The Role of Mutual Empathy in Relational/Cultural Therapy

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Central to the notion of healing in connection is the power of mutual empathy in the therapeutic relationship. Isolation is a major source of human suffering and is often accompanied by immobilization, which prevents movement back into relationship after disconnections. Healing is seen as occurring in connection with others. In order for patients to relinquish strategies of disconnection and shift their negative expectations in relationships, they must actually experience a sense of relational efficacy, of having an impact on the other person, the therapist. This happens when the therapist is emotionally present, attuned, therapeutically authentic, and working with the connections and disconnections in the therapy relationship itself. In this way, people begin to move back into growth-fostering relationships, expecting that others may respond empathically and finding that they can be effective in shifting and moving relationships in ways that allow them to bring themselves more fully into relationship, to be more whole and authentic. © 2000 John Wiley & Sons, Inc. J Clin Psychol/In Session 56: 1005–1016, 2000.

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Traditional psychodynamic models of treatment emphasize the importance of therapist neutrality, nongratification, uncovering and interpreting unconscious conflict, and vigilance around countertransference problems that suggested overinvolvement of the therapist. Although most therapists currently eschew the rigid application of any of these tenets, and many have abandoned them altogether, some of the early psychoanalytic beliefs subtly permeate therapies as diverse as cognitive behavioral and classic psychoanalytic approaches. To understand the biases of these early models and how they still often affect, in unacknowledged ways, the therapy we practice, let me first point out the larger context within which psychotherapy exists.

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Western Science is primarily based on Baconian notions of mastery over nature, objectification of that which is known, instrumentality; this contrasts with other epistemologies that depend more on knowing through joining, a kind of Platonic or empathic knowing, seeking harmony with nature (Keller, 1985). Psychology as a field sought early to demonstrate its scientific rigor by modeling itself on the most esteemed of the hard sciences—Newtonian physics. Physics not only emphasized the aforementioned objectification, instrumentality, and distance between knower and known but also selected as its unit of study the atom, the molecule . . . the separate object. Ironically, as psychology was attempting to model itself after Newtonian physics, the most creative minds in physics and ultimately the whole field of physics were moving in the direction of an appreciation of quantum physics, of indeterminacy, of the primacy of relationships rather than separate objects. But the bias of separation was taken up by the field of psychology, and it became preoccupied with the separate self. And clinical psychology has largely looked at pathology within the separate self. This is epitomized in the diagnostic manuals that use a medical/disease model to locate pathology in the individual.

It is important to recognize that “self” is a metaphor. The metaphor as carried forward in most psychodynamic theories is one of separation, autonomy, agency, and defined by intrapsychic structure. Although various theories have paid attention to the mother-child dyad, or the family, there is usually the notion that the basic unit of study, interest, and intervention is the separate self. The goal of most treatment interventions is to make this separate self increasingly autonomous, self sufficient, and independent. In Western cultures, and especially in the United States, we put great emphasis on the importance of independence. The individual is celebrated. Context and community are paid lip service but rarely seen as primary.

When this model of separate self is applied to certain groups of people, it often portrays them as deficient or pathological. Thus, women have often been pathologized using traditional psychological models as too dependent, too emotional, too needy. People of color, including African American and Asian American families, and other marginalized groups similarly have been seen as deviant or deficient when standards constructed on the dominant paradigm of separation and individualism are applied to them. Yet, we know that cultures vary widely on the dimension of individualism and communalism (Markus & Wurf, 1987).

In therapy, this has translated into an emphasis on individuals in treatment, looking at individual personality structure or the lack thereof, and unraveling internal conflicts. The emphasis has often been to try to assist the person in forming a more firmly defined sense of self, a greater sense of autonomy and self sufficiency (The literature is replete with references to “enmeshed” families, overly dependent individuals, people whose emotions are too chaotic, etc.) Traditional psychoanalytically oriented models of therapy, arising from within what we might call the larger “separate self” culture of psychotherapy, also emphasize a sense of containment, separation, nonresponsiveness on the part of the therapist, and what some now would call a one-person system.

Although there have been other theorists who contributed enormously to a more interpersonal psychotherapy (e.g., Rogers, 1951; Sullivan, 1953), explicitly relationally oriented theorists have begun to emerge in several different areas; these include the relational psychoanalysis (Aron, 1996; Mitchell, 1988) and the intersubjective theorists (Stolorow & Atwood, 1992). Another major focus on relational/cultural practices in therapy was developed by the feminist relational theorists (Belenky, Clinchy, Goldberger, & Tarule, 1986; Gilligan, 1982; Jordan et al., 1991; Miller, 1976) who began writing in the 1970s. Their work suggested that traditional psychodynamic models pathologized women’s ways of being in the world. They also pointed to the need for a new psychology of women.
The Relational/Cultural Model

The core ideas of the relational/cultural model developed by the theorists at the Stone Center, Wellesley College (Jordan et al., 1991) are that:

- people grow through and toward relationship throughout the life span
- movement toward mutuality rather than movement toward separation characterizes mature functioning
- relational differentiation and elaboration characterize growth
- mutual empathy and mutual empowerment are at the core of growth-fostering relationships
- in growth-fostering relationships, all people contribute and grow or benefit; development is not a one-way street
- therapy relationships are characterized by a special kind of mutuality
- mutual empathy is the vehicle for change in therapy
- real engagement and therapeutic authenticity are necessary for the development of mutual empathy

Furthermore, the relational/cultural model developed at the Stone Center (Jordan et al., 1991, 1997; Miller & Stiver, 1997) emphasizes the importance of context. Cultural issues as well as sociopolitical forces are central to people’s functioning.

The work of relational/cultural therapy focuses on the understanding of people’s patterns of connections and disconnections. It is not just understanding these connections, but actually reworking them in the therapy relationship that contributes to change. The central paradox in this model suggests that disconnections (defined as breaks in connectedness) occur in relationships all the time (Miller & Stiver, 1997). Disconnections are ubiquitous; people misunderstand one another, hurt one another, fail one another empathically, and simply let one another down. When someone is hurt in a relationship and can represent her feelings of hurt authentically to the other person, and the person responds in an empathic, caring way, the disconnection can move back into connection. By this movement, the relationship is actually strengthened and transformed. The connection becomes stronger and more authentic. If, however, the other person does not respond and if the other person has more power, the disconnection will not be reworked. Instead, the less powerful, hurt person will begin to develop strategies of disconnection. He or she will withdraw and present only what is acceptable to the other person in the service of staying in the relationship. But at that moment of withdrawal, the relationship loses much of its authenticity and vitality as the less powerful person keeps increasingly more of herself out of relationship in order to stay in the semblance of relationship. Both people lose out in such an interaction.

When these interactions happen frequently, the acute disconnection settles into a chronic disconnection. Then the less powerful person twists herself to fit into the only relationship that exists, one that is not characterized by mutual empathy or mutual interest in the other’s growth. Carol Gilligan (1982) talks about this as keeping yourself out of relationship in order to stay in relationship. This is at the core of a normative crisis for white adolescent girls, when they suffer a massive drop in self-esteem as they begin to lose their voices, their authenticity. In this process, one loses authentic connection both with the other person and with oneself. Vitality is drained from the relationship, people become less clear, less productive, and tend to begin to withdraw from other relationships as well. They also experience a sense of relational incompetence. They do not feel they
can be competent in relationships because they cannot have impact, they cannot move the relationship, they cannot expect a response from the other person. This often contributes to a pervasive sense of inefficacy and depression. Or it can involve a less visible loss of voice, loss of confidence, and withdrawal.

These strategies of disconnection develop when people are hurt, not responded to, or violated in relationships; they learn to keep aspects of themselves out of these potentially destructive relationships. In other words, strategies of disconnection are protective; they allow an individual to keep certain aspects of the experience alive but out of connection. In cases of severe abuse, these strategies literally becomes strategies for staying alive (e.g., dissociation). But strategies of disconnection get carried into other relationships as relational images and expectations and prevent the person from bringing her/himself more fully into new relationships. Thus, they lead to ongoing isolation.

The Stone Center relational/cultural theory suggests that a major source of suffering for people is the experience of isolation. Isolation is not the same as being alone or in solitude. In fact, often when people are alone they may be in a state of connectedness with nature, with memory, with some activity such as drawing or reading. Isolation involves a sense of being cut off from connection. In a state of isolation, one feels immobilized and self-blaming. Shame often accompanies a sense of isolation; one feels unworthy of connection. In shame, one feels disconnected, that one’s being is at fault, that one is unworthy of empathic response, or that one is unlovable. Often in shame people move out of connection, lose their sense of efficacy, and lose their ability to authentically represent their experience. Shame is one of the major experiences of chronic disconnection. A way of healing shame is by bringing the person back into empathic connection. It also involves assisting the person in coming back into connection with his or her own experience as well as reentering the human community of responsiveness and love. One moves back into a belief in empathic possibility.

Much has been written about empathy in the therapeutic literature (Kohut, 1984; Rogers, 1951). Few therapists would suggest that empathy is of no importance in the healing work of therapy. But empathy has often been relegated to a supporting role, as necessary to establish rapport so that the “real” work of uncovering, exposing conflict, and working on transference distortions and interpretation can take place. It has also been seen as facilitating a therapeutic context in which a person can learn coping skills. Kohut thought of empathy as a means to understand another’s experience. The Stone Center model suggests that solation is one of the (if not the) primary sources of suffering in people’s lives and also points to movement out of isolation as one of the main achievements of therapeutic intervention. Thus, empathy becomes not just a way of knowing another’s subjective experience but a way of actually experiencing connectedness. In empathic joining, one comes out of isolation and begins to believe that one is worthy of empathy, connection, and love.

Mutual Empathy

What is pivotal to this understanding of therapeutic change is the idea of mutual empathy. Mutual empathy in therapy does not suggest a trading back and forth of empathic attune-ment between therapist and patient. Rather, in mutual empathy we acknowledge that both people are affected by the other and that this knowledge is valuable to both people. That is, in order for the empathy of the therapist to be useful to the patient, the patient must be empathic with the therapist being empathic with him or her. The patient must be able to see, know, and feel (empathize with) the therapist being impacted, touched, and moved
by him or her (reminiscent of Buber's [1958] I-Thou relationship). The therapist's empathic response must be felt by the patient. This suggests that a neutral, uninvolved, unexpressive position on the part of the therapist may actually interfere with therapeutic healing. This is quite opposite to the more traditional analytic stances that suggest that in order for therapy to be effective the therapist must remain objective, at some distance, and nonexpressive (at its extreme, the blank screen). The Stone Center relational/cultural model suggests that this latter traditional stance would not be healing; in fact, it might be iatrogenic. Thus, for someone who is suffering from chronic disconnection, shame, a sense of unworthiness, and a sense of not being effective or competent in relationships, it is destructive not to see that he or she can evoke a response, that another can be empathic and moved by him or her.

Chronic disconnection results from nonresponsiveness or aggressive, hostile responses from the more powerful person in a relationship. For instance, in the original relational context the child might have learned that she was not responded to when sad. She was told she wasn't sad or her feelings went unnoticed or she was made to feel bad for feeling sad. In therapy when as a patient she begins to express sadness, the therapist might well be moved to an empathic response of sadness as well. This might even take the form of the therapist tearing up and the patient noticing this. In this therapeutic encounter, the patient actually sees that she has an impact on the therapist. It is an experience of mattering, of getting a response, of moving another human being. In this moment of healing, the old relational expectations of nonresponse from the other person, the conclusion that "I don't matter" or "Something's wrong with me" begin to soften and possibly alter. We called this a corrective relational experience, similar to Alexander and French's (1946) corrective emotional experience (although not purposely manipulated by the therapist). If the therapist were to remain impassive or unmoved, the patient might be left with a repetition of the original relational failure and the conclusion that she could not have an impact on relationships and that her feelings don't matter, that she is relationally incompetent. For patients who suffered traumatic relationships, this can be especially upsetting and possibly retraumatizing. To be in a state of distress and vulnerability with a powerful other and not to be responded to can plunge a trauma survivor back into an experience of the dangerous unresponsiveness of the original abusive situation.

By its very nature, therapy threatens people's strategies of disconnection. The patient comes to the therapist with a tremendous sense of vulnerability and often hope. The therapist is someone who is supposedly trustworthy but also powerful and somewhat unknown. Therapy invites the patient into increasing vulnerability and greater depth of sharing. This awakens the yearning for connection but at the same time triggers the fear of being violated or injured. Therapy presents the patient with a relational dilemma: It reawakens the original promise and yearning for empathic connectedness and brings forward the terror of vulnerability in a potentially unsafe relationship. Many patients entering therapy feel some mix of the yearning for growth-fostering connection and the fear of increasing vulnerability. Each deepening of the therapeutic process and movement toward surrendering strategies of disconnection as the healing progresses stir an increased dread and fear of vulnerability. The more traumatic the early disconnections, the more ragged and potentially derailing the movement of healing. Each movement into greater trust, closeness, connection, and hope for the trauma survivor, for instance, often brings in its wake a whiplash-like movement into traumatic disconnection. This can be very unsettling for both patient and therapist. For the patient, it recreates a relational pattern of instability and unsafety. For the therapist, there is often a sense of despair or not understanding why an increase in trust and closeness would result in abrupt and unexpected disconnections, distance, self-injury, or rage.
Although traumatic disconnections occur in trauma work when there are empathic failures and misattunements, they also happen when there is accurate empathy, an opening. The traumatic disconnections in the wake of empathic failures are easier to understand and explain. But in cases of both misattunement and increasing connection, the strategies of disconnection are reinvoked in full force. For the therapist, the job is to allow and honor the disconnects because to push to more connection at these times will only increase the terror and sense of unsafety of the patient. But the therapist must also "hold" the yearning for connection and the belief and vision of the overall movement toward greater growth-fostering connection, even in the face of these temporary and necessary disconnects. For the trauma survivor, it is a journey of building and ensuring safety in connection. For people abused as children, connection does not promise growth or healing or safety; connection means abuse of power, danger, fear, and trust that is unwarranted. All of these feelings are easily triggered in the therapy relationship.

Mutual empathy comes naturally for many people in relationships. It is a process of flowing back and forth, of being moved, of feeling safe in sharing one's own vulnerability, and of disclosing the impact of the other person on one. But many therapists are actively trained to hide their natural feeling response to patients. There is much anxiety about therapist disclosure in most psychotherapies; thus, therapists are taught to remain impassive, not to show their feelings. Therapy is not an ordinary social relationship in which all responses and feelings hold sway. Therapists are not entirely spontaneous nor is kneejerk reactivity appropriate. The therapist is in a role that involves professional responsibility and professional ethics of care. The job of the therapist is to be of assistance to the patient to the best of his or her ability. Each intervention should involve some consideration of whether it is going to facilitate the growth and healing of the patient. But the idea that this is best facilitated by a nonresponsive therapist may be an accident of personal preference of many of the early analysts who felt uncomfortable being scrutinized or noticed. Early classical psychoanalytic theory suggested that the development of a transference neurosis that would then be resolved was best done in an atmosphere of neutrality. There has been a notion that transference phenomena are delicate, that they can be easily disrupted. I think most therapists, to the contrary, experience that transferences are ubiquitous and quite robust. However, there is a bias in some therapeutic communities that neutrality of emotional expression and disengagement on the part of the therapist are conducive to good treatment. I believe this reflects a bias in the dominant culture that separation is the valued endpoint of development.

Nonengagement and relative anonymity of the therapist pose several problems to a model that holds mutual empathy as the main curative factor in therapy. The nonresponsiveness of the therapist often reinforces the patient's relational images of relational incompetence, of not mattering; it leads to unauthentic relating and locks patients into a sense that their feelings and thoughts do not matter. The therapist's distance also can become part of a mystification process by which the patient is free to idealize the therapist, and the therapist's power is artificially enhanced. Therapists often give the impression that they have gotten "beyond" the dilemmas and challenges and suffering that plague their patients, the classic "we/they" position. We convey the impression, "Oh yes, I was once someone who suffered but having been through my own therapy I have achieved a state of awareness and insight and harmony." I do not find this to be the case in my own life or in the lives of the therapists I treat or in the lives of the therapists who are my colleagues. The suffering, the dilemmas, and the growth go on.

In order to engage in mutual empathy, the therapist must participate in an authentic way in the treatment. This does not mean that the therapist is fully spontaneous, totally open, or completely disclosing. Therapists have a right to privacy; they have a responsi-
bility not to play their foibles out in the therapy. Therapists are not there to be helped or healed by their patients, although in a good therapy, both therapist and patient will grow and heal. However, it is not the patient’s job to take care of the therapist. Mutuality is not about equality; roles are different. Mutuality is not about disclosure. It is about a quality of engagement and being real, with a constant awareness of what the possible impact will be on the other person, the patient. Therapists must practice a kind of anticipatory empathy, a mix of “educated feeling guesses” about how things will impact the patient. These guesses are built on empathy, knowledge of the patient, and the joint history created in the therapeutic relationship. The therapist must exercise a constant self-correcting system where she or he takes in the feedback from the patient about whether she or he is on the mark, off the mark, helpful, unempathic, and so on.

The authenticity of the therapist is always informed by the possible impact on the patient. In addition, it is used in the service of the growth of the patient. But it does involve real responsiveness on the part of the therapist, and real responsiveness often involves real vulnerability as well for the therapist. Again, therapists should not expose themselves to vulnerability that is beyond their level of comfort. The safety and relational comfort of the therapist is as important as it is for the patient. In order for a relationship to be safe for one member, it must be safe for both people. Safe does not mean absolutely armored or absolutely unchanging. In fact, in the authentic response of the therapist, he or she must be open to being changed by the therapeutic engagement as well. We do not come to therapy as therapists with all the answers and with everything settled in our own lives. Each therapeutic relationship is an opportunity for new learning and growth for both people. There is a kind of “fluid expertise” (Fletcher, 1996); both people bring strengths, wisdom, gifts, troubles, and blind spots to this relationship. The therapist holds some special expertise in the area of mental suffering and relationships. Patients bring knowledge about themselves, wisdom about many matters, and even insights about the therapist that are invaluable.

Case Illustration

Presenting Problem/Patient Description

Cindy was an 18-year-old woman who had been in one form of treatment or another for seven years when she first consulted with me. She had been hospitalized first at the age of 12 with a diagnosis of severe anorexia; at discharge her prognosis was guarded and she subsequently became severely suicidal. A severe depression that included hallucinations of being told to kill herself led to a second hospitalization during which she was diagnosed as schizophrenic. People were extremely pessimistic about her ability to use treatment. She was seen sequentially by several therapists but it was difficult to establish a working relationship. Many of these therapists followed a traditional model in their work with her, being reflective and kind but not very interactive. When she would inevitably begin to “act out” by cutting herself, threatening suicide, or flying into rages, several of these therapists grew impatient and impasses developed in the treatments. She fired several therapists, and several others discontinued treatment when they felt no progress was being made. Cindy remained virtually isolated from peers and alienated from her family. In her third hospitalization, for suicidal ideation and severe depression, she again had difficulty settling in with a therapist.

Cindy arrived in my office after several unsuccessful attempts to engage with other therapists at the hospital I worked in. She was initially rather guarded and quite dissociated. She seemed glad that I talked more than some of her other therapists and said I
seemed "different" but could not articulate how. She was often quite critical of my comments. In the early months of therapy, I felt quite anxious and worried about her as her suicidality was still active. I also felt that I did not really understand what was making her so unhappy and so disconnected.

Case Formulation

After about six months, Cindy began to report that there had been sexual abuse by her father when she was eight or nine. She never lost the memory of this abuse but never spoke about it to anyone. At the time I was treating her (many years ago), I had had no training in sexual abuse treatment. I believed her story, I listened, but I was not sure what she needed in order to heal. I consulted with colleagues, most of whom also were never trained in trauma work. I realized that my best teacher was to be the patient herself, and I knew that the learning would not be easy or comfortable. At that time, I practiced in what I would call a modified psychodynamic approach: I was struggling with many of the constraints I had learned in training but was not confident enough to begin to clearly articulate some of my critiques of traditional approaches. There was a strong analytic bias in my training. I was initially more silent and, now I would say, withholding, feeling pressure to come up with insightful comments and more than a little constrained in terms of spontaneous expression and engagement. She was a spirited young woman but very depressed and very confused by her own behavior and feelings.

Rather early in the treatment, she began a pattern in the therapy that was extremely difficult and perplexing to me. But more than that, it had a big impact on me, which I initially tried to hide from her (and perhaps from myself as well). Whenever I said something unempathic, unhelpful, or just plain stupid, she would phone other clinicians she had seen in treatment in the hospital where I worked and report to them verbatim what dumb thing I had said. Initially, I began to hear about these calls when I would stroll unaware into the cafeteria and one of her previous therapists (and I might add often these were former esteemed supervisors of mine) would come up to me and say "Cindy called last night and said that you said such and such. You wouldn't have said that." I would blush and admit I had (she was an absolutely accurate reporter) and I would leave the cafeteria feeling exposed, incompetent, and irritated. I tried to figure out why Cindy was doing this. I tended to feel she was doing it "to me." I came up with worn-out explanations about her anger at me, her projection onto me of shame, and so on. The real problem was that I was becoming more disconnected from her initially, more protective and self-preoccupied, but not really letting her know either my discomfort or my own self-protectiveness. My narcissism, my own shaky sense of myself as a competent therapist, felt on the line a lot in those difficult days, weeks, months. The best I did during this time was stay in the uncertainty and stay with her, trying to figure out what was going on and trying not to sacrifice her to my narcissism.

Slowly, slowly, I began "to get" what some of this was about. Each of my empathic failures signified for her a potential injury, triggering a danger signal to her that abuse might be imminent. For the trauma survivor, empathic failures set off alarms (amygdala short-circuits). The hurts in therapy made her feel very unsafe in this relationship with a powerful adult, who, she was told, she could trust (and yet she did not know that herself yet) behind closed doors. This felt just too reminiscent of the childhood abuse situation: being vulnerable with a powerful person, someone she was told she could (and someone she should have been able to) trust, behind closed doors. So she did the one thing she felt she could do in this relationship that she had not been able to do in the childhood situation
of abuse: She made the relationship public and particularly broadcast to others the failures and places of hurt. This actually was a brilliant maneuver that allowed her to stay safe enough to continue in what felt like a potentially unsafe relationship.

**Course of Treatment**

As I slowly began to appreciate her wisdom and her contribution to our staying connected, I gave up my own need to be in total control and began to talk about some of the ways I was affected by this strategy. I was also appreciative that she had worked out a very wise strategy to make our relationship safe enough for her. I validated her desire to heal, her need to have the safeguards of other witnesses to our therapy. I acknowledged that at times her reporting my string of errors to others made me feel self-conscious or exposed as a very flawed therapist, but I also let her know that I thought my minor discomfort was a relatively small cost to pay for these safeguards that allowed her growth. She could see my vulnerability in terms of not having all the answers, not having all the power, my willingness to be a bit exposed and uncomfortable. She saw I was not going to sacrifice her to my own needs to maintain an image of myself as a “very empathic therapist.” She also could see that I was willing to give a little in our effort to build a safe enough relationship for both of us to move forward with her increasing vulnerability as she recounted and reexperienced the intense terror and vulnerability of the original abuse situation.

Every step of the way, I let her know how much wisdom she demonstrated in her own healing, and I let her see and know the impact she was having on me; some of the impact was enormously powerful, moving, and sad as I heard about her terrible fear and violation. On one occasion when she told me about her mother’s anger when she had attempted to tell her about her father’s abuse, I found my eyes welling up with tears as I exclaimed “How awful and how lonely for you. No wonder getting heard has been of utmost importance to you!” Some of it was painful in a different way, as she would move into rage or distrust or I would feel helpless in trying to stay with her through some of the hard stuff. But she hung in there. I stayed with my own uncertainty and her pain. Slowly, with mutual empathy, tears, laughter, and frustration, she began to move into more full connection with me. Ultimately, she began to move into more trusting, growth fostering connection with others.

**Outcome**

This young woman, a social isolate when she came into treatment, carrying various diagnoses of schizophrenia, borderline personality, severe anorexia, and paranoia, moved on in her life. She went to college and she got married; recently I got a card that she had a baby girl and that although her life was not perfect, she was happier than she ever imagined she could be. I wept. I wrote back to her to tell her how happy I was for her, how I had wept, and how I still often thought about her. She taught me so much... about her, about trauma, about my own blind spots, and about connection. The responsiveness, the mutual growth, and the respect that grew as we worked through the hard places was crucial to her development. Mutual empathy grew. She saw how she impacted me; this did not lead her to feel she had to take care of me. Rather, the responsiveness I showed her was modulated, real, and gave her the message that she had an effect on me, that she moved me. I also saw the ways my emotional presence and responsiveness moved her. We both grew.
Cindy’s history of abuse and her efforts to reveal the abuse to her mother, which had been unheeded, left her feeling as if she did not matter, as if she could not expect responsiveness and care. She literally felt she deserved to be treated badly and that her needs and feelings did not matter. Furthermore, she was left feeling shame, self-blame, and a sense that she could not be effective in any relationship. The world felt frightening and unpredictable, and she felt she was not someone who could make a difference.

Relatively early on in our therapy, she felt safe enough to begin to share with me the childhood sexual abuse. However, this sharing increased her experience of vulnerability and she then felt the need to go into a major disconnect, possibly terminating therapy abruptly as she had done many times before, or she had to make this relationship safer. In this case, probably somewhat unconsciously, she came up with a way to make the relationship safe enough to stay in it. That is, instead of feeling paralyzing terror and vulnerability when she felt I was unresponsive or not a good caregiver (making empathic failures and mistakes), she found a way to make our relationship, particularly my failures and mistakes, public. It was a way of making this relationship safe enough for her to risk the ongoing exposure. As I came to understand it, it was brilliant in several ways. She let me know that she could protect herself by bringing others into this private relationship, and she also tested my willingness to forgo self-interest (preserving my own image as a good therapist) in order to try to be there for her. This strategy slowly began to allow her to stay connected with me through the fear and the vulnerability. It allowed her to begin to rework the relational images that led her to seek safety in isolation rather than in connection. She began to come into a healing connection with me and with others in her life. Her lifeline had been reconnected.

Conclusion

Because relational therapy is not so much about technique but about attitude, values, and point of view, it is sometimes hard to convey to people exactly what is different or how it works differently. My responsiveness to Cindy was crucial to her relinquishing patterns of disconnection that, although life preserving at one point in her life, were no longer serving her as they kept her locked in isolation. Nonresponsiveness on my part, or more distant mediated, cognitive responses would have left her feeling alone, ineffectual, and perpetually endangered. It is unlikely she could have remained in the treatment. Allowing her to see her impact on me, allowing her in that way to see my vulnerability at the same time that I could stay in connection with her, was very important to her. This did not involve a great deal of personal disclosure, although occasionally when I could tell that my fatigue, for instance, was making me seem disinterested in her and throwing her into a spiral of self-blame and withdrawal, I would spontaneously comment on my state and let her know that it was not about her. She could be appropriately angry that I could not show up fresh and alert for each session, but she also could be appropriately forgiving. Once, when I expressed frustration with our work together, after her initial disappointment and irritation with me she thanked me for being honest and not pretending that I never felt irritated or angry. Learning that we could stay connected through anger was freeing and calming for both of us.

I want to emphasize that I am not suggesting that therapists be totally honest and spontaneous in therapy. My anger with Cindy was modulated, expressed at a time when we had already built a solid connection and in the context of a clear message that we would work through this acute disconnection. It was used in the service of growth and was about showing engagement and impact. What I am talking about is a quality of presence. The therapist’s emotional presence is an important source of information for
the patient and a resource for growth in the therapy relationship. It is important for all patients to develop a realistic awareness of the impact of their actions and words on other people and on relationships. The therapist's authentic responsiveness contributes to a sense of relational competence as the patient begins to experience him or herself as effective in moving or affecting the therapist. It also contributes to the development of anticipatory empathy on the part of the patient, a most important interpersonal skill. This is the ability to anticipate the possible impact of one's actions or feelings on another person. Patients need to begin to understand their own patterns of connections and disconnection, to be able to address the question "Where is this feeling coming from? Is this about you or about me? What am I contributing to this interaction and what are you contributing?" This leads to the growth of mutual empathy. The capacity for mutual empathy increases as the therapist and patient work through connections and disconnections in an authentic, growth-fostering way.

By suggesting that therapy involves mutual empathy, which depends on the practice of therapeutic authenticity on the part of the therapist, we are not suggesting that therapists simply engage in ordinary social relationships with patients. The therapy relationship is intentional and professional; its aim is to help the patient. Therapist authenticity does not involve total self-disclosure or even much factual disclosure about the therapist's life. It is important that both therapist and patient can say no, feel a right to privacy, and maintain clarity of whose experience is whose. Mutual empathy does not involve what has traditionally been viewed as "loss of boundaries." I might add that I have trouble with the "boundary language," feeling that it is anchored in the view of separation as safety. We need to look at boundaries as places of meeting, and we need to think of safety as residing in the development of growth-fostering connections. However, I do think that many of the concepts subsumed under the boundary language (i.e., safety, protection of the patient's vulnerability, clarity, privacy, learning to state limits, and say no) are important to the therapy relationship.

In the relational/cultural model, empathy and the development of good connection in therapy are not simply the backdrops for the work of therapy. In the joining, in the meaning making, in the expansion of a sense of connection, healing occurs. People move into the possibility of being empathically responded to. They come more into their own wholeness as they also begin to appreciate the gifts they have to offer others in their growth. Empathy for self and others flourishes. This is about mutual growth, mutual respect, and mutual engagement. Mutual empathy is the vehicle for change and lies at the heart of growth-fostering relationships.

Select References/Recommended Readings
