced as soon as a relationship began to be important to her. And fewer still appreciated her incredible courage. Certainly the people in the emergency room where she went to have her stomach pumped or her wrists sewn found her to be a nuisance.

In the early days of our work together with the increasing vulnerability she experienced in the deepening therapy relationship, where she felt some inkling of trust, her self-cutting and ingesting of pills increased. As her yearning for connection grew, her strategies for disconnection escalated. I was often getting calls from the emergency room where she showed up on an almost monthly basis in the first tumultuous year of therapy. Both she and I struggled with our concern for her safety and our sense of inadequacy, verging on shame, about her unremitting self-destructiveness. On one occasion a staff psychiatrist called and said he wanted to see if I agreed on the diagnosis; weary and intimidated by the psychiatrist on call and feeling my own sense of uncertainty in my work, and probably angry as well, I agreed with his diagnosis of borderline personality disorder. At that moment I was clearly unable to speak a voice of resistance or courage. I did not know Dee was in the room with him at the time and that he then turned to her and said, "Borderline, just as I expected." She was devastated by my betrayal. In our next session she confronted me, "Did you call me borderline?" With reluctance and pain, I admitted I had and I noted that I felt terrible that I had done something that I knew was so hurtful to her. We worked on her rightful sense of hurt and anger.

After her anger and disappointment with me abated some, we spoke about what else I could say when they called me from the emergency room the next time and asked for a diagnosis. Would I label her

PTSD? That didn't feel right either. Why did I have to *label* her anything she wanted to know. With some hesitation I said, "When they ask me what to call you, maybe I could say, 'Dee is someone whom I care about very much.' " She smiled at that, and then wondered whether I would really be able to say that. I also wondered with her about my ability to do that, whether I could resist the pressure to join the other treaters in their objectification of her or whether I could stand *with* her in our joint vulnerability. I never had the chance to find out. Dee never again overingested pills or cut herself. She never again went to the emergency room. That was six years ago. Although I'm not sure *exactly* what shifted, I think in this exchange she found out that I would stand *with* her (or at least I would *try* to stand with her), not objectify and belittle her, not betray her with distancing diagnoses and my own need to be perceived as a "competent therapist." It was as if she heard clearly that she mattered, that our relationship mattered. She also noted that she was extremely moved by seeing my pain at having caused her pain. She remarked that she especially appreciated my sharing this vulnerability with her.

How we deal with the inevitable moments of hurting someone we care about is crucial; it is in those moments that our capacity for empathy and mutual connection is most challenged. As one of my clients said, "When someone else hurts my daughter I'm 100% there for her. I'm empathic, comforting, on her side, *with* her. And that really makes a difference. But when I hurt her? I get defensive, I don't want to hear about it or I fall into a total funk and hate myself for being such a bad mother." As therapists we often offer a ready compassion when someone else is the source of injury to our client. But the attention and care we provide when we ourselves are the cause of the pain can be especially healing. Staying out of our own narcissism or self-preoccupation is essential and difficult.

We cannot eliminate power politics (as much as I fantasize about a political party called the "empathy party") or privilege; and we may even have trouble challenging hurtful diagnoses and practices in our own field. But we can, each of us, begin to look at what blocks empathy and love, personally, therapeutically, and socially. I think many of our clients have much to teach us about this, particularly those people who have been most hurt by the violations of a nonrelational world. Like canaries in the mines, many of the trauma survivors I have worked with, including Dee, show an acute sensitivity to: the injustices and inequities of power; the imbalances of vulnerability in relationships; and the rush to "blame the victim" that infiltrates our field from the dominant society. We need to listen to their voices. I also think that listening *(really listening)* and responding to women, to people of color, to gays and lesbians, to all people who are not fully invested in the dominant power imperative is an act of revolution, an incredible act of empowerment for both speaker and listener. In our effort to empower women, as Carol Gilligan suggested, we have emphasized voice; that continues to be essential (Gilligan, 1982). But we must also value the capacity to listen, for voice is not just about speaking. It is also about how we are received, how we are assisted into speech. There is a Spanish word "capacitar" which means "to enable, encourage and to bring forth." Our context is central to the emergence of our voice. In some contexts I become mute, unable to think or speak with any clarity or purpose.

When I was helping start a women's program at a psychiatric hospital several years ago, I was involved in many heated discussions with the administration about the constraints they tried to place on the program, including their very first suggestion that a male psychiatrist should head up the all women's program. When I vociferously opposed this, noting that I thought this would undercut our whole emphasis on empowering women and that I thought surely a competent woman could be found to do this job, I was told "Don't you women ever do anything but whine and complain?" I was momentarily ashamed; I thought, "Why can't I do this the way I'm supposed to? Maybe he's right. I'm a *whiner*." I was embarrassed, on the verge of tears. An image of my client Dee, courageously speaking up in emergency rooms, flashed through my mind; then I thought of the women clients in the program. Remembering this relational community, somehow I pulled myself together and I said "You know I think the capacity to complain is one of the most important human skills we have. It allows hurtful things to be recognized and possibly changed . . . if someone is listening!" But there are times I don't have the courage or presence to resist that kind of silencing.

The quality of listening and response provided by the other person powerfully determines the voice that we can bring to a particular context. As therapists we

know that, deep in our hearts. While we can help our clients develop courage and self-empathy or overcome their terror of both connection and disconnection, we can also help them appreciate the disempowering impact of a nonrelational context. We can help individuals find and create their voices in contexts which are truly supportive of their growth and we can work to alter the larger, often nonrelational context. I believe the relational paradigm has much to offer not only in the area of individual change but social change as well.

bell hooks, in her book *talking back*, suggests that "true speaking is not only an expression of creative power; it is an act of resistance, a political gesture that challenges a politics of domination that would render us nameless and voiceless. As such, it is a courageous act . . . as such, it represents a threat" (hooks, 1989, p. 21). She also cautions us that we all have the capacity to act in ways that oppress, dominate, and wound and we all must seek to resist the "potential oppressor within." I do believe that valuing connections and positing that relationships lie at the very heart of human existence is a threatening stance in a nonrelational world that has built it's economy, politics, and sense of purpose around separation and exaggerated individualism. The words of Martin Luther King capture *my* hope that we *can* support the growth of connection and empathic responsiveness in all people and thereby transform some of our most destructive nonrelational patterns. He notes, (King, 1987, p. 17), "An individual has not started *living* until he can rise above the narrow confines of his individualistic concerns to the broader concerns of all humanity."

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