From shame to self-acceptance: A hermeneutic literature review.

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Love (III)

Love bade me welcome: yet my soul drew back,
Guilty of dust and sin.
But quick-eyed Love, observing me grow slack
From my first entrance in,
Drew nearer to me, sweetly questioning
If I lacked anything.

“A guest," I answered, “worthy to be here”:
Love said, “You shall be he.”
“I, the unkind, ungrateful? Ah, my dear,
I cannot look on thee.”
Love took my hand, and smiling did reply,
“Who made the eyes but I?”

“Truth, Lord; but I have marred them; let my shame
Go where it doth deserve.”
“And know you not," says Love, “who bore the blame?”
“My dear, then I will serve.”
“You must sit down," says Love, “and taste my meat.”
So I did sit and eat.

George Herbert, 1593 – 1633

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Attestation

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature: _____

Date: _____

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Abstract

This dissertation is a hermeneutic literature review of the dialectic of shame and self-acceptance, and how it informs the concept of self-acceptance as the goal of psychodynamic treatment.

The dissertation's inception was inspired by the quotation from McWilliams (2004): "Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them" (p. 137). The context of hermeneutics of trust as conceptualised by Orange (2011) provided the framework of a new, more accepting approach to the suffering stranger.

During my exploration of the psychodynamic literature the themes of shame, gaze and self-acceptance emerged as leading the inquiry. The intersubjective perspective informed the exploration of shame and acceptance as relationally engendered and maintained affects. The concept of gaze functioned in this study as an experiential bridge between the states of being hidden and being seen, and at the same time I consider gaze as a milieu of the dialectical dance of shame and self-acceptance.

This research became a personal journey of discovering my shame and it lead me to a deeper understanding of the McWilliams' quotation. Shame is an universally experienced affect and is present throughout the psychotherapeutic process. The awareness of it, and the therapist's connection to his own shame, may be helpful in embracing shame and working with it. As a result, the patient is offered a new experience of being gazed upon by the accepting therapist, and given an opportunity to self-reflect with an acceptance of those aspects of themselves that may have been seen as shaming. Self-knowledge has always been considered as an important goal of therapy, but self-acceptance is posited as a more profound goal of psychodynamic treatment. Self-acceptance is understood as self-reflection on aspects of oneself that may never change; which, as a result of therapy that has reached its goal, are not seen as shameful any more.

Chapter One: Introduction

This dissertation was originally initiated by a succinct yet memorable excerpt from McWilliams (2004) that I encountered a few years ago: "Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them" (p. 137). The context of this statement was the author's considerations on reducing shame in the patient during therapy; these two sentences seemed suspended in the text and burdened with meaning; yet were abandoned too early without any further analysis. This absence ignited great curiosity in me, and made me wonder why the author did not elaborate on it. I also soon realised that my own inner dynamics contributed to my urge to explore the possible meanings of McWilliams' concept. Self-knowledge was always something I sought as helping me deal with my internal battles. I entered the psychotherapy room when my seven year old marriage was coming to an end. The space allowed me to explore my 'self' and slowly gain an understanding of why I was who I was. My therapist generously shared his knowledge with me, suggested books and directed me towards studying psychotherapy. During my clinical training, I gradually came to the realisation that knowing was not bringing me enough sense of relief and that insight was the "popcorn" of the therapy, as Lewis, Amini, and Lannon (2007) proposed, but I did not know the movie that went with the popcorn. I wonder whether McWilliams' quotation resonated with me on the very first reading, because it was pointing me to a new direction; towards the healing I was seeking without yet fully understanding what it was that needed to be healed.

As my study journal records, this research was initially woven by two simultaneous threads: the first one referred to how the research would be conducted; the second, gaining a greater understanding of the topic of self-acceptance. I started researching the methodology I was to use, and a hermeneutic literature review was chosen without hesitation; my intention was to read the psychodynamic literature in search of hidden meanings. The book I engaged with as an introduction to the methodology was *Suffering Stranger* (D.M. Orange, 2011), and Orange's compassionate stance was profoundly touching. I became aware of my inclination towards the intersubjective perspective professed by Orange and her colleagues, and it informed the study in a significant way, as will be presented later. The second early thread was a reconnaissance of the topic I was about to study. I started researching self-acceptance, and a reading of the first text I found titled "Self-acceptance" (Wenkart, 1955) brought

to the foreground a feeling of dissatisfaction. I was slowly coming to a recognition that my dissatisfaction stemmed from the absence in Wenkart's work of McWilliams' stipulation of the requirements for self-acceptance: that self-acceptance is gained only when we accept aspects of ourselves that have been seen as shameful, and in Wenkart's article, shame is absent. Thus the dialectics of shame and self-acceptance had become the essential framework of my research. My research question was slowly taking shape: I was interested in self-acceptance as a profound goal of psychodynamic treatment, and self-acceptance was to be considered in the dialectic relationship to shame. I saw this important consideration with increasing clarity when I tentatively attempted to identify what self-acceptance is, and how it differs from the similar concept of self-esteem. It became apparent that self-esteem refers to self-evaluation (Alexander & Friedman, 1980); how one perceives oneself as an agent of one's action, whilst self-acceptance touches on the core sense of whom one is; and a feeling of shame belongs to the core of self, according to McWilliams (2004).

From this point, shame became the focus of my study, and as a result the study became marred with my reluctance to engage with the subject. I explored this reluctance in my personal therapy and supervision and realised that I was gathering the courage to look into the eyes of my shame. I had enjoyed conducting the literature searches, but as soon as it came to engaging with the texts, I felt resistance. My study journal for the first four months had been filled with reflections on shame, anxiety and the avoidance of writing. It was during the text selection process, when I started looking for texts on shame in Polish, that I realised that reading about shame in Polish was even harder. I became aware of having used English as a filter in my therapy; as a protector from the painful memories and thoughts that in English did not seem as real, so they were lost in translation. Whenever I ventured into translating my description of my feelings and thoughts into Polish, I would experience an overwhelming feeling of discomfort, and the desire to shrink and to shiver. This experience surprised me as I did not expect it, yet I also realised that it has always been present. Connecting for the first time to my shame has been a purgative and slow experience. Its importance made me decide to describe the process of my research by choosing shame as a starting point. From this very slow and fragile beginning, I have been gradually moving towards self-acceptance and its cathartic meaning.

I return to McWilliams' (2004) quotation and her suggestion that the therapeutic goal of self-knowledge is insufficient, and I wonder whether it can be seen as a contemporary

development of the field. The wider context of understanding how emotional health and psychopathology have developed has been recognised in the literature as essential when setting up therapeutic goals (Horney, 1991; Kilpatrick, 1956; Weiss, 1956). Horney (1991) traces the development of goals in psychoanalytic treatment from symptom removal in Freud's work, to Alexander's idea of neurosis as a matter of a disorder of personality. Horney's notion of the therapeutic goal is "to help a person find his own self, to rediscover his own feelings, his wishes, what he really believes" (p. 223). She posits, that without finding himself, the patient cannot "grow and fulfil himself" (p. 223). She recognises that knowing about oneself is not enough "without taking a firm viewpoint or reorienting oneself" (p. 225).

Similarly Rudnick (1982) reports symptom removal as not only insufficient, but at times as hindering the healing process. She describes a vital shift in her work with a schizoid and delusional patient from her desire to get rid of the patient's symptoms, as pleaded by the patient himself, towards acceptance of the patient's reality. She explains: "my acceptance of the worm [the patient's delusion] led to the beginnings of his own compassion for himself. This beginning of self-acceptance from someone so drastically alienated opened the door to movement towards others and activity in the world" (p. 269). Rudnick understands the change in her approach as moving away from a "more formal analytic approach [which] communicated a profound rejection of the patient" (p. 267). She realised that the patient needed something else: "Clearly, an approach which acknowledged the reality of the worm, and conveyed acceptance, was necessary" (p. 268). It seems to be in accordance with what McWilliams (2006) observes in her work with schizoid patients, and she postulates that "these patients need to have their subjective experience acknowledged and accepted" (p. 20).

The theme of self-acceptance as a beneficial factor in treatment appears not only in the literature on schizoid dynamics. Gregory (2014) points out the importance of self-acceptance and accepting one's feelings when working with patients who suffer social phobia: "accepting these feelings opens the door to being able to think about approaching situations that have become associated with phobic fear, as long as this is done in such a way that the degree of anxiety remains low enough to be manageable" (para. 5).

In his seminal article on self-acceptance Weiss (1956) too dismisses the relief of the symptoms or adjustment to reality as ultimate goal of therapy. He argues that for a

healthy development a child needs to feel loved and accepted in his individuality. If this does not happen, the child instead moulds themself to the expectations of others and as a result "moves further away from his self [sic]" (p. 16). Weiss identifies self-awareness as "the most important factor in the therapeutic process" (p. 18), but not a goal in itself. He concludes that "a dynamic self-acceptance, with full awareness of the potentiality and of the responsibility for further growth, could be called the basic goal in therapy" (p. 18). His article became important to me for one particular meaning: there is a recognition of the Other in the development of self-acceptance. This ideation enriched my interpretative efforts throughout the study.

This brief literature review on therapeutic goals indicates some major changes in thinking about health and pathology from the original thoughts of Freud and early psychoanalysis. Contemporary theorists do not insist on change in the patient, but suggest that even though the patient and therapist focus on relief from uncomfortable symptoms, it may be a more self-accepting attitude that provides support during therapy and eventually amounts to the desired goal of the therapy. This shift is a significant move from an approach that pathologised the patient and their distress, so common in the older psychoanalytic tradition, to a new more empathic approach to patient's suffering. It illustrates the major shift in psychodynamic theory, which Orange (2011) conceptualised as a move from the hermeneutics of suspicion to the hermeneutics of trust. It is a move from an analyst who is remote, passive and distant to an engaged therapist who relentlessly tries to "contact and understand the suffering other … and that the other in turn is always affecting us" (p. 4). The therapist is thus aware of his limited understanding of the "suffering stranger" (p. 3), and instead walks alongside the patient in a dialogical embrace of internal complexity, without harmful reductionism of symptom and diagnosis orientation. The certainty is replaced by bewilderment, knowing by curiosity, "shaming and blaming" (p. 32) by trust in the meaning of the individual's experience. A therapist submerged in the hermeneutics of trust is aware of his own limitations and presumptions, and strives for honesty with himself, and attends to his own vulnerability when present with patients. This major shift affects the therapeutic setting and treatment goals and the implications of it will be recognised in the latter part of this study.

Another noteworthy observation the preliminary literature review seems to point out is a shared silence. During reading those texts I realised that there was a conceptual gap between how the goals of therapy have been considered and what McWilliams' (2004)

quotation conveyed. This gap was the context of shame; none of the texts conceptualised self-acceptance as the antidote of shame. The closest to McWilliams' thought was a reflection by Morrison (1984), a well-known shame researcher, who says "As the desired antidote to guilt is forgiveness, the comparable yearning generated in shame is for acceptance by the self and by the analyst" (p. 481). Thus the research question started to come into shape in a more specific way: How is self-acceptance as the therapeutic goal portrayed in the literature in the context of the dialectics of shame and self-acceptance?

Before I commence to discuss it in more depth, I come back in a circular movement to take another look at McWilliams' (2004) quote, and at its esoteric message: "Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them" (p. 137). This passage comes from a chapter describing basic therapy processes and the subsection in which it is located is titled "Styles of listening". McWilliams is setting up a scene by acknowledging the difficulty the patient may experience in the beginning of the therapy to talk openly about herself. She stresses the importance of the therapist's supportive style of listening, in order to encourage the patient to "expose as much inner life as possible" (p. 137). Indeed, the patient needs to feel safe and supported if they are to expose themselves, and in this way acquire a new self-knowledge. This requires from the therapist a communication that will "prevent or reduce feelings of shame and humiliation about whatever is revealed" (p. 137). McWilliams recognises that such sensitivity is particularly significant in the beginning of the treatment, however it is important throughout the therapeutic process. When I read this, however, I found a discomfort within myself: there seems to be pressure on the patient to disclose themselves as much as possible. I see it as belonging more to the hermeneutics of suspicion, with an expectation that the patient needs to do something in order to progress. There is little trust vested in the patient and her own readiness to disclose, and I feel resistance in me to the therapist's idea of 'right' therapy versus the patient's reality. Secondly, I wonder whether an attempt to reduce feelings of shame and humiliation are yet another way of removing symptoms. Further, I wonder whether embracing shame in the therapeutic process, and being aware of it without premature soothing, would be more helpful. It thus allows the patient to fully experience the shaming aspect of the therapeutic setting, and eventually facilitate connecting to shame in the later stages of the treatment. I explore these ideas further in chapter 3.

This is a brief description of the structure of this dissertation: I start with a discussion of the methodology and methods applied in this study, which constitutes chapter 2. I then introduce shame and my personal meanings as a researcher of the dialectic of shame and self-acceptance as part of hermeneutic process in chapter 3. In chapter 4 I explore the theme of gaze, which emerged during the research, and became a conceptual and experiential bridge between shame and self-acceptance. In chapter 5 the concept of self-acceptance as the goal of treatment is discussed. I summarise the findings in chapter 6.

It is necessary to clarify a few aspects of the glossary of this study: I choose a word the *patient* throughout the text rather than *client*. The gender I assign to the patient and researcher is female, as I am aware of my identification with the patient and researcher; and the therapist is male. The words *psychoanalytic* and *psychotherapeutic* are used interchangeably, as are *analyst* and *therapist.*

Chapter Two: Methodology and Methods

> The person who is understanding does not know and judge as one who stands apart and unaffected but rather he thinks along with the other from the perspective of a specific bond of belonging, as if he too were affected.
>
> *Gadamer (1975, p. 288)*

Overview

The aim of this study was to engage with the literature on the dialectic relationship between self-acceptance and shame, and how this dialectic informs thinking about self-acceptance as a goal of psychodynamic treatment.

As described in the introduction, a preliminary literature review indicated that self-acceptance is mentioned in the psychodynamic literature, however there are few references that shed light on self-acceptance as a therapeutic goal in the dialectic relation to shame as suggested by McWilliams (2004). Due to this hidden phenomenon, I have engaged with the existing material with an openness to find new meanings, which is a characteristic of qualitative research; rather than aiming at creating new observable and measurable data, which is the realm of quantitative research. I approached the subject with the awareness of my personal presumptions, which is a characteristic of the researcher accepted in qualitative research; but without pre-defined hypotheses and variables, as is typical in quantitative research.

Thus, my aim was to deepen my very own understanding of the meanings available in the text, as I believe an act of interpretation is always a subjective endeavour; rather than a quest for an objective truth as pursued by a quantitative researcher. There has been an acknowledgment of the limitations of quantitative research (Guba & Lincoln, 1994) that positions the researcher as an independent observer who describes phenomena as they are. I deliberately chose the paradigm of qualitative research, which rejects the idea of an objectively perceived reality, and instead recognises the psycho-, socio- and historical context of the researcher as an important contribution to newly found meanings within the data. Therefore, the methodology used in this dissertation is located in the interpretative paradigm, within which I read selected data as sources of meaning yet to emerge. The hermeneutic literature review seemed the warranted option for the study, as the aim was a deepening of understanding.

According to the *The SAGE Dictionary of Qualitative Inquiry* (Schwandt, 2007) hermeneutics "refers to the art, theory, and philosophy of interpreting the meaning of an object" (p. 136), in our case, the object primarily being the psychodynamic literature. The modern hermeneutic theoretical approach, and in this case, the Gadamerian version, is favoured; with its assumption that the process of interpretation is infinite and never completed in reaching a full understanding (Smythe & Spence, 2012). I appreciate this epistemological attitude, as the positivist aspiration of finding the ultimate Truth has been long abandoned, and hermeneutics provide a forum where it is not demanded from interpretation. This humble approach informed the whole process of the research, beginning with the data selection, and going through to the interpretative aspect of the research, to the final arrival at new meanings.

This study was conducted within the hermeneutic framework in order to "provide context and provoke thinking" as described by Smythe and Spence (2012, p. 14). This particular methodology was chosen for three reasons: firstly, in the hermeneutic approach a researcher is aware of her prejudices, and her past and present. Such inclusion protects the interpretation from unthought-of bias to the subject and enhances the dynamics of converging meanings. Secondly, hermeneutics allows access to much more data; according to hermeneutics anything can be considered a 'text' (Gadamer, 1975). This "reading broadly" (Smythe & Spence, 2012, p. 21) encourages the openness to multiple texts without the rigidity of a systematic literature review. As encouraged by the aforementioned authors, the scope of literature choice was approached with hermeneutic openness beyond the stated "psychodynamic literature" in the title, and mythological and philosophical texts were referred to. Thirdly, I engaged in the hermeneutic process of data analysis with an openness to the unexpected that appears. This openness and attunement to the text was performed in a circular movement, shifting from a part (the small data) to the whole (the context) and back to the part, in a so-called hermeneutic circle. This process of understanding allowed new meanings to emerge, which, in the final part of the analysis, I attempt to summarise with openness to being changed and influenced by the material.

Design of the Study

The design of the study was informed by Smyth and Spence (2012), who set out a number of steps when undertaking a hermeneutic literature review. The following section is an elaboration of the steps in relation to the current study.

1 Recognising the pre-understandings of the researcher.

In hermeneutics, the text and the researcher come into a dialogue and each of them have a different context, therefore it is essential to identify these differences. Smythe and Spence (2012) suggest that "the starting place when examining the meaning of a literature review is the reviewer" (p. 16). The so-called "effective historical consciousness" (Gadamer, as quoted by Smythe & Spence, 2012, p. 13) of the researcher has to be described and its meanings recognised. I recognise my personal affinity for such an attitude; I appreciate how the context is always embedded in the text, just as personal history and cultural context is in the researcher. It is from my personal experience in relationships that I feel understood, or explicitly accepted, when the other attempts to get to know my history and my journey to our mutual encounter. This approach has outgrown my early convictions opposing such an attitude, when I studied literature in my twenties and sought the independent, objective value in each literary work regardless of its historical context. Looking back, I wonder whether it had stemmed from the absolutist thinking to which I was accustomed, when submerged in the Christian worldview of the Absolute Truth in the *Bible*. I am now sceptical towards the studies in which the researcher is presented as an objective expert who remains neutral in the view of the researched data. The implication of the above for this research is that the first part of the study was focused on the meanings of my beliefs and my 'fore-havings', as conceptualised by Smythe and Spence.

1.1 The fore-havings

The research was an incredibly enriching process of discovering new meanings and transformation throughout the process. When I chose this subject of the research, I was not fully aware of my horizon. I was intrigued by McWilliams' (2004) statement, and felt stirred internally by its recognition of the limitations of self-knowledge. The pressure of change I have imposed on myself throughout my lifetime was often experienced as shaming. The self-acceptance as the profound goal of therapy, then for reasons unknown to me, promised me something to which I was attracted. In the process of researching the literature, and simultaneously during my own therapy, I have

opened my eyes to the hidden face of my shame and the desire to heal. If my fore-sight guided my research process and its methods, as described later, I have grown in the awareness of my 'fore-having' throughout my encounter with the texts. Smythe and Spence (2012) define it as "understanding we have in advance that allows us to begin to make sense of that which we encounter" (p. 16). I believe I have always felt shame, yet it was at the edge of my awareness. I can now mentalise shame: when I feel shame I feel inadequate, unworthy, faulty, and I feel I am constantly failing myself. I also feel inferior to the Other: I feel I am bad in the eye of the Other and I do not deserve to receive goodness. I describe it in my therapy as a disability; something that precedes thought, not dissimilar from the way Tomkins (2008) describes affects. I feel shame before I can think about it. My natural tendency, therefore, is to judge myself for anything I feel or think, rather than observe it with curiosity. It is a crippling blindness. It is important to note that this new experience of my shame, resulting from the initial readings, overshadowed the research process for a long time. It manifested in my feelings of fear that I am not good enough to complete this project and that this work, which became a very personal journey, would be published on the Auckland University of Technology library website. More importantly, I needed to achieve a certain level of comfort when looking into the eyes of my shame. Although it slowed down my process of writing, I now acknowledge the need to take time and work through this painful connection to my shame. Only when I felt that my shame was not threatening me anymore, could I re-engage with the research, and then my attention very slowly returned to self-acceptance. I strongly believe that without the acceptance of this delay, I would not fully understand the meaning that McWilliams (2004) offers in the analysed quote, its implication for the therapeutic process, and more importantly, the significance of this research.

1.2 **Methods: Journal, Self-reflexivity.**

As my fore-havings have been thus summarised, my intention was to observe how this personal horizon may have converged with the meanings discovered in the texts. In order to achieve this throughout the research, I kept a journal describing my responses to the material and observing "dynamic reflexivity" (Smythe & Spence, 2012, p.14) with regard to my pre-conceptions and personal context. The dynamic dialogue between the texts and myself was present throughout the research, and subsequently has helped to identify the new insights, independent of my pre-understandings.

The potential difficulty of this aspect of the research was my blind spots as the researcher, of which I cannot be fully aware. I believe though that as long as the personal reflexivity was conducted throughout the process, recorded in the journal, then adequately discussed in the supervision, it warrants the validity of the research. I have kept a research journal throughout the process, which vouches for the honesty with myself and the proximity to the texts, and helps to separate my presumptions from what the authors' intended meanings were. Similarly, the relativist or solipsistic critique of hermeneutics could be warded off with the assertion that any research is indeed a personal account.

2 Selecting the text

In hermeneutics, anything published and publicly available can be a text: an article, a chapter of a book, a poem, a myth (Smythe & Spence, 2012). Engaging the research question with the textual world has permeated throughout this research process. Unlike a systematic review's closed reading list, which can limit the study in terms of any possible deviation from the original research question in view of the literature, the hermeneutic text finding is never completed. I initially found this openness to the endless textual world challenging, as I was apprehensive as to how to select relevant texts in a disciplined way. I eventually observed that there were certain texts that I was drawn to, and throughout this dissertation I describe how I made the particular choices. Smythe and Spence describe this preferential selection as "fore-sight", which "guides the process and pre-shapes reading decisions" (p. 16). It was my openness to the texts that helped me define the research question.

2.1 Search methods.

The method utilised here was a database search; search terms including key words such as: self-acceptance, acceptance, shame, goal of therapy, gaze. The AUT online databases, namely PEP, PsychInfo, Google Scholar and Scopus were the main sources of material. I then used the combination of Boolean operators AND/ OR /NOT, which allowed me to widen the choice of texts.

3 Reading and analysing the text.

Hermeneutic reading is performed in a circular and ongoing movement from the researcher to the text; from the known to the new meanings. Initial reading of the wide range of texts, referred to by Boell and Cecez-Kecmanovic (2014) as "orientational reading" (p. 265) has given me a sense of the whole, an "overall impression of their

content" (p. 265). As described in the introduction, after the initial reading I located self-acceptance in the paradigm of the hermeneutics of trust, and became aware of the dialectical dynamics between self-acceptance and shame. The theme of gaze arrived while reading about shame and its provenience in being seen. As I explore in the later chapter gaze has become a kind of conceptual and experiential bridge between the first two themes of self-acceptance and shame. Reading broadly texts that referred to these three themes has been a satisfying experience. I noticed that there were more texts that explicitly talked about shame, and far fewer on self-acceptance, which confirmed my findings from the initial literature review. I slowly developed a certain alertness to words that in my view had connection with self-acceptance: recognition, confirmation, appreciation. Finally, I realised that, in order to engage with the texts in a hermeneutic way, I needed to focus on a limited number of texts; and as presented later, each theme was examined through a prism of only a couple of texts. That allowed me to engage with the authors and their horizon, and the texts and their meanings while holding awareness of my own presumptions.

3.1 **Method: Dialogical Q&A.**

Once the meaning of a whole text emerged, I moved to the exploration of the meaning of the parts. In order to identify the parts, or themes, I engaged with each text searching for something that would stir me; that would either intrigue or anger or excite me. I was also sensitive to some repetitive words or phrases in the text, and I would observe their context and the variety in meaning, depending on the context. This process is dialogical (Smythe & Spence, 2012) in nature and involves asking questions and looking for answers in the text. I have presented a comprehensive description of the hermeneutic reading and analysis in the following chapters. In order to keep this process systematic, each theme was subsequently documented in a separate folder with a simultaneous movement to the whole and the meanings of relation between them. I have created mind maps, as conceptualised by Boell and Cecez-Kecmanovic (2014), that assisted my thinking process by finding correlations between themes and the research question.

Once I reached a sense of themes, I then moved back to establish how the parts related to the whole. I then critically analysed the data looking at its relevance, weaknesses and contributions to the research question. The circular movement from the whole to the parts takes place in the reading process and in the analysis, and note keeping is an important method in order to stay continuously engaged and become aware of the new meanings. Using a graphical representation of my findings was useful for me to keep

the large amount of data cohesive. The subthemes would often move from one theme to the other, as the connection to the whole influenced the meaning of the parts. I was reflective on how it may have been affected by my fore-havings, in order to maintain the rigour of the study, following Gadamer in the importance of being "aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" as quoted by Boell and Cecez-Kecmanovic (2014, p. 263). The process of deepening my understanding of the subject, lead to the crystallisation of the research question. From the very beginning, that is, the reading of Wenkart's (1955) text on self-acceptance and its lack of shame, my attention was shifted to shame as described above. From then onwards self-acceptance became imbued in the dialectics of shame. When the meaning of gaze emerged as new, I allowed it to take me into its depth and seek its correlation to the research question. In the final chapter I will present the findings and the clinical implications of this study.

On Rigor

The potential difficulty of this part of the research was the concern as to how I separate my own meaning from that of the text, named by Smythe and Spence as "fore-conceptions" (Smythe & Spence, 2012, p. 16). In this part I asked, "Do I find the answers I actually want to find?" I believe that the presented analysis of the texts will display my relentless awareness of this issue and my commitment to ensuring that I was open to new meanings being recognised, acknowledged and integrated into my understanding. Throughout this research project I reflected on how it may have been affected by my fore-conceptions to keep the rigour of the study. Maintaining my reflective journal and perpetual awareness of my own dynamics of shame was helpful in recognising my horizons. Beck, when defining the rigour of the qualitative study, states that credibility of the study lies "in how vivid and faithful the description is to the experience lived" (Laverty, 2003, p. 23). I believe that the experiential aspect of this study has been methodically presented in this dissertation throughout the process. Thus the rigour of study was maintained.

Chapter Three: Shame

"aspects of the self that have been seen as shameful"

(McWilliams, 2004, p. 137)

As I indicated in the introduction the initial part of the research was dominated by my personal process of connecting to my shame. This chapter describes the essence of how this research impacted on me and brought about the feeling of saturation. It was from the very moment I realised, or self-reflected on my shame, that I have started my journey towards self-acceptance. This chapter honours the hermeneutic process of my dialogic engagement with the texts and of allowing them to change me. The preliminary literature review revealed that shame has been explored in the psychodynamic literature; however as Morrison (1984) states, its importance in the therapeutic process has not been fully acknowledged. The reason for this phenomenon I believe merits a separate study, and I endeavour to review the current literature on shame and its manifestations in the therapeutic settings.

Shame is described as universal or innate (Tomkins, 2008); an affect of "a profound sense of inadequacy and worthlessness" (Hahn, 2000, p. 10), "the most unbearable of all emotions" (Böhm, 1996, p. 134), and its complications are recognised as "incapacitating and destructive" (Hahn, 2000, p. 10). Often confused with guilt, which refers to the person's actions, shame touches on who the person is. While guilt guides us on how to repair what has been done wrongfully, shame sticks to us without an immediate remedy. Pines (1995) uncovers the genesis of the word shame from the Indo-European root '*skem'* meaning 'cover*',* illustrated in the *Bible* in the story of Adam and Eve who covered their bodies when they experienced shame for the very first time. When I reflect on the word 'cover' I think of the aspects of cover as protective, but also obscuring. I wonder whether shame's hidden aspect explains its persistence, and unspoken of anguish: we cannot see it, therefore we are not aware of it and cannot easily acknowledge it in the therapeutic process. One of the examples of blindness in therapy is presented in an article co-written by McWilliams herself "Inventors of the new selves" (Atwood, Carroll, & McWilliams, 1983). The authors describe a newly identified group of patients who are characterised by their need to re-invent their personalities and become someone new. I cannot help but wonder whether the authors, in their effort to understand the patients' psychodynamics, were blind to shame in their

study. Paradoxically, one of the vignettes is titled "Benjamin: A flight from inner badness". The description of Benjamin's inner dynamics details his parental rejection, unceasing criticism, and experienced absence of empathy that led to his self-description as "a pile of undifferentiated 'shit'" (p. 251) and "an approval junky" (p. 250). This reflection on his inner world was identified by the authors as his "core self-representation" (p. 251), yet shame was not conceptualised or offered as a possible core vulnerability of this patient group. The words in the article that resonated with me as descriptions of shame are: the feeling of inner badness, overwhelming badness, and being undeserving, unappreciated, unworthy, and unlovable. I also noticed the word "undifferentiated" (p. 251), and appreciate the authors' notion that the difficulties of these patients are "traceable to interferences with the separation-individuation process" (p. 253) in early childhood. This is a clue that I follow in the next chapter. I am struck by how both shame and self-acceptance make an appearance at the end of the article: "The willingness of the analyst to speak from her *self* [italics in original] effectively neutralized Benjamin's shame about the felt badness of *his* [italics in original] self in a way that educative remarks about people in general could not have done" (p. 257). Such self-disclosure is encouraged in order to alleviate the patients' fear of rejection, and at the same time is used as a modelling tool of the self-accepting therapist "encouraging the patient's move towards self-acceptance" (p. 256). The article was written in 1983, over twenty years before the writing of McWilliams' quotation. I ponder how significant these twenty years were in formulating the idea of shame, and eventually the shame and self-acceptance dialectic.

Shame: My Un-covered Horizon

The main article on shame with which I chose to engage hermeneutically with was written by Orange, "Whose Shame is it Anyway?" (2008). The authorship attracted my attention instantly. I have long appreciated Orange's writing on intersubjectivity and her passion for the philosophical dimension of psychotherapeutic theory and practice. I failed to find any biographical information on Orange, therefore I can only infer from her texts that she values knowledge and describes herself as a lifelong student of philosophy. She has the capacity to be an iconoclast, as described by Brandchaft (2007), and has vast clinical experience. She seems to be a humble practitioner who fully engages in each encounter with patients. She belongs to the intersubjective paradigm of thinking about, and practising of, psychotherapy, and co-wrote many articles with Stolorow and Atwood, two main theorists of intersubjectivity. As I

expected, her article on shame resonated with me, not only on the cognitive level; more importantly I found its meaning touch me emotionally, and this transmuting quality I wish to call 'cathartic': I felt recognised (Jacobs, 2008) and empathised with.

Orange (2008) defines shame as "between cognition and affect, or, as I would prefer to say, between thought and emotional life" (p. 86). I find myself drawn to such a definition, as it opens up the rigid binary, either-or frame of thinking. It is no surprise that the first sentence of her article describes shame as "intersubjectively generated, maintained, exacerbated, and, we hope, mitigated, within the relational system" (p. 83). She explicitly states that this is her main thesis of the article. She also, in the first paragraph, mentions the treatment setting as a source of shame, and what she calls "the lifeworlds" of shame that the patient and therapist bring into the therapy, which I describe later in this chapter. Orange's description of the experience of shame is as follows:

> a complex emotional system regulating the social bond, that is signaling disturbance to the status of the self within the social order: what is one before oneself and others; one's standing, importance, or lack of it: one's lovability, sense of acceptability, or imminent rejection, as seen before the eye of the other or the internal self-evaluative eye of the self. (D. M. Orange, 2008, p. 84)

I understand this cognitive description; however I asked myself a question: how are these words actually experienced? The description follows in the next paragraph and resonates with me: feeling inadequate or deficient, needy, empty, rageful, embarrassed, humiliated, inferior. My very personal surprise encounter with my shame and its felt manifestations was followed by engaging with the concept of the lifeworlds of shame as described by Orange (2008). One of my lifeworlds of shame I identified with was the Christianity I was born into. I am a granddaughter of a Lutheran pastor, attended church regularly as a child, was confirmed at fourteen, and eventually became a youth leader. The teaching of the church meant to me that the world and what it contained was either good or bad, but never cleansed from the fate of sin and being unworthy of God's love. I was also not meant to have certain feelings; anger being one of the seven deadly sins. If feelings of anger, sadness, fear, jealousy, envy, and pride were disallowed, the feelings of guilt and shame were made ego-syntonic. This lifeworld cultivated also a familial shame: there were things we were ashamed of, such as my uncle's homosexuality, which was always hidden and never spoken about. The other

aspect of my religious upbringing was feeling ashamed of being different as a Protestant in predominantly Catholic Poland. Being a minority, as Akhtar (2014) points out, is not only a matter of being outnumbered; but it is a feeling of being singled out, a curiosity, something misunderstood, and something that had to be explained to the Other. I often had a sense of not fitting in, being an odd one, and having to hide it to protect myself from an unfriendly gaze. An additional aspect of this shame was that paradoxically we were never really noticed, as Akhtar puts is "absent as minority" (p. 138). This had an impact on me in my teenage years: I was aware of my religious absence, yet at the same time I felt different in my peer group. In the cultural space there was no representation of Protestants; I remember however that there were post-war voices calling Protestants 'Germans', which felt humiliating. Akhtar describes it as follows: "The eyes of the majority can change their pasty indifference into piercing accusation" (p. 140).

Over the years I felt like faulty goods, a bad one and I felt I could never remedy it; it was fate. I dealt with it by affirming my otherness and not allowing myself to experience how truly isolated I had felt. There was another social phenomenon that defined my childhood and adulthood alike: living in a communist country under a Soviet regime evokes feelings of shame in those who feel they have to comply. This shame was very well hidden under the mask of anger and hatred towards the system. The injuries received to one's freedom when living in a totalitarian country make the people feel helpless and manipulated. So they reject this part of themselves which cannot protest; which is only able to comply. A totalitarian system demands for one to be hidden, compliant and fearful; it takes away the sense of agency, which all contributes to feeling ashamed of oneself.

Even if I were too young at that time to fully appreciate the damaging atmosphere of living in such oppression and its shamefulness, I imagine I perceived it and it became a part of me. Studying psychotherapy was yet another lifeworld of shame: the eyes of the tutors and other students permeated every nook and cranny of my psyche. I felt exposed and perpetually ashamed. I dreaded group therapy sessions: the gaze of the other was so focused and unyielding that I felt I had to hide. In every minute of the sessions I felt unsure of myself, inferior to others, often paralysed by shame and not knowing what to say. I had developed a protective shield of being agreeable and co-operative in the last two years of training, and it was only in the very last session of the group therapy that I

made a confession how shaming this space had been for me. That was perhaps a first glimpse of my shame, which was slowly coming out to the surface.

There was another lifeworld of shame, and as I am writing it, I am aware how this should be the beginning of my self-reflections. Yet I now recognise I have been too ashamed and anxious to do so. From some point in my childhood my mother's alcoholism had become a new source of shame. I felt ashamed of my father's shame so never allowed myself to feel shame, and had hidden what was to be hidden. The silence, typical in alcoholic families, was covering the true feelings we all had. This silence was a language of shame, of vulnerability and helplessness in front of the hurt we were feeling, but could neither think of nor express. This soundless blindness has been very harmful. Unable to experience the pain of continuously feeling rejected by my mother, and ashamed of my need for her, I learnt to hide my fragile self. When I opened my eyes in the therapy, the awareness of my hidden feelings brought shame to the surface. I realised I felt inadequate and a failure.

My shame in the therapeutic relationship has been caused by awareness of my need for my therapist, my vulnerability that may make me unlovable yet again. My growing self-knowledge was mercilessly adding shameful feelings with every session. I found myself in a vicious circle of the more I got to know myself and the feelings I discovered within myself, the more I felt shame. To date my therapy has been a painful process of uncovering myself to the therapist, bearing the pain of being seen by her, and fearing her gaze. The momentary relief from the overbearing feeling of shame came in moments of feeling accepted by the therapist; feeling that I am not that bad. These reflections on the lifeworlds of my shame encapsulate the profound impact this research has had on me. It provided me with a live experience of the meaning residing in McWilliams' (2004) quotation. Only when I realised the aspects of my self that have been seen as shameful, was I able to accept them and move towards freeing myself from the constraints, and control, they have imposed on my inner dynamics.

In the context of my experience, in this study I returned to Orange's article, and I find the intersubjective paradigm and its description of shame as cathartic. The shift in psychoanalysis from theory of drive to "the motivational primacy of affectivity" (Stolorow, 2013, p. 385) vouches for the definition of shame as affect; as "something that from birth onward is co-constituted within ongoing relational systems" (p. 385). In this paradigm, trauma is understood as "an experience of unbearable affect" (p. 385),

and I feel compelled to insert a larger quotation from Stolorow's (2013) article which, in my view, captures the essence of shame development:

> From recurring experiences of malattunement, the child acquires the unconscious conviction that unmet developmental yearnings and reactive painful states are manifestations of a loathsome defect or of an inherent inner badness. A defensive self-ideal is often established, representing a self-image purified of the offending affect states that were perceived as unwelcome or damaging to caregivers. Living up to this affectively purified ideal becomes a central requirement of maintaining harmonious ties to others and for upholding self-esteem. Thereafter, the emergence of prohibited affect is experienced as a failure to embody the required ideal, an exposure of the underlying essential defectiveness of badness, and is accompanied by feelings of isolations, shame, and self-loathing. (p. 386)

This explanation of the origins of shame resonates with me, as I recognise how I judge my feelings of vulnerability and desire for dependence and love as shameful. Since I have gained a deepener understanding of shame as an affect and my own experience of it, I move back to McWilliams' (2004) quotation and wonder what she means by controlling aspects of shame. McWilliams postulates that the more accepting we are of the aspects of our self that have been seen as shameful, the less we feel controlled by them. This concept has two messages: first, shaming aspects control us; second, it is self-acceptance that meliorates this control. When contemplating how feeling shame can be controlling, my immediate thoughts veer towards blindness: when we feel shame, we cannot see clearly, because we need to hide. It is like putting on dark glasses to hide behind, and at the same time to protect ourselves from seeing. The need to hide is overpowering, and this is the only way of protection from the annihilating gaze of the other, as I describe in the next chapter. Stolorow (2011), in his article on authenticity, suggests that it is shame "that most clearly discloses inauthentic existing" (p. 286). When we feel shame "we are held hostage by the eyes of others; we belong, not to ourselves, but to them" (p. 286). The gaze of the other imprisons us, disabling out authentic living. The inventors of the new selves are the embodiment of this despair. We are controlled by the expectation of the other, and cannot afford to be who we truly are. The next question I ask is: how do we work with this painful internal imprisonment?

Working with Shame

This part of the research was particularly difficult for me, as I was aware that I had only recently connected to my shame. I therefore engaged with the literature that offers clinical vignettes and reflections based on therapists' experiences and describe my personal experience of attending to shame in the therapeutic process.

McWilliams (2004) claims that shame is present throughout the therapeutic process, and it is the therapist's role to "prevent or reduce feelings of shame" (p. 137). As I explored in the introduction, I found myself wondering whether preventing shame is not dissimilar to symptom removal in the spirit of early psychoanalysis. Understandably, reducing feelings of shame can contribute to the patient's openness in the therapeutic process, however the question that emerges as I read the text is: could the shame reduction prevent the patient from experiencing it in the therapy, therefore closing the door to the full experience of shame in the patient? I wonder whether gentle acknowledgement of the patient's shame in the therapeutic setting is initially enough to normalise it, without efforts towards shame prevention. I wish to stay open to the emerging meanings of this, and will come back to it later.

My personal connection to shame, I realise, is somehow unusual: it did not happen in therapy in a natural way, but was a combination of two concurrent processes: a long felt need to uncover what was painful yet hidden from me, and researching the subject for this dissertation. My current therapy has been a relatively new relationship, as I started working with my new therapist just over a year ago. Her patience and emotional dwelling with my recurring feelings of shame were essential: she bore my suffering with tears in her eyes, and endured my emotional self-flagellations with compassion. Her verbal communication mirrored the dread of my own vulnerability, and helped me to start accepting the most unwanted feelings I have accessed. We have been uncovering different shades of my shame, and the more I was able to see, the less afraid I was of it. This in turn created the sense of safety and trust and allowed me to experience the shame of my needs for dependency and of my vulnerability. But the question that arises for me is: what happens in the therapeutic situation before the shame becomes present and named?

Therapy: Shame-Inducing

The shaming aspect of the therapeutic setting has been recognised since Freud (Jacoby, 1993). Perhaps positioning the patient on the couch and the therapist's averted gaze had been a measure to mitigate the shaming gaze, in the interests of both the patient and the analyst. Jacoby, in his article on therapy as shame-producing, points out that shame in therapy has two sources: firstly, it is shaming to uncover oneself in front of the other; secondly, shame is produced in the analytic situation in its unequal relationship. It is the patient who comes with her problems and vulnerabilities to the therapist, who is not known to the patient. She discloses her most secret feelings and thoughts, while the therapist stays hidden. She becomes attached to him, becomes aware of dependence on him, and may even develop sexual fantasies, and he is only able to frustrate her needs. Jacoby suggests that the aim of therapy cannot be to provoke even more shame, and establishing trust is very important as the protection of the patient's vulnerability, which, he acknowledges, may take a long time.

I appreciated Jacoby's (1993) effort to address shame in the therapy with a shame-ridden person by tentative phrasing of her struggle to speak. In the example that he describes, this gentle naming of shame made a big change for the patient, who was then able to open herself to the therapeutic process. Jacoby describes therapy with this patient as a balancing act of his active approach of naming her feelings of shame while maintaining care for her fragility and sensitivity towards shame. This thoughtful stance, I believe, provides more reliable care than reducing shame as suggested by McWilliams (2004). I feel drawn to yet another statement from Jacoby: "sensitivity to the patient's open or hidden shame is crucial to the analytic endeavor" (p. 434), and I am aware of my own horizon that may be fusing with the author's.

Shame is difficult to see, as it is masked by withdrawal and concealment (Morrison, 1984); and Kilborne (1999) compares grasping shame in the therapeutic setting with wrestling Proteus: shame keeps changing shapes. It employs helpful protective measures such as grandiosity, compulsive behaviour and anger. To work with shame the therapist first ensures trust has been established, and observes what can be seen as shame behaviour: the patient's face hidden behind her hair, the averted gaze, her body turning away from the therapist, staying silent, avoidance: not attending the session, not paying. This behaviour can have other sources, therefore empathy is the best tool in differentiating shame from other affects. Once shame has been recognised by the therapist, he may gently name the dread of such an experience. The initial reactions of

the patient can serve as a guide to how ready she is to see the unthought unwanted, using Orbach's (2005) phraseology. It is a balancing act of therapist's bravery, Maroda (2009) names the therapist as being "fearless" (p. 25) in such moments to acknowledge the hidden shame versus the patient's ambivalent wish to hide and disclose. The good therapist, as Maroda asserts, "is a lot like a detective" (p. 22). She hints at a reluctant therapist as a response to the reluctant patient, and as such "creating an unproductive mirroring" (p. 22). Therefore, it is empathy for the patient's vulnerability to shame that guides the therapist in the acts of naming shame, and when named the patient may fully experience her shame, and validate her feelings and fragility.

When submerged in my own experience of shame and thinking about it in the therapy room, I came up with a sentence that resonates with me: "the more I know you, the more I accept you". There is a healing for me in this sentence; it acknowledges my history and how I see myself, and this self-knowledge leads to self-acceptance, rather than causes shame. I found solace in making sense of my shame: Stolorow's (2011) theory of trauma, as per the quotation above, helped me come to terms with my shame as being not as yet another source of shame, but as a result of developmental trauma. I remember a similar sense of relief when I engaged with the text on trauma by Briere (2002); his description of how the emotional dissociation occurs, even though he does not mention shame, stirred me and helped me make sense of my experience: "because early traumatic abuse typically pulls the child's attention away from internal experience and towards the external environment (where danger exists and must be assessed), the maltreated child may grow to become primarily 'other-directed'" (p. 13). I recognise that such explanations of my personal experience provide me with validation and making sense of the way I gain self-knowledge, without the overwhelming sense of shame.

The Therapist and His Shame

Working with shame may prove difficult for a therapist who is not connected to his own shame. If, however, the therapist has resolved his shame, he is aware of its hidden, Proteus-like nature (Kilborne, 1999). He can see beyond what is presented and can actively seek shame that may be well hidden. Hahn (2000) captures the potential difficulty of this requirement, when he names the experience of shame as an "anathema to the competent and compassionate self-image of most therapists" (Hahn, 2000, p. 10). Yet, as Orange (2008) points out, shame is engendered within the relational system, and

we cannot talk about the patient's or the analyst's shame, but about these two people co-generating the system of shame. The patient will become aware of the therapist's shame simultaneously with the therapist, and this relational dynamic, when made conscious, may have a huge positive impact on the therapeutic process. The other important aspect of the therapist's blindness to his own shame is described by Kilborne (1999) who notices that children "who are shamed often grow into adults who shame, evidence of a dialectical process of shame reactions" (p. 368). I wonder whether the therapist who has not connected to his shame may show limited empathy, as his shaming responses may stay outside his awareness, and result in the patient experiencing the therapist as not validating her and her feelings. Working with shame is demanding as it evokes many countertransferential reaction that have been well documented in Hahn's (2000) article "Shame: Countertransference identifications in individual psychotherapy." However, the first step towards patient's self-acceptance is the therapist's own wrestling with shame, which can ultimately move towards self-acceptance.

Summary

Shame presents as a universally experienced affect that is engendered in the relational matrix and converges with the lifeworlds of shame of the external reality. In the process of reading, my experience of shame emerged and enabled its recognition as my horizon. The shaming aspect of the therapeutic setting and the therapist's own shame dynamics were recognised, and the clinical implications of these outlined.

Chapter Four: Gaze

"have been seen"

(McWilliams, 2004, p. 137)

As described in the previous chapters the initial stage of the study was completely engulfed in exploring my own shame. I identified shame as my core vulnerability and consequently self-acceptance became visible to me as the curing factor. One of the best descriptions of shame belongs in my view to Ayers (2014) who captured the essence of shame when she said:

> To the person who suffers shame, the world is full of eyes, crowded with things and people that can see. Cold, annihilating eyes watch every movement and moment of self. The point of anguish and despair in shame is this element of exposure. One is visible and not ready to be visible, looking and not ready to see. (p. 1)

These words describe my experience of the world: I am aware of the power of the observing eye of the other. This notion has drawn my attention to the gaze, powerful in its potentiality to accept or annihilate (Bonomi, 2008). In this chapter I reflect on the concept of gaze which functions in this study as an experiential bridge between the states of being hidden and being seen; and at the same time I consider gaze as a milieu of the dialectical dance of shame and self-acceptance.

The Mother's Gaze: "Mirror-Role of Mother"

Perhaps the first psychoanalyst who devoted his attention to the importance of gaze was one of my favourite writers Donald Winnicott, proclaimed by Orange (2011) as a hermeneut of trust. He preceded the current theories of the importance of the mother's gaze when he stated that "the mother's role [is that of] giving back to the baby the baby's own self" (Winnicott, 1971, p. 117). He posits that, in the child's emotional development the mother's face is the precursor of the mirror; the baby sees herself in the mother's eyes. It is in these eyes that the baby receives a sense of being: "When I look I am seen, so I exist" (p. 114). Winnicott qualifies this experience by noticing that this happens when the mother's caring is present. At the later stage of maturational process,

Winnicott says “the child becomes less and less dependent on getting back the self from the mother’s and father’s face and from the faces of others who are in parental or sibling relationships” (p. 118). Winnicott suggests here that, in healthy development, the infant and child depend on the faces of others to in order to get back their sense of self. However, when mothers do not respond to their babies in a loving way, the babies "look and they do not see themselves" (p. 112). The mother’s face is not a mirror anymore and that will create “the threat of chaos” (p. 113) and unpredictability. Winnicott describes the trauma of it: “If the mother’s face is unresponsive, then a mirror is a thing to be looked at but not to be looked into” (p. 113). In order to protect the self from such an insult the infant will cope with it by withdrawal of their own needs.

Perhaps this is a description of the emerging False Self (Winnicott, 1971), who cannot be creative but must comply. Under the annihilating gaze of the mother, the child has no other option but to reject herself and her vulnerability, and adapt to what is expected from her. Winnicott makes an important observation: developmentally, he highlights the importance of gaze during the separation process, when “the separating-off of the *not-me* from the *me* takes place” (p. 111). He postulates that if during this process “no one person is there to be mother the developmental task is infinitely complicated” (p. 111). I wish to hold on to this notion, as I have an emerging sense of its powerful meaning. Lastly, I wish to highlight here that Winnicott does not describe the affective states of the infant at that time (the same critique has been applied to Lacan and Kohut by Kirshner (2004)), and it is only in Stolorow’s writing, as we saw in the previous chapter, that we observe how shaming such rejection of one’s vulnerability may become.

I cannot help but think of one of the best literary illustrations of gaze, of looking at but not into: the sad myth of Narcissus so present in psychoanalytic literature. I was invited by the myth into an exciting journey of reading about the beginnings of Narcissus (Anderson, 1972) and wondering about his parents: his mother was a water nymph, whose name meant ‘face of Narcissus’. Her name implies that she only started to have a name, started existing, after she gave birth to a baby, who, according to one version of the myth, was numb and devoid of excitement, which is a meaning of the Greek word Narcissus. She was described by her name not as herself, but as a face of a limp child. Perhaps confused herself, she became a mother who was only able to reflect her son’s beauty back to him, as according to the myth Narcissus was adorable from birth. She could only reflect the surface, the superfluous and superficial, as that was what her

fluid, watery nature would allow. I wonder about his father the river god Kephisos, and what comes to my mind is the notion of never stepping twice into the same river, of constant change, and never knowing as Heraklites proclaimed: "We both step and do not step in the same rivers, are and are not in the same rivers" (Annas, 1989, p. 1) So Narcissus' father was one of a constant change, and I am wondering how such elusive parents would have affected a baby Narcissus, or any baby for that matter. Living in isolation, the first time he reached a sense of himself he could only see his beauty but not himself. Never mirrored in his parents' eyes, he dies prematurely, without ever feeling loved for who he was. No child can survive such malattunement, so it is no wonder that his character in psychodynamic literature has associations with narcissistic vulnerability and shame, as so extensively explored by Kohut (2013).

The question I ask is: can we be truly seen by the other? Fonagy and Bateman (2010) suggest that mirroring is never perfect in matching the babies' affects, as the mirroring is always a shared experience of mother responding to the baby within her own area of experience. Aron (2006) describes this phenomenon as "the parent's mirroring behaviours convey a sense of 'nearly like, but clearly not identical to me'" (p. 358). In intersubjective theory, mirroring is a dyadic experience, and there is the third created between the mother and the baby; the space in which the baby learns self-reflexivity. Self-reflexivity allows the baby to develop mentalisation and affect regulation processes. It is perhaps similar to Lacan's (Malin, 2011) understanding of the symbolic value of mirroring: it is not an exact reflection of what is seen, but an in-between phenomenon. The difficulty lies in the baby not having the capacity to separate the real from the symbolic; it would fit into fore-mentioned Winnicott's (1971) understanding of the gaze's importance during the separation process. If the baby separates successfully, she will be able to distinguish between what is seen and reflected and who she actually is. The success lies in enough felt omnipotence and illusion by the baby who is held and cared for by a devoted mother who can adapt to the baby's needs. The child then feels powerful and creative, accepted in her needs and vulnerabilities that are not felt as shameful. The infant, who has not experienced good enough care, will be ashamed of her need for omnipotence, of her need to be mirrored. The baby may be perceived by herself as 'needy', 'not worthy of love', as is often heard from patients. The developmental process of separation will thus be interrupted.

Annihilating Gaze

As a result of the database search for texts on gaze I found myself drawn to the article by Carlo Bonomi "Fear of the mind. The annihilating power of the gaze" (2008). Its title seemed burdened with meanings that I was hoping to uncover. I enjoyed the first reading of it, as it provided interesting reflections on the concept of annihilating gaze and good clinical manifestations of the concept. His suggestion that the gaze has annihilating qualities when "the boundaries between the self and the others are not yet established" (p. 171) resonated with Winnicott's thought, and I wanted to deepen its meaning. On the second reading however I pondered over some questions that I was asking Bonomi and his text: firstly, I longed for some mention of a more multi-dimensional gaze. The author failed to name the different types of the gaze, focusing solely on its annihilating aspect. I also wonder if it is possible that the boundaries between *me* and *not-me* may not be established, yet the gaze may be perceived as approving and accepting. It reminds me of my critique of Winnicott's (1971) concept of the "use of an object" in one of my essays. Winnicott posits that the capacity to use an object is the developmental stage in which the object has to become independent from the subject; that is, external to it, rather than being a part of a subject. I postulated that this complex process may never be fully completed and it is more realistic to talk about it as a developmental striving, similar to self-acceptance as presented later in this dissertation.

My other inquiry was to try to find the enhanced meaning in the context of my research question and what I found was that the disclosure of the annihilating gaze and its power to induce fear of the mind of the other was deprived of the ideation of shame in Bonomi's article. He mentions shame and insecurity experienced by one his patients, but there is no importance attached to these feelings. Upon further reading, I was drawn to the final conclusion of Bonomi's (2008) article and intended to engage with his critique of self-reflexivity theorists, and yet I could not agree with him. He claims that his patients did not lack the capacity to self-reflect, but rather they could not see beyond the "black mirror" (p. 175) and restore themselves away from being an object. I wonder whether the lack of conceptualisation of shame somehow blinded Bonomi; if he did recognise the shame hidden behind the dark glasses, he would perhaps realise that the dark glasses are as much a protection from the shaming gaze, as from protecting oneself from seeing. Shame controls the patient and demands to be hidden; it prohibits the patient from being seen and from seeing. If one needs protection, full self-reflexivity is

not possible. Bonomi describes that his patient "**never thought** [bold added] that she could exist in spite of her parents" (p. 174), and indeed I believe she could not think; her self-reflexivity incapacitated her early development due to her parents' annihilating gaze, as analysed earlier in the chapter on shame. Bonomi explains that the objectifying gaze of others is the source of the patient's suffering, which when "clear boundaries between the self and others are not yet established" (p. 171), is felt as annihilating. He relates it to Broucek's link between "undesired self-objectification" (p. 172) and shame. Even though Bonomi recognises shame as affect present in the experience of being objectified, his focus stays on the fear of becoming someone's object and of "the enigmatic mind of the other" (p. 175). Yet I do not feel he gives a full explanation of the possibilities, as we are always in the relational matrix and therefore being gazed upon.

Slade (2005) further explores the meaning of a developmental process of reflective functioning: she posits that a child learns about his emotions through affect mirroring. When the mirroring is inappropriate the reflective functioning is affected, and a child is unable to develop the capacity to make sense of her feelings. As a result, self-knowledge of her subjective experience is impaired, and mentalisation, conceptualised by Fonagy and Bateman (2010) as the capacity to understand one's own and others' behaviour in terms of underlying mental states and intentions, is not achieved. In the most severe cases of mirroring being absent "the child experiences his inner life as barren and unknowable", and this experience is lined with the development of borderline traits (Slade, 2005, p. 5). Slade's reflections exceed Winnicott and Kohut's thoughts on mirroring by focusing on the affect, and how vital affect mirroring is for the development of reflective functioning (Aron, 2006), emotional regulation and their importance for the ability to form successful social relationships. Successfully developed reflective functioning allows a person to differentiate her own thoughts about others' experience from their actual subjectivity.

Towards Self-Gaze

Bonomi's (2008) patient was controlled by the fear of annihilation when under the gaze of her parents. He describes a process of a healing shift in patients who experience similar annihilation: we feel we exist, not only because we are seen by others, but because of "our perception of ourselves as agents" (p. 174). Conveying this message to the patient by Bonomi was met with surprise, as "until that moment she was completely

identified with the object of a rejecting parent" (p. 174). She could not imagine being a different object to that one that was mirrored back to her in the gaze of the other. Such a description of an internal state resembles Winnicott's (1971) description of an infant that has not yet separated *me* from *not-me*. Winnicott would explain such a state as a result of the mother not meeting the infant's gesture, and leaving the baby in a state of chaos; in Bonomi's words, under "the spell" of "an undifferentiated feeling" (p. 174). Using Stolorow's terminology to describe the surprise Bonomi's patient experienced, she had a chance for the first time to experience *her-self* instead of *they-self* (Stolorow, 2011, p. 285). The process of disidentification, defined by Bonomi as "restoring the capacity of experiencing oneself as both subject and an object" (p. 174), leads to a new capacity of self-reflexivity. The annihilating power of the gaze of the other is being placated by the patient and integrated into a self-gaze that is capable of drawing the boundary between the object and the subject, between shame and self-acceptance.

In the mother's gaze, the child gets to know herself: she recognises her affect states, and learns about her thoughts through her mother's ability to contain them. Her self-knowledge happens in the mirroring experience. Yet, as Aron (2006) observes, the mother's response is marked by her own experience, which creates mother's own version of the infant's response. It is only when the child is able to realise the *not-me*, the separation from the mother, that she is able to differentiate the two subjectivities. Mirroring in his view creates "a third symbolic intersubjective space of representation between infant and parent allowing for and facilitating mentalisation and affect-regulation" (p. 9).

This addition to our exploration of gaze seems pregnant with meaning: mirroring, and what it creates, is required for child's development of two very important skills: mentalisation and affect regulation. We can infer that, should the mirroring be missing or inappropriate (Slade, 2005), the mentalisation and affect regulation will be impaired. Following Aaron's thought, this may impact on the child's ability to differentiate the self and other. We may infer further that the more loving the mother's gaze, the more able the baby is to separate from her. If the mother's gaze is shaming, i.e. disapproving, rejecting the baby's needs, the child is unable to be creative (Winnicott, 1971) and cannot develop self-reflexivity, but instead seeks what the mother is expecting from the child. The eye of the mother becomes annihilating rather than creating; objectifying rather than promoting self-reflexion.

Self-reflexivity is a rich and exciting space: it engages the intrapsychic and intersubjective functioning. It engages cognition and affect. Aron (2000) defines it as "dialectical process of experiencing oneself as a subject as well as of reflecting on oneself as an object" (p. 668) and it "develops within the relational matrix and is inherently an intersubjective process" (p. 669). In Aron's view, this reflective self-awareness, or self-reflexivity, "the capacity to maintain the dynamic tension between experiencing oneself as a subject and as an object" (p. 673) is a goal of psychoanalytic treatment. He thus argues with the theorists who expect this capacity to be present before the analysis commences. Also he expands on the early psychoanalytical goal of insight, which is not enough to regard a treatment as successful, but rather it is the patient's developed capacity to self-reflect, that when mastered, will allow the patient to have the flexibility to move between *I* and *me*.

Gaze of the Therapist

As I mentioned in the previous chapter, the analytic situation is shame inducing. Patients coming to therapy are being gazed upon, and as Bonomi (2008) says "it is difficult to overemphasize the significance of looking and being looked at in states of enhanced vulnerability" (p. 170). Orbach (2005) similarly describes the therapeutic process as "the relationship in which the unthought unknown can be spoken of, heard, and embraced" (p. 71), and she shed light on an aspect of one of her patient's vulnerability: "desire to be attached and dependent … causes him shame" (p. 75). The nature of the therapeutic relationship evokes the archaic "dependency need" (p. 75), and that brings out, from the unknown, shame that could not have been thought of before. The gaze of the therapist brings these shameful hidden needs into the open, echoing McWilliams' (2004) words "the aspects of the self that have been seen as shameful".

Winnicott (1971) compares the mother's gaze at the baby with the analytic situation, and says: "psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings" (p. 117). This sentence resonates with McWilliams' quote, in that it diminishes the value of knowing and interpretations of the analyst. Kohut, as Orange (2009) observed, was a clinician who appreciated the shaming space in the analysis. No wonder he offered psychoanalysis a concept of empathy that "is emotional survival because, unless you have empathy in your surroundings, you feel you cannot show what you are and who you are" (as quoted by Orange, 2009, p. 178). Without the empathic gaze of the therapist the analysis is not

possible, as the patient will not be able to access her vulnerability. Stolorow takes empathy even further, and he critiques Kohut's conviction that empathy of the therapist can be neutral when he "gazes directly upon the patient's inner experience with pure and preconceptive eyes" (Stolorow, 2014, p. 80).

Stolorow (2014), positioned in the intersubjective paradigm, suggests that "the therapist's subjectivity makes an ongoing, unavertable, and indispensable contribution" (p. 81). When the patient talks, she gazes at the therapist, which was Freud's fear, in order to find herself; not unlike Narcissus. The therapist gazes back, never without disclosing his own feelings, and it is in this relational, intersubjective space that the mutative process takes place. The therapist offers his patient what Stolorow calls "emotional dwelling" (p. 81), which extends the concept of empathy: "one leans into the other's emotional pain and participates in it, perhaps with aid of one's own analogous experiences of pain" (p. 81). In such dwelling, the therapist is able to name "the unbearable and the unendurable, saying the unsayable" (p. 81), I feel compelled to expand on this: to see the unseen and uncover the covered. This mirroring of patients' affective experience gives it validity and acceptance. I appreciate what I find a profound and cathartic description of empathic gaze in therapeutic encounter by Greenberg and Elliott (1997):

> Some of the most powerful moments in therapy occur when therapists are able to convey genuine acceptance of clients' expressions of strong, vulnerable, self-relevant emotions. … Clients offer fear that if they reveal themselves and fully express these painful emotions, or other **seemingly unacceptable aspects** of themselves, that the therapist will not understand, will judge them, feel alienated from them, or even reject them. …In this whole process, vulnerable clients are confirmed by making contact and being accepted as they are. … they cease to feel as overwhelmed by the vulnerability and can see the feared aspect as part, rather than as all, of themselves. (p. 183)

I am not afraid of venturing beyond psychodynamic thought, as the authors of the quotation belong to the humanistic tradition, because I believe that in hermeneutic thinking the openness to other texts that may enhance our understanding is encouraged and recognised as part of foresight (Smythe & Spence, 2012). I notice my own cathartic response to the quote and how it resonates with McWilliams' (2004) quote, as I

indicated by highlighting the words in bold. It is in the relational matrix of the therapeutic relationship that the patient may access her shame and vulnerability, which is possible as she develops capacity for self-reflexivity in the gaze of an empathic and accepting therapist. And I take note of the words that moved the study forward into the reflections on self-acceptance: in genuine acceptance, clients are confirmed as they are.

Summary

One of the first experiences of the infant is being gazed upon by the mother. If this gaze is loving and reflects back the infant's existence, the infant will develop self-reflective capacities and a cohesive sense of self. If however she is met with an annihilating gaze, that is, malattunement, she will experience chaos and a sense of non-existence. Her needs will be seen by her as shaming and unbearable. The therapeutic situation, albeit by its nature is shame inducing, offers an emotional dwelling experience in which the developmental trauma and shame can find an empathic relational home and be gazed upon with acceptance. Thus the needs and vulnerability of the patient will be honoured and her capacity for self-reflexivity enhanced. In the accepting gaze of the therapist she will develop a capacity to gaze upon herself with more independence.

Chapter 5: Self-Acceptance

"Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them."

McWilliams, 2004, Psychodynamic psychotherapy, p. 137

As mentioned in the very beginning, this dissertation was ignited by my strong response to the above quotation. The quotation was promising me healing I was seeking without yet fully understanding it. When I approach the subject of self-acceptance now, I have a sense of reaching a new, profound understanding of myself. My experienced connection to shame helped me become aware of my core vulnerability and enhanced my understanding of McWilliams's words. If I were to define self-acceptance, I would hermeneutically engage with the concept by asking questions, and the first most obvious one is: what is self-acceptance? My further reveries are: is it an affect or a thought; what is self*;* what is it that is to be accepted? McWilliams calls self-acceptance a profound goal of therapy, more profound than self-knowledge. We saw in the tragic story of Oedipus, who learns the truth about himself, that self-knowledge may have disastrous implications: paradoxical in nature, self-knowledge may bring out shame and blindness. I recall my reflection from chapter 3 on shame, an ideation of a remedy when reflecting on the paradox of the therapeutic process: the more I know myself, the more I accept myself. I am enlivened by the profound and cathartic message in this sentence, and wish to be guided by it when engaging with the literature on self-acceptance.

To answer the question about self-acceptance being an affect or thought, I am honouring the development of psychoanalytic theory and its latest destination at the intersubjective understanding of the therapeutic situation. I am returning to Orange's (2008) reflection on shame: "between cognition and affect, or, as I would prefer to say, between thought and emotional life" (p. 86). I infer that just like shame is intersubjectively engendered and maintained, so is self-acceptance.

In order to move forward with developing the concept of self-acceptance I now reflected on self and its meaning. I asked myself questions: how do I understand self? Who is it that is being accepting of oneself? I found myself less engaged in these questions, and I wonder whether it is linked to the maze of the vast literature that I

found overwhelming. At the same time, I wondered whether if I also felt that perhaps it is futile to describe something that will depend on the writer's theoretical background. The first article I was drawn to was "The questions of the self and self-esteem" (Alexander & Friedman, 1980), as it seemed to allude to the two core concepts of my interest. On completion of the first reading, I found the article confusing: the sense of the maze remained as its scope was very wide and it seemed over burdened with meaning. Its reflections of meaning of self provided, however, a poignant conclusion. The historical gaze returned to the beginnings in Greek philosophy, in which self was identified with the 'soul'. In modern times, the contribution of Brentano and Husserl was recognised, as they posed the essence of the self as a question of the "intentionality of consciousness" (p. 367); ergo the self was identified with the consciousness. Although Freud never attempted to define self, as the article mentions, he would strongly disagree with the idea of self without the unconscious. If Kohut is recognised as the one who placed self in the centre of his human experience, he is also critiqued for the same omission of the unconscious. The article's initial reflections brought about the humble conclusion that there is no satisfactory definition of 'self'; yet, as Kohut is quoted: "The self … as the center of the individual's psychological universe, is like all reality … not knowable in its essence" (Alexander & Friedman, 1980, p. 366).

Thus, as such, the self is a noumenon, 'a thing in-itself', using Kant's philosophical concept; something that can never be known to the mind and its reasoning. I come to an agreement with the authors' conviction about the "'incomplete nature of the self as a positive attribute" (p. 367). Advancing on these musings, I wondered whether I would be satisfied with a definition that self is something that each person has a sense of, rather than understanding of; something that is positively incomplete and located between the conscious and unconscious, as Van den Berg-Cook observes in her lecture on the mythological meaning of a mirror: "The mirroring is always by way of the symbolic image that has a place in both worlds [the consciousness and the unconsciousness]". Therefore it may be more helpful to talk about self-experiencing, which when thinking of self-acceptance indicates *I* reflecting on its experience of *me* (Aron, 2000, p. 684).

During the second reading of the article, I stayed open to meanings that could inform my study and appreciated the emerging concepts. Guided by them I defined self-acceptance as a reflexive phenomenon, where self is experiencing itself with acceptance, based on prior experience of being accepted by the other, and this self-

experience allows more authentic living without needing to resort to former defences and their censure. This preliminary definition is comprised of self-reflective capacity, and the accepting gaze, but does not include shame. I therefore engaged with the texts that helped me expand on the current description.

The very first text I engaged with hermeneutically was the article "Self-acceptance" (Wenkart, 1955) which I chose for a rather simple reason: it was the only one that emerged in my initial literature search with the words 'self-acceptance' in its title. It was written by Antonia Wenkart, an author then unknown to me, and from reading the first sentences I was charmed by its philosophical angle and the linguistic flair. The first appealed to my natural inclination to think and analyse, which in the process of my therapy I recognised as a way to protect myself from feeling the pain. The linguistic flair appealed to my love of language and literary expression. The first sentence states what acceptance is: affirmation, towards which every human effort is directed. Wenkart further posits that self-acceptance is not only the aim but also "a premise to inner growth" (p. 135). This dual aspect of self-acceptance was noted by McWilliams (2004) too, when she recognises the necessity of some level of self-acceptance, or reducing feelings of shame, in order to facilitate the patient's openness and honesty in the therapeutic process.

I recognise my own reflections in Wenkart's notion that "lack of acceptance creates indifference of negative rebellion against the nonacceptable" (p. 135). Ignoring unacceptable aspects of oneself or dynamic rebellion against them resonates with my idea of the tiresome internal fight to protect one's awareness from the distress of unwanted and rejected feelings. I agree with the author: such a perpetual fight prevents "initiative and the desire to take care of that which has to grow and develop" (p. 135). Wenkart then conceptualises the opposite of acceptance as "any repudiation, denial or rejection of oneself" (p. 135).

What is it that Wenkart (1955) suggests we need to accept? She posits it is reality and totality. The first refers to the reality of death, smallness and aloneness of human existence, which she calls "the unavoidable" (p. 136). The totality is understood as naturalness, co-existence of good and bad, ugly and beautiful; totality is an acceptance of ambivalence. I observed that during reading I slowly developed ambivalent feelings in me; on the one hand, I recognise the existential philosophy that has always been close to me. I appreciated the existential awareness of Yalom and May who enhanced the

psychotherapeutic understanding of the human condition. On the other hand, I noticed how, the more I read the text, the more I felt my resistance to it. I soon realised why; the author does not mention shame. I wondered whether it is shame she describes when she names rejection of oneself as the opposite of acceptance. Once my initial disappointment came to my awareness, I decided to remain curious and keep reading. But the sense of intellectual cavort remained; when describing therapeutic meanings of self-acceptance, Wenkart normalises her patient's worry about the pimples on her face. She explains how natural they are therefore they should be accepted. I wondered whether the pimples on the patient's face could be an expression of the shameful feelings that are only at the patient's edge of awareness. I was curious about Wenkart's thinking oriented towards normalising the patient's pain, but not empathising with the emotional content, as if the emotional dwelling was not available to her. My discomfort slowly grew, and I felt that my pain of shame is not validated in Wenkart's text. What is worse, I felt rebuked by some of her writing, as if I deprived myself of self-acceptance by my own accord.

Finally, I realised Wenkart's (1955) article is devoid of the dialectics of shame and self-acceptance. Currently, I stay with my emotional discomfort and this conceptual vacuum, and in a hermeneutic way engage with the author. I had decided to read everything I could find about her life and what she wrote, and realised there was very little information about her on the databases to which I had access. The first striking moment was when I found something about her that was of particular significance to me: when I chose the article, I could not know that it was written by a Jewish woman born in Poland, my country of origin. I reflected on this fact, and on her linguistic flair, on her obvious existential inklings. Everything seemed so close to me and my own interests. I found out that she suffered much adversity in her life; there were personal tragedies: the death of her son and sister; and the global ones, such as the Holocaust. As a young woman, she was rejected from university in Vienna because she was Jewish and female. I wondered how shaming these situations could be, and reflected on the centuries-long prejudice towards Jewish people. I found myself searching for articles on shame amongst the Jewish society, and an article on Arendt (Samnotra, 2014), a political theorist and an assimilated Jew, expressed something of my concern:

> Rahel's [Arendt's heroine] partial transformation from a parvenu towards conscious pariahdom involves both an acceptance of 'reality' – that she belonged to a pariah people – and a coming to terms with the shame she felt her

> entire life. On Arendt's reading, Rahel cherishes the moment where she has finally ceased striving for acceptance by gentile society and is amongst friends who recognize and accept her Jewish origins. But she would also not miss the experience of a lifetime of shame. Indeed, the former depends on its meaningfulness on the presence of the latter. (p. 341)

I wondered how similar Wenkart's, Arendt's and Rahel's experiences could have been, yet it may have been too difficult for Wenkart to "come to terms with the shame she felt her entire life" (p. 341). I recognise how my experience of unknown shame could have been parallel to hers. It could only remain on the edge of her awareness. She too, just like me, intellectualised her internal world in order to keep herself safe from the unwanted and threatening feelings of vulnerability. In her short article "The 'We' Generation" (Wenkart, 1981) I sensed her compulsion to honour the World War 2 and the overwhelming suffering of this time. Wenkart writes of the youth of that time as lost, angry and pained, and yet I wondered whether she felt a part of this generation too. She describes the shift to what she called the "Me" Generation as the ones who searched for awakening and salvaging what was lost. She writes about the Me Generation's need for self-acceptance, "to appeal to some compassion for self-acceptance" (p. 289). It too feels very tentative, and tender. The remedy she offers is "a dash of narcissism" (p. 289), and I wondered how she understood it: perhaps the dash of narcissism is pleasing oneself, "in total disregards of others" (p. 289) she pronounces. Is this idea close to Winnicott's ides of the ruthlessness in an infant, the early need for the integration, to feel whole, and it is not done in hate? The downside of this narcissistic position is, however, aloneness, Wenkart notes; a lack of capacity to embrace the other.

Then I found myself surprised and awakened by the sentence as if from McWilliams' quotation: "self-knowledge does not automatically become self-acceptance" (p. 290). Whatever we know about ourselves, about our aloneness, "external searching has to be redirected from fact to curiosity, from certainty to meaning" (p. 290). My excitement gives way to unsatisfied curiosity, as when reading McWilliams' (2014) quotation about self-acceptance: the sentence appears, burdened with a promise of meaning, yet I am left with a feeling of not-enough. The concept of self-acceptance remains at the edge of awareness, mentioned yet not given its wholeness. Wenkart (1955) concludes that the best part of the "Me" Generation was "the search for what has been lost" (p. 290) and this search allowed the "Me" Generation to evolve into the "We" Generation. I find myself not completely clear on her writing and the meaning; I sense what has been

searched for is the feeling of wholeness, which as she points out, depends on "a well-centred integration" (p. 290). However, I am left with a feeling of a silenced voice; of something that perhaps wanted to be spoken of, yet is too early to be known. Perhaps the devastating trauma of the Holocaust needed more time and care before the full extent of its meaning could be accessed. Yet I believe my engagement with Wenkart's writing is not wasted; on the contrary, it confirms how the absence of shame, when discussing self-acceptance, is ubiquitous, and I can only presume the reasons as to how and why her understanding of self-acceptance is devoid of the dialectics of shame.

After not feeling satisfied with the first text, I did find an intense feeling of affirmation in an article written by Lynne Jacobs (2008), an American psychoanalyst and Gestalt therapist. I am using the word *affirmation*, as nearly being synonymous with, and nearing, self-acceptance. Her understanding of recognition is defined as "orienteering towards a 'good'" (Jacobs, 2008, p. 409), and I reflect on one of the descriptions of shame as inner badness. I wish to deepen the meaning of shame in the context of recognition and I wonder whether I could say that shame refers in some way to orienteering towards one's badness. In that context recognition would be very close in meaning to self-acceptance. As I progress in reading I find her description of the phenomenology of recognition compelling. Perhaps I sense and acknowledge how Jacobs manages the affective and cognitive aspects of recognition entwined in a gripping harmony. Her description of recognition is so convincing that I realise that if I exchanged her usage of *recognition* with *self-acceptance* it would be a description of my felt self-acceptance. This passage follows:

> Perhaps my argument may make more sense if I stay close to experience… we can probably all recall experiences of being recognized. My experience includes often a sense of surprise. One surprise is that I have been seen in a way that I was not seeing myself, and yet that yields a "gestalt shift" in my own sense of myself. The gestalt shift, even if it brings intensified awareness of an aspect of myself I am not proud of, also usually brings a surge of self-love or compassion for myself: a deepened self-acceptance; or the surprise comes from not having expected that some striving, or experience of mine could actually be well understood, appreciated as having an understandable place in my wholeness. In either case, there is a strong sense that what is being seen fits me well—even if it is a new awareness for me, and consolidates or expands my own sense of myself. (p. 412)

Just as with descriptions of self, self-acceptance perhaps can only be described by relating an experience. I too have been often surprised when I felt accepted in the therapeutic relationship and in other relationships, as I was initially unable to make sense of what I felt. I was surprised that I felt understood and my emotions were justified. When Jacobs (2008) talks about "intensifies awareness of an aspect of myself I am not proud of" (p. 412) my thoughts move towards shame. I too can say that this awareness now enhances my sense of self and self-acceptance. The more acceptance I receive from the other, the more loving, self-accepting I experience myself. It seems that my journey towards self-acceptance has only started, and the loving, accepting gaze is the cathartic medium. This gaze gives me courage to look in the eye of my shame and slowly separate myself from my own annihilating gaze and from the gaze of the other, towards the sense "that what is being seen fits me well" (p. 412).

Continuing on with the article Jacobs' (2008) article, she also sheds light on McWilliams' notion of being less controlled:

> The experience of recognition also includes for me, as freeing up of some constraint, an accompanying sense of relaxation and momentary wholeness and humility and a sense of gratitude to the recognizer, whose welcoming of me in my wholeness … has brought me home to myself". (p. 413)

Coming back home to oneself sounds deeply poignant, it implies becoming who I originally was: before shame and rejection, before the experience of being seen by an annihilating gaze. Coming back to being confirmed in my feelings, and accepted in my need for dependence on others and for their love. The case study Jacobs presents titled "Dialogue between a Jew and a non-Jew", is a description of a deeply moving meeting of two people who recognise each other, who accept each other, and as a result experience mutual transformation. The patient allows herself to feel the pain and to cry only when the therapist cries the tears she could never afford, and at the same time the therapist experiences her own recognition in the meeting and her self-doubt becomes redundant. Powerful words are spoken by the patient at the end of the therapeutic encounter: "Perhaps we *are* [italics in the original text] more alike than different" (p. 426). This speaks to me of recognition, self-acceptance and its occurrence in the relational space of the therapeutic setting. My thoughts go back to another Jewish woman, Wenkart, who perhaps never experienced such a deeply moving sense of acceptance and recognition.

Towards Self-acceptance

I wish to make yet another circular movement to the beginning of this dissertation: McWilliams (2004) suggests that the more accepting we are "of the aspects of ourselves that have been seen as shameful, the less one is controlled by them". I have explored in the previous chapters what she may have meant by "shameful aspects" and the gaze that feels shaming. What remains is the part about oneself being less controlled by the shame, feeling freer. Dialogically engaging with her thought, I want to ask a question: does she mean that self-acceptance as a goal of treatment means more freedom, less control by shame, or some new flexibility? Her choice of words, according to the hermeneutic tradition, is meaningful: I wonder about the "have been seen". It seems to remove the subject from the sentence and indicates the passivity or separation from being seen. Shame, as I explored, controls the subject; the gaze of the other paralyses and locks the object into a certain position that blinds. The less annihilating the gaze is, the more loving the gaze is perceived as, the freer the person feels to be who she is and freer to exist without the need of the approving gaze. The internal battle of being compliant, of self-rejection, of denial of one's feelings, is replaced with the ease of being content with "I need be no different than I am" (Jacobs, 2008, p. 413). I believe this notion sheds light on self-acceptance not only as a goal of treatment, but as an ongoing aspect of the therapeutic setting, which facilitates change. In other words, the more accepting the gaze of the therapist is, the more self-accepting the patient; therefore the patient may experience more freedom to connect to her shame and protective ways, which will be less needed and replaced with self-compassion.

As I mentioned earlier, the loving gaze will have directed the self towards more self-compassion that assists the process of self-knowledge. Such a gaze in the therapeutic setting will be a perpetual attunement to who the patient is, and not merely to how she is perceived. Again, Jacobs' (2008) words struck a chord with me when she describes the mutual emotional transformation that takes place in therapy: "I also have a humble sense of witnessing from the distance of being an 'other' to the other, and the simultaneous closeness of being with her in our shared human vulnerability. I cannot go away from such a moment unchanged" (p. 426). I find her honesty and mutuality profoundly touching, and I was not surprised when in the article that I explored in the chapter on shame Orange (2008) quoted passages from the article written on shame by Jacobs. I have a strong inclination to think that only the therapist who has gazed at his

own shame could describe the therapeutic process with such empathy, compassion and mutual recognition.

When thinking of the accepting gaze of the therapist and how important it is for the patient's developing self-reflexivity, I contemplate a theory that conceptualises a treatment plan for a vulnerable borderline patient group: dialectical behavioural therapy (DBT). Due to high distress and the inability to manage life tasks amongst borderline personality patients, the therapist is aware of the need for change. At first he must ensure that the patient comes to the therapy, so he gives her tools to stop self-harming and manage suicidal thoughts. He teaches her how to regulate her emotions and tolerate distress. The original focus of behavioural therapy on rationality and change was recognised by Linehan (1997) as invalidating the patient who is painfully aware of her ongoing failures at changing herself and her life. She believed that as a result of such invalidation patients often ended the treatment prematurely. Linehan therefore incorporated the balancing of acceptance of the patient's emotions and the need for change. She developed validation, mindfulness and radical acceptance as the core strategies of the treatment. Linehan's awareness of the continuous acceptance of the patient's internal and external reality as a necessary aspect of therapy stresses how self-acceptance can only arise in such an affirming environment.

There is one more aspect of self-acceptance that emerged in the preliminary literature review and I wish to engage with it. The new approach in psychotherapy acknowledges and accepts the patient's reality. In relation to psychotic, anxious or depressed patients the acceptance of their emotions and internal reality allows the patient to consider themselves as understandable. What is even more important, is that when the patient's inner dynamics are understood and accepted, so is also a reality that some of their characteristics may never change, but the therapy may be helpful to accept them and help the patient to learn how to manage these malfunctioning characteristics. The goal of the therapy for the depressed person will not be to stop being depressed, but learn how to manage it. An anxious person may learn how to prepare themselves for the demands of threatening situations. I was further impelled towards these reflections when reading *Psychodynamic techniques* by Maroda (2009), who expands on the dynamics of change: "the original neural pathways are never erased. Rather, parallel, new pathways are introduced by repetitive new ways of thinking, feeling, and behaving. Through this process the client both remains the same and changes" (p. 33). I find a sense of inner freedom evoked by this passage: I feel I am acknowledged and accepted

in the way I am, yet I also feel encouraged that through new experiences I may change. This captures my experience of wrestling with my shame that I may never fully abandon, yet I am more self-accepting of it and feel free to acknowledge myself in the therapy and in my relationships as "that what is being seen fits me well" (Jacoby, 2008, p. 412).

Summary

Self-acceptance is an intersubjectively engendered experience that occurs in therapy once the patient's shame has been acknowledged. It requires a therapist who has connected to his own shame, is aware of its pervasive quality, and is able to make use of it with empathy for the patient's distress. The more self-acceptance is modelled by the therapist, the more available such an experience is for the patient. Self-acceptance is understood as self-reflection on aspects of oneself that may never change, but that, as a result of therapy that reached its goal, are not seen as shameful any more.

Chapter Six: Conclusion

My research, as stated in the introduction, was inspired by a succinct quotation from McWilliams: “Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them” (McWilliams, 2004, p. 137). The hermeneutic engagement with the literature in order to deepen the meaning of this quotation has taken me on an unexpected and very personal journey of connecting to my shame. As a result, I came to an understanding that it is through experiencing my shame that I have started growing in self-acceptance. This healing process has only commenced, and I realise this account of the research project in some ways is also just the beginning. I am grappling with the sense of its incompleteness, and at the same time I am reminded of the hermeneutic understanding of interpretation as never being complete.

Boell and Cecez-Kecmanovic (2014) describe leaving the hermeneutic circle when “a point of saturation is reached”. It can be established through achieving confidence that that the research provided new findings and that they amount to a significant contribution to our current knowledge. I agree with this notion, however I appreciate Kvale’s description of the end point in hermeneutic research: when “one has reached sensible meanings of the experience, free from inner contradictions” (as quoted by Laverty, 2003, p.22). I believe it captures well the completeness of this dissertation for me as the researcher, when I came to the point of feeling that I have been changed by the new meanings that have arrived in the research process. My journey, as presented in this dissertation, has been completed in the sense that I have experienced the meaning of McWilliams’ quotation; I understand that self-knowledge is only a part of my therapeutic process. The more profound goal of my experience of therapy is ultimately a journey towards self-acceptance, through connecting to my shame, and thus connecting to my feelings without rejection and the tiresome fight against their control. In this final chapter I will summarise my findings about self-acceptance as conveyed in the literature, and try to describe how they may contribute to the current understanding of self-acceptance as a goal of treatment. I will then state the study’s limitations and will outline what I believe could be a potential for further research. I will end the dissertation with the clinical implications of the findings.

Summary of Findings

The preliminary literature search has demonstrated that the subject of self-acceptance in psychodynamic literature has not been elaborated on (Bernard, 2013). It seems that shame has been explored (Morrison 1984, Pines 1995, Orange 2008) while self-acceptance, which I posit following McWilliams' quote as an antidote of shame, has remained underconceptualised. I approached my curiosity by looking at the development of psychoanalytic theory in the hope of finding some clues as to why self-acceptance, named by McWilliams as a profound goal of therapy, has not been fully explored.

Away From the Gaze

My thoughts meander back to the illustrious beginnings of psychoanalysis: Freud famously stated he did not wish to be stared at for eight hours a day (Freud, 1913). I wonder what was the source of his discomfort. Accustomed to treating patients in hypnosis, Freud requested his patients to be in a reclined position to encourage free association, but I suspect that it is not a full explanation. I wonder about the vulnerability of the patient obeying the order of the powerful analyst to lie down, which was not very socially acceptable during Freud's time. I imagine Freud's discomfort of not wanting to be stared at: is it because he did not want to reveal himself, hidden from his patients behind their lying bodies? Maybe it was too uncomfortable to exist in front of the other. Or his wish to stay hidden may indicate some shameful feelings that Freud was perhaps unaware of. The efforts to bring into the conscious what has been repressed using interpretations of the analyst may have given the patients insight into their psyche, yet it may have also left them with a sense of disempowerment and more shame. I sense that such an analytic situation may have exposed the patient's vulnerabilities who would then seek 'defences', in language of hermeneutics of trust 'protection", from 'truth' pronounced by the expert psychoanalyst. Perhaps the therapist, hidden from the patient's gaze, was left with a limited experience of himself in the therapeutic encounter. I stay with the image of early psychoanalysis and its averted gaze, perhaps symbolising the gaze averted from shame in the theory and practice of psychotherapy until recent times.

Into the Gaze

I recognise the major shift from early psychoanalytic thought in the emergence of the hermeneutics of trust as described by Orange (2011): Winnicott contributed the baby-mother dyad, the gaze of the mother in which the baby finds its own existence; while Kohut conceptualised empathy, and thus acknowledged the patient's need for sustained mirroring in the shaming therapeutic situation. The ensuing relational therapy recognised the mutuality of the therapeutic relationship: the therapist is not any more a neutral observer, but someone who is gazed at and emotionally engaged. The intersubjective theory even further acknowledges the mutual gaze as meaningful, in the way it recognises the perceived otherness of the subject and the object, and their co-creation of an emotional third in the therapeutic setting.

Our perception of the patient has changed with the development of the theory of psychoanalysis; she is no longer a victim of internal drives and the id's unconscious strivings, someone who is pathologised and diagnosed. She is now a person in transition, using Wachtel's (Wachtel, 2011) words. She developmentally experiences shame from very early on (Stolorow, 2013); as soon as she is born, she is gazed at. In this gaze she may experience acceptance of her existence or annihilation. When her feelings are not mirrored or responded to, she may feel rejected and not worthy of the love she so needs, and her need for dependence on the other may be felt by her as shaming. She will develop a protective means of hiding from unbearable affects (Stolorow, 2013) so she does not feel defective. This process of hiding will impair her capacity to separate *me* from *not-me* (Winnicott), and her development of self-reflexivity will be overburdened with looking outwards for a basic confirmation of her existence. The difficulties she presents in the therapeutic room are not seen as failures resulting from arrested development and deficits, but validated and accepted ways of coping with what feels to her like unaccepted and unbearable affects. Such awareness of shame, in my view, is only emerging as a concept in the psychodynamic literature, and this may be the reason why, as Morrison (1984) points out, the therapeutic implications of shame are still not explored in the practice of psychotherapy.

Our perception of the therapist has changed too in result of the hermeneutics of trust; the therapist is not hidden from the patient any more. He is within the patient's gaze, seen and exposed, whether he is aware of it or not he self-discloses: in the way he dresses, how his room is decorated, and through his facial expressions and words he utters (Bloomgarden & Mennuti, 2009). Both Wachtel (2011) and Havens (1986)

uncover the importance of the words the therapist uses. Both recognised that the patient responds in her idiosyncratic way to the therapist's words, but the therapist's choice of words and phrases cannot be underestimated as contributors to the patient's responses. One of Wachtel's most profound observations I feel stirred by is the recognition of language being an expression of something much more crucial: what therapists actually think of their patients. I am encouraged by this and wonder whether this observation may take us even deeper: what therapists actually think of themselves. Wachtel (2011) claims that "Good psychotherapy … places both patient and therapist in a position of potential vulnerability" (p. 57). Perhaps the shift from the hermeneutics of trust to the hermeneutics of suspicion, from averted gaze to mutuality in the therapeutic relation, is most critically visible in the new idea of the therapist. He knows he contributes his own beliefs and established ways of emotional responding (Maroda, 2009), and he is now aware how vulnerable he is in the gaze of the patient. He does not need to hide his vulnerability and shame behind the cover of power and knowing, but can use them in meeting his patient's vulnerability and shame.

Therapy: From Shame to Acceptance. Emotional Dwelling.

Wachtel (2011) conceptualises the development of psychoanalytic theory by naming two major changes that took place recently: a focus on affect and a more accepting attitude towards patients. Both have huge clinical implications: we can now talk about human development, not only by describing the processes of mirroring and separation, but most importantly considering the affective states that accompany these processes. Secondly, we are aware that the affect that is inherent in the gaze in therapy may be shaming, and from this comes the awareness of the need for acceptance by the patient, which is of paramount importance in promoting change. Here the therapist's effort to maintain the patient's self-acceptance is an ongoing aspect of the therapeutic setting. I wish to draw on my personal experience of therapy that assisted me during the research project. Therapy provided a safe environment, where I was gazed at with acceptance, and because of that I was able to experience the horror of looking into the eyes of my shame. I have a felt sense of emotional holding in the concept of therapy as an affective home (Stolorow, 2014), as a means of supporting the patient in transition (Wachtel, 2011) with continuing acceptance of her current dynamics. What also emerges from such a perspective is the understanding of the therapist's contribution to what emerges in the therapeutic relationship; the act of gazing is a mutual experience. This understanding of two equally engaged partners will have significant implications for the

therapist's ways of communicating, as will be discussed later. My most cathartic experiences in the therapy were moments when my therapist brought herself into the relation as an emotional participant and someone who may be experienced by me in a certain way, and she plays a part in it too.

Considering the significant transformation of psychoanalysis since Freud, I hope this research helps to highlight that our thinking about the therapeutic process and its goals has not yet caught up with the transformation. When setting the goals of treatment the focus on pathology still seems to dominate the theory (Wachtel, 2011). I wonder whether openness to a new way of looking, towards health, or in Jacobs' (2008) words, towards recognition, has the potential to enhance the therapeutic process. Wachtel is a strong supporter of recognising patients' strengths and points out that "it is difficult, if not impossible, to enable people to change their problematic patterns if one cannot already see within them the potential for new ways of behaving and experiencing" (p. 82). It seems that the research on shame, and its pervasiveness in the therapeutic setting, that has emerged recently, may have opened our eyes to the need for acceptance. Just as this dissertation, and my experience of it, commenced with shame, so did the consideration of the concept of self-acceptance in psychodynamic theory and practice.

Emerging Self-acceptance

The gaze of the other is the locale of the emergent shame, and at the same time the space of healing it. It is in the therapeutic setting that the patient may experience an accepting gaze for the very first time. She may be initially surprised (Jacobs, 2008) that she has been understood and recognised, and with time become more accustomed to this new image of herself. She may realise that her-self (as differentiated from Stolorow's they-self, 2011) had not been fully experienced before, as there were aspects of her-self at which were too shameful to look at. She attempted to hide them from her-self, thus became unable to give herself any positive gaze, and in result, not unlike Narcissus, sought the approval in the gaze of the other. Yet the gaze of the other has often been experienced as annihilating, pushing her into a deeper state of shame. The therapy, which can wrestle shame, may provide her with an accepting gaze she has not experienced before. She then may be able to make sense of her experience and self-reflect on what it is that she thinks of herself. She will be able to undergo this tiresome journey from shame to self-acceptance because her therapist accepts her transition and

continuously models self-acceptance. When she grows in self-acceptance of her difficulties, she slowly becomes less afraid of who she is in the gaze of the others. She will be able to separate her own thoughts and emotions from those of the other. She will feel less controlled by the gaze and freer to be who she is. As the self-acceptance is slowly becoming closer to the experience, she also realises that some parts of her will never change (Maroda, 2009), and acceptance of that may help her to avoid "the vicious circles" (Wachtel, 2011, p. 73) of her experiential patterns that may thus become less painful and shaming.

When I return to McWilliams' quotation there is a final question I feel compelled to ask: is it possible to limit the goals of psychodynamic therapy to one as McWilliams bravely proposes? The literature abounds in answers, from the radical concept of goalless therapeutic effort, to the Freudian idea of curative insight, to the detailed hierarchical structure of therapeutic goals. I agree with Sandler and Dreher (1992) that every therapist is affected by thinking of what the desired outcome for each patient is, "whether they know it or not" (p. 2), and it is important that therapists are aware of the nuances of this reality: who defines the goals of the treatment, how the goals may change during the treatment, and the differences of goals in relation to the patient's life and her treatment (Ticho, 1972). According to Wenstenberger-Breuer (2007) "a single goal description cannot claim to cover the complex events" (p. 479), yet I am open to McWilliams' bold statement and consider self-acceptance as a single profound goal. I hope that this dissertation sheds light on how shame is a universal experience, and how the newly discovered dialectic relationship of shame and acceptance can inform our thinking of self-acceptance as the profound goal of therapy.

Limitations and Further Areas for Research

There are numerous limitations that affected this study. The external reality of my private life has been one of them. Since completing clinical training I have been engaged in a private practice and agency work as a psychotherapist which amounted to working full-time. The sense of responsibility of these engagements is significant, and has created time constraints for this research. I am fully aware that there are many threads that I had to abandon too early.

There are other significant weaknesses of the study, one of them being an intended omission of sexual issues, which could deliver a vast material on the dialectics of shame and self-acceptance, which were, however, too vast for the scope of this dissertation.

Shame is ubiquitous in our experience of sexuality, as it regulates the boundary between public and private. My professional care for patients presenting with sexual issues and transgender patients provides me with an increased awareness of issues of shame, rejection, and lifelong striving for being accepted and self-accepting in these patient groups, but its adequate consideration would require much more space than this research could allow.

As indicated in chapter 3, I recognise there is minimal cultural consideration in this research. Similarly to sexual issues, I chose not to give it more attention due to the limited scope of this research. However the considerations of the dialectics of shame and self-acceptance may present variably when working with patients from different geographical, religious and cultural backgrounds. Recognising the patient's shame coming from living as a racial or religious minority and attending to the external reality of the patient may be paramount to progress in treatment. Facilitating the patient's psychic journey through these shaming feelings, hidden and not spoken about before, may bring awareness, understanding and relief, and eventually promote self-acceptance regardless of the patient's external circumstances. With regards to the geography of shame, as Kilborne (1999) suggests, it may well be that Northerners are more prone to shame, and that further to the East, less religious shaming takes place. All these complex issues, however, require further thoughtful consideration in order to fully attend to the social and cultural aspects of shame.

Another weakness of this research is that there is no attention paid to gender issues, and the rationale behind this is not different from the above; gender issues, when considering the experiences of shame and self-acceptance, merit a separate study.

There are theoretical gaps that I recognise as limitations for the development of a clinical practice: the comprehensive psychodynamic understanding of self-acceptance, exploration of the importance of working with shame in the therapeutic setting, and the inclusion of more studies into attachment styles and shame experiences. I also identify that understanding of shame in the context of trauma could be very useful in promoting the patients' self-acceptance. Lastly, I recognise the significance of potential study into the experience of shame in patients struggling with addictions and eating disorders.

Implications for Clinical Work

When I think of Oedipus I wonder whether there is a warning for therapists in his tragedy: could self-knowledge, without continuous attention to shame, cause tragic blindness in our patients? The figure of a blind prophet who knows Oedipus' fate could remind us of the analyst belonging to the hermeneutics of suspicion paradigm: knowing, yet blind; authoritarian and threatening; possessing knowledge and power that may become persecuting without careful and caring attention to shame.

Just as writing about shame may be anxiety provoking (Kilborne, 1999), so can talking about it in the therapeutic setting. A therapist, who has not connected to his own shame, may be anxious that talking about the patient's shame may be shaming. To take this further, the therapist, who has not attended to his own shame, may lack self-acceptance, and, as described by Pines (1995), or as we observed in Wenkart's article, they may make mistakes in treating their patients. However, the therapist who is able to recognise shame and wrestle with it (Kilborne, 1999) will be able to see the patient's efforts to protect herself from being seen. He will recognise that, behind the need to withdraw and avert the gaze, is the shame of dependency.

In the context of this study, it transpires that the more the therapist is connected to his own shame, the more self-accepting he is. Only then will he be available to the patient in the profound way of deep empathy towards her needs for withdrawal and averted gaze, and be able to help the patient to feel dependency and attachment, not only without feeling ashamed, but also most importantly with self-acceptance. A recent study on the attachment style of the therapist and the patient and its relevance to creating a good therapeutic match has not provided conclusive ideas, apart from a hypothesis that a more securely attached and self-loving therapist promises more successful therapy (Wiseman & Tishby, 2014). It is easy to agree with this statement: therapy is a space of mutual affective influence. The therapist himself may be used as a means to decrease patients' shame and encourage self-acceptance. Self-disclosure has been noted in the literature as curative factor; the sense of comfort may come from the patient's realisation that the therapist shares her vulnerability and emotional struggles, as described by Yalom (2002) who recalls the healing words of his therapist: "this is the way we're built" (p. 218).

The words of the therapist, who uses his own vulnerability for the empathic experience with the patient, are chosen carefully to convey not just insightful comments, but

acceptance and recognition of transition. Wachtel (2011) is aware of the potential harm of such communication of 'truth', and offers a new glossary of therapy based on acceptance. He suggests permission-oriented interpretations, which convey acceptance towards the patient's experience. In such milieu Maroda's (2009) comment to a patient: "you seem angry" (p. 20), Wachtel replaces with: "I have the sense that you're angry but feel you're not supposed to be" (p. 126). Wachtel quotes Havens' words that are permission-oriented: "No wonder you were frightened!" and adds so-called "entry phrases": "at least" and "even more" as facilitating comments (Wachtel, 2011). He calls for less accusatory phrases to be used to frame the patient's experience. I feel touched by his attention to language, as I vividly remember feeling rebuked and shamed when my supervisor on one occasion expressed an insight that felt to me premature and accusatory in nature. Wachtel directs the therapist's communication towards self-acceptance. If, in early psychoanalysis, the interpretations of the repressed unconscious by the expert psychoanalyst amounted to powerful words of wisdom, Wachtel offers a very different approach: he initially encourages gentle exploration of the patient's situation without confronting the patient's vulnerability, with a purpose of protecting the patient's self-esteem. Only once this work has been done, will the therapist ask a question that the patient will now be able to hear. This, in my view, is the hermeneutics of trust in action.

Closing

The process of researching self-acceptance as a profound goal of therapy has been challenging and rewarding. With very few textual directions the journey of deepening the meanings was at times difficult, yet the changes that I have experienced have been invaluable to me, as a person and a therapist. I believe I have become more aware of my shame, of my need for self-acceptance, and my understanding of my patients' needs has been enhanced. I am a different therapist; more empathic and more courageous. I am more aware of the necessity of balancing the patient's need for change with my accepting attitude of what is. I am also more aware of the understanding that some things will never change in the patient's dynamics; yet through an informed acceptance of this fact the patient has an opportunity to gain insight into, and, more importantly, accept these aspects of herself.

It was difficult to decide when I was ready to end this research, still seeing potential for more conceptual deepening and personal benefits. However, once I observed that

continued reading did not expand significantly on what I have already found, and that there seemed to be cross-references between the texts of Orange, Wachtel, Jacoby and Aron, I decided that the process came to an end. I am left with a sense that the point of saturation had been reached, and that it was time to step outside the hermeneutic circle.

I wish to end this dissertation with a quote from an article by Cohen (2006) titled "Loving the patient as the basis for treatment", which in my view summarises the meaning of this research and in a circular movement takes us to the poem by Herbert which opened this dissertation:

> I feel that within this therapeutic session … there occurs a crystallization of the Self, which, paradoxically, requires a unification with the therapist – a unification facilitated by a loving glance. Yes, there is a kind of seeing that confirms that the reality in fact exists, it is a seeing that, in itself, constitutes a kind of proof. But there is another kind of seeing, which in a way creates the reality … It is the glance to which Winnicott ascribes the formation of the Self in the infant who contemplates the face of his loving mother. It is the constructive look of love … there is no real therapeutic action possible without an infrastructure of love between this dyad (patient and therapist). (Cohen, 2006, p. 153)

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