Work in Progress

Relational Development: Therapeutic Implications of Empathy and Shame

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Abstract

A perspective which emphasizes relational development leads to a shift in understanding therapy, which can be thought of as a process through which individuals find ways to bring themselves more fully into relationship. Empathy serves our basic desire for connection and emotional joining. In shame, we experience a loss of empathic attunement. The experience of being shamed thus leaves one feeling disconnected and disempowered. Marginalized groups, in particular, struggle with this form of disempowerment. Shame is also a powerful obstacle to connection in psychotherapy, but an empathic, relational approach in therapy can significantly alter the experience of shame.

What is relational development?

Western science, including psychology, rests on the assumption of a primary reality composed of separate objects which secondarily come into relationship with one another. As Helen Lynd notes, "The separation having been initially assumed, the problems of relation and integration are posed" (1958, p. 81). Moving from Aristotelian logic and Newtonian physics to quantum physics, we begin to see reality defined by relationships, continuities, and probabilities rather than by discrete objects and dualities. Traditional psychological theories view "the self" as the basic unit of study and emphasize its independence, security, and separation from other selves. In the existing paradigm of "self-development" the task is to internalize resources of love in order to create an ever more unique, self-sufficient, and separate structure: the self. Control, boundedness, and ownership of action have been essential to psychology's view of the individual (Jordan, 1988).

In the image of a separate self, boundaries are construed as necessary protections, giving shape and strength to the inner person who is threatened from without. Viewing development from a *relational* rather than a *self* perspective, boundaries could be understood as processes of contact and exchange, moments of knowing and movement and growth. Thus, we evolve from a metaphor of a bounded self whose task it is to "master" reality, to a relational self "meeting" reality and growing with others.

The Stone Center relational perspective on human experience posits that, optimally:

l) we grow in, through, and toward relationship;

2)for women, especially, connection with others is central to psychological well-being;

3)movement toward relational mutuality can occur throughout life, through mutual empathy, responsiveness, and contribution to the growth of each individual and to the relationship (Jordan, 1983; Kaplan, 1983; Miller, 1984, 1986; Stiver, 1984; Surrey, 1985).

Moving away from the primacy of the "intrapsychic self" in no way suggests that there is not a real inner life characterized by organization, a sense of personal history, feelings, expectations, and internal respresentations of self and other. From a relational perspective the movement of relating, of mutual initiative and responsiveness, is the ongoing central dynamic in people's lives. A psychology of relationship goes beyond the dualities of intrapsychic versus interpersonal, selflessness versus selfishness, altruism versus egoism (Jordan, 1988).

Our perspective emphasizes that in growth-enhancing relationships people take mutual responsibility for relationships and provide the means for each other's development. One client summarized the importance of both people caring for the relationship: "There is Len, me, and the relationship. When I feel that he is paying attention to the relationship, it feels so much better. Usually, I carry that by myself." Another woman, in the middle of a fight with her husband in which both were escalating hurtful remarks and in which she was feeling victimized, suddenly stopped and said, "Wait a minute, who's the *real* victim here?" and found to her surprise that her transforming answer was, "the relationship." When both people share a respect for and desire to nurture the relationship, mutuality is created.

Piaget's theory of adaptation, comprises accommodation and assimilation and provides one model of the dynamic of relationship (1952). Our internal images, expectations, and organizations of experience change to accommodate newness in our surroundings, and we later change what we take in during the process of assimilating it. Ideally, growth occurs through mutual initiative and responsiveness in relationship, what we might call mutual accommodation and assimilation. Responsiveness to other individuals, as well as having an impact on them, leads to our own growth.

As therapists, we stress the development of relational awareness and an interest in the movement of relationship, not just attention to self and other. With a real appreciation of the "ongoingness" of a need for connection, we will cease infantilizing needs for intimacy, tenderness, nurturance, and deep involvement in relationship. The shift from pathologizing the powerful motivation for connectedness to honoring it, produces a marked change in the way we undertake therapy. It would be like taking all the popular books about women, like, *Women Who Love Too Much,* or *Men Who Hate Women and the Women Who Love Them* and retitling them: *The Courage to Care, The Power of Taking Responsibility for Relationship,* or *Women Who Care Enough About Relationships to Buy Thousands of Books on the Subject.*

What is relational therapy?

Writing about Dora, Freud suggested that in therapy, "I set myself the task of bringing to light what human beings keep hidden within them" (1905/1959). This is another way of saying that one attempts to make the unconscious conscious or, "Where id was there shall ego be." In the Freudian model of therapy, there should be a decrease in intrapsychic conflict, with a subsequent increase in exercise of will and autonomy. There is also an increasing internalization of function and structuralization leading to greater interpersonal independence. The interpretative activity of the analyst should cause a lifting of repressions, bringing the unconscious to light. In object relations theory if a "good enough" holding environment is provided, the "real self" will emerge (Winnicott, 1971). In Kohut's unidirectional model the empathic therapist, used as a self-object, provides a function for the derailed narcissistic development of the individual, ultimately leading to increased internal capacity for self-esteem regulation (1984). In all these models the transference is honored and observed, but the actual engagement in the therapeutic relationship is paradoxically aloof and counterrelational.

I would like to suggest that the most obvious and overlooked event in therapy is that when one brings oneself more fully and clearly into relationship, one enhances self, other, and the relationship. One increases one's capacity to be more whole, real, and integrated in all relationships; split-off energy begins to flow back into connection. Here I include relationships with people, nature, material objects, and work. In the following discussion I will not focus on matters of technique so much as a change in attitudes and understanding. These guide the practice of therapy so that the perspective shifts from one of control and self-sufficiency to one of relatedness and movement. The core relational goals are: increased

mutuality (an interplay of initiative and responsiveness) and increased capacity to grow in connection and to contribute to the growing connection.

At the heart of relational therapy is the relationship between therapist and client. A return to the pain of the past becomes possible and healing because in this journey the client is not alone. Empathically present, the therapist joins in the experience. One sexually abused client beautifully expressed her dilemma in therapy, showing her empathy for the therapist as well as an understanding of the task at hand, when she said to her therapist: "I hate to bring you back with me into all this pain. I shouldn't be so specific about all this abuse...it's too terrible. But I need someone to help me to be with it." It is by the very specific and, in this case, extremely painful detailing and reliving of the abuse situation, that the client creates real, emotional resonance with the therapist. The therapist, while feeling the pain, is not overwhelmed by it. The message is, "We can bear this together." The client and therapist begin to appreciate the meaning systems that have grown around the pain and how it has shaped the person's life and understanding. And the relational images that have formed as a result of these experiences become more obvious and available for change. The therapist is committed to *trying* to understand; the failures in empathy are valuable places for the therapist and client to work together toward a clearer understanding.

I would like to address several key issues in relational therapy: authenticity, mutuality, trust, and empathy. I will then explore narcissism and shame as they shed light on this perspective.

Where and how do we experience aliveness, a sense of being real?

Movement toward congruence between inner and outer experience is a goal often sought in psychotherapy, as is the goal of personal knowledge. We develop a sense of personal authenticity largely in relationship and, paradoxically, as we move into relationship, coming to know the other more fully, we also greatly expand our knowledge of ourselves.

Sometimes the old spatial metaphor of the "real me," buried deep inside the body makes it seem that the "real self" is only impinged upon and damaged by relationship. The "real self" can take on a reified quality, something inside the child that is unfolding in some coherent and predetermined direction, which then becomes distorted by interactions with others. This leads to conceiving of boundaries as walls protecting vulnerable intrapsychic reality from external influence. In contrast, from a relational perspective, "vulnerability" can become an opportunity for growth rather than an invitation to possible danger. And safety resides in connectedness, not separation and power. Rather than the "emergence" of a reified "real self," we speak of the development of clarity through connection, a kind of co-creation. That is, there is not a "real self" which can "emerge" fully formed, but the possibility of the co-creation of an increasingly authentic self.

If there is a consistent imbalance so that one person is always altering her experience to fit the other person's needs or, alternately, demanding that the other person be a certain way in order to stay in connection, there will be serious distortions in self- and other-expression. The sense of aliveness in the relationship will suffer. As one of the women I work with said, "If I distort myself to be loved, is it real? Is it worth it? What, who gets loved?"

Often in dealing with a sense of lack of personal authenticity (which usually coexists with a lack of relational vitality), people mention striving to "speak their truth" or to find their voice. Carol Gilligan's book, *In a Different Voice,* brings this into clear focus (1982). Being able to say what you see, think, feel, and need is tremendously important. I am reminded of a quote by Adrienne Rich: "Listen to the small, soft voices, often courageously trying to speak up, voices of women taught early that tones of confidence, challenge, anger, or assertiveness, are strident and unfeminine. Listen to the voices of the women and the voices of the men; observe...the male assumption that people will listen, even when the majority of the group is female" (1978, p. 243).

Both the voice as reality and the voice as metaphor are to be taken seriously. Voice, like the notion of "real self," rather than being something that emerges fully formed from within, is contextual (Jordan, 1988). Thus the "audience" to whom we speak greatly affects the way we speak and the content of our utterances. In real dialogue both speaker and listener create a liveliness together and come into a truth together. Dialogue involves both initiative and responsiveness, at least two active and receptive individuals. In speaking to groups about our perspective on the psychology of women, we have felt the flow of life and confidence coming back to us from groups of women clinicians as they find the freedom to utter their truths regarding clinical practice, sometimes for the first time in public.

Trust and mutuality

Therapy occurs in a context of trust; both therapist and client must develop trust for each other and for the relationship developing between them. Many clients come to us experiencing difficulty trusting others; but many also feel untrustworthy, a powerful experience for those suffering with shame (which I will discuss later). It may be just as important that therapists learn to trust clients, that the trust created be mutual. Therapy involves growth in trust of the other which — again, seemingly paradoxically — leads to growing confidence in our own view of reality, a process of gaining a sense of our own voice or truth.

Mutuality does not mean "sameness." It involves openness to change and healing on both sides. Therapy requires mutual trust, respect, and growth. It is not just two people getting together to talk about their lives; in the therapy relation, the two individuals join in the intention to assist the client. While the therapist exercises certain kinds of authority and the client moves into a place of vulnerability, the attitude is one of empowerment rather than "power over." The client's position of vulnerability is at all times respected and protected; the therapist is there to serve the client's needs. Helen Lynd notes, "Relating to another person in terms of superiority and inferiority, aggression and submission can only interfere with mutual discovery and love" (1958, p. 155). The therapy relationship should never include an attitude of superiority; both members of the interaction must be open to influence by the other. Both must risk change and the uncertainty which accompanies growth. This does not imply that both grow in the same way, or that there is no difference between therapist and client. But mutuality in therapy does rest on the assumption that real growth of an individual can occur only in the context of a real, mutually responsive relationship.

Clearly, this model values relatedness, although it in no way undermines the capacity to experience joy and nourishment in solitude. Though alone in solitude, one can relate fully to nature, books, animals, or one's internal images, and one can expect to return to the human community. By contrast, in isolation, one feels cut off from others, wishing for reconnection but unable to achieve it.

Furthermore, this perspective in no way negates the importance of initiative and responsibility, features that have often been connected with "autonomy." Rather than talk about "autonomy" which carries with it connotations of freedom *from* relational consequences, I prefer to speak about the capacity for

l) initiative, creativity, and responsiveness;
2) clarity of perception and desire;
3) capacity to act with intentionality;
4) the capacity to effect change.

All of these capacities are expressed in a relational context where we feel active concern about the consequences of our actions for others. This concern should also include an openness to others' impact on us. Perhaps we could call this "responsive initiative." This is the dwelling place of morality, which Carol Gilligan explores, and it is at the vital core of human caring (1982).

Goals of therapy do not include the attainment of some conflict-free state of harmony and happiness, but the development of an increased openness to learning and growth and more capacity to tolerate tension and conflict so that movement into isolation and, hence, fragmentation does not occur. Suffering is recognized as inevitable and the common lot of human beings. As such, suffering becomes a cause for joining others in alleviating pain and developing compassion. This is very different from experiencing suffering as a personal injury which reveals personal insufficiency. Relational competence, reaching out to others *for help* and *to help* are ultimate human responses, acknowledging the ongoing interdependence of all people. Instead of a therapy that supports the myth of attainable self-sufficiency and individual perfectibility (self as intrapsychic island), we recognize the necessity of mutuality in the face of inevitable uncertainty and suffering. We are not "bad" and therefore guilty if we cannot control and shape our lives in some ultimate way; we are simply subject to the inevitable human limitations which create the humility upon which our interdependence and humanity is predicated.

Empathy and therapy

Empathy allows an understanding of each other's subjective world; it involves a direct movement from subject-object relating to subject-subject relating. Here is another person I can understand, in some ways different from me, but also like me, like all people. Poets have suggested that in moving more fully into the particular, we can experience the universal. It is the paradox of empathy that we appreciate the unique, differentiated characteristics of this particular other person, and we move past the particular to join in a place of commonality.

Translation of the original German word for empathy, *Einfuhlung*, stresses the capacity to "feel into" another's experience. Another possible way to think about this word is "to feel at one with." The

joining aspect of empathy, the mutuality involved, and the increased sense of relatedness is not of primary interest in most models of development that address empathy, including Kohut's (1984). There, the therapist's resonance with the other is seen as important because it leads to the therapist's better understanding of the other. In fact, in addition to increasing their understanding, *both* people draw nearer each other in the empathic moment in a way which expands their sense of human community. Kohut talks about the "recognition of the self in the other" as the central dynamic in empathy (1978). But there occurs an equally important experience of recognizing the other in the self.

Similarly, in the process of self-empathy, one also develops an empathy for that which is human in oneself, often for very real and inevitable human failures or losses. Where expression of feelings has been curtailed or the premium on control has led to a suppression of spontaneous affect, the capacity to experience empathic resonance with others or to develop empathy toward one's own feelings suffers.

We all struggle with the need to recognize our unique experience; yet we also wish to be with others in some identifiable commonality or sameness. Because much of boys' gender socialization is based on making them *not like girls or women*, the wish for joining in commonality or likeness may become a source of conflict or anxiety for boys and men. Identity for men is importantly shaped by "differentness." The great emphasis on boundaries as forming protection and securing separation also evolves in this context. Hence, any movement toward sameness may be viewed with alarm; I suggest it is this fear that is mirrored in psychology's overconcern about movement toward "regressive merging" or experience of sameness. Connecting around difference is exciting, expanding, and challenging, but the capacity to move into a place of resonance is equally growth producing.

Emphasis on the autonomous self, or the "real self" unfolding, can culminate in the creation of a pathologically isolated individual struggling to maintain the illusion of self-sufficiency and boundaries: the narcissistic solution of the 20th century Western man. The wish for connection and the inevitable vulnerability to shame that accompanies this wish are largely disavowed aspects of the human condition which women often carry, as Jean Baker Miller notes (1976). This imbalance is most clearly expressed through gender and leads to male disconnection and overreliance on "power over" others; in women pathological shame develops. Both men and women suffer in such a system. Mutuality, the movement toward integration of initiative and responsiveness, where both the individual's and the relationship's well-being are honored, becomes severely curtailed.

The need to be connected and the need to feel special: Empathy and narcissism

I suggest that the need for connection and emotional joining is our primary need; empathy serves this need. The need to feel *special* becomes paramount when the need for relatedness is not met. The failure of connection and the resulting need for admiration can often take the form of needing to be "better than." Kohut's understanding of narcissistic development posits that failures of admiring self-objects lead to an internal deficit in the capacity for regulation of self-esteem (1978, 1984); there is then an ongoing narcissistic need to be "mirrored" and an unconscious anxiety about the resulting dependence on others to provide this function.

It is not their difficulty with self-esteem regulation which, I think, is most damaging for narcissistic people, but their difficulty in letting others really have an impact on them, their difficulty being responsive to others. This difficulty leads to encapsulation, a failure of connectedness, and a disruption of the sense of well-being which comes from relationship. The search for adulation and admiration is a futile attempt to restore a sense of connection; there is an illusion of safety and control in being highly esteemed by others. The need to feel *special* defensively replaces the desire for connection.

The capacity to take joy in the growth of another is utterly absent where narcissistic issues predominate; the other's existence is but a reflection of the self, to be used by the self to buttress self-esteem. Real responsiveness, mutuality, and the creation of something new and spontaneous together are not possible. The other person cannot be allowed to be genuinely responsive because the response may not contribute to one's image, and one cannot respond freely because that admits the possibility of being affected by the other. Dominance and control become an essential strategy in narcissistically distorted relationships, and vitality is drained from the connection, contributing to the inevitable interpersonal boredom and the quest for newness and excitement. Using the metaphor of voice, the dialogue has become imbalanced, with little energy devoted to real listening.

Shame: Wishing for connection, feeling unworthy

Thus, with narcissistic problems there is often increased effort towards invulnerability and diminished responsiveness to the reality of the other; interpersonal injuries lead to narcissistic rage. In shame we experience a heightened sense of vulnerability and our sense of initiative falters; in interpersonal failures we attribute personal responsibility and unworthiness to ourselves. Many of the problems we deal with in therapy reflect the pervasive pain created by shame: addictions, sexual abuse, eating problems, many depressions, impulse problems, and post traumatic stress disorders.

Shame is often seen as the opposite of narcissistic pride, the loss of self-respect or self-esteem. (There may be sex differences in the experience of shame; what I am about to describe may be more characteristic of shame in women.) I would like to suggest that shame is most importantly a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others. While shame involves extreme self-consciousness, it also signals powerful relational longings and awareness of the other's response. There is a loss of the sense of *empathic possibility*, others are not experienced as empathic, and the capacity for self-empathy is lost. One feels unworthy of love, not because of some discrete action which would be the cause for guilt, but because one is defective or flawed in some essential way.

In the moment of shame, one feels exposed, looked at; the characteristic response is to blush, pull away, avert the gaze. Nathanson comments, "During mutual gaze we feel attached. In the moment of shame, we feel shorn not just from the other but from all possible others" (1987, p. 9). One feels separate, outside the pale; Jean Baker Miller has spoken of "condemned isolation" or "being locked out of the possibility of human connection" (1988), a feeling state which I think is central to much of our work in therapy. Tomkins places shame as one of the original negative affects (1987). Helen Block Lewis notes, "In this affective tie the self does not feel autonomous or independent, but dependent and vulnerable to rejection. Shame is a vicarious experience of the significant other's scorn" (1971, p. 42).

Shame can occur in response to many different events. Common precipitants involve some exposure in which one is made to feel defective, weak, out of control, " foolish," babyish, dirty, stupid, awkward, betrayed, or, in a love relationship, more involved or vulnerable than the other. Loss of a sense of containment or of being in control figures importantly in most of these feelings and reflects our cultural preoccupation with control. Sometimes merely being "different" becomes a source of shame. But all of these imply some interpersonal situation in which one no longer can feel valued or worthy of connection. The effect of shame is global and immobilizing. One does not feel capable of making the situation better. So we move into hiding and secrecy; in this case the opportunity for a reparative interaction with another is lessened. It is as if we lose the ability to reach out. The helplessness of the situation leads to further shame. It is the very tendency to pull away from relationship to protect oneself that, in fact, most locks one into the shame. In the extreme, shame contributes to dissociation and inner fragmentation as the person struggles to be free of the experience of personal defectiveness. Guilt is about identifiable acts and transgressions; reparation is generally possible. Amends can be made. Shame is about *being* and feels less easily modified, at least in our culture.

Mild shame may actually be a healthy signal that one must bring awareness to one's relating, balancing initiative and responsiveness. But in an unequal power situation or where mutual empathy is absent, shaming others becomes a means to control them. And this can produce pathological shame. Socialization of children is very shame-based. Children are shamed out of babyhood, away from being helpless, needy, readily expressive of feelings, vulnerable, and dependent. Gender socialization is also laden with shaming, both in the home and in the world. Boys are shamed if they act or feel too dependent, scared, out of control, "weak," tearful; anything that is categorized (stereotypically) as feminine is to be avoided at all costs. Girls are shamed for being uncaring, angry, competitive, unloving, "selfish". Much adult gender-determined behavior is burdened with shame; if we cross the line of what is considered gender-appropriate, we often feel intense shame, unworthiness, a wish to hide.

Women's sense of shame

Male standards of psychological maturity and adult functioning have consistently judged women's' way of knowing and being as less "good" than the male way (Broverman et al., 1970). A debilitating response to these societal standards has led women to feel defective or inadequate about who they are. Helen Block Lewis notes women are far more susceptible to shame than men (1987). I think there are three major reasons for this:

l) patriarchy is actively invested in shaming and in silencing women's reality;

2)because women are especially open to their desire for connection, they are especially vulnerable to its threatened loss, which occurs with shame;

3)if we care how we *are*, with, and for, other people in relationship, we will experience shame when we feel we have let others down or when our being impinges on or hurts them in some way. This I would call healthy shame.

As a result of prevailing male standards and the silencing of women's reality, for women there is a broad and widespread sense of "being" wrong; that is, one's *being* is wrong. One's reality is not right, one looks for the wrong things in life, one's cognitive capacities are not developed in the right direction. Such a pervasive sense of deviance and inferiority leads to a profound disempowerment, and one loses the ability to represent one's own reality, ultimately, to even know one's truth (Miller, 1988). Shame becomes a way of *being* and a way of being disempowered; in shame we lose our ability to speak, initiate, and expect respect. In shame we feel painfully disconnected, longing to repair the rupture but unable to move in that direction. Thus, shame is a powerful factor in women's lives. A characteristic lament from one woman was, "Bob doesn't listen to me; then, when I 'up' the volume, he calls me a screamer." (Or, in the field of psychology, we are called hysterics, manipulators, borderlines, masochists, dependent personalities).

Another path to disempowerment and the paralyzing experience of shame, is to be treated as if one is invisible and inaudible. William James noted, "No more fiendish punishment could be devised, were such a thing physically possible, than that one should be turned loose in society and remain absolutely unnoticed by all the members thereof. If none turned around when we entered, answered when we spoke, or minded what we did, but if every person we met 'cut us dead,' and acted as if we were nonexisting things, a kind of rage and impotent despair would ere long well up in us" (1890/1968, p. 42). What James describes fits well, I think, with the experience of shame, wanting to be acknowledged and connected and feeling hopelessly cut off from that connection, "cut dead," as he notes. An intrapsychic, self-psychology rendering of this might suggest the person needs to be mirrored, acknowledged, admired; a relational perspective views the essential injury here to a sense of connection and, hence, to vitality.

The silence that shame creates

A powerful social function of shaming people is to silence them. This is an insidious, pervasive mode of oppression, in many ways more effective than physical oppression. In a supposedly egalitarian society, shaming becomes a potent, indirect exercise of dominance to subdue certain expressions of truth. By creating silence, doubt, isolation, and hence immobilization, i.e., shame, the dominant social group (in this case white, middle class, heterosexual males) assures that its reality becomes *the reality*. This dynamic has dictated the social experience of most marginalized groups, be they women, blacks, lesbians, gays, Hispanics, or the physically challenged, whose voices have for too long been unheeded and whose reality has thus been denied.

When people are shamed and silenced by their shame, they cease trusting their own perceptions and sense of reality. Their sense of injury and violation of trust in themselves and the world is often profound (Lynd, 1958). Isolation enlarges the sense of self-doubt, uncertainty, and "wrongness." This renders them more vulnerable to other people's reality claims, self-distortion, and hence to further victimization. This may account for some of the revictimization that occurs for survivors of sexual abuse and contributes to the difficulty for many in leaving an abusive situation. In recent years, sexual abuse survivors have begun to help each other speak out. This courageous capacity for utterance is also developing among clients abused by therapists, doctors, and other caregivers. The 12-step programs have already discovered the power that comes from joining in the admission of a need for help and thereby loosening the grip of shame and secrecy. There is also the empowering experience of giving to others. This is a profoundly balancing and relational program.

People who are "shame prone" are used to taking responsibility or "the blame" for relational failures; in an interpersonal situation where there is an injury, there are several possible responses. One can get angry and blame the other (perhaps the narcissistic solution); one can take personal responsibility, sometimes inappropriately (the place of shame). Another response, suggested by a relational model, is to take both people into account and move toward understanding the relational patterns that led to the failure, assuming a kind of relational responsibility.

Creating this kind of "relational empathy," similar to Kaplan's notion of "process empathy" (1988), may be at the heart of growth-enhancing relationships. Therapy offers an invaluable opportunity to heal the long-range wounds of shame. We are finally heard. Our reality is acknowledged. We are trusted and become trusting. We have an opportunity to create a relationship in which we can more fully represent our experience and find acceptance. In an empathic milieu we can look at shameful experiences freshly, with a view to understanding how they came to be, rather than with a view toward judgment. Very importantly, the therapist acknowledges and respects the client's experience, something that might be called empathic respect. In affirming the client's experience, the therapist conveys the recognition that the client's feelings and behavior make sense in the context of her or his situation.

S. is a woman I worked with who dealt with multiple issues of shame. At age 12 she was hospitalized with severe anorexia; her prognosis was guarded. She felt deeply ashamed of her body, but it was not until five years later when she began treatment with me that she could share the shame of sexual abuse by her stepfather from the time she was nine until age 13. Added to this was her sense of self-blame and shame at not having been able to protect herself; over and over she anguished, "Why didn't I tell anyone? Why didn't I stop it?" She felt profoundly immobilized and had great difficulty moving from this position of withdrawn self-hatred. Her desire to reach out and to be accepted was blocked by her absolute conviction that she was bad, unlovable, and not to be trusted. Her self-hate and despair were often painful for me to experience with her, although sharing the pain was valuable for both of us. Then, in the course of treatment, she was revictimized in a grueling rape. Again, her sense of shame increased, as she wondered why she hadn't perceived the danger and averted it. This idea was fueled by her reading of popular psychology which suggests that at all costs we must see ourselves as being in control; hence, victims too are to blame. The initial violation in which her vulnerability as a child made her prey to a destructive parental figure left *her* feeling shame, cut off, beyond understanding. What then ensued is characteristic of the cycle of shame; more and more isolated and silenced, she became increasingly fragmented and suffered with an intense sense of unworthiness. Only very slowly, by learning to trust and finding herself trustworthy in treatment, through our building a reliable, safe, and growth-enhancing relationship together in therapy, could she begin to bring these silenced aspects of her experience back into relationship. The beauty of her growth from isolation and shame into self-empathy and real relatedness has been deeply moving.

Shame in therapy

Therapy often challenges us to be with the most extraordinarily painful experiences. Much suffering arises in the context of shame, and often therapists may have the impulse to avert our gaze as well, to move out of the pain of the empathic moment. But we are committed to trying to see and listen and understand. Therapy, by its very nature, addresses shame; we ask people to talk with us about those things that they feel most uncomfortable about in themselves, things they might not be able to speak about with anyone else, things we may feel uncomfortable about in ourselves...helplessness, rage, lust. Therapists, too, can create feelings of shame by interpreting only the regressive or infantile aspects of an individual. Infantilizing clients and seeing their needs for connection as pathological is powerfully shaming.

Therapists sometimes further shame clients by assuming a position of power through knowledge which suggests, "I know better than you." The way some therapists interpret unconscious material, or resistance and the like, also may carry shaming implications. The therapist's silence itself may be experienced as scornful. And therapists often shame with their attitudes of judgment and condescension, as typified by the pejorative use of such concepts as masochism, borderline personality, and manipulation (Stiver, 1985). Nothing could be more countertherapeutic and damaging than these attitudes of disrespect, whether subtle or blatant.

A relational therapy also works toward releasing the shame which so frequently arises in this culture about not being an autonomous, self-sufficient person, in control of one's life. In a way, the shame experience often pushes one back into an almost preverbal mode. Others often withdraw from people experiencing shame in this way, leaving them alone in their silence. In therapy which emphasizes empathic attunement, the therapist will note these moments and will, through empathic listening, provide the client a response that does not rely solely on the client's capacity to verbalize the experience. This, then, slowly allows the experience to be brought into the verbal, communicable domain. One client, commented, "When I can't articulate things so you understand them, I feel abashed and embarrassed." An exploration of our mutual responsibility for achieving clarity

diminished her sense of embarrassment and shame.

Often work on shame must precede work on sadness or grief; in clear sadness or grief, one is usually reaching out, believing in the possibility of reparative connection (Stiver & Miller, 1988). In more complicated grief reactions and depressions, shame may prevent the person from feeling the connection necessary for expressing sadness, or a person may feel ashamed of negative feelings, embarrassed about being out of control or about some undesirable reaction to the pain (i.e., seeming selfish). Often there is shame about caring so much about relationships in a culture which values them so little. Sadness also places one in a more vulnerable position, thus more open to shaming.

Healing pathological shame is not about increasing the narcissistic self-sufficiency or self-esteem of the individual or building some intrapsychic structure. Healing shame essentially involves enhancing empathy for self and other and bringing the person back into connection in which empathic possibility exists. This point highlights one of the major differences between a therapy guided by a theory of self-development versus one occurring within a relational perspective.

The therapist's shame

Therapy cannot be a mechanistic enterprise but must take the therapist as well as the client to deep places of vulnerability and possible shame. Unlike many professions that count on definable skills or taking particular roles, psychotherapy calls upon the presence of the whole person of the therapist. How we *do* therapy is a lot about who we *are* as people. Therapy is importantly about *being*. It does not depend on a clear and easily mastered set of skills. We, too, must struggle to stay in connection in the face of vulnerability. There is, then, much room for the experience of shame in the therapist, particularly the beginning therapist. Therapy happens behind closed doors, with little direct validation of what we do. Because the work is difficult and often not immediately rewarding, there is much room for self-doubt or possibly shame, a secret belief that someone else would be better at this. The rendering of the process in textbooks often contributes to a feeling that the books do it right, and we do it wrong; there, highly rationalized interventions and emphasis on the successful moments give a very skewed and unrepresentative picture of the process. (If there is one plea I can make to anyone writing about therapy, it is to please say what is actually happening in the therapy relationship, not what theory prescribes or what sounds smart or clever or theoretically informed).

Furthermore, much supervision is carried on in an atmosphere of shaming. Supervisors with clear theories of what should happen, particularly in terms of neutrality, nongratification, and nondisclosure can also be very critical of supervisees who have a different notion of the therapeutic process. A young therapist came to me after one of my presentations about the importance of mutuality in the therapy process and shared the following experience: She had been with a client who was experiencing terrible grief about her mother's death. The therapist herself began to cry as she listened to this pain, and her quiet tears were noted by the client, in an appreciative way. When she reported this to her supervisor, however, he exploded: "You just raped that patient. Why did you inflict your feelings on her? Where were your boundaries?" With a sense that what she did was humanly compassionate, therapeutically useful, and certainly not destructive or hurtful, this young therapist felt assaulted by her supervisor but not ashamed. She had a clear sense of the importance of relationship and of allowing herself to be affected by clients. Had she been more uncertain she would have felt devastated rather than appropriately critical of her supervisor's rigidity. Another beginning therapist commented that a supervisor had criticized her "lack of boundaries" when she stood up and passed a box of kleenex to a sobbing client.

A psychiatric resident commented that one of the most important things she had learned in her residency was how to lie to supervisors. She was told she was "too relational" by her male supervisors, so this young woman stopped telling her supervisors how she was responding with patients. As a result she felt lonely and vulnerable. One often feels this way even when supported by a supervisor, but her loneliness and sense of risk were even greater.

Old theory dictates that we remain impassive, "neutral," nongratifying. Many beginning therapists have been shamed by supervisors for being too responsive or too transparent. How many opportunities for growth on both sides of the therapy relationship would be lost if we adhered strictly to these dictates! While different responsibilities are assumed in the therapy relationship, the relationship develops between two real people. The therapist must be *real* as well, and this authenticity is informed by an ever-present sense of responsibility *to* and, initially, *for* the relationship and the client. As the therapy progresses, the client will, in fact, assume more responsibility for the relationship.

C. is a woman I had seen for two years in treatment who appeared very disconnected from herself and others and who had recurring dreams of being made of brittle metal, unable to bend or feel. She had never cried or expressed any spontaneous feeling with me or with her two former therapists. Following the death of my mother, which she knew about, I was in deep grief. On one occasion tears came to my eyes in response to something she said about her grandmother, a person to whom she had felt close and who had died the previous year. She stopped and said, "You're sad about your mother right now, aren't you?" I said I was. She too began to cry and said, "I've felt so bad for you. I'm so sorry about what you've been through." I thanked her and let her know how much I appreciated her responsiveness. All of my training would suggest that I had committed the error of burdening my client with my personal concerns, or that I had made the mistake of allowing her to help me. In effect, this was a moving, alive moment in our work together that dramatically altered the quality of our relationship and subsequent therapy.

Such responsiveness can pose problems. If one has a rule *never to respond in a personal way*, the decisions are arbitrary, clearer (although I get less and less sure about how one actually does this). When we choose to be more real and revealing in therapy, we must make more difficult judgments about what will be in the service of the client and the relationship. This intentionality is at the core. Each relationship will shape different decisions. It is the particularity of the relationship that must be honored.

In summary, our model of development influences our practice of therapy. Evelyn Keller has pointed to the difference between the Platonic knower who "seeks to approach and unite" with the essential nature of things and the Baconian scientist who equates knowledge with power and dominion over things (1985, p. 95). Therapy at its best represents an effort to understand through empathic joining not through exercising "power over". In the empathic listening of therapy, we must be more open, unformed, *atheoretical*, and capable of uncertainty than is ordinarily comfortable in a society that stresses control and predictability. Until recently, our scientific model has pushed us in the direction of answers, certainty, theory. The more I practice therapy, the less theoretical and certain it becomes. Each therapy is radically different, as each relationship has a texture, shape, and pattern of its own. We must *listen*, not *impose;* we must *follow* as well as *lead.* Each person's voice is valuable; each person's capacity to listen is important. The tension of creating a dialogue can be difficult; it can be wonderful. We must be mutually responsive and initiating in order to grow. Jean Baker Miller has suggested that in order for a relationship to be enhancing for one person, it must encourage growth in both participants (1986). In therapy, we move, not in the realm of control and prediction, but together we create connection and understanding. The therapeutic dialogue is between two real people, each experiencing more aliveness in connection, with a shared primary goal to enhance the client's wholeness, well-being and capacity for relationship. Perhaps more useful than any "scientific," clinical guidelines for doing therapy is Rilke's advice in his letters to a young poet:

> Be patient toward all that is unsolved in your heart and try to love the questions themselves...Do not seek the answers which cannot be given you because you would not be able to live them. And the point is to live everything. Live the questions now. Perhaps you will gradually, without noticing it, live along some distant day into the answer (l934, p. 35).

Discussion Summary

After each colloquium presentation, a discussion is held. Selected portions are summarized here. At this session Irene Stiver of McLean Hospital, and Jean Baker Miller and Alexandra Kaplan of the Stone Center joined Judith Jordan in leading the discussion.

Question: I wanted to make a comment about shame as it's related to humiliation. I had an experience in couple's therapy where I felt my husband and the therapist ganged up on me. My feeling was one of extreme humiliation. I left very upset. I could no longer work with them. I couldn't understand my reaction at the time, but now, listening to what you're saying, I think that humiliation is connected to rage that cannot be expressed in the situation. I was powerless.

Jordan: I think there is a connection. If the anger at being hurt or exposed can't be expressed either because of power imbalances or because you're concerned about hurting the person to whom the anger is directed, then you may pull away sometimes to protect the other person as well as yourself. You are in a no-win position. You feel powerless, and that in itself can feel shameful. In that moment you feel that there's no empathic possibility.

In your case, the other two people were not able

to be there for you in a way that you needed them to be, so your response was to do what people do when shamed: to pull away and withdraw from the situation. Another factor with anger, in particular, is that for women there are a lot of "shoulds" about anger; in other words, we are not supposed to "be" angry. We are definitely not supposed to show it. If we feel ashamed of certain emotional reactions, which is what happens when we feel something that we think we shouldn't feel (involuntary and involving our whole being), the feeling can become laden with shame. I think that in the case of anger and shame, this can lead to a kind of silent fury which then makes us feel even more ashamed since it seems so out of proportion with the original instigating event.

Stiver: In listening to your question and in response to Judy's paper, it seems that in couple's work we could do a lot of reframing in terms of looking at what we can do to help the relationship. Couple's work often focuses on one or the other in the couple as if one is to blame. Judy's paper suggests a shift from an individual to a relational perspective. I think this is important because I think there is a lot of blaming in couple's therapy.

Jordan: One of the common examples I've seen in couples' work with men and women is when the relationship is very difficult, and one person, typically the woman, has been putting a lot of energy into trying to make it better, she may be blamed by mental health professionals for "loving too much" or be labelled as masochistic. This is often the burden of the one who takes primary relational responsibility: to be seen as "trying too hard" or as "self-sacrificing." A better way to think about this would be to look at the real imbalance in the couple about who is taking responsibility for the relationship and try to work on that. Mutual responsibility-taking for the welfare of the relationship would be the goal.

Question: When you distinguished between guilt and shame, you said that guilt was about actions that could possibly be amended and that shame was about *being*. Can you elaborate on what you mean by *being*?

Jordan: I think one of the distinctions between guilt and shame has to do with the difference between voluntary and involuntary action. Guilt is about an action that one sees as voluntary and that one sees oneself as having some control over, some moral responsibility for, if you will. Shame is experienced often as about something that happens involuntarily to one or about some failure to live up to some ideal about how one should be; it involves the entire sense of self. I meant by *being* that it involves the whole person, our whole being. Guilt is about particular transgressions and violations of standards.

Miller: When people experience shame, it's about everything they are. You feel less than human when you're made to feel ashamed. As Judy said, you feel you are outside the possibility of human connection because of this awful "thing" that you are. Guilt seems to be about a more discrete act and not about your total existence as a person.

Comment: Part of a research study done at the University of Michigan found that when they asked depressed women to talk about their guilt and embarrassment, that embarrassment was experienced very frequently by the women; whereas guilt, which is normally associated with depression, really wasn't noted that often. I could never make sense of that finding until tonight; so, thank you.

Comment: I wanted to comment on dealing with shame, with being shamed in a relationship. My husband uses shame to control. He uses nonresponse when I ask him something he doesn't like. He acts as if I don't exist. One of the things that helps me reject being shamed is the realization that if he needs to control me, he is dependent on me. He is dependent on my cooperating with him. That frees me to perceive his dependency in that situation. He is operating out of fear and a need to control, and I don't have to buy into his fear.

Comment: It seems to me there's a great deal of implicit criticism in what you say of the way psychiatrists and psychologists are being trained. I wonder what sort of changes you might make in training.

Jordan: First, since the most important training in therapy occurs in supervision, it is very important that supervisors become sensitive to the issue of shaming the trainee. With so much uncertainty and sense of personal exposure on the part of the trainee, it is terribly easy to be shamed by a critical or judging attitude on the part of the supervisor. Similarly, the supervisor should explore with the trainee how easily clients are shamed in the therapy setting. It is terribly important to help a beginning therapist develop sensitivity to the client's sense of exposure and feelings of being cut off from empathic possibility. Openness to uncertainty and exploration, rather than defining and labeling, are central to therapy. Therapists are there to understand, not to shame or judge.

Question: When you talked about the potential for the therapist to shame the client, I thought you were pointing to the fact that the end does not justify

the means. I struggle with how to help people who are engaged in very self-destructive behavior without shaming them, how to help them give up the behaviors without attacking the self.

Jordan: One of the places where that happens is when people are in relationships that are destructive. If the therapist takes a relational perspective and looks at the relational imbalances, that is very freeing for people. It removes a sense of self-blame, and together you can really try to understand the destructive relationship. Also, when the therapist becomes more sensitive to the possible shaming implications of certain interventions, that is quite helpful. It also helps to be clear that while you are upset with the self-destructive actions, you can appreciate that the person often is trying to do something constructive through these behaviors, often trying to understand or communicate something. Ironically, the person is frequently working to establish a better sense of connectedness. It's important for us as therapists to appreciate that person's "ends" as well as to work on shifting the sometimes self-destructive "means." *Respect* for the client's *efforts to connect* and to make sense of experience is terribly important always, but especially when shame is involved.

Comment: I was glad, Judy, that you mentioned minority women and lesbian women in your talk. I was thinking how for lesbian women there is such a large part of us that we need to keep hidden when we're not in safe situations, particularly professionally. I was also thinking about how my gay male clients share that experience of shame, and they have that empathic ability. It leads me to wonder about the experience of shame and the connection of that experience with the ability to be empathic.

Kaplan: That opens up a huge area for all of us. We all carry our own shame as therapists in our work. In some cases we know where our shame is, and in some cases we don't. It is an important task to know where our shame is and how that affects our clients. If we know it, it can help us to be more empathic.

Question: With guilt, we make the distinction between neurotic guilt and appropriate guilt. Is that distinction meaningful where shame is concerned? Or is it always deleterious?

Jordan: I think there is a mild shame which might be thought of as appropriate humility. Appropriate guilt is about doing something wrong, realizing it, and feeling remorse about it. Similarly, for instance, in mild shame or humility, I realize in an interpersonal situation that I am not perfect, my *being* is imperfect in certain ways. I become aware of a wish to be more worthy of relationship, to be more lovable and loving. It brings my attention to the desire for connection in a healthy way. Humility, if you will, is at the heart of the relational self; I think it represents a balance of awareness of the other person and of oneself. Compassion comes alive here...for self and other.

Comment: I'd like to elaborate on something you said which I think is relevant to the treatment of sexual abuse. An important acknowledgement is not just that violence was done to the victim, but that violence was also done to the relationship. From what you've said, we could see that part of the anger at the perpetrator is about his failure to take responsibility for the relationship and for the damage done to the relationship as well as to the abused individual.

Jordan: Yes, both the abused person and the relationship are betrayed and violated in such situations. And one of the outcomes is that the victim learns not just that this particular perpetrator is destructive or dangerous, but also comes to fear that all close relationships can be similarly hurtful. Building relationships marked by mutual responsibility for the relationship becomes very important and can be an important focus for the treatment.

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