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Shame and Humiliation: From Isolation to Relational Transformation

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Jean Baker Miller Training Institute
at the Wellesley Centers for Women

(2000) Paper No. 88

Work in Progress

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Abstract

This paper is a discussion of shame and humiliation that goes beyond individualistic perspectives, offering a broader, relational analysis of these profound and complex experiences. In addition to defining and examining the harmful consequences of various forms of derision and degradation, the authors explore clinical encounters with shame and humiliation, present a case, and describe relational practices that can transform shame and humiliation into opportunities for growth and greater connection.

A Relational Conceptualization of Shame and Humiliation

Linda Hartling, Ph.D.

While most of us can think of at least one occasion in which we felt shamed or humiliated, in many instances these types of experiences are difficult to identify, difficult to acknowledge, and difficult to express. To recount experiences of shame or humiliation, we risk revisiting painful images of being devalued, disempowered, or disgraced, perhaps triggering or reinforcing further feelings of shame. Yet, below our immediate awareness, these experiences can have a profound and enduring influence over our daily behavior. Jean Baker Miller and Irene Stiver note that "we become so fearful of engaging others because of past neglects, humiliations, and violations...we begin to keep important parts of our experience out of connection. We do not feel safe enough to more fully represent ourselves in relational encounters" (1995, p. 1). Experiences of shame or humiliation—including experiences of being scorned, ridiculed, belittled, ostracized, or demeaned—can disrupt our ability to initiate and participate in the relationships that help us grow.

To begin examining the painful impact of shame and humiliation, we must call upon our best relational practices to create a context in which clients feel safe enough to represent their experiences. These practices include:

1. **Listening *and* Responding**: Experiences of shame or humiliation often alienate and silence individuals, in extreme cases, leading them into what Jean Baker Miller describes as "condemned isolation" (Miller, 1988). To overcome the silence and disconnections induced by these experiences, Judith Jordan reminds us that, "In real dialogue both speaker and listener create a liveliness together and come into a truth together. Dialogue involves both initiative and responsiveness..."

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(1989, p. 3). Within a context of responsiveness—a context of listening and responding—we offer clients an opportunity to feel safe and to fully represent their experience.

2. **Mutual Empathy:** Mutual empathy not only entails empathizing with a client's experience, but it also encompasses empathizing with the client's *strategies of disconnection* (Miller & Stiver, 1994), the strategies that may have allowed the client to survive sometimes unimaginable, dehumanizing encounters with others. Moreover, mutual empathy means identifying and empathizing with *our own* experiences of feeling shamed or humiliated as well as our personal and professional strategies of disconnection, which can interfere with our ability to be fully present and engaged in a relationship.
3. **Authenticity:** The practice of authenticity is about being authentic in a way that facilitates the growth of our clients. It is not about self-disclosure, but about being fully present and engaged in the relationship, a point made clear in the Stone Center paper, "Therapist Authenticity," (Miller, Jordan, Stiver, Walker, Surrey, & Eldridge, 1999).
4. **Movement Toward Mutuality:** Shaming or humiliating interactions can thrive within a context of dominant-subordinate relationships (i.e., non-mutual relationships) in which one person holds the power to degrade another. By moving toward mutuality, we are moving away from the power-over dynamics that promote and perpetuate shame and humiliation (see Jordan, 1986).
5. **Humor:** One relational practice that many of us use, but rarely acknowledge, is the practice of humor. Humor can be an effective method of disarming or neutralizing some feelings of shame or humiliation, specifically, humor in the form of taking ourselves lightly and laughing with each other about vulnerabilities and imperfections that make us unique relational beings.

These are only a few of the relational practices that can potentially bridge the disconnections caused by shame or humiliation. All too often, shaming experiences have taught clients that safety lies in disconnection and separation. Relational practice invites clients back into relationship and offers them the opportunity to find healing through connection.

From a Separate Self to a Relational Perspective

Shame and humiliation, along with guilt and embarrassment, belong to a family of emotions that have been referred to as the *self-conscious emotions* (Tangney & Fischer, 1995). They are called the self-conscious emotions because they cause us to reflect upon ourselves; we become *self-conscious.* However, this view is based on a traditional perspective that emphasizes a separate, independent self as the primary unit of study (Jordan, 1989). If we expand our understanding to incorporate a broader, relational perspective, experiences of shame and humiliation might be described as causing us to reflect upon *ourselves in relationship.* Therefore, it might be more accurate to say that these emotions make us *relationally-conscious*, which is most obvious when shame or humiliation serve as precursors to disconnection or rejection.

Relational/Cultural Theory (R/C Theory) offers us the opportunity to move beyond separate-self analyses to an awareness of the relational dynamics of these experiences. Throughout this paper we will describe and expand a relational perspective to achieve a deeper understanding of shame and humiliation.

A Relational Understanding of Shame

The word shame comes from a variety of European words that literally mean "to cover, to veil, to hide" (Wurmser, 1981, p. 29). The literal meaning of the word is consistent with the individual responses associated with shame, e.g., feeling exposed, avoiding eye contact, wanting to hide or withdraw. Examinations of shame found in the literature often describe this emotion as an experience of the self, a failure of being, a global sense of deficiency, or a failure to achieve one's ideas (Lewis, 1998). The literature recognizes shame as an intense, enduring experience that affects the whole self.

Applying a relational perspective, Judith Jordan defines shame as "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" (1989). Further, Jordan suggests that shame diminishes the empathic possibility within a relationship, cutting off the opportunity for the individuals engaged in the relationship to progress toward mutuality and authentic connection. All of us can likely recall feeling isolated or cutoff from others after experiencing some form of shame. Jordan brings our attention to these relational dynamics. While separate-self analyses acknowledge shame as an intense, enduring experience involving the whole self, a relational perspective significantly enhances our understanding, suggesting that shame is an intense, enduring experience, involving one's *whole being in relationship.*

The Relational Dynamics of Humiliation

The word humiliation is derived from the Latin root word "humus," which means earth or soil (Barnhart, 1988). When this root word is combined with the suffix "ate," meaning "cause to be," to humiliate literally means "cause to be soil," or, stated in contemporary terms, to "treat someone like dirt." In other words, humiliation is a form of human interaction that puts an individual—or group—in a degraded or lowly position, inciting feelings of devaluation or disgrace.

Compared to shame, the experience of humiliation has been relatively neglected in the literature (Hartling & Luchetta, 1999; Hartling, 1995). One possible explanation of this oversight is that the characteristics of humiliation do not fit into the individualistic analyses that emphasize experiences of a separate self. Paul Gilbert contends that humiliation is distinguished by a relational dynamic when he suggests that "in shame the focus is on the self, while in humiliation the focus is on the harm done by others" (1997, p. 133). Regardless of this and other possible distinctions, shame and humiliation are frequently used interchangeably in the literature. Perhaps this is because these emotions result in similar behavioral responses, e.g., avoiding eye contact, withdrawing, and hiding. By shifting from an individualistic perspective to a relational view, we may be able to clarify and enhance our insight into both of these emotions.

Judith Jordan's relational definition of shame—a felt sense of being unworthy of connection—provides us with a starting point for describing the closely affiliated experience of humiliation. Humiliation might be thought of as a feeling associated with *being made to feel unworthy of connection.* This definition begins to draw attention to the interpersonal characteristics of humiliation; humiliation is inflicted on another person engaged in a relationship. It is a relational violation that causes an individual to feel degraded, devalued, or unworthy of connection. Applying a relational approach, the relational dynamics of humiliation move to the foreground.

Within a broader, relational framework, it may be easier to describe some of the similarities and differences between shame and humiliation, including those characteristics that have important social implications. For example, scholars suggest that these emotions are similar in that they are both more prevalent in relationships characterized by power imbalances, as in hierarchical, dominant-subordinate relationships (Klein, 1991; Hartling, 1995; Miller, 1976). The power-over conditions that promote shame and humiliation are readily observed in a variety of settings, ranging from playgrounds to battlegrounds.

In describing a difference between shame and humiliation, Donald Klein asserts that, "*People believe they deserve their shame; they do not believe they deserve their humiliation*" (1991, p. 117). With shame, we tend to blame ourselves for the damage we have brought upon ourselves (Lewis, 1987). With humiliation, the damage is viewed as unjustly inflicted upon us by others. This distinction helps us understand how shame and humiliation can be used as a form of social control. It is advantageous to the dominant group to persuade the subordinate group that they are deserving of shame, that they are responsible for the damage they have brought upon themselves, to blame themselves for some deficiency or supposed inferiority. Convincing subordinates that they are responsible for their humiliation and deserving of shame diverts attention away from the actions of the dominant group. Alternatively, if members of the subordinate group were to clearly identify their experiences as undeserved humiliation, they might begin to focus their attention on the behaviors and practices of the dominant group and challenge those behaviors.

These are only a few of the dynamics illuminated through a relational exploration of shame and humiliation. Continued study may reveal other important characteristics that will enhance our understanding of these emotions.

Shame and Humiliation in Therapy

A relational approach helps us recognize the many types of human interactions that may trigger feelings of shame or humiliation. These interactions can range from interpersonal encounters (e.g., ridicule, scorn, contempt, harassment) to social or institutionalized practices (e.g., racism, sexism, classism, heterosexism, etc.). They can even include international events (e.g., ethnic cleansing, armed conflict, genocide; see Figure 1). It is important to be aware of the numerous forms of behavior leading to feelings of shame and humiliation as we begin to explore the effects of these experiences in therapeutic settings.

Therapy is a complex relational context. A therapist must navigate the intricacies of the client's culture and experiences (e.g., past neglects, history of abuse, strategies of disconnection, relational strengths), as well as moderate aspects of his or her own culture, experience, education, and training. Furthermore, a therapist must negotiate the influence and impact of the larger culture and the culture of therapy itself, which is largely informed by separate-self models of psychological development (see Figure 2).

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Given these complexities, encounters with the dynamics of shame and humiliation in therapy become almost inevitable.

R/C Theory suggests that relationships naturally move through periods of connection, disconnection, and reconnection. Resolving disconnections offers individuals the opportunity to not only reconnect, but to move the relationship toward a new, enhanced connection. However, when shame or humiliation is the source of the disconnection, the movement in the therapy relationship may be disrupted or derailed (see Figure 3). The significance of this disconnection should not be underestimated. After all, if one cannot feel worthy of connection (i.e., one feels shamed)—or is made to feel unworthy of connection (i.e., one feels humiliated)—within a therapeutic relationship, with whom can one feel worthy of connection? The fear generated from these types of ruptures may prompt a wide range of difficult reactions in our clients and ourselves, arousing painful relational images or triggering perplexing strategies of disconnection. Being attuned to and accurately identifying shame or humiliation as the source of the disconnection and the source of the concomitant behavioral responses, are essential to effectively repairing the rupture in the relationship.

One way of understanding responses to being shamed or humiliated is to utilize a model originally developed by psychiatrist Karen Horney as a typology of personality types (1945). Adapting Horney's model, we can classify responses to shame or humiliation under three broad categories (see Figure 4). Some individuals may engage in a "moving away" strategy, separating themselves from relationships (e.g., withdrawing, silencing themselves, or making themselves invisible). Many children shamed through neglect and abuse may adopt this strategy of survival. Other individuals may exhibit a "moving toward" strategy by keeping important parts of their experience out of relationship in an attempt to earn or keep connection, that is, they may attempt to appease or please the other to secure the relationship or just to survive in the relationship. This strategy may explain the logic underlying the behavior of some individuals coping with difficult, problematic, or even abusive relationships. Finally, still others may exhibit a "moving against" strategy, directing anger, resentment, and rage against those whom they believe to be the source of their shame or humiliation. Media accounts of the recent series of multiple murders in school or workplace settings—such as the Littleton, Colorado tragedy—suggest that the killers were retaliating against shame or humiliation in the form of ridicule or public disgrace.

In therapy, variations and combinations of these three strategies may become evident in our clients' behavior as well as our own behavior, diminishing the relationship's capacity for mutual empathy and authentic connection. Recognizing these strategies early can lead us to address the genuine source of the disconnection. Furthermore, applying the relational practices we have already identified can help us transform experiences of shame or humiliation into opportunities for growth and greater connection.

Shame and Growth in the Therapy Relationship: The Case of Carol

Wendy Rosen, Ph.D.

My first reactions in hearing the prologue to Carol's life story were fear and reluctance, and I hadn't even heard any real details yet. She certainly wasn't the first client with a history of abuse with whom I'd worked; yet something felt different this time. I simply had the feeling that this would be a long, unnerving ride with Carol, and I felt scared. Do I want to take this on, I asked myself? Interestingly, in the first session, she asked me if I thought I could handle hearing about her history. I "assured" her that I was no stranger to hearing about abuse, and while I imagined by her question that some pretty bad things had happened to her, I thought I could bear hearing about them, despite its being painful in the listening.

Carol had tried a number of other therapists in her recent effort to resume therapy, but hadn't found any therapist with whom she clicked. She described these other therapists as either too "by-the-book" clinical and aloof, too naïve, not strong enough, or having had bad taste in office décor. By the end of our first hour, Carol was tearful and seemed quite fragile. It was clear to me that she was desperate for someone who felt willing and strong enough to handle her. I suggested we both think about our meeting and whether or not it felt like a good fit and suggested that she call me within a week. I knew when Carol left that she had touched me and that I was already engaged in some kind of wrenching emotional tug of war that I did not yet understand. I also believed that she really needed help right away and that, despite my trepidation, I wanted to try this relationship with her. She called shortly thereafter and set up her next appointment.

Carol was 33 years old, white, Protestant, and raised in North Dakota in a working class family with eight children. While she identified as a lesbian, she acknowledged an uneasy relationship to her sexual identity. She had a twin brother, Carl, and they were

the middle siblings. Her father was a laborer, and her mother was unemployed outside of the home. All of Carol's siblings have remained in North Dakota, not far from their parents. While growing up, Carol's home life was utterly chaotic and frightening. Over time and with a great deal of shame, she described her family to me, referring to them as "poor white trash." The house was typically dirty and completely cluttered. There were no clear rules in the house, such that the kids remained unsupervised with no guidance available. Fist fights and running wild were the norm. Survival relied upon knowing how to defend yourself at all costs, figuring out how to play the system and getting whatever you needed by any subversive means possible.

Carol described her father as passive and often absent. He gave her mother carte blanche to run the house and handle the kids and rarely intervened. Neither Carol nor her siblings had much of a relationship with him. Mother, conversely, was omnipresent. Carol had a lot to say about her mother who was the recurrent menacing presence in just about all of her flashbacks and nightmares. Beginning with Carol's premature birth and continuing into adolescence, Carol's mother maintained a highly paranoid, delusional, and abusive relationship with her daughter. While she could be quite harsh with the other children, all of the siblings agreed that Carol had it the worst. The fact that she was a twin and a girl became the basis for her mother's delusional belief that Carol "came from the devil" and that there was something very wrong with her, especially with her body. Mother continuously taunted her that she was really a boy, but that her body was somehow deformed into looking like a girl. She would handle her daughter's body roughly in a range of abusive ways, beginning in infancy.

Whenever I would ask Carol to tell me about some of the things that her mother would do to her, she would respond that she couldn't talk about them, and often she would have a frightening flashback of her mother threatening her in some way. Therefore, instead of having to speak of the many abusive acts she suffered, Carol eventually decided to make a list of all the words that came to mind regarding her abuse, such as "kick," "bite," "beat," "burn," "penetrate," and many others. In my mind, this list of fragmentations represented her private experience of these traumatic assaults in the form of encapsulated, codified moments of terror. To present them in sentence form would have defied the reality of her dissociated management of the events and their encoding in the form of repetitive flashbacks of images and bodily sensations. Even more unbearable, it would have forced her to become the living subject of this horror story in all of its terror and shame.

Early in therapy, Carol's anxiety was so great that it took her most of the hour to feel she could settle down and sit still. She was extremely hyper, made only sporadic eye contact, and typically would joke or be evasive and sarcastic. When the hour was over, she justifiably would feel that we hadn't really talked about anything or made any kind of connection. We both would end up feeling frustrated and incompetent in our efforts at engaging the other's attention. Carol admitted that her anxiety was so great at seeing me each time that it took her a long time to settle down and feel more comfortable. Because of this and at Carol's suggestion, we eventually decided to meet for an extended two-hour session each week. While I was apprehensive about this at first, as I wasn't sure I could endure for two hours, I had this feeling that Carol was pretty adept at assessing her needs around comfort and safety. I also figured I could stand to learn something about endurance from someone whose life was a study in just that. We both needed time together, and we were both a bit afraid of actually having it. I was always exhausted at the end of these sessions, but I no longer felt that either of us parted unaffected.

Carol's "suggestions" regarding the design and direction of the therapy relationship became central to our work together. Our relationship became a forum for cycles of mutual resistance and surrender, the former leaving each of us feeling safe, smug, and out of connection, and the latter finding us feeling scared, vulnerable, and ashamed. This, of course, paralleled Carol's adaptive and miscarried lifelong efforts at survival during which she walked a fine line between life-sustaining decisions and impulsive actions. Oftentimes, this line became blurred, as an elaboration of her history reveals.

Carol learned how to survive her childhood through lying, stealing, and dissociating on the one hand, and through humor, athletic skills, and an engaging, curious mind on the other. She also survived through stolen moments of illicit contact, including incest with a brother, an incident of her fondling a small child for whom she had baby-sat, and an intimate liaison with one of her female high school teachers. Carol felt irreconcilable shame about the former two in that she saw herself as a willing participant, despite her better judgment. She felt no shame or remorse about the latter, however, as her felt experience was inarguably one of loving comfort and growth, particularly around her burgeoning sexuality

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as a lesbian and the chance for a safe, sensuous physical engagement with another. When Carol ran away at age 17, this teacher had taken Carol in to live in her home with her husband and children. She sheltered, cared about, and believed in her and enabled Carol to graduate from high school and go on to college. Their sexual relationship was sporadic and short-lived as her teacher realized that prolonging it was not a good idea for either one of them, and thus, she ended it. It was a rather abrupt ending, which hurt Carol, but the two of them have maintained a lifelong, caring connection ever since. Carol's teacher has not been able to talk about that chapter of their relationship, however, which has left Carol with a lingering curiosity about just what it was that her teacher felt with her at the time, how exactly she had experienced her emotionally and physically. She needed to know who she was through the eyes and benign touch of an intimate other. Was she tainted? Did she indeed come from the devil? Was she really a girl or a defective boy? Was she capable of being handled and held and loved?

These have been the central questions of Carol's therapy and of our relationship throughout our work together. Given her history of abuse, her own impulsivity, the sometimes muddiness of her boundaries, and her very real ignorance of what constitutes safe connection, I knew I was being invited into some really dicey territory. There was simply no good psychotherapy handbook for these issues. There were plenty of blanket rules and professional warnings, but there wasn't much in the way of a finer honing of responses to the very unique meanings and idiosyncrasies of each particular client and the client-therapist relationship. Given my own young adult history of precocious intimacy as a means of satisfying certain physical and emotional questions, I knew that some fragile territory of my own would be entered. These would be private places in me of uncertainty and shame. Added to this was the consistent driving force to all of Carol's momentum through life, that of challenge. Her life has been a series of mind-numbing challenges, and she has met and often attempted to preempt them through indiscriminately challenging just about everything in her path. I knew, then, that our relationship would very likely become one of throwing down the gauntlet over and over again, as survival and success had become defined by such victories. Whether or not I was up to the mutual challenge our relationship would be was no longer a question, as I had already accepted it. Whether or not I would be able to discern the differences between the growth-promoting challenges and the self-defeating, relationally damaging ones was the bigger concern, especially as I had to be both participant and observer. On the other hand, by being both participant, and especially observer, I would have countless opportunities myself to either hide or to shame, each time "protectively" taking myself out of connection. As I was to discover, I was far from always being able to make these delicate choices with conscious ease and care.

Off and on during our relationship, Carol would complain that she had a hard time remembering me between sessions. She'd say, "I can't feel you. I can't see your face." She acknowledged how hard this was for her, as picturing me was a source of comfort to her whenever she had a bad flashback. I thought about this inability to remember, on the one hand, as both her way of paradoxically protecting me and preserving our relationship from what she felt was her own toxicity, and also, protecting herself from what might prove dangerous in me. On the other hand, I also knew that enduring internal connections are built on experiences of empathic love and truly being in an authentic relationship, and these were all but absent from much of Carol's early life.

Eventually, Carol began to complain further that I was sitting too far away from her and that this was part of the problem. She couldn't feel my presence. I agreed to pull my chair up more closely during our sessions, but I secretly began to feel some anxiety and the faint rumblings of resentment. I felt nervous about our physical closeness for reasons I could not clarify, except perhaps to chalk it up to my own issues about intimacy and physicality. I was also feeling challenged, however, as if Carol were testing me and taking some small delight in seeing me squirm. Carol initially described the greater proximity as helpful, but this was a short-lived remedy. She soon began to say that she needed to be better able to truly feel my presence and asked if I would sit on the couch with her. She wanted to be able to hold my hand at times when she was deeply upset and shaken or when she felt unbearably alone. While her request made me even more anxious than before, it did not irritate me as much, since I felt that I could say no and provide "sound clinical reasons" for my refusal. There ensued a protracted phase in our relationship where we focused on this very issue in an exceedingly painful, angry, and confusing series of emotional interactions and eventual negotiations at the heart of which rested some of our most shame-ridden places.

The first part of this phase consisted of my attempts to explore with Carol the reasons for and meanings behind her request. I framed them against

the backdrop of her history of sexual abuse and the dismantling of traditional boundaries in her student-teacher relationship. I emphasized the importance of communicating through words and feelings, highlighting repeatedly the definition and limits of our relationship in this regard. I made clear the central importance of her emotional safety through the maintenance of clarity in our relationship, so as not to repeat past transgressions and injuries. With each explanation, clarification, and interpretation, I was met with increasing tears of frustration and anger and accusations that "you're not understanding me." I began to feel my blood pressure rising with each and every one of her imploring protests. I started to feel harassed and abused by her. Eventually, I could neither stand it nor understand it, and so I fired back my own accusations of what I perceived as her almost sadistic attempts at undermining what I also perceived to be my best therapeutic efforts. I told her that I felt like she was relentlessly pushing me to go beyond my own comfort and what I truly believed was right. I told her it felt suspect, given her history of abuse by her mother, and also given her past relationship with her teacher. She protested that sexual feelings for me were not an issue for her, that I was treating her as if she were asking for something more than she in fact was, that I was making her feel like she was a truly harmful person, and that maybe some of the problems we were having were mine, rather than hers.

This suggestion touched a nerve in me, leaving me feeling confused and ashamed, as if she'd unearthed some ugly secret or character flaw in me. She also felt terrible, and I believe, diminished at how little I seemed to trust her. She would sometimes call me during the week, feeling utterly bereft and alone, but our conversations offered no antidote to the rupture between us. During this whole series of exchanges, I held inside the nagging feeling that there was something very wrong with this picture. I was feeling angry, hurt, defensive, stuck, relentlessly challenged, and yet emotionally detached from my many well-versed clinical rebuttals. Most of all, however, I was painfully aware of how wrenching this seemed for Carol and that I somehow was clearly contributing to it. These observations and the widening chasm between us propelled us to the next phase of interactions.

I felt thoroughly saddened by the shared challenge at this point and began to think that maybe Carol had a point, that I, in fact, was not really understanding her entirely. At the same time, in my weariness, I felt that she was not understanding me either, that, at the very least, there was occurring some very mutual failure of empathy. Each of us was feeling accused, humiliated, and terribly unseen in some way, but I remained thoroughly confused about where we were so tragically missing one another. What I did know, however, was what I was feeling about Carol's request that I sit with her and that she be able to hold my hand sometimes. Instead of trying to assume Carol's experience and unconscious motivations, therefore, I began to explore and speak some of my own. From this vantage point, I could at least return to some more authentic and truly present place in the hopes that Carol could meet me there and that something more clear and connecting might emerge for us. I felt immediate relief. At last, I had given myself permission to own and acknowledge my discomfort without having to understand it entirely. I could tell Carol that not only did I feel some concern about her request for such closeness due to her trauma history, but that it made me anxious to think about sitting on the couch with her and for any form of touch to be a part of our relationship. I didn't know all the reasons for my anxiety, nor did I feel that she needed to be privy to all my internal processes in this regard, but I felt I could tell her some of what I did know.

I talked to her about my professional training regarding the place of touch in therapy, about my fears of how this could get interpreted, and about fears of reprisal or professional censure. In other words, I was frightened, but also I couldn't bear doing anything that in any way might harm her. Carol responded that she truly trusted me and added that she, likewise, would never choose to do anything to hurt me. In fact, what hurt her most was that I didn't trust her. I also told Carol that I thought I had some of my own issues around intimacy and physical closeness that were affecting my response to her, and while I didn't really understand them all, the important point was that they were mine and not hers and that I would keep working on figuring them out. In fact, I had begun privately to question my own sources of shame and apparent discomfort about physicality, which felt painfully deflating, yet equally humbling and personally touching. This whole process of exploration felt, in many ways, like a loving act and a shared gift. I gradually came to the conclusion that I could find no convincing reason to deny Carol's request that I sit with her and be open to touch, such as holding her hand or putting an arm around her shoulder during tearful moments of great pain. Even further, it might very well prove to be a mutually growthful move to make in our relationship. I was very clear with myself and with her about the limits of this contact, that this touch would not be motivated by or aimed at anything of a sexual nature,

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and if any such feelings arose, we would talk about them. I believed that Carol knew at heart what she needed and that I could challenge my own limits just a little more than I had dared before. It felt like a chance to move out of a lonely place of shame into one of mutual respect, important growth for both of us. So, I nervously moved over to the couch with Carol nervously checking in with me about whether I was ready and okay with this. I've since never left her side nor failed to hold her in comfort when the moment called for it.

In sum, this case describes the relational process of moving through feelings of shame toward important points of connection by successfully negotiating a mutually respectful meeting place for a therapeutic relationship, a place that leads to health and growth. Over time, my relationship with Carol has become an increasingly strong one, though certainly not without its bumpy moments. These moments, however, no longer feel terribly threatening to either one of us. Our challenges to one another continue, but they have turned playful, more benign and strengthening. It feels stunningly respectful and loving, filled also with sadness, longing, grief and quietly dissolving shame.

Anger, Shame, and Humiliation: Legacies of a Power-Over Paradigm

Maureen Walker, Ph.D.

I am moved by Wendy's account of her relationship with Carol, as it bears witness to one of the most potent premises of Relational/Cultural Theory: that authentic relationship offers us the gift of conflict—the opportunity for the emergence of something new (Miller, 1986). In preparation for our presentation at the Summer Training Institute, we (Judy, Wendy, Linda, and I) talked at length about what happens in those moments of genuine encounter when both therapist and client are moved by and moved into those private spaces where shame, anxiety, and fear reside (L.M. Hartling, R. Rosen, M. Walker, J.V. Jordan, personal communications, January-June, 1999). It is likely that in those moments both the therapist and the patient experience an intense and unforgiving awareness of fragility and helplessness. In a culture that overvalues certainty and control, this awareness can trigger painful disconnections and violations.

In the course of one of our discussions about shame and humiliation in the therapy relationship, I somewhat reluctantly recounted an incident that occurred when I was in graduate school. At that time, I worked as a counselor in an in-patient alcohol and drug treatment program. In addition to being the only student clinician, I was also the only person of color and the only non-recovering person who had been hired as a primary therapist. I fought hard to gain credibility with the patients and the rest of the clinical staff, most of whom were white, male, grizzled survivors of the "street" or veterans of well-known treatment programs. In many ways, my colleagues enjoyed a built-in status that I could not lay claim to. I had only my book learning, or as one of my colleagues said to me: I was trying to learn about addiction "the hard way." Over time, I gained a reputation as savvy, confrontational, and insightful—an image in which I took particular pleasure as it gave me access into relationships with my patients and colleagues.

As primary therapist, my job was to lead process and education groups. On one particular Monday morning, I came in ready to "take charge." There was a new patient whom I will call Rick, who had been admitted over the weekend. According to the nurse's report, he had been disruptive on the unit, rude to the staff, and contemptuous of his peers, whom he nevertheless regaled with stories of the many treatment programs he had "outsmarted." Rick was a lawyer by training. He walked with a decided limp and was missing his right arm, having lost it, as the story went, in a drunk driving accident. Group was proceeding with usual Monday morning check-ins. Rick's check-in was quite predictably some expression of his disdain for the treatment program. I'm not at all sure how I responded to him, but I am sure it was pretty important to me to feel as if I could have some impact. So I said something. To which he responded that the last thing he was interested in was my "K-mart psychology." I have no idea what happened after that. I probably responded, or more likely issued some confrontational retort. He walked out. The group probably rescued itself and me from his withering judgment by talking about his denial—I honestly don't know. What I do know was that I was stunned, and felt momentarily reduced to nothingness.

If it is true that we are at any age all of our previous ages, I was in that moment the three-year-old kid who waited behind the fence for the older school children to walk past, so that I could hear snatches of their conversation. I was still the three-year-old who was ecstatic to figure out that y-o-u spelled "you." In my three-year-old world, having that knowledge meant that I was worthy of connection, or at least, worthy of notice by the older, wiser seven-year-olds. Something had happened in what Klein (1991) calls the "emotionally relevant field" (cited in Klein, 1991) between Rick and me: a relational space that encompasses both the interpersonal and the cultural-

collective. The critical paradox was that what is held in isolation as intensely private shame is both an impediment to and an expression of our yearning for connection. Because of the terror that often accompanies the yearning, we retreat into self-absorbed disconnection (Stiver, 1998). It is a space where the collective dimension of the private shame is not easily recognized and named.

As Linda Hartling (1999) has pointed out, humiliation involves being put in a lowly, debased, powerless position by someone who, at the moment, has greater power than oneself. In that moment, Rick and his peers—the witnesses to our exchange—held the power, and I was the three-year-old behind the fence wanting very much to have significance and value in their eyes. In that private space of shame and fear, I lost significance and value in my own eyes when I failed to come up with the right answer, the perfect, *break-through* intervention that would cause some shift in Rick (and perhaps bolster my own credentials as a non-recovering addiction counselor). The point is that my sense of connection was quite tenuous, a commodity that had to be earned daily by unerring insights and certain knowledge. My need to be right and my need to know were my defense against the fear of invisibility and the shame of nobody-ness. I have a sense that in that private space, which in my mind had been exposed to public view, my fears of invisibility, powerlessness, and nobody-ness were not unlike Carol's in her implicitly accusatory plea to Wendy: "You don't understand me."

Maury Silver and his colleagues (1986) have suggested that humiliation consists, in part, of a particular sort of powerlessness, in that the person lacks a quality or resource that enables her or him to achieve some goal or standard. In the culture of traditional therapy, some part of that standard has to do with certainty and control. The alarm signals from my own private defenses were compounded by the unrelenting admonitions from supervisors:

- never get into power struggles with clients;
- never let the client take control (along with the dire warnings that some of them would surely try); and
- maintain the therapeutic frame lest you leak away your power.

Missing from most of those conversations were guidelines, or even support for remaining authentic and present in the face of uncertainty and pain. The implicit metaphor is that of therapy as conquest —an encounter that "good" therapists always win. Indeed, the language of conquest permeates much of the discourse about therapeutic practice; for example, it is not uncommon to hear therapists speak about *breaking through* a client's resistance. Because of the exaggerated emphasis on control, a therapist is left with few options for staying in connection when she or he experiences anxiety or confusion in a session. Within the context of a power-over or "conquest" model of therapy, there is little room for self-empathy, a quality that enables presence and authenticity. Under these conditions, the default option in conflict is disconnection, whether through rigid certainty or self-effacing avoidance. Each is a strategy of disconnection that pulls the therapist out of active engagement with the client, thus depriving both of the opportunity to use anxiety and conflict as paths to expanded awareness.

Rick and I were situated in a traditional power-over model of psychiatric treatment; within this frame I felt sorely exposed as lacking the power (e.g., insight, confrontation skills, control) I should possess. The public-ness of our encounter posed an additional threat: that in losing "control" of the session in front of other patients, I would be exposed as unworthy of connection, not only within the group, but also in the larger culture of psychologists that I was training to join.

Humiliation is endemic to "power-over" cultures. Donald Klein (1991) describes such cultures as humiliation-prone. Interestingly, power-over cultures are likely to view this humiliation as pro-social. That is, after a series of ritual humiliations a person is somehow transformed and achieves fitness for membership and belonging. The unfortunate by-product of pro-social humiliation is that it instills a lasting sense of vulnerability (e.g., fear of censure and exclusion), as well as a penchant for imposing such humiliation onto others. Again, Klein describes the phenomenology of humiliation as something akin to one's losing face or sense of identity. Whether in the case of a fledging graduate student or an accomplished therapist, that sense of identity has much to do with the relational images we form of what a good therapist should be. Our investment in holding onto those images is meant to ensure our survival in the professional community.

Humiliation can be traumatic (witness my dissociation during my "public shaming" by Rick). It brings with it the threat of being "turned away from" (Klein, 1991), of being publicly exposed as unworthy of connection. Add to this individual trauma the impact of social marginality. Whether by reason of race, sexual orientation, gender, or some temporarily disabling condition such as grad-student-hood, the threat that one's collective identity might be

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besmirched heightens the potential for trauma.

I started this talk by mentioning a relational conception of conflict as an opportunity for transformation or the emergence of something new. I think Wendy has provided a reassuring example of the growth-fostering possibilities through her relationship with Carol. Over several months, we often talked about paths to reconnection, or as Linda has put it, transforming humiliation into humility (L.M. Hartling, R. Rosen, M. Walker, J.V. Jordan, personal communications, January-June, 1999). When I told this story, Judy asked a playful but poignant question: "So what would be so bad about being a K-Mart psychologist?" We all laughed. What would be so bad about providing a serviceable product at a reasonable price to large numbers of people? Her question brought into clear view the relational images that are part and parcel of non-relational training in psychology. Implicit in those images are elitist fantasies of being perhaps "Armani" psychologists, or better yet one of those exclusive salon purveyors whose customers come only by appointment. Judy's question facilitated renewed awareness of the healing power of humor, especially as it helps us to explore the hidden relational images that constrict our capacity for mutuality in relationship.

At the time of the telling, my memory of my encounter with Rick seemed to come completely unbidden. Such is the power of relationship to awaken, renew, and transform. Rick and I brought into the room our common humanity, the needs and vulnerabilities that become the substance of growth in relationship. We brought with us our yearning for meaning and connection, as well as our very powerful strategies for staying out of authentic connection. From our own private spaces we brought relational images that defined safety as maintaining dominance and control over the other, thus postponing for at least one more day the threat of nobody-ness. He bolted from the room. I dissociated. The lesson of my dissociation is that in my attempt to save face, I lost touch. It is probably a safe bet that now, sixteen years later, Rick is not sitting in some parallel universe in a room with his colleagues talking about his encounter with me. But maybe he is. Such is the gift of conflict and the possibilities for transforming re-connection.

Restoring Empathic Possibility

Judith Jordan, Ph.D.

In an earlier paper on shame, I suggested that shame is an essential relational affect, and I defined it as a sense of unworthiness to be in connection, an absence of hope that an empathic response will be forthcoming from another person (Jordan, 1989). There is an ominous and despairing feeling that one is beyond empathic possibility. Furthermore, shame is a sense of unworthiness about one's very being, not just about one's actions. Traditionally, guilt has been described as involving discrete acts of transgression or violating standards of behavior; the experience of shame is global and immobilizing. It is a ubiquitous human experience and it often leads to withdrawal and isolation accompanied by an immobilizing sense of self-blame and an inability to move back into the very connections that could provide repair.

Shaming, unlike the spontaneous arising of shame from some sense of inadequacy or failure of our being, is done to people by other people, usually to control or disempower them in some way. It plays a role in almost all socialization to greater or lesser degrees. Socialization toward independence and socialization toward gender role compliance are among the areas where the most stringent shaming typically occurs. It is used by parents and it is used by peers. Shaming serves to disconnect people from themselves, from their real feelings, and from others. It also serves to silence and isolate people. Shame is directed at marginalized groups and serves to put and keep them in a place of disempowerment and silence; they are made to feel that their reality is deficient or lacking. Dominant groups characteristically use shame against subordinate groups to keep them from expressing their reality in a way that would threaten the dominant view of reality.

Healing the shame that spontaneously arises in us, or that is done to us by others to control or disempower us, involves reestablishing a belief in empathic possibility. That is, the person struggling with shame must come to believe that another person can respond empathically to his/her experience. The shamed person must come to know that she is respected and matters to the other person, that her efforts to bring herself more fully into relationship will not be met with severe judgments and rejection, and that there will be the possibility of mutuality. Relational therapy, with its non-judgmental stance and its emphasis on mutual empathy, provides an opportunity for the deep healing of shame.

Helen Lynd (1958) wrote a wonderful book on shame in which she noted "enlarging the possibilities of mutual love depends on risking exposure." Both Wendy and Maureen have spoken about opening themselves to being responsive to their clients and to their own deep feelings and uncertainty. They describe a kind of emotional vulnerability and

exposure that does not necessarily involve personal disclosure of facts about their lives. In Wendy's case, she acknowledges how afraid and uncertain she felt and how these feelings threatened to take her into the safety of a non-response, into disconnection. But her handling of the potential disconnection leads us to think about how shame can serve as a signal to move toward deeper connection rather than moving us into disconnection. It is often unacknowledged shame that leads to disconnection. Maureen touches on the issue of shame, of not wanting to be seen as foolish by her client or others (including herself), and she embraces the often painful growth that happens in conflict. The relational model, with its emphasis on mutual empathy, supports the therapist in staying in her/his vulnerability, which also takes us closer to an edge of uncertainty and possible shame. There are no easy, pat answers in this territory.

Linda beautifully outlined for us the strategies of disconnection, of shaming and humiliation. She referred to Karen Horney's work on moving towards, moving against, and moving away from. Our model offers another way: that is, moving *with*. We suggest that in therapy it is important for the therapist to be moved by the client's experience, to be moved with the person. In order to do this, we must be open and vulnerable. We must struggle with our own images of perfection or with images of what constitutes an ideal therapist—all knowing, always in charge, always empathic.

Mutual empathy involves allowing our clients to see, know, and feel that they have moved us, that they have had an impact on us, that we are vulnerable, open, in process with them. The therapist's authenticity and vulnerability, necessary to mutual empathy, provide invaluable information to the client and they contribute to building reliable, trustworthy relationships, which lie at the heart of real safety and growth in therapy.

Wendy addresses the disconnections and threatened disconnections as she struggles to stay present with her client, particularly when she's struggling to discover what will be in the best interest of this client. It is a challenge to stay in empathic connection when, as a therapist, you feel pushed to an edge with which you're not comfortable. And part of staying in connection is staying in touch with and being aware of what's arising in you, what's coming from the client, what's in the relationship, as well as what's in the context, what's coming from the culture of therapy. The culture of therapy often permeates the therapist's thinking, sometimes supporting our work and sometimes creating doubt or shame. Are we doing what our supervisors taught us, right or wrong? Our work occurs behind closed doors, with few clearly defined procedures and techniques. There is much room for self-doubt, a secret belief in difficult moments, that someone else would surely be better serving this client than we are. Or in Maureen's experience as a graduate student, there is the very real concern about being evaluated by peers and supervisors. We have many questions: Is this helpful to the client? Is this deemed useful and ethical by the psychotherapy culture I belong to? Does what is deemed useful and ethical by the surrounding psychotherapy culture match what I, as a therapist, have found effective and healing? If not, how do I deal with that dilemma?

I believe that empathic possibility is the antidote to shame. Clients must develop empathy with others and with themselves. The dominant, white, middle-class culture overvalues control and certainty; not to be in control is to be vulnerable to shame. We are shamed when we are told we are not separate and autonomous enough, not contained enough, not neutral enough, that our boundaries aren't good enough. Typically, as therapists (and as people) we become armored, we get defensive and we get rigid (i.e., disconnected) whenever we're ashamed and anxious. The challenge is to work with and transform the disconnection of potential shame, vulnerability, and exposure, being caught in the headlights, as Linda Hartling notes. How can we stay open and responsive in the face of shame? As therapists we need to know when we are disconnecting in shame.

Shame involves judgment and blame. The person suffering with shame feels self-blame or turns the blame against others. The challenge is to take appropriate responsibility for the uncertainty that occurs around vulnerability without moving into blame of other or self. The question becomes: How can we look together at what's happening in this relationship? How can we bear the uncertainty and vulnerability together?

As therapists we need to examine our own shame and vulnerability. I think we need to ask ourselves: What are the places of our own fear of exposure and sense of unworthiness? What do we value? What happens when clients seek to meet us psychologically where we feel most vulnerable? Wendy addressed the areas of professional boundaries and values around touch, but she also examined her own personal vulnerability around intimacy and closeness. As therapists, we have a responsibility to be acquainted with our own vulnerabilities. We have an opportunity to possibly recognize our own vulnerabilities more

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clearly and transform some of them. We can look at how to transform shame, which is potentially a source of terrible disconnection and isolation for all of us. And in so doing we can contribute to the re-working of the shame of our clients.

Humiliation is often public, clear, and sharp. It is done to us. We are seen in, or put in, a humiliated position. Shame can also be done to us and can be public. Although shame is often subtle and private, arising within an individual, one person or group often does it to another. It is silencing and disempowering. The dominant culture, for instance, develops standards for behavior and shames those who do not match those standards. Similarly in therapy, the dominant therapy culture develops standards of practice and if therapists don't subscribe to those standards, if therapists practice from a different model, they may be shamed. Therapists who question some of the more stringent rules of being objective, neutral, non-gratifying sometimes feel shamed into silence. Therapists sometimes are shamed into not communicating what they're actually doing in therapy because they fear censure and shaming from colleagues. Clearly, ethics and standards of practice that are instituted to protect the safety of clients are necessary. We must adhere to ethical and legal standards in our professional work. But there are also therapeutic opinions of what constitutes "good treatment," often unproven biases that are presented as "good practice," that are then used to shame practitioners into a kind of constricted and disconnected practice of therapy. To the extent that therapists feel they must adhere to a dogma or rigid set of practice principles which they may not feel are truly healing for their clients, they are silenced and possibly rendered less effective. Janie Ward and Tracy Robinson (1991) have written beautifully about bringing African American adolescent girls into voice and into resistance for liberation. It is a guide to survival and transformation for African American adolescent girls growing up in a racist culture. A large part of their strategy is to point out that there is not just one reality, but many different views of reality, that the dominant reality is not always right and that it is important to think critically about any dominant reality. These authors also suggest that alternative models of healthy development and points of view need to be created and enunciated. This is true in the field of therapy as well.

Therapists, too, need to construct new paradigms of development and treatment. We must struggle with the mainstream tenets rather than simply accept and/or be shamed by them. We can be interested in these principles of treatment, question them, learn from them, try to understand their possible usefulness, and be empirical about them (Do they work?); but we need to keep representing an alternative view of healing where it seems appropriate. Let's think critically about therapy, about what heals, about our own practices. We don't just have to accept the values of the dominant culture, whether it's the dominant culture at large or the dominant therapy culture. We need to seek change in the context that shames or disempowers us.

One path to transforming shame is increasing empathic responsiveness and rebuilding a sense of empathic possibility. Courage, too, can function as an antidote to shame. Courage is about bringing oneself more fully into connection. It involves finding out that you're not alone. It answers the lonely question, "Am I the only one?" with a resounding, "No, you are not alone." Can we share our vulnerability and be strong and stay integrated in the face of shaming strategies? In her work, *Feminist Theory: From Margin to Center,* bell hooks (1984) looks at the strengths that are developed at the margins of societal power structures. To the extent that we participate in the power and privilege of the center, each of us needs to look to the paths of courage and wisdom that the people at the margin have developed, often in response to extreme oppression. People of color, lesbians and gays, people in classes other than middle-class, and people outside the dominant power dynamic often develop a wisdom, an awareness, and the ability to resist the dominant paradigm. The dominant culture is preoccupied with control, with certainty, rationality, and predictability. There is a perpetuation of the meritocracy myth, that people get what they deserve, that it's a "just world." Unfortunately, sometimes therapists engage in shaming; therapists can shame one another and supervisors have the power to shame students. Strengths (defined in a narrow and autonomous way) and separation get idealized. Much energy goes into keeping the voices of people who are shamed and humiliated from uniting, from coming together to express and create an alternative reality.

Joining together, hearing each other into voice, coming out of the isolation that keeps us in doubt and shame can lead to transforming the dominant values of both therapy and the larger culture. It takes courage to work with new models, to challenge the old. The growing edge is not always totally safe or clear. There is vulnerability at this growing edge. Together we need to work on developing protected vulnerability and prudent trust. Therapists should not

practice without a network of colleagues with whom they can share new insights about practice, uncertainties, and difficult therapeutic decisions. In such a supported and witnessing context, therapists like Wendy and Maureen will find the necessary and safe-enough freedom to explore and be responsive to learning about what actually heals the disconnections, shame, and pain that bring our clients into therapy.

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Figure 1

Acts of Shame/Humiliation

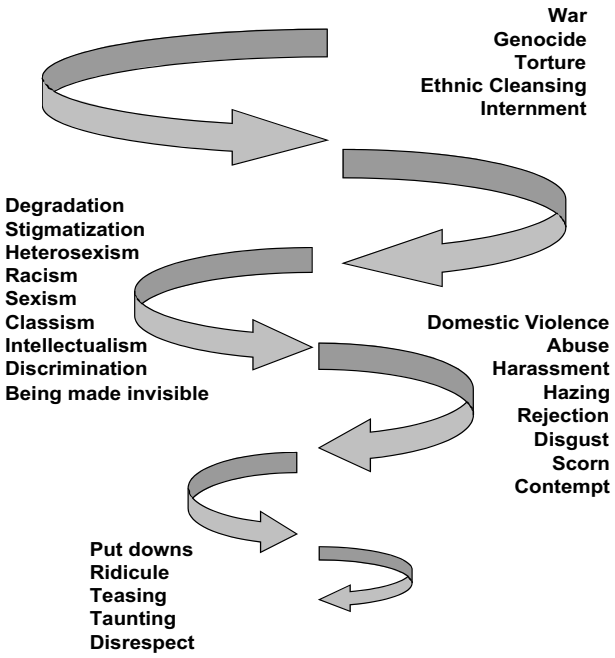


Figure 2

Relational Complexity

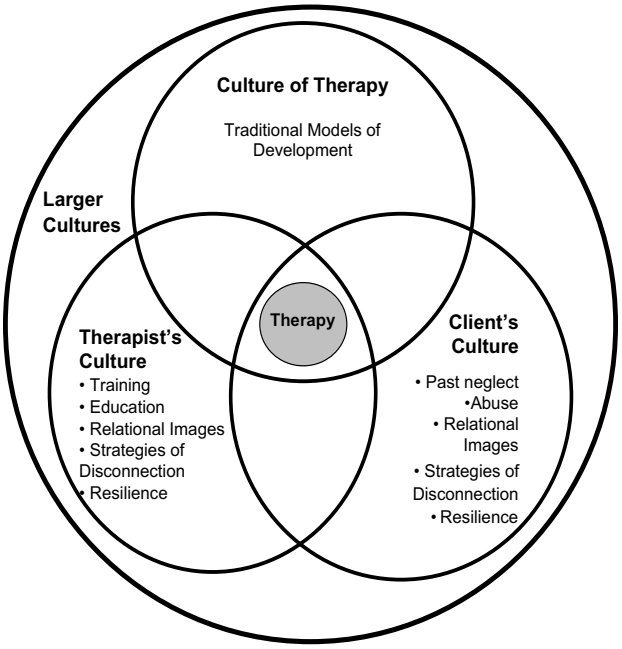
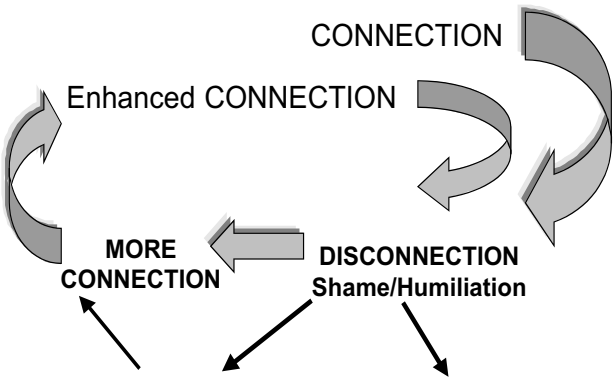


Figure 3

Movement in Therapy



- Zest, energy
- Empowered
- Clarity
- Sense of Worth
- Desire for More Relationships
- Good Conflict

- Energy is drained
- Immobilized, stuck
- Confused, disorganized, disoriented
- Feeling worthless, incompetent
- Turning away from or rejecting connection
- Frustration, anger, rage

Figure 4

Strategies of Disconnection/Survival

Shame/Humiliation

Trigger

Past Relational Images

Strategies of Disconnection/Survival

Moving Away

- Withdrawal
- Hiding
- Silence
- Secrecy

Moving Toward

- Attempts to earn connection
- Appease and please

Moving Against

- Power-over
- Counter-humiliation/ shame
- Aggression

Greater Disconnection; Greater Isolation