Work in Progress

A Relational Reframing of Therapy

Jean Baker Miller, M.D., &
Irene P. Stiver, Ph.D.

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About the Authors

Jean Baker Miller, M.D., is Director of Education at the Stone Center for Developmental Services and Studies at Wellesley College; a Clinical Professor of Psychiatry at the Boston University School of Medicine; the author of <u>Toward a New Psychology of Women</u>; and the editor of <u>Psychoanalysis and Women</u>.

Irene Pierce Stiver, Ph.D., is Director of the Psychology Department at McLean Hospital, Belmont, Massachusetts; a Principal Associate in Psychiatry at the Harvard Medical School; and a Visiting Scholar at the Stone Center, Wellesley College.

Abstract

This paper explores the implications of a relational perspective for psychotherapy. It posits a basic paradox: People yearn for connections with others yet feel they have to keep large parts of themselves out of connection because of past experiences of being hurt, misunderstood, or violated. The theme of connection and disconnection becomes the central principle guiding the therapist. A safe, mutually empathic, and mutually empowering context is essential for this work. Transference, countertransference, the unconscious, and resistance are reframed in this relational context.

Studying women's lives can lead to a new understanding of all psychological development. We, along with the group working with Gilligan (Gilligan, 1982; Gilligan, Lyons, & Hanmer, 1990; Gilligan, Brown, & Rogers, 1990), have found that an inner sense of connection to others is a central organizing feature in women's development. In this paper we will explore the implications of this perspective for psychotherapy.

It is interesting to note that in the history of psychotherapy there have been voices introducing a more relational component into psychotherapeutic approaches, such as Fairbairn (1952), Rogers (1951), Sullivan (1953), and others. However, the field in general has always resisted placing them in the center of interest.

Again, more recently, in the last 5 to 10 years there has been a resurgence of attention to therapy as a relational process, for example, in the work of Gill (1983), Havens (1986), and Modell (1984). In particular, a growing recognition of new levels of meaning of countertransference has led to a greater focus on the interactional dynamics between therapist and patient (Epstein & Feiner, 1983; Tansey & Burke, 1989; and others).

Kohut's contributions initially encountered enormous resistance from the analytic establishment but have over the years gained a large following (1971). In self-psychology there has been more of a shift from the one directional "self-other" empathic conceptualization to a somewhat greater emphasis on two-way process in the therapeutic encounter (e.g., Wolf, 1983). The works of Stolorow and his colleagues (1987) best illustrate this trend. Here it is worth noting that even in those writings more attentive to relational dynamics, the language and the use of highly intellectualized concepts convey an attitude of objectification of all persons involved and a movement away from the powerful affective meanings of the ideas presented.

A number of papers on the relational approach have already made contributions to understanding the therapeutic process in a new way. For example, Kaplan (1984), Jordan (1991), Stiver (1990c), and Surrey (1987) have written about mutual empathy, mutual empowerment, and disclosure in the therapeutic encounter. From the work of Gilligan and her colleagues a very important paper by Steiner-Adair (1991) offers an innovative reframing of therapy and especially countertransference.

In a paper on "Connections, Disconnections and Violations," one of us (Miller, 1988) focused on those relational, or more accurately, those "non-relational" settings in a family which lead to significant disconnections in all the people involved. More particularly, the child growing up in such settings experiences a deep sense of isolation and self-blame. Under these conditions a significant paradox emerges that is central to understanding relational development and analogously to understanding the therapeutic framework and process.

A Paradox

As Surrey has proposed (1987), we see the underlying processes of psychological growth as occurring in relationships which are mutually empathic and mutually empowering. Trying to spell out mutual empowerment more concretely, we've described it as composed of at least five beneficial components. These are: an increased sense of zest or well-being that comes with feeling connected to others; the motivation and ability to act right in the relationship as well as beyond it; an increased knowledge about oneself and the other person(s); an increased sense of self worth; and a desire for more connection beyond this particular one (Miller, 1988).

We would define the goal of therapy *precisely* as mutual empowerment that includes these five elements. These components are not only the goals in the sense of the endpoint of therapy, but also the features which occur at many steps along the way whenever patient and therapist engage in a growing connection. Of course, we don't attain them at every moment, but we can keep trying for them.

However, therapist and patient have to struggle with the forces within them which stand in the way of creating mutual empathy and mutual empowerment. We all grapple with these forces. They follow from those experiences in childhood or in later life which occur whenever a relationship has been hurtful, disappointing, dangerous or violating — that is, disconnecting and not mutually empathic or mutually empowering. When this happens, we experience a

reversal of these five "good things." It is not a simple reversal, however, it is a compound and confusing mixture: We feel a decreased sense of vitality because of feeling less connected and more alone in the face of a difficult experience. Along with it we feel less able to act, but more than that, we have the sense that action out of our own feelings will lead to destructive or bad consequences. We have less knowledge about ourselves and others, that is more confusion and also a diminished sense of worth. As a result we turn away from others and toward isolation.

Most important, when this kind of disconnection or violation occurs, a person tends to feel the problem is all in her, especially, but not only, if she is a child. This perception occurs precisely because of the disconnection — because she cannot deal with what is happening in true engagement with the other people involved. The problem is "between them," in the relationship. If, however, the other person(s) is not engaging with it, the child or adult begins to feel, not just alone with the problem, but that the problem is all *in her*. She *has* the problem. (Incidentally, by contrast with projective identification, this process is much more common and important. If we were to use similar terminology, we might call this phenomenon something like "introjective relational identification," i.e., the individual taking into herself a problem which is relational — or which, in large part, originates in the other person, if the other person is an abuser or even unresponsive to what's going on in the relationship. This process occurs especially when one person has more power to determine what can happen.)

In the face of repeated experiences of disconnection, we believe people yearn even more for relationships to help with the confused mixture of painful feelings. However, they also become so afraid of engaging with others about their experience, that they keep important parts of themselves out of relationship, i.e., they develop techniques for staying out of connection. Again, we all do this to varying degrees. Several people recently have described specific steps in this process, e.g., Stiver in alcoholic, incest, and Holocaust survivor families (1990b),and Steiner-Adair (1991) and Mirkin (1990) in anorexic and bulimic adolescents and their families.

Thus, we see the central problem as the *paradox* that in our deep desire to make connection, we keep large parts of ourselves out of connection. Precisely in the face of so needing connection, we develop a repertoire of methods, which we believe we must maintain, to keep us out of real engagement. As we have described elsewhere, some people may present a picture of seeming connection, for example, as they

play out a role, such as that of the good wife or caretaker; yet this very role serves to keep them out of true engagement about *what matters* for them (Stiver, l990b; Miller, 1988). The central issue is the power of the often unseen desperate reaching for connection, hoping others will perceive and respond to this yearning while simultaneously continuing the techniques for staying out of connection. This is the paradox which patient and therapist face as they undertake therapy.

Here we want to note that Gilligan and her colleagues (Gilligan, 1990) in their work on adolescent girls arrived at almost exactly the same statement. They have beautiful data to indicate that at adolescence, girls begin to keep large parts of themselves out of connection in order to try to stay in connection in the only ways available in this culture.

Another way to put this main point is to say that being in connection means to be emotionally accessible. And this means to be vulnerable. First of all, to express our own perceptions and feelings always places us in a vulnerable position, opening ourselves to the responses of others to "what is really me." To do that we really do need other people who can resonate to the feelings, or who can bear them with us, in contrast to not engaging, withdrawing, punishing, or violating us — that is, disconnecting in various ways. When the latter occurs regularly, the child learns that allowing herself to be vulnerable is too dangerous. Here, as Jordan (1989) has described it, shame enters, and with it the terrible feelings of loss of empathic possibility.

Another result is that a person is forced to lose the full possibility of representing herself and of developing knowledge about her experience, of developing authenticity. If we don't have people who can emotionally resonate and respond, we have to start to focus, instead, on methods of not putting forward our perceptions and feelings. We start down a path away from knowledge of ourselves and away from a sense of authenticity.

Connections and disconnections as the guiding theme in therapy

This paradox of connections-disconnections translates into the central framework to guide the therapist. The therapist cues her listening, her understanding of the material that emerges, and her emotional attunement in the context of how connected or disconnected she experiences both herself and her patient at various stages of the encounter. This approach contrasts with prevailing theories.

For example, when we hear cases discussed today, it is usually in terms of how dependent or "narcissistic" a patient is, whether a patient is still struggling with preoedipal or oedipal issues, whether she is too enmeshed with her mother, the extent of underlying "aggression," whether there are major conflicts around gender identity, and whether the patient is highly resistant, defended, and the like.

Our perspective helps organize the material in a very different way. We are all familiar with some of the ways our patients stay out or move out of connection — for example, the person who talks most of the session leaving no room for any form of exchange, or the person who appears very compliant and apparently responsive and yet nothing moves in the process.

We are making the bold statement then, that we see all the problems which emerge in therapy to be at one level or another reflections of this central paradox. A wide range of symptoms, such as phobias, depression, dissociative states, paranoid ideas, self-sabotaging behaviors, and other problems can be ways of attempting to stay out of relationship and to hide deep yearnings for connections. Two rather different vignettes illustrate this perspective.

A 40-year-old woman we'll call Clara, entered therapy because of a significant depression which developed when she moved back to the city where her extended family lived and where she had grown up. Although there were many practical issues which determined the move, she had also looked forward to being closer to her family. Instead, once settled, Clara didn't pursue her career; isolated herself from friends and family; stayed in bed all day; and felt irritable, bleak, and without energy. She felt that she dragged herself to therapy and could not muster much interest or hope in the process. I actively had to resist being pulled into her depressive spiral and feelings of hopelessness when I was with her. (We will use the pronoun, I, when presenting individual therapy or supervision experience.) I noticed, however, whenever I had the opportunity to focus on her particular day-to-day experiences and could really join her in some of her concrete disappointments, I could feel "something" with her. At those times Clara would perk up and become more responsive.

After a session in which I noted how much she minimized the power of significant events in her life, she entered the next session unusually cheerful and recalled that that morning when she went to the bank, the teller said, "You know you have a very nice smile." That — "for some reason" — made her feel good. I then said, "It feels good to be seen, to be noticed; you

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feel less alone." I reminded her that she has recognized more and more how much she had not felt seen in her family and that she never believed that her problems "were serious enough" to be noticed. Rather she thought she was too demanding and there was something wrong with her.

Clara then said that at that moment an old memory came to mind, of "a minor event" in her childhood. The memory is of herself at 5 years of age coming home from school, when a man appeared, pulled his pants down and said, "This is for you." She recalls being terrified, starting to run and falling down, clutching the grass under her. At that moment a teacher arrived, the man fled, the teacher called her mother, and she went home. Her mother reacted to her distress saying, "But nothing happened, why are you making such a fuss?" Clara told me this without emotion, almost as though she saw it as a "non-event" since "nothing *really* happened." My response was authentic surprise at her minimization, and I said with feeling that something indeed had happened and that it must have had a powerful impact on her.

She then began to talk with much more energy, citing the various ways through adolescence and even in a more recent — disguised but clear — sexual encounter, that she has been haunted by that memory. Yet she always feels foolish about "making a fuss" about it and is never sure whether she has correctly perceived a situation as a sexual threat or not. Typically she blames herself for "misunderstanding" a situation and being too self-conscious. I then said, "It's so hard to believe something happened when it is questioned and then you begin to wonder what's real and what isn't." She began to weep, and I felt her sadness in a way I had not before.

That session and subsequent ones began to move in a new way. Clara learned more about how her longings for connections with her family now were as disappointing as always. She recognized that she had retreated from all opportunities for connections as a consequence of the experience in her family.

Another woman, Pat, who was in her 50s, was extremely energetic and accomplished. Her internist had suggested that she seek therapy because of a weight gain of over 70 pounds in the past year. At our initial interview she described how a lifetime of binge eating had gone out of control over the last few years. She also was having difficulty sleeping. She was once an actress and speaks with dramatic style, reporting events with color and flare. Although she appeared very friendly and outgoing, I sometimes felt quite removed from her. I soon learned how much pain she felt, but I was often not in touch with it in a way that

helped me feel present and involved. Her son's alcoholism had intensified these past few years, and he was becoming more and more angry and estranged from her. A daughter had even more recently become depressed, made a serious suicide attempt, and had refused to see her mother.

In one session, Pat came in saying she would like to ask a favor of me. The favor was: "I want to just talk, and I'd like you not to say anything until I'm finished," and she added, "You can take notes if you like." She then reported in detail a series of events involving different family members, all of which involved her sacrificing her time, energy, and abilities to do for them, always resulting in her giving up things for herself. I was not feeling very empathic, and instead felt critical of her doing so much for her family. I was clearly feeling more and more disconnected from her, increasingly bored, and not present. As the hour progressed I felt it required enormous energy to keep awake. About 40 minutes into the session, as she was apparently coming to the end of her recital, I suddenly began to feel both very sad and wide awake. Pat ended this long recital by saying, "I cried all last night." I am not completely clear what happened; but I assume she had gradually become more open in some way, and that I resonated with her beginning ability to feel "something" about her underlying distress.

I then said, "We have to stop shortly but I have to tell you something. I had a hard time today feeling in touch with you, and I didn't feel I was able to reach you. I thought it was because you were protecting yourself in some way. There seemed to be a wall between us. I understand that there are powerful reasons for you to feel terrible, but I could not truly feel it with you . . . then suddenly I felt your sadness and heartbreak." Pat nodded, and said soberly, "I feel terrible, I don't know what I'm going to do." She added with much more feeling than ever before, "It feels hopeless to me." As we moved to the door I said, "The fact that you were able to feel that here and that I could feel with you tells me we're moving, and I am really hopeful about that." Subsequent sessions truly began to feel different, and now, many months later, I have not felt that boredom or sleepiness again, although I certainly continue to feel disconnected at times.

In both instances the whole relational dynamic began to shift as I struggled to move from an experience of disconnection to a greater sense of connection. As this shift occurs, the patient feels more energetic and becomes gradually more empowered to

risk exposing her vulnerability and acknowledging at various levels the underlying wishes for connection.

This focus on connections and disconnections as the central guide in therapy, can develop only in a setting of safety and mutuality. We will now discuss this setting and its important components.

Components of a new relational context

First it is important to say that what we are always seeking in therapy is change, *movement* — out of isolation and/or suffering to empowerment and fulfillment. This is central to our perspective. As illustrated in the examples, the basic process of therapy occurs because the therapist can be moved by the patient and the patient can be moved by the therapist. This movement occurs through empathy. If the therapist can feel with the patient and be with the patient's experience, she will be moved. The patient will be moved when she can "feel with the therapist feeling with her," or can feel with the therapist's experience.

However, as also illustrated in these examples, it is the therapist's responsibility to find the ways to facilitate this movement. In the face of the power of the paradox, we believe that people can only begin to risk moving out of disconnection about important experiences if the therapist struggles to create an empathic and responsive relational context, not if the therapist is distant and affectively neutral.

To create this relational context, the therapist must make it very prominent that she takes the patient's experience and emotions seriously. This point may sound obvious, but we must remember that, like the women just described, so many people have been made to feel that their experience isn't important, doesn't matter. They will continue to feel that unless the therapist makes it very apparent that she r*eacts differently* from the people in the past.

A related point is that the therapist has to let the patient know that she has an impact on the therapist. The therapist makes it palpable that this impact is moving her. Again, so many people have experienced disconnections in which they were so unable to have an effect in the important relationships in their lives, to reach the other person(s).

If, as in the above examples, the therapist can keep struggling to create a relational context which includes the therapist's authenticity and presence, and her demonstrating the client's impact on her, she contributes to creating an enlarged sense of connection. It is this sense which makes it possible for the client to move out of immobilization and hopelessness, to feel empowered to risk exposing her

vulnerabilities, and to acknowledge her longing for connection. Our patients enter therapy often believing that their feelings have no legitimacy, and that another person will never be able to participate with them in their inner emotional life. But even more significant is the need to help ourselves and our patients become aware of how disconnections emerge, how awful they feel, and how to begin to name them and understand them.

Therapists' responsiveness in this way, of course, stands in contrast to traditional teachings. We will review more of this contrast below. Here, let us just stress a point made by Jordan (1991) that for some people the therapist's neutrality can create intense anxiety, because they will assume that this relationship will be the *same* as the past, e.g., hurtful, violating, or the like. The patient may then try to make some connection but in more desperate ways, often in non-relational or maladaptive forms, sometimes labeled manipulative or acting out.

Some authors have talked about parts of these points in other terms, e.g., being able to identify with the various introjects a person has taken in (and which she may also project onto the therapist) and being able to sense how the person feels in relation to each of these introjects. We think of this more as being able to be empathic with the patient's internal images of past *relationships*, images which are more complex than can be covered by a static term such as introjects. We also stress the two sides of these pictures, i.e., the side that is struggling to be in connection in the face of the past relational images which militate against it.

The work of therapy, then, is to discover together the ways to continue to move so that the relationship can become responsive to more of the parts of life which each person believes she has to keep out of relationship. We can probably talk about this best by another example, that of a 40-year-old woman we'll call Ellen, who came to therapy because of depression. She and her husband both worked, she in a helping profession and he as a doctor. However, she took care of almost everything for their home life and their two children, eight and ten years old.

Initially, I tried to convey my empathy with almost everything Ellen discussed because I believe I felt it. For example, her husband still expected her to do even more for their children. She did do a great deal, but he often criticized her as if it wasn't enough. He expressed no recognition for the things she did do for him and them. When she took some courses to increase her professional possibilities, he belittled her efforts with jokes and put-downs.

I spoke of how hard it is to feel she had no one with her in so many parts of her life. She'd reply in ways which tended to be self-derogatory such as, "But why do I let it bother me so much?" or "Why do I need that? I'm not a child." I'd say something like,"I think everyone needs that. It makes things feel good or bad in a basic way." This kind of work helped somewhat, but not enough.

The next step occurred in an interchange that went something like this: After one of my comments, Ellen said again something like, "But why should I feel so bad about it?"

I: "Are you thinking that I should be able to make you feel better faster?"

Ellen: "Oh, I'm certainly not criticizing you."

I: "I really think you don't want to criticize me, but you could have the wish that I would make you feel better faster."

Ellen: "Well, sure I do."

There, I made a guess from what I'd call "attempting to be empathic." I think I felt how much she didn't want to criticize me, but I could be wrong. Maybe she does want to, and I shouldn't make it even harder. This is the kind of choice which we cannot avoid in therapy. We can tell if we are wrong only by observing what happens next.

I thought, too, that she wished I'd just get her better. Therapists can perceive such a wish in a number of ways. Ellen could be viewed as dependent, or as seeing me as the omnipotent mother, or in other such terms. However, I think such a wish is quite legitimate, and I wanted to affirm her understandable desires. I think we all have such wishes often.

I said next something like, "I'm guessing that you so want to feel better, and when we can't get there, you could feel angry that *we* haven't made it happen. It's awful to feel awful." Ellen then said, "Yes, but I know you're trying."

Again, there are a number of ways to hear this comment. Once more I could hear it as criticism, that is, I'm trying but I'm not doing so well. However, I felt that in this statement Ellen was being empathic with me. I was trying and she was accurate about that. I said, "Yes, I'm trying. I know you feel that. It can be particularly hard to be dissatisfied or critical or angry if you also feel that I am trying."

At this point, the feelings really mounted. Ellen began to talk in a whole new way, very energized and with a great deal of sadness and anger. She said no one ever cared how she felt or was interested in her, not in her own (original) family, not her husband. I'm the first person who ever did. How could she want to hurt me? She then talked of much more deeply felt disappointment and anger at her own family. I felt very moved and felt that she had advanced us to a new level of connection.

In addition, I felt affirmed because I felt that Ellen was feeling something new and I was feeling something new in our interchange. Just as we said about patients, we as therapists feel enhanced ourselves when we feel we have had an impact (Stiver, 1990a). It's the opposite of the feeling of helplessness or powerlessness. More important, I had a new experience of this woman. She now appeared a much stronger, active woman, engaged in this way. I felt better because I had someone who was *much more with me*. This is what we mean by increasing empathy and empowerment — and this empowerment helped me.

A more accurate way to state this is to say that the relationship between us was enlarged and empowered. We now had more resources — more energy, action, knowledge, and sense of connection in the relationship — that is, as we suggested at the beginning, the components of all mutually empathic and mutually empowering connections. These aspects of the relationship were there for both of us. It is not a question of giving or getting for one person or the other, nor of being gratified or not gratified in the usual sense of those terms.

Some steps in mutual empathy had led to this movement. I felt some approximation to Ellen's thoughts and feelings, and she was empathic with my feeling this. She felt some of the feelings I was having. As a result of this mutual empathy, we created mutual empowerment.

Ellen had contributed to this more empowered connection in a major way and in a way that was particularly difficult, as it always is when anyone moves into previously forbidden and fearful areas. By bringing into the relationship parts of her experience which she had not done before, she found that this action led to more connection for both of us, not less. These steps are the essence of growth, expansion.

At these moments of interaction, a person moves into more connection based on her more truly representing herself, and she simultaneously makes a change in her inner experience. She comes to feel in greater connection with this experience and to feel a right to that experience. She grows in authenticity. There is a greater sense of her "being there," her presence in the moment.

As we said at the beginning, we believe that these moments of greater connection are the "levers" of movement, in therapy. We all know that we can make all the interpretations in the world but nothing changes. Some therapists have said that the affective

level has to be added or, for example, that the therapist has to respond to the self-object needs at the right level. But we believe it is not a question of the affective level nor self-object needs only; it is feeling moved in the relationship, the kind of experience in which patient and therapist feel that they are becoming more connected. We can't know these moments beforehand; we have to discover them with each person by working together.

These steps toward increased connection also lead to the expansion of the therapist's knowledge and ability to act both in each particular relationship, and also in her breadth and depth as a therapist and a person. Each person will call for the therapist to stretch in certain dimensions. Thus, each therapy relationship can enlarge the therapist on many levels.

We want to make clear that we are not talking about any sort of quest for some ecstatic experience or emotional high. Nor are we talking about gratification of the therapist in the usual sense of that term. We are talking about the therapist *participating* in the relationship in a way that will lead to mutual empathy and mutual empowerment. If both therapist and patient participate in this way, they will inevitably move toward a sense of increased connection. We don't see how it could be otherwise!

Having used these illustrations, we would now like to expand our description of the goal of therapy. We suggested that the goal is change; we would add that the only way that change happens is through movement toward better connection. Thus, we would say the goal of therapy is increased connection — connection which is mutually empathic and mutually empowering. This is very different from dependency. Indeed, it is the opposite.

All therapists have talked about the therapeutic relationship. Very often in therapy, as in life, this relationship is seen as a means to another end, such as individual development. We view it as the means and the end, and also as Jordan has put it, the key to the process of therapy, not just the backdrop (1991). That is, therapy is about making it possible for a person to bring more and more of herself into the relationship. This can occur only in a relationship which is moving toward increasing empathy and empowerment. Without this movement, we don't believe it can happen.

We suspect that good therapists of many schools of thought do something like this, at least in part. However, they have not described their work in terms of building connection; we believe that it will be very helpful to continue to work on enlarging the description of therapy in these terms.

This reframing leads to new ways of thinking about all of the central concepts in therapy such as transference, countertransference, the unconscious, and resistance.

Transference

In reframing both the understanding of transference phenomena and the ways of using these phenomena therapeutically, we would like to focus on two of the differences between the relational model and traditional approaches: 1) the need for the therapist's neutrality in order for the transference to emerge and 2) the usefulness of "interpreting" the transference as the major work of the therapy.

We contend that transference phenomena emerge in all relational settings; it is important to know that and to recognize and respect their significance in the therapy setting. But, in addition, we believe that it is the very neutrality and distancing of the therapist which impede the ways in which therapy can provide a new and different experience. As long as the therapist remains "neutral" or relatively non-communicative, the patient is not confronted as effectively as she could be with the significant differences between her relationship with the therapist and those relational images from the past which she re-experiences in therapy.

As discussed above, if the therapist strives to create a new relational context in which she is authentic and caring, she creates a more fertile ground for the essentials of transference to emerge. Since we are all replaying all significant relational dynamics in our lives in all relationships, we cannot avoid doing at least that in the therapeutic relationship.

In fact, transference is very much a relational phenomenon. Memories of one's past relationships, with their connections and disconnections, are expressed in many ways, in "a playing out," sometimes symbolically and without awareness, and often in displaced and distorted forms. Contrary to the notion that it is the "blank screen" of the therapist that allows the transference to emerge, we believe that a genuine relational context provides *the safety* and conducive setting to attend to representations of old relational images as expressed in the transference in a way that can be most helpful.

A short vignette will best illustrate the power of the transference in the face of an ongoing "real" therapeutic relationship. As a result of a minor accident, I had a bad foot sprain and could only walk in my Nike sports shoes. A woman, whom I had been seeing for more than 3 years, and with whom I felt comfortable and authentic, entered therapy the first

day after my accident and had to see me walk ahead of her with a decided limp. Clearly very angry, she sarcastically began the session saying, "So now in addition to everything else you do, you're out there running with your friends every morning." This reaction was meaningful to me. I understood it as her expression of the kinds of feelings of inadequacy, envy, and anger which characterized her early relationship with her mother, who displayed enormous activity and energy and expected her daughter to perform and achieve for her.

So, lack of neutrality does not seem to ward off the development of transference. We believe that focused attention to the connections and disconnections as expressed in the transference (and countertransference) phenomena, provide the central work of the therapy. Through attending to the relational images which emerge in the transference, it is possible to gain greater clarity and understanding about the nature of past relationships that have led to significant disconnections and distancing from others. The alertness of the therapist to the distortions in these expectations can lead to engaging the person to explore with the therapist how the disconnections happened and how to find new ways of being in relationship.

A brief vignette illustrates the ways in which transference images can be addressed productively with a relational perspective. A therapist I supervise told me about a young woman she has been seeing for almost a year who expressed great difficulty in talking and is often mute. I learned that l) the woman's ostensible reason for coming into therapy was that her mother didn't want her to; and 2) that over time she has been able to state that she is afraid that if she does talk about herself, the therapist will tell her to leave. The transference issue that is most apparent is her replication in the therapy of her struggle with her mother, that is, how to stay connected with her but also how to be out of relationship with her and defy her because of past hurts and anger.

To come to therapy but not talk allows her, on the one hand, to ward her mother off by defying her; but she also stays in connection with her by complying with her through not truly engaging in the therapy, i.e., not talking. With her therapist she replays the same dilemma and distances and disconnects from her. This seems to be an expression of her expectation that the therapist, like her mother, will not want to hear what she has to say and will not respect her need to talk about herself and get help. She is then left feeling as conflicted with her therapist as with her mother and as isolated and disconnected. Her

therapist can address this with this woman by beginning to name this dilemma, to see it *not as resistance* but rather as the woman's intense efforts to *maintain connection* with her mother while she tries to *protect* herself from being wounded again.

The next point is about the interpretation of the transference. We are not at all persuaded that the therapist offering formulations about the transference is effective. These formulations can be experienced as highly intellectualized, not very meaningful to the person, and often as criticism. In the relational model, as two people struggle to establish a sense of trust and mutuality, the therapist needs to be keenly aware of how she feels she may be misunderstood in the light of the patient's past experiences. As she begins to understand more, she can become increasingly aware of her own experience of difference as well as of some similarities between her and these projections on her which she experiences from the patient. She can then begin to modify her inner attitudes and overt behavior in a way which will consistently and regularly highlight to the patient the significant differences between her and those disconnecting relationships in the past; all of this need not necessarily be verbalized.

Perhaps it may be best not to verbalize about transference until enough trust and mutual participation in the therapeutic process has evolved. We do not mean the therapist should role play nor behave in some contrived fashion to "look" different from past important people in a person's life; rather we mean that the therapist needs to become more aware of who she is and how she sincerely wants to relate to the person more constructively.

If the interpretation occurs without living out this difference, it may be experienced only cognitively — as an intellectual exercise, making little difference in reorganizing a person's experience of relationships. It may also be too hurtful to call attention to the destructive aspects of past relationships without first establishing a solid sense of connection and mutual understanding with the therapist.

Countertransference

The concept of countertransference has probably undergone more modification and elaboration than any other feature of therapy. Freud's notion was that countertransference got in the way of therapy since it reflected the unanalyzed neurotic conflicts of the therapist (1923/1957). This point was consistent with the need for the therapist's neutrality, which meant that all feelings for the patient were suspect. In the 1950s a number of papers introduced a more relational view. Heimann (1950) and Racker (1953) explicitly

moved away from this pathological view and saw countertransference as an opportunity for the therapist to learn more *about the patient* through examining all the thoughts and feelings stirred up in the interaction. Other analysts writing at that time supported and expanded this view, e.g., Fromm-Reichmann (1950), Sullivan (1953), Winnicott (1949), and Little (1951). It is worth noting that a declining interest in this broader notion of countertransference then occurred over many years. In the past ten to fifteen years, however, similar ideas have come forward again.

Current analytic writers, especially of the Kohutian school e.g., Wolf (1983), Stolorow, Brandchaft, and Atwood (1987), and others such as Gill (1983), and Tansey and Burke (1989), see projective identification, countertransference, and empathy as integrating intrapsychic and interpersonal phenomena. Most therapists today acknowledge the use of countertransference as a window into the patient's experiences. These ideas have made important contributions to a more "interactional" view of the process of psychotherapy; still the focus continues to be on the "individual self" rather than on the relationship and the mutuality of the therapeutic encounter.

Steiner-Adair, in a paper on the treatment of eating disorders (1991), offers a concept of countertransference which is most consonant with our perspective. In particular, she defines it as "the thoughts and feelings that take the therapist out of connection with the patient" (p. 233). When the therapist feels disengaged from the patient, when there are breaks in her empathic responsiveness, these are signs for the therapist to attend to these experiences and what they mean for the relationship. She states that feelings of connectedness, such as love and caring feelings, need also to be acknowledged.

Contrary to the original notion of therapist neutrality, we believe the therapist is always experiencing a wide range of thoughts and feelings, at various levels of awareness and articulation. Thus, in our view, countertransference includes all the factors which both facilitate and impede the therapist's ability to connect with her patient.

These factors cover the range of ways in which the therapist disconnects in the face of a variety of personal preoccupations and dynamics, her own struggle with the paradox of connections and disconnections, as well as her reaction to the barriers experienced with each specific person.

Since we believe that movement and change happen through the focus on the connections and disconnections in the therapeutic relationship (in the

here and now, and in the relational images from the past which inform the transference), countertransference becomes the center point of therapeutic work. Careful attention to it provides the primary opportunity for enhancing mutuality in the therapeutic encounter.

As we suggested above, the therapist's attentiveness to feeling disconnected begins the process of determining the sources of this feeling and communicating to the patient the thoughts and feelings which will help to move both therapist and patient back into connection. The communication need not always be verbal, nor does it need to be "interpreted," but the therapist has to be ready to change and modify her way of being if that will move the relationship further.

The first two vignettes described above illustrate this process. My countertransference with both these women was an inability to feel their distress, and I felt alone and disconnected as a result. In the face of that disconnection I felt uncomfortable, removed from my own feelings, unable to be empathic, frustrated, and at a loss. Particularly with the second woman, Pat, when I had little opportunity to interact for most of the hour, what helped me was using this perspective. I could then seize the moment of feeling "something" and I became less stuck. I don't think I would have shared my sense of being so removed from Pat until I could identify some opening up in her, that is, when *I* began to resonate with her pain. If we take seriously the paradox people bring into the therapy, of wanting to be in connection but being too afraid truly to be in relationship, then I would need to respect her continued need to keep me at a distance.

Steiner-Adair (l991) especially stresses the need for the therapist to acknowledge her experience of feeling shut out by the patient, sharing the whole gamut of feelings as they arise, from joy and caring, to anger and frustration. Here it is important to address the complicated question of what, when, and how the therapist shares and communicates those thoughts and feelings which impede the movement in the therapy and lead to disconnection.

The issue of therapist disclosure is an extremely complicated one. Surrey (1991) has said that non-disclosure may at times have as significant consequences on the therapeutic process as disclosure. Sometimes the therapist's silence may have a very negative effect in working with people who are struggling with authenticity and vulnerability. As Surrey suggests (1991), whatever will facilitate growth in connection, whatever moves the therapy from

disconnection to connection, should serve as our guidelines about disclosure as well as any other interventions.

The therapist needs, of course, to be exquisitely sensitive to a person's readiness for openness and vulnerability, when communicating feelings of distance, anger, sorrow, and the like. But we cannot underestimate how much we may at times communicate all these feelings at a non-verbal level (Searles, 1978). Such non-explicit communications can be devastating since a person can readily misunderstand them and re-experience herself back in the original family settings of disconnection and denial.

One of the women whose therapy I supervised was becoming more and more distressed by unspeakable memories of sexual abuse and flashbacks. She began to call her therapist as often as ten or more times a day; she was feeling always on the brink of some desperation, about to cut herself, having just cut herself, or feeling suicidal. In this process she appeared sad and very needy at times, and at other times she was enraged and abusive with the therapist for not helping enough. In supervision the therapist expressed genuine concern about what this woman was going through, felt horrified by the stories of abuse, but also was becoming clearly more and more frustrated and angry at feeling overwhelmed by the demands, by the attacks on her, and by her own sense of helplessness.

I felt the therapist's anger had become so central that the patient had to "know" it at some level, which was adding fuel to the fire, and leaving both of them out of connection, neither one free to be authentic with the other. In this instance, I thought the therapist's forthright expression of her feelings, in the context of understanding this woman's profoundly painful experiences, would have a beneficial therapeutic effect. In fact, the woman was much relieved. She had been filled with a nameless terror that the therapist hated her and wanted to leave, or wanted to get rid of her, and the like. As she could hear more about her impact on the therapist, she could begin to take another person into account and there were some steps toward mutuality. I don't mean to suggest that all the difficulties disappeared after this; they didn't. But there was movement toward more connection and collaboration.

We all have known the discomfort of feeling helpless in the face of dilemmas and pain, of feeling afraid of being taken over by the intensity of some people's experiences, of being fearful and angry as our strong feelings sometimes threaten to overwhelm us.

A therapist cannot be open and willing to change in the process without experiencing all of these feelings at various times. It is through these experiences, that we can "know" about our patient's feelings in a deeper way and also know about ourselves more profoundly. It is this process that does communicate to the patient that she has an impact on the therapist who moves and changes as a consequence.

The unconscious

If the relational contact develops so that a person feels safer and safer over time and experiences the therapist as real, accessible, and truly participating in the therapeutic work, then "unconscious" memories do begin to emerge which were previously "repressed," split off, or robbed of their meanings and importance. The notion that a "correct" interpretation with perfect timing lifts the repression, that the unconscious becomes conscious, and that dramatic change occurs, has not been part of our clinical experience. Rather as the sense of connection between therapist and patient grows, the patient feels more understood and gains greater clarity in her feelings and thoughts which leads to more readiness to understand the meanings of her experiences.

In the same way, those relational distortions and destructive relational experiences which may have been too threatening to even look at before, can begin to emerge when a person can trust that the therapist will be able to tolerate these experiences, and will respond genuinely and affectively to them. As the person feels more accepted, she can bring more and more of her whole person into the relationship; she gains access to unconscious, or previously split off experiences.

Resistance

Another major concept has been the notion of resistance, which has always had some connotation of blaming the patient. We believe that what is called resistance is what we have called methods of staying out of connection. We find it helpful to think in terms of a person's fear of bringing parts of her experience into connection — along with keeping in mind always that the person probably wants so much to make these connections. Rather than seeing resistance as a battle between therapist and patient, this approach helps the therapist to stay empathic with both sides of the paradox — and thereby, able to help legitimate with each person her desire for connection and her reasons for fear of it. In our experience in therapy and in supervision, we have found that this focus helps

therapists find the paths to move out of stuck places — and to avoid creating some common impasses in the first place.

Many times, the things that are called resistance are life-saving — or mind-saving — methods people have developed for which we should have great respect. For example, sometimes people are saying, in effect, "No, I won't engage with you because that means I have to turn into what you want and I won't do that." The way people play out this message can take a variety of difficult forms for the therapist, but the recognition of the deep importance of such a stance can help patient and therapist.

Conclusion

We began by describing a perspective that originated at a very different point from other psychodynamic approaches, not with the attempt to account for pathology, but rather with the attempt to describe healthy development in women. We saw that the center of that development was connection, and optimally, connection characterized by mutual empathy and mutual empowerment. We moved next to an attempt to describe how this development can become derailed in the face of conditions which create disconnections and the loss of empathy and empowerment. These conditions are inevitable in a society which is not yet based on mutuality. We all develop various methods for staying out of connection while needing and yearning for fuller connection.

This perspective creates a whole new attitude that we bring to the therapeutic encounter and to an understanding of what it is to struggle with problems in life. It moves away from objectifying, hierarchical, pejorative ways of describing people and leads us to appreciate how everybody comes into relationships carrying this paradox in some form. The only difference between therapist and patient is that it is the therapist's job to observe and facilitate the movement to more connection.

We believe that the focus on connection and disconnection speaks to the central core of the human condition, the core which has remained obscure and out of focus in other psychodynamic approaches. While all theories have spoken about relationships, this core remains obscure because these theories emerged from an underlying preoccupation (although one usually not made explicit) with individual gratification and power. This preoccupation could arise only from the thinking of a group which is a dominant group in society and which would inevitably reflect a distorted view of the total human condition. Once we examine more accurately the lives of all people, we inevitably find ourselves moving away from this preoccupation and toward a recognition of the necessity of human connection and the sources and consequences of disconnection.

Discussion summary

A discussion is held after each colloquium presentation. Selected portions of the discussion are summarized here. At this session Drs. Alexandra G. Kaplan, Judith V. Jordan, and Janet L. Surrey joined Drs. Jean Baker Miller and Irene P. Stiver in leading the discussion.

Question: It's so important to move toward mutuality, but how do the many structural elements in psychotherapy affect that? For example, the client pays the therapist money, or, the client is called by her first name but the therapist may be called "doctor."

Stiver: A main point is that we were taught that all of these obstacles to mutuality were virtues. They were used to justify the fact that the therapist had more power or that her decisions took precedence. It's important not to pretend that these structures don't exist and to talk about the discomfort the therapist feels. That certainly doesn't remove these features.

Kaplan: Often the client and the therapist can join together to create ways to think about some of these boundary issues and work out ways that will work for them.

Jordan: Mutuality doesn't exactly mean equality or sameness of roles. In therapy, we can acknowledge that each person is in a different role as well as being a real person. A lot of what we're talking about is authentic responsiveness, a very important piece.

Surrey: Just this week, a client said, "This is not a two-way process. I'm sick in the hospital and you phoned me. If you were sick, I may not even know you were in the hospital." Something like this generates feelings that we can talk about together. I remember that I had been trained that such a statement was a defense mechanism, a form of resistance. Today I wouldn't take that stance at all.

Question: My question has three parts. If you have many patients who are very ill and you are empathic to them all, how do you survive? Second, isn't self-revelation a part of mutuality? That is, you can tell who you are as well as what you're feeling at the moment. That also is part of the relationship, for example, to reveal how you dealt with something. That seems to work in groups like AA. Third, if we're going to have this kind of therapy, aren't we going to have to train different kinds of therapists — people who are truly in touch with feelings? Most people

were chosen for their intellects, and I think those are two different tracks.

Stiver: I'll start on the first question. We have not yet paid sufficient attention to the relational needs of therapists. To be open in this way means to be vulnerable, and this means there need to be relationships for therapists which supply resources and supports.

Miller: To emphasize that point, in the past we haven't thought about how much therapists need help. We haven't admitted it before. We've had an image of the lone therapist, and we have to start to think in a whole new way. About your third point, I agree with you. We need therapists who can be emotionally responsive, vulnerable, at risk. These haven't been explicit criteria in traditional training programs. Not that this is easy. As we tried to say in this paper, each of us brings our problems about being more fully in relationship. The important thing is that each of us can look to working on these obstacles in us.

Jordan: I feel increasingly that we have to pay attention to therapist's self-disclosure because it is an important piece of mutuality. The past rules served very much to protect the therapist. This is not to say that I advocate total spontaneity or reactivity. Most important, we need to demystify the idea that the therapist is someone who has worked it all out in the past in her own psychoanalysis. Rather, we're all struggling with a lot of suffering.

I was thinking that when Jean and Irene were describing the yearning for connection while keeping ourselves out of connection that that describes a lot of therapists. The traditional therapy relationship allows a lot of room for therapists to do just that.

Kaplan: On the other hand, I also think there are ways in which we are always self-disclosing. If we're at all active, we're giving clients tremendous amounts of information about us. It's a question of how these reactions can be part of the process which can lead to more connection. They are not just pieces of information.

Surrey: Back to your first question, I have come to know that I have certain limits. Even if I had all the support in the world, I can do therapy only a certain number of hours. Also, I see therapy more and more as existing within a context of relationships. We now have the idea of "taking the relationship" to a consultant for help, or having a co-therapist or groups, plus individual therapy. It's important to think about how we can support the relationship and not just the therapist. We need new ways of conceiving of how we can move into better connection by using other relationships to help the therapeutic relationship.

Question: Given all the information we now have about the differences between how women relate and men relate, have you used this way of working with men, and what has been your experience?

Stiver: I think that I work with men in many ways that are similar to the ways I work with women, and the men grow in connection powerfully when they're able to stay in the process. Of course, one has to be sensitive to men's greater needs to move away from connection at times; one needs to titrate the movements toward connection and the attention to the person's experience of vulnerability. This is, of course, true for all people because of the basic paradox we've described. Men may fall at a different place on the continuum of the paradox since they are socialized so differently from women, but the basic issues remain the same.

Surrey: Steve Bergman has talked about men's development very much in the context of the same paradox, of the deep yearning for connection and all the ways the culture impacts on male development, which lead to major disconnections at very early ages. For men, the yearning may be so problematic and create such dread in working with me, a woman, that I need to be very sensitive to that difference.

Question: My question concerns the issue of power again. I am more concerned about male therapists. Jeffrey Masson recently spoke very critically of psychotherapy with the strong implication that any reasonable person would stay away from it. He may have exaggerated but how would you respond to his radical critique? It struck me that although he didn't make the direct comparison, there is an implicit similarity between the cases of sexual abuse of children and Masson's description of certain therapists treating their clients in abusive ways. Given that we do live in a patriarchal society, would a male therapist have to pay more attention to his own power needs than a woman, or would you just say don't go to a male therapist?

Miller: I think I would agree that some therapists can use power in ways that are similar — not the same, but similar — to adults sexually abusing a child. And, of course, we know that some therapists actually sexually abuse their patients, in fact a very high percentage, about 10%, of male therapists. I think all therapists have to be concerned about power issues in therapy. There are so many subtle ways that power can be exerted on people, but I think male therapists have to be particularly aware of this issue. Therapy situations so readily replicate the societal situation, and for many men it is quite ego syntonic to feel that they should have power over the other. And women

especially can so readily fall into various forms of compliance. Because it is so much a part of the culture this replication may not even be noticed, which makes the problem even more dangerous.

Surrey: We know that many therapists who have abused patients are very experienced. More and more I feel the dangers involved in the isolation of the dyad. I think peer discussion and co-therapy and groups are very important in countering the dangers of this isolation. I believe we need to keep an ongoing openness about our work.

Jordan: Not only are abusing therapists often experienced, but they are often in positions of great power. There is, then, tremendous opportunity for abuse of power in the therapy relationship, related to such characteristics as rampant narcissism, failure of empathy, objectification of the client, etc. It can occur because so much of therapy happens behind closed doors. There is a sense of entitlement by many of these powerful men to exploit the vulnerability of the people they are treating, whether it's frank sexual abuse or whether it's more subtle abuse of the other, through objectification, not listening, and getting their own narcissistic needs met.

References

Epstein, L., & Feiner, A. H. (1983). *Countertransference*. Northvale, NJ: Jason Aronson.

Fairbairn, W. R. D. (1952). *An object relations theory of personality.* New York: Basic Books.

Freud, S. (1957). The future prospects of psychoanalytic therapy. In J. Strachey, (Ed. and Trans.), T*he standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 139-152). London: Hogarth Press. (Original work published 1923)

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago Press.

Gill, M. (1983). *Analysis of transference* (Vol. 1). New York: International Universities Press.

Gilligan, C. (1982). *In a different voice*. Cambridge: Harvard University Press.

Gilligan, C. (1990). Joining the resistance: Psychology, politics, girls, and women. *Michigan Quarterly Review, 29*, 501-536.

Gilligan, C., Brown, L. M., & Rogers, A. (1990). Psyche embedded: A place for body, relationships, and culture in personality theory. In A. Rabin et al. (Eds.), *Studying persons and lives*. New York: Springer.

Gilligan, C., Lyons, N., & Hanmer, T. (1990). *Making connections*. Cambridge: Harvard University Press.

Havens, L. (1986). *Making contact*. Cambridge: Harvard University Press.

Heimann, P. (1950). On contertransference. *International Journal of Psychoanalysis, 31.*

Jordan, J. (1989). Relational development: Therapeutic implications of empathy and shame. *Work in Progress, No. 39*. Wellesley, MA: Stone Center Working Paper Series.

Jordan, J. (1991). Empathy, mutuality, and therapeutic change: Clinical implications of a relational model. In J. Jordan, A. Kaplan, J. B. Miller, I. Stiver, & J. Surrey, *Women's growth in connection*. New York: Guilford Press.

Kaplan, A. (1984). The "self-in-relation: Implications for depression. *Work in Progress, No. 14*. Wellesley, MA: Stone Center Working Paper Series.

Kohut, H. (1971). *The analysis of the self.* NewYork: International Universities Press.

Little, M. (1951). Countertransference and the patient's response to it. *International Journal of Psychoanalysis, 32,* 32-40.

Miller, J. B. (1988). Connections, disconnections, and violations. *Work in Progress, No. 33*. Wellesley, MA: Stone Center Working Paper Series.

Mirkin, M. (1990). Eating disorders: A feminist family therapy perspective. In M. Mirkin (Ed.), *The social and political contexts of family therapy.* Boston, MA: Allyn and Bacon.

Modell, A. H. (1984). *Psychoanalysis in a new context*. New York: International Universities Press.

Racker, H. (1953). *Transference and countertransference*. New York: International Universities Press.

Rogers, C. R. (1951). *Client centered therapy: Its current practice, implications, and theory*. Boston: Houghton Mifflin.

Searles, H. (1978). Psychoanalytic therapy with the borderline adult. In J. Masterson (Ed.), *New perspectives on psychotherapy with the borderline adult.* New York: Brunner/Mazel.

Steiner-Adair, C. (1991). New maps of development, new models of therapy: The psychology of women and treatment of eating disorders. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia.* New York: Guilford Press.

Stiver, I. (1990a). Dysfunctional families and wounded relationships - Part I. *Work in Progress, No. 41*. Wellesley, MA: Stone Center Working Paper Series.

Stiver, I. (1990b). Dysfunctional families and wounded relationships - Part II. *Work in Progress, No. 44*. Wellesley, MA: Stone Center Working Paper Series.

Stiver, I. (1990c). *Movement in therapy*. Paper presented at the annual meeting of the American Psychological Association, Boston, MA.

Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, NJ: The Analytic Press.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W. W. Norton.

Surrey, J. (1987). Relationship and empowerment. *Work in Progress, No. 30.* Wellesley, MA: Stone Center Working Paper Series.

Surrey, J. (1991). What do you mean by mutuality in therapy? In J. Jordan, A. Kaplan, J. B. Miller, I. Stiver, & J. Surrey, Some misconceptions and reconceptions of a relational approach. *Work in Progress, No. 49*. Wellesley, MA: Stone Center Working Paper Series.

Tansey, M. J., & Burke, W. F. (1989). *Understanding countertransference: From projective identification to empathy*. Hillsdale, NJ: Analytic Press.

Winnicott, D. (1949). Hate in the countertransference. *International Journal of Psychoanalysis, 30*, 69-75.

Wolf, E. S. (1983). Countertransference in disorders of the self. In L. Epstein & A. H. Feiner (Eds.), *Countertransference*. Northvale, NJ: Jason Aronson.