A relational-cultural model: Healing through mutual empathy

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Relational-cultural theory offers an alternative to traditional theories of psychological development. Whereas traditional theories view mature functioning as characterized by movement from dependence to independence, relational-cultural theory suggests that maturity involves growth toward connection and relationship throughout the life span. After contrasting these two theoretical perspectives, the author describes a therapeutic approach based on the relational-cultural model, which involves mutual empathy and working with shame. A case example illustrates this approach. The author suggests that the relational-cultural model has applications at both the personal and societal levels. (Bulletin of the Menninger Clinic, 65[1], 92–103)

Traditional theories of psychological development emphasize movement toward autonomy, separation, and self-sufficiency. Reflecting the Eurocentric cultural bias that extols independence, most psychodynamic psychological theories suggest that people grow from dependence to independence, that "mature" functioning is characterized by the capacity for logical, abstract thought, autonomous thinking, and separation of thought from emotion. Rarely is the cultural bias in these theories acknowledged, and yet there is a great deal of evidence that our model of science itself is saturated with cultural bias. Baconian models of science, which emphasize objectivity, mastery over nature, instrumentality, neutrality, and the primacy of separate objects, are quite contextually biased (Keller, 1985). And Newtonian physics, rooted in Baconian models of science, emphasizes the primary separateness of objects. Unlike Newtonian physics, quantum physics posits the primacy of relatedness and mutual effect. Yet since its inception, psychology has sought to establish itself as a "hard" science according to the model of Newtonian physics; it has focused

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its analysis on the individual, the intrapsychic, and proposed movement toward separation as the path of development.

This is most evident in what might be called the "separate self" model of human development. It is important to remember that self is a metaphor and that the way we conceive of that metaphor is influenced by prevailing values and biases. Thus, when Newtonian physics reigned, atoms and molecules were seen as the basic units of reality; separation was primary and relatedness was secondary. Similarly, in the separate-self model, the self is conceptualized in a spatialized way and portrayed as contained by boundaries that protect it from the impinging surround. Freud (1920/1955) once wrote, "Protection against stimuli is an almost more important function for the living organism than reception of stimuli" (p. 27). The bias of a need for protection against an impinging and distorting context is deeply embedded in many of our theories of development and clinical practice, and it is a bias that is rarely questioned or examined. Yet from a relational perspective, a "boundary" could be conceived of as a place of meeting and exchange with the surrounding milieu rather than as a place of protection from it. In fact, biologists now conceptualize the cell membrane more in line with this thinking, as a place of intense exchange and activity rather than as a static armored protection from the dangerous surround.

In Freudian theory, relationships are secondary to the satisfaction of primary drives, and protection against the surrounding environment is more important than creating connection with one's environment. Although the object relations theorists made significant modifications in the model of primary separation, they remained anchored in the primacy of drive. In Winnicott's (1971) explanation of the development of the capacity for concern for others, the emphasis is on the primacy of aggression. This is similar to the understanding of Melanie Klein, who suggested that concern grows from guilt over aggression against the mother. Thus, in these models, connection, concern, and love emanate from a reaction to the core primary aggressive drive. Fairbairn (1946/1952) and Guntrip (1973) moved more significantly away from drive theory toward an appreciation of essential relatedness. Fairbairn (1946/1952) noted, "It is impossible to gain any adequate conception of the nature of an individual organism if it is considered apart from its relationship to its natural object, for it is only in its relationship to these objects that its true nature is displayed" (p. 139). He suggested a developmental pathway that moves from infantile dependence to mature dependence rather than from dependence to independence. In Fairbairn's formulation, there is an appreciation of the primacy of connection and the inevitability of interdependence

throughout the life span. Guntrip (1973) also addressed the importance of mutuality in relationships throughout the life span.

While Kohut's (1984) emphasis on empathy has suggested to some that his work is primarily about relationship, I believe that his work is truly a psychology of the self, a psychology about the development of the separate self. Kohut's acknowledgment of a lifelong need for selfobjects to maintain self-cohesion and self-esteem is not a theory of mutuality or connection. Selfobjects are used by the self for self-maintenance; in the best of all possible worlds (which Kohut acknowledged rather late in his life did not exist for anyone), this self-object function is internalized in intrapsychic structure. But it is important to note that needing selfobjects is not the same as needing other people; selfobjects are under the fantasied control of the self and operate in lieu of internal psychic structure.

Thus relationships are acknowledged as important in almost all psychodynamic theories, but relationships have been seen as secondary to the primary condition of separateness. The resulting clinical paradigm has been shaped around the notion of a one-person psychology. Until recently, in clinical models there has been an emphasis on the separate self, boundaries, autonomous functioning, and the superiority of logic over affect.

In the past decade, several different groups of theorists have been challenging and reorienting some of the mainstream psychoanalytic theories. For instance, in the analytic field, Mitchell (1988) and Aron (1996) have studied the centrality of relationships in their model of relational psychoanalysis. Stolorow and Atwood (1992) have emphasized intersubjectivity in the analytic work of self psychologists. Stern (1985) has looked at the basic mutuality in mother-infant interactions. And several groups of feminist theorists and clinicians have been reworking our understanding of both developmental and clinical models (Belenky, Clinchy, Goldberger, & Mattuck, 1986; Brown & Gilligan, 1992; Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller, 1976).

The impetus for the Stone Center relational-cultural model (Jordan, 1986, 1992, 1997; Miller, 1976; Miller & Stiver, 1997) came from evidence that women were being misunderstood and misrepresented by traditional psychodynamic models (e.g., classical analytic, object relations, Kohutian). Ultimately the relational-cultural model seeks a better understanding of both female and male development and also places great emphasis on context. As Carol Gilligan (1982) notes, "The disparity between women's experience and the representation of human development, noted throughout the psychological literature, has generally been seen to signify a problem in women's

development. Instead, the failure of women to fit existing models of human growth may point to a problem in the representation, a limitation in the conception of the human condition, an omission of certain truths about life" (pp. 1–2). When "female" is defined in contrast to "male," women are often seen as deficient in important human (male) qualities. This tradition has a long history. Aristotle noted: "The female is a female by virtue of a certain lack of qualities; we should regard the female nature as afflicted with a natural defectiveness" (cited in Sanday, 1988, p. 58). In listening to and learning from women, current feminist psychologists seek to correct these misunderstandings.

Relational-cultural theory

Relational-cultural theory suggests that the primary source of suffering for most people is the experience of isolation and that healing occurs in growth-fostering connection. This model is built on an understanding of people that emphasizes a primary movement toward and yearning for connection in people's lives. It is posited that women grow through and toward connection rather than toward separation, and that their sense of meaning and well-being is anchored in relationships throughout the life span.

In this journey of increasingly differentiated and sustaining connection, there are inevitable disconnections. Acute disconnections are ubiquitous and, when addressed, can actually lead to strengthened connection. Acute disconnections occur when people fail each other empathically, do not understand, or let each other down in a myriad of ways. To illustrate, let us assume a primary relationship between people with unequal power, such as the parent-child relationship. A child is hurt by the parent; the child then represents this hurt to the parent, who in turn expresses concern and sorrow for hurting the child. The parent responds to the child's pain in such a way that the child feels he or she has been able to represent the experience to the parent; that is, the child feels heard and understood. The child feels effective and that his or her well-being matters to the parent. The child thus learns that he or she is relationally effective (can move the other person and can shape the relationship) and can represent himself or herself as fully as possible in this safe relationship. The child begins to feel that he or she can make a difference in other relationships as well. This leads to relational images that contain expectations of being able to be who one is, of staying connected with self and other people, and of being able to have an effect on relationships.

Now let us look at another scenario: The parent hurts the child, the child tries to represent the experience, and the child is greeted with anger, rejection, denial, withdrawal, or other messages indicating that the parent does not want to acknowledge or address the child's pain. In such a situation, the child begins to disconnect from his or her own experience and begins to hide or twist the experience to fit what is acceptable to the more powerful adult. In this instance, the child learns, "When I am hurt or angry, there is something wrong with me and I lose the connection with this important person." There is self-blame and disconnection from certain aspects of inner experience, and one's understanding of reality is altered. The child begins to act inauthentically in relationships and, thus, although feeling superficially safer, feels less real, less seen, and less understood. The child also begins to feel ineffectual and helpless in shaping relationships. This creates what we call chronic disconnections, which actually move people into isolation, self-blame, and immobilization, the hallmarks of what clinicians call pathology. In the relational-cultural model, we refer to these as strategies of disconnection; in the original context, they are often strategies for survival. The child must keep certain aspects of experience out of the relationship in order to preserve the larger, although increasingly inauthentic, relationship. The yearning for real connection remains, but the vulnerability needed to enter authentic relationship feels much too dangerous to someone whose expression of feelings and needs has been neglected, rebuffed, or attacked. This is most extreme for those who may have experienced chronic abuse of power or outright abuse by parental figures. Thus the child in this case is confronted with the paradox of connection: While the yearning for connection gets stronger when one experiences early chronic disconnections from caregivers, the fear of the vulnerability needed to connect authentically gets more intense. The person is then caught between the intense yearning for connection and the terror of it.

The relational-cultural model suggests that this paradox and this pattern of destructive chronic disconnection occur both at personal and societal levels. At a societal level, people are forced by judgments, prejudice, and bias from more powerful others into inauthentic connection or are allowed to bring only certain parts of themselves into connection (Chin, De, Cancela, & Jenkins, 1993). Often they are silenced. This leaves many individuals and groups of people in states of chronic disconnection and marginalization. All the ways that the dominant groups shame and silence nondominant groups contribute to disconnection at a societal level. The cost of marginalization and chronic disconnection is great for both the individual and

the larger culture. Chronic disconnection is accompanied by a drop in energy, lack of clarity, withdrawal from social engagement, feelings of depression, and lower levels of creativity and productivity (Miller & Stiver, 1997).

Therapy

Therapy based on the relational-cultural model suggests that the primary work is to bring people back into healing connection, where they begin to reconnect with themselves and bring themselves more fully into relationship with others. We posit that growth occurs in connection and that we grow, learn, expand, and gain a sense of meaning in relationship. This does not mean that we are in actual physical relationship with people at all times, but that there is an attitude of relatedness, of mutuality, of openness, of participating in experience. This can occur in solitude, in nature, when we feel connected and in relationship with our surroundings. In isolation, we are not in relationship, we are cut off, we are not in mutual responsiveness. Often we are immobilized and self-blaming.

The general work of therapy is to explore and make meaning of the connections and disconnections in one's life. In the process, people explore the relational images that shape their expectations and interactions with others. Relational images are those affectively encoded shorthands for what we expect in connection. For instance, if in the primary relationships in my childhood, my anger was greeted with punitiveness, anger, denial, or judgments about what a bad person I am, I will learn that when I am angry, I am bad, there is something wrong with me and with my feelings. I will learn to keep my anger out of sight and out of connection. This means that I begin to keep aspects of myself out of connection in order to maintain connection. As I move on to new relationships that might not in fact confirm this expectation, I do not have the opportunity to learn new relational expectations because I represent myself partially in the hope that past injuries and failures that I think I have caused will not be repeated. In therapy I have the opportunity to reshape and relearn some of those relational expectations, because in this empathically healing relationship, I, the patient, slowly begin to bring more and more of myself, including my split-off places of shame, into the relationship.

Mutual empathy

In relational therapy, the attitude toward patients is one of deep respect and mutuality; it is about an engaged and responsive way of lis-

tening and participating in the relationship with the patient. The notion of mutuality in no way suggests full disclosure or equality or sameness of role between patient and therapist. Nor should it obscure the inequality of power or role in the therapeutic relationship; therapists have a special role that needs to be adhered to. The role includes the following guidelines: The primary goal of therapy is to help the patient; the therapist is not there for personal gratification; the therapist has a responsibility to ensure the safety of the patient; all interventions on the part of the therapist should be guided by clinical judgment about what will be of most use to the patient. Mutual empathy is about cognitive-affective engagement in the therapy on the part of the therapist, about working with the impact of the patient on the therapist. But this, too, is not about totally spontaneous, authentic responding on the part of the therapist. This is about therapeutic authenticity and clinically informed responsiveness.

What do we mean by therapeutic authenticity? Most people think of authenticity as being about total honesty and spontaneous expression. This actually is quite nonrelational. It does not take into account the possible impact on others of our expression of affect or thinking. Therapeutic authenticity is based on the development of an understanding of the patient, a caring about the impact of what we share on the patient, and careful clinical consideration based on our work, our understanding of what would be therapeutic for the patient. This understanding is gained through empathy and through having built a sense of the relational history of the patient, including the history of the therapeutic relationship. It involves real responsiveness, finding the "one true thing," as Irene Stiver (personal communication, January 1996) notes, that can be said to be helpful to the person. It is also not about self-disclosure, but instead about being present and responsive emotionally.

This clinically informed responsiveness is also not just knee-jerk reactivity. What is needed to help the chronically disconnected or isolated person come back into connection is authentic responsiveness. If, as we posited, much human suffering arises in the context of chronic disconnection and isolation, what we seek to change in the therapy work is this experience of isolation. Mutual empathy and responsiveness is the route to this change. To reiterate, the original hurtful withdrawal and chronic disconnection in the patient's life occurred in the context of nonresponsiveness and failure of empathy in the primary relationship. In the therapy relationship, the patient has the opportunity to begin to respond in an authentic way, particularly in response to failures of empathy on the part of the therapist. The therapist can then remain empathically attuned and caring about the well-being of the patient, unlike t
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well-being of the patient, unlike the original caregiver who might have withdrawn, retaliated, or denied the person's feelings. Thus the therapist is empathic, is moved, is affected by the patient. The patient knows, sees, and feels the therapist being empathic (i.e., is empathic with the therapist's empathy). In that interaction, the patient feels that he or she has had an impact, has emotionally affected the therapist, matters personally, is relationally competent and effective, and can make a difference in this relationship. This affords the possibility of a real reworking of some of the more isolated and immobilizing relational images and thus opens the door of hope, new learning, and growth in connection.

Case example

Bonnie is a 36-year-old woman who suffered abuse at the hands of an older brother when she was a young child. He tortured her and physically assaulted her on several occasions, with virtually no intervention from their parents, although Bonnie in fact tried to tell her mother what was going on. Her mother's response was that Bonnie's imagination was running away with her and why would she say such a thing? Bonnie's agony and pain about the original abuse from her brother were never acknowledged, and her hurt at her mother's response could not be registered. Bonnie withdrew, felt she was a troublemaker, and did not try to tell anyone about this abuse for another 30 years, until her therapy with me. Over time she had begun to mistrust her perceptions and to wonder whether she had made it all up. At the time she came to therapy, none of these memories were available to her in much detail, although she did remember being afraid of this brother and thinking that he was "mean" and threatening. But she was depressed, had recurring nightmares of being in a concentration camp, and felt self-destructive at times. As she began to review some of her childhood experiences, she still had trouble being empathic with her own experience.

One day Bonnie was describing her terror of being home alone with her brother (something that occurred all too often) when I suddenly became teary-eyed and said, "It's like those horrible dreams of the concentration camps ... all alone, unprotected, scared, no one seeing the terror, trying to hide from your brother." Usually very disconnected from her own affect, she suddenly looked at me closely, and said, "You're crying? You care that much?" She too became tearful. We both sat in pain and appreciation of her terror. Later she often described this moment as the moment of her reentry into the human community. She suddenly knew that her

perceptions were right when she could see that her pain affected me and that she mattered to me. It gave her hope, it gave her a sense of effectiveness, it allowed her to begin to feel all the other feelings: sadness, outrage, helplessness, pain, betrayal. She began to become a more fully multidimensional person. She connected not only with her pain but also with her joy and her creativity. This was a profoundly intelligent, artistic individual who had been living a rather circumscribed life. As she came out of her inner disconnection and her disconnection with others, her intellectual and artistic talents began to flourish and she was able to overcome her own terror about becoming a mother. The healing was breathtaking and moving. I felt so touched by her and so honored that I could help serve as her bridge back into the human community.

Shame

Often shame locks people in isolation; work on shame is essential in relational-cultural therapy. In two earlier papers (Hartling, Rosen, Walker, & Jordan, 2000; Jordan, 1989), I suggested that shame is an essential relational affect and that it can be defined as a sense of unworthiness to be in connection, an absence of hope that an empathic response will be forthcoming from another person. There is a despairing feeling that one is beyond empathic possibility. Shame is about one's whole being (Tomkins, 1987). One feels unworthy of love, of connection. One feels that something about one's being locks one out of connection. In guilt, there is a sense that one has done something that violates standards or hurts other people. When guilty, one can make amends. Shame feels more total, more encompassing, and more immobilizing. One feels that there is an inherent defect that makes one unacceptable, unlovable. In shame, people begin to keep shamed parts of themselves out of connection.

The experience of shame takes us out of connection and locks us into isolation. Thus we have difficulty making the reparative responses to move back into connection where the shame could actually be healed. To preserve the relationship, we do not let people see or know those aspects of ourselves that are shame-filled because we fear rejection and judgment. Thus what Jean Baker Miller (1988) calls "condemned isolation" is a common part of shame.

To heal shame, the person suffering with shame must come to believe that another person can respond empathically to his or her experience. The shamed person must come to see that he or she is respected, that he or she matters, that the shamed parts are also empathically responded to by the other person. The shamed person

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comes to believe that efforts to bring oneself more fully into relationship will not be met with severe judgment, rejection, ridicule, and further shaming. Relational therapy and mutual empathy provide an opportunity for significant healing of shame.

Mutual empathy allows our patients to see, know, and feel that they have an impact on us, that we are responsive to them. Slowly, feeling more effective in relationships, patients begin to take risks in the therapy relationship, giving up strategies of disconnection. The therapist's authenticity and vulnerability, necessary to mutual empathy, provide invaluable information to the patient and contribute to building the reliable, trustworthy relationship that lies at the heart of real safety and growth in therapy.

Empathic possibility is the real antidote and healing path for shame. Patients must develop empathy with themselves (self-empathy) and with others. This expansion of empathy both with self and other is at the heart of coming into deeper, more healing connection. It is through connection that the patient begins to let go of maladaptive relational images. Thus as the shame starts to lift, the patient takes some risks in bringing more and more vulnerable aspects into the therapeutic relationship. As these heretofore split-off aspects are empathized with and accepted, the patient begins to experience a renewed sense of relational hope, possibility, and safety. While all of this occurs alongside what might be called the meaning-making work of therapy, the empathic connection is not simply the backdrop for what has often been considered the real work of therapy. The empathic joining is an essential part of the healing, and it is never separate from the meaning-making work.

Conclusion

The relational-cultural model seeks to assist patients in their struggle to become more integrated and connected. It recognizes the inevitable interdependence of human beings throughout the life span and suggests that some of the most important work we can do in therapy is to help our patients move out of isolation into growth-fostering relationships. Thus there is little emphasis on the creation of self-sufficiency or independence. Rather, helping our patients move into healthier, more mutual relationships in which they can grow and contribute to the growth of others is at the core of the therapy. Similarly, at a societal level, the relational-cultural model seeks to develop strategies by which the hurtful disconnections between groups of people (e.g., along lines of race, class, or sexual orientation) can begin to shift so that an attitude of respect and mutuality can develop at this level as well.

While the work of therapy with individuals, families, and groups offers great benefit for most who avail themselves of it, there is also a need for those trained in healing the human psyche to work for changes at a societal level as well. Nowhere is this more evident than in the area of shame. Shame is not just an intrapsychic experience, an individual affect; it is also used to alter people's behavior, often to silence and to exercise power over them. Working to reduce the marginalization of groups is paramount to fostering enhanced mental health. Listening people into voice, into authenticity, into mutuality involves respect, deep understanding, and an appreciation of the forces that create isolation. This is at the heart of the healing connection.

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