Work in Progress

A Relational Approach to Therapeutic Impasses

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Work in Progress

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Abstract

A relational approach to therapeutic impasses leads to the recognition of 1) their inevitability in the course of therapy; and 2) the fact that their resolution can lead to growth and change in both therapist and patient. The paradox of connections/disconnections helps us understand the dynamics of these impasses and guides us in our efforts to move the therapy out of impasse and into more authentic relationship.

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More than ten years ago I was asked to be a discussant at a symposium entitled "Regression in Psychotherapy." I am embarrassed to say that the title of my discussion was "Regression in Borderline Personalities"; but that's only the half of it. I never recognized what I now know was a history of sexual abuse in most of the patients whose "regression" I described, and I used language such as: "fixated," "symbiotic relationship," "fusion," "merger," "false self/true self," and "sado-masochistic interactions" (Stiver, 1981;1988).

On the positive side of this venture, I arrived at several interventions which I thought might reverse the "regressive" process in patients who began an apparent downhill course over several years of psychotherapy. One of these interventions was the use of an extended consultative process which I hoped would offer support to both patient and therapist to help them move out of stuck positions and "negative therapeutic reactions."

As a consequence, I have had many requests over these years to do such consultations, sometimes initiated by a therapist, sometimes by a patient, sometimes by both therapist and patient together. I have had, therefore, the opportunity to witness and learn from a range of impasses in the course of psychotherapy, from the patients', therapists' and consultants' perspectives.

But more important, over the ten years since I first became interested in what I would now call therapeutic impasses, I have traveled a revolutionary path with my colleagues at the Stone Center. At that time, we had already begun meeting regularly, struggling to move ourselves out of traditional assumptions, techniques, and perspectives, when they did not seem to fit our clinical experience, that is, listening and learning from our women patients. We spent many hours examining the language of our

profession, with much of its pejorative connotations, language that is often objectifying, hierarchical, and pathologizing, as well as elitist, sexist, and the like. And we continue to struggle to find new ways and new language to talk about how we understand psychological difficulties and how to treat them. The work of Carol Gilligan and her colleagues has further enlightened my understanding over these years (Gilligan, Ward, & Taylor,1988; Gilligan, Lyons, & Hanmer, 1990; Gilligan, Rogers, & Tolman, 1991).

A Category of patients

I would like now to return to those patients who captured my interest more than ten years ago. These patients appeared at the outset of therapy to be functioning fairly well in the world and seemed to engage quickly in the therapeutic process; yet after a significant period of time (typically, two or three years), during which they appeared to be progressing, the therapy began to go downhill. The patient became more distressed, often disorganized, sometimes seriously suicidal and violent, and episodically entertained "delusional" ideas, and often had to be hospitalized. Once the downward course began, matters continued to get worse, and the therapy clearly reached a dramatic impasse. The patient felt desperate about how attached she felt to the therapist; yet she would often become enraged and aggressive toward him. The therapist, in turn, felt at a loss about how to respond effectively to this turn of events.

I thought then, and now too, that these impasses developed out of an interactive, relational dynamic since they reflected the patient's style of presenting herself and the therapist's countertransference reactions to it. Initially, these patients, all women, seemed to be engaging in the therapy with considerable verbal facility and the capacity to communicate their experiences in rather colorful ways. They quickly developed idealized transferences toward their therapists, who were mostly men — although there were some women therapists in this group too. They responded insightfully to the therapists' interventions and seemed soothed and comforted by the therapy.

Early in the treatment they appeared compliant and somewhat childlike; yet they put high value on their needs for independence and autonomy. Thus an appealing quality of helplessness emerged, which aroused rescue fantasies in the therapists, but simultaneously the patients apparently reassured the therapists about their ability to be self-sufficient. All of these features contributed to the "specialness" of these patients to their therapists who clearly appreciated them, sometimes presenting the course of their therapy at conferences as intriguing case examples and dramatic illustrations for teaching.

It should be noted also that, despite how engaging and competent these patients appeared, there were indications in their family histories that they had endured serious past difficulties and that their past relationships were very problematic. Typically these patients had a very intense relationship with one parent, while the other parent was either absent, or rarely mentioned and often devalued.

Formulation of impasse

I would like to summarize briefly how I understand the pattern I have been describing, in the context of a relational perspective. How did it happen that these women, who presented so positively to the therapist at the outset and appeared so motivated and responsive, began to look more and more harmed than helped during the course of the therapeutic process?

I believe that these patients' style of interacting in the beginning of therapy was a form of role play, which reflected a strategy to protect themselves against being wounded and violated in this new relationship. These women were, in fact, highly vigilant to the expectations others might have of them and were quite adept at figuring out how to win other's approval and acceptance. They had developed excellent interpersonal skills that allowed them to give the impression of a higher level of adaptation than they experienced inside; they were very good at hiding their deep feelings of inadequacy, terror and profound distrust of all relationships. Their interpersonal skills concealed from the therapists the extent of their underlying distrust, ultimately leading the patient to feel misunderstood by the therapist and the therapist to feel misled by the patient's presentation.

Before the beginning of disillusionment with each other, however, the patient had begun to build up a degree of trust in the therapist — who was so able to listen and who clearly liked and valued her — and gradually became more in touch with strong yearnings for connection with her therapist and began to relax the facade she had learned to present to the world. However, without the armor of previous protective strategies, she felt at a loss about how to behave and express her feelings. She became more and more overwhelmed by the intensity of her yearnings and as she felt increasingly vulnerable, her vigilance over her therapist's response to her heightened.

At the same time, the therapist became more and more troubled when he saw that the patient who had seemed so amenable to psychotherapy was becoming more acutely distressed and instead of being self-sufficient seemed to become more dependent and demanding. Another facet that I understand better now than before, which relates to learning about the history of sexual abuse, is that the patient's intense yearnings were often sexualized. The therapist either overresponded, terrifying the patient, or suddenly began to distance himself, confirming the patient's worst fears — that the exposure of her yearnings and vulnerabilities would result in her violation or abandonment.

The increased intensity of feelings these patients experienced toward their therapists, together with the increased terror of exploitation and rejection, stirred up strong love/hate feelings. The patient, confused and terrified by these powerfully ambivalent feelings, in some instances developed psychotic transference reactions, which both patient and therapist felt impossible to manage. One of these patients said, "I want him always inside of me and I want to murder him."

Thus the downward course of therapy developed out of an interactional dynamic in which both therapist and patient struggled with the expression of yearnings for connection and the fear of such yearnings that led to various modes of distancing and disconnection.

The Paradox

This therapeutic impasse can best be recast in terms of the central paradox conceptualized by Jean Baker Miller in her paper on *Connections, Disconnections and Violations* (1988). When a person's yearnings for connection are met with sustained and chronic rejections, humiliations and other violations, then the yearnings become even more intensified. At the same time these yearnings are experienced as dangerous. The person then tries to connect in the only relationship available but does so by keeping more and more of herself out of relationship. She tries to protect against further woundings and rejections by not representing herself authentically; rather she alters herself to fit with what she believes are the wishes and expectations of others. These inauthentic expressions become ways of distancing from others, hiding her vulnerabilities and deep longings for connection.

We believe this paradox is a central feature of all relationships, but more profoundly of those characterized by power inequities, which impede the development of mutually empathic and mutually empowering connections. Thus women in general, and patients in particular, struggle with their yearnings for connection, on the one hand, and on the other, their need to hide these yearnings by various means, which keep them more or less out of relationship.

For the group of patients described here, a history of sustained and chronic disconnections in their family histories contributed to their desperate needs to establish strong ties to their therapists, but they could do so only through playing a role. This role play allowed them to accommodate to what they saw as their therapists' need for a responsive patient, amenable to the process of psychotherapy; at the same time it kept large parts of themselves out of relationship. These patients also felt deep frustration and anger because they did not feel safe enough to represent themselves more fully; they remained highly vigilant to any sign that their therapists, like family members in the past, would violate their trust.

The therapists, in turn, struggled with their own paradox of connections and disconnections. As the patient's yearnings for connection became more intense, the therapist saw her as more dependent than he had expected, and he distanced himself from what he considered her increasing demands. And, as the patient's anger and violent outbursts became more frequent, the therapist often felt frightened and angry at a patient whom he had apparently misunderstood.

Before addressing the kinds of interventions that can begin to reverse the downward course of therapy with this particular group of patients, we need to move to a broader delineation of the concept of therapeutic impasse. I would like to explore its prevalence and meanings in all therapeutic relationships, not only those with the particular group of patients described so far. Here it is important to clarify how I will be defining therapeutic impasse.

Impasse defined

My understanding of the term "therapeutic impasse" is that it refers to relatively protracted periods in which both therapist and patient feel increasingly less connected, more alone and isolated; *and* neither can see how to move from these feelings of disconnection back into connection. The reasons for feeling disconnected and the forms that it takes are highly variable and unique to each relationship. For example, these periods of disconnection can be experienced by either or both therapist and patient as boredom, disappointment, hopelessness, helplessness,

anger, frustration, or preoccupation with "external" issues and other relationships.

Holding in mind this conceptualization of therapeutic impasses, what I have discovered over these years is that they are hardly limited to the kinds of patients I have just described; nor are the formulations of the dynamics leading to the impasses limited to this group of patients. In fact, I believe that these impasses reflect the dynamics underlying the central paradox of connections/disconnections, which characterize all relationships.

Perhaps what is most surprising is how little has been written about the different kinds of stalemates which occur during therapy, those painful ruptures when the therapy ends abruptly as a consequence of a significant impasse, and/or therapy which clearly has been experienced by the patient as harmful. Nor is there sufficient recognition of how often patients are blamed and blame themselves for these impasses and ruptures and how often many therapists also feel guilty and like failures as a consequence.

Harmful therapy

A few studies dramatically highlight the extent and consequences of various forms of impasse and therapeutic ruptures. Grunebaum (1986) interviewed 47 therapists (psychiatrists, psychologists, and social workers); they ranged in age from under 25 to 50. Thirty-two were females, 15 males. Twenty-two percent reported that they had been moderately harmed by their own therapy; 14% felt severely harmed, and 2% rated themselves as "very severely harmed." Thus a total of 38% of this group of therapists had had a moderately to "very severely" harmful therapy experience.

In a study of Jungian therapists (Auger, 1986), 43% reported negative therapy experiences of their own. Buckley, Karasu, and Charles (1981) found that 21% of therapists in their sample felt they had had harmful therapy. Elkind (1992) recently completed a study of 330 therapists. Fifty-three percent reported ruptures in their therapy, and 19% had more than 2 such ruptures. In 72% of these ruptures, the therapists felt they had been very harmed by the therapy.

She also asked the therapists in her sample how many had had patients leave therapy in a therapeutic impasse, and 87% stated that they had. The therapists also reported that as a result they felt they were failures, angry at their patients, and devastated by the experience. The most common response in the face of impasse was the patient's belief that it was her fault. One patient said, "Even if I had thought that he did something wrong, I kept coming back to feeling I should have handled the situation differently; something was the matter with me for being so very hurt and upset." (Elkind, 1992, Chapter 3, p.1).

Although Strupp and other researchers on the outcome of psychotherapy report that 47 percent of experts in psychotherapy believe that negative effects of therapy present a significant problem, (Strupp & Hadley, 1985), there are limited data on the reasons behind these effects. Grunebaum's study (1986) did do a break down of those therapists who felt harmed by their own therapy; 33% reported that their therapists were "cold, rigid and distant"; 16% thought their therapists were emotionally seductive, that is, they fostered an intense and intimate relationship, yet blamed their patients for expressing their feelings when they were finally able to do so. Other reasons included poor matches and explicit sexual abuse. Other than Grunebaum's study there are no comparable studies of patients' opinions about what they felt was harmful to them.

Theoretical perspectives

Over the years when therapeutic impasses, or "negative therapeutic reactions" have been addressed, the focus has been mainly on the patient's pathology, her resistance and guilt as the basis for these reactions. Although countertransference reactions have been identified for some time as contributing to therapeutic failures, the emphasis has certainly been on the patient's recalcitrance, "actings out," and the like. Rarely has the focus been on the relationship itself.

Recently there has been a growing interest in therapeutic impasses in more traditional therapies. Maroda (1991) stresses the need for greater awareness and admission of possible therapeutic blind spots. Kantrowitz and her colleagues (1989) have been investigating the mismatching of psychoanalysts and patients as a source of impasse. She believes that many analysts significantly overestimate the positive effects and outcomes of their treatments; in particular, she suggests that the analyst may prove to be a potential hindrance to the analytic process when narcissistic issues are involved. This research yielded two types of mismatching, but in both types, the analyst was unaware of his own "dynamic or characterological issues" in relation to the patient. One type of mismatch occurred when the analyst was unaware that his style or personal issues were similar to the patient's; the other occurred when the analyst was unaware that the issues the patient was expressing were those he needed to disown and

defend against in himself.

Kantrowitz (1992) uses her own case example to illustrate a stalemate in therapy as a result of her style in working with the patient. She was not aware of a possible stalemate until she ended an hour ten minutes early, which she understood to be a "countertransference enactment". These enactments result from the patient tapping into and stimulating some unconscious aspect of the analyst's emotions. In this instance, Kantrowitz believes that it was the patient's attempt to get her to experience his feelings of helplessness that led to the stalemate. Through her use of consultation, Kantrowitz was able to recognize that her own unconscious need to be helpful was interfering with her patient's ability to assume more responsibility for his own affairs. Through the use of consultation, she modified her style by using more confrontative as well as empathic interventions with this patient.

Atwood, Stolorow, and Trop (1989) offer a different perspective and see the therapeutic impasse as an opportunity to help both therapist and patient develop in the process. In fact, they see the impasse as offering "a royal road to change" in both therapist and patient. In particular, they note that when the intersubjective themes which unconsciously organize the experiences of therapist and patient in an impasse can be looked at, there are new understandings for them both and the therapeutic process is advanced.

Despite this growing recognition of the interactive nature of therapeutic impasse, most of the analytic writers focus on the need for the therapist to learn more about his unconscious intrapsychic issues, and blind spots, which have led to various countertransference enactments, such as mistakes and empathic failures. It does move away from blaming the patient for these impasses. While their approach does include relational dynamics, it does not focus sufficiently on the inevitability of impasses in any relationship in which two people struggle with their yearnings for connection and their needs to protect themselves from the pain of rejection and abandonment.

There are, however, a number of therapists who have made important new contributions to our understanding of therapeutic impasse, therapists who focus on their own powerful active personal participation in psychotherapy. They see the potential value of therapeutic impasses in moving the therapy and the therapist and patient into new, more authentic, and more growth-promoting interactions.

Ehrenberg (1985,1992), an analyst from the William Alanson White School, brings an interpersonal perspective to therapeutic impasse which is in many ways consistent with our relational approach. She sees the impasse as the opportunity for the therapist to use her countertransference reactions as a way of moving into a more interactive and productive relationship. In particular she believes that stalemates can be avoided by going more deeply into the nature of the interactive impasse. She sees these periods in therapy as the occasion for the therapist to become more disclosing and communicative about her experiences within the relationship, particularly when she feels her patient distancing from her or when she believes she has distanced from the patient.

Elkind (1992) has recently written a book on therapeutic impasse which brings a strong relational perspective to this important topic. Again, it is amazing that it is the first book of this kind on a subject that is so central, so pervasive, so inevitable in the kind of work we do. Elkind makes a point of depathologizing different kinds of stalemates, impasses, and ruptures in the therapeutic process, observing how painful these experiences are for both patient and therapist. She notes how isolated and shamed both therapists and patients are when they experience their therapeutic work as a failure, and how little our profession respects these occurrences or provides legitimate avenues of support.

Response to impasse

Although I believe all therapy inevitably contains a series of impasses, they may become more seriously problematic for a number of reasons, which I'll discuss a little later. At such times more formal outside intervention, in the form of a consultation, can sometimes be very helpful. In fact, what I will be proposing is that broader relational opportunities be available for both patient and therapist in all therapeutic endeavors.

It is not surprising that impasses are inevitable in the normal course of therapy, when one considers how very complicated and powerful the therapeutic relationship is. We at the Stone Center believe that when the therapy is characterized by "good enough mutuality," and the therapist engages authentically with the patient, then the therapeutic process should continue to evolve gradually and effectively through the necessary impasses. I will not discuss here our relational reframing of therapy, presented in a number of our working papers (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Heyward, Jordan, & Surrey, 1992; Miller & Stiver, 1991), other than to note again the

importance of creating a safe relational context in which the ethic of mutuality can find consistent and full expression.

I would, however, like to return to the paradox of connections and disconnections as the central source of therapeutic impasse throughout the course of therapy. That is, both patient and therapist will be continuously struggling with their yearnings for connection, and their needs to defend against exposing their vulnerabilites in the face of potential hurt, violation, and rejection. In a previous paper, Miller and I noted that "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" (Miller & Stiver, 1991, p.3). It is the therapist's major responsibility and task to help move the relationship back into connection from periods of disconnection.

This process requires the therapist's active involvement and responsiveness to her sense of disconnection in the relationship. By active I mean her full participation in the interaction, and her serious consideration of the disconnection. Surrey (1992) describes it as a kind of "jumping further into" the process, and becoming more engaged in what is going on. This acknowledgement of disconnection may be conveyed nonverbally or by a simple statement validating that something has shifted in the relationship. As Ehrenberg noted (1992), in this process the therapist needs to become more forthright and to disclose her countertransference reactions. We believe then that what is required of the therapist in the face of impasse is an energetic response as she struggles to understand the nature of the disconnection and how to move back into connection.

When patient and therapist can move with the rhythms of connection and disconnection and come to understand together what triggers disconnection and how these problems can be resolved, the therapeutic alliance becomes strengthened. This kind of work requires enormous resilience, courage, and faith *in the relationship,* which can develop over time in settings characterized by mutual empathy and mutual empowerment and where power issues are acknowledged and processed (Jordan,1992).

Impasse themes

In reviewing the consultations I have done through the years, which were initiated because either the patient or therapist or both experienced a significant impasse in the therapy, one major theme emerges — a theme that reflects the central paradox as the underlying dynamic of these impasses. In the course of therapy, when the patient begins to feel safe enough to talk about what really matters and feels listened to, she becomes increasingly vulnerable, slowly shedding some of the protective strategies used in the past to protect against hurt and disappointment. Here, the therapist's presence and engagement help move the process along, in spite of the inevitable disconnections, such as empathic derailments, and transference distortions. When, however, there is a sudden shift in the therapist's involvement, and the patient experiences him as distancing himself from her just when she is becoming more vulnerable, a major impasse may evolve.

Sometimes an external event and significant change in the therapist's life, such as a marriage, divorce, a pregnancy, a death in the family, a suicide of a patient, can decrease her availability to her patient. Already feeling vulnerable, the patient becomes more vigilant for any sign of rejection and abandonment. She may respond by withdrawing herself, leaving the therapist feeling more alone, or she may become very angry, usually around a displaced issue, since she is often not consciously aware that the therapist is preoccupied or more distant. The patient may also become increasingly demanding and hostile, which leaves the therapist feeling helpless and hopeless about making a difference.

Sometimes a significant change in the patient's life may precipitate a similar impasse. For instance, when the patient loses an important person in her life through death or divorce , she may become more desperate about her need for the therapist. Whether she adopts a "clinging dependency" or an intensified counterdependent stance, the therapist may distance herself from the patient.

What I have been struck by in talking to patients during the consultation process is how exquisitely perceptive they are about their therapists' personalities, their foibles, and the possible cues about changes in their lives. They typically keep these observations to themselves and only self-consciously report them to the consultant after several sessions. They apparently feel very protective of their therapists, not wanting to "tell on them" or embarrass them. It should be noted that this keen sensitivity to the flaws and foibles of the their therapist's personality, needs to be spoken out loud because of the way the patient may distort her understanding of these "astute" observations — typically blaming

herself for his behavior.

One young woman told me that she noticed that her therapist's picture of his wife had disappeared from his desk, yet she did not connect this with her sense of his distancing from her. She wondered if he were perhaps lonely and unhappy. She also felt he had "too much on his mind" to attend to her "insignificant" problems.

Another woman I saw in consultation began to wonder if her therapist was working too hard since she had started developing another area of interest in her profession. As we pursued this line of thought, it became apparent that the patient had been worried for some months that her therapist might be leaving her private practice to engage more fully in this new interest. When, with my encouragement, she talked to her therapist about her concern, her therapist acknowledged that she had just recently begun to wonder about how she might best allocate her time and was considering cutting down on her practice. Both therapist and patient were impressed by how astute the patient was to be aware of the therapist's conflict about her plans even before the therapist was fully cognizant of it herself.

With this awareness, the nature of their therapeutic impasse became clear to them both. They saw how the patient's improvement, namely, her increasing ability to be in touch with intense and painful feelings, and her greater awareness of her affection for her therapist, all led to her feeling more vulnerable, which terrified her. The patient believed, at some level, that her therapist was turning more and more to this new endeavor because she was "fed up" with her and because she saw her as "getting worse," not better.

Frame of therapy

Other major impasses may be triggered by acts or events arising from what is is sometimes called the "frame" of therapy. I was, of course, taught that time and money were ultimately the central issues of therapy. Thus, when patients were late, missed appointments, didn't pay their bills, the interpretation was that these were all expressions of unconscious resistance, acting out and the like. The therapist's personal and power investments in these issues never came up.

Yet these are often the very issues which lead to impasses, primarily when the patient feels disempowered and disenfranchised; she recognizes at some level that this issue reflects the therapist's needs more than his concerns with the therapeutic relationship and its process. When therapists insist on charging their patients for missing appointments, even though the patient may cancel because of an automobile accident, a miscarriage, or the birth of a baby, there is a powerful impact on the patient and the therapeutic relationship. The patient may feel that the events in her life are insignificant, that she is powerless to negotiate real life issues with her therapist, or that she must be foolish and rebellious to even question the therapist about his policy. Yet she remains furious, and her trust in the therapist is seriously eroded.

Other more distressing examples of therapeutic impasses are those which reflect unacknowledged power inequities, such as the therapist's own lack of timeliness, his use of the telephone during sessions, or evidence of glitches in maintaining confidentiality. It is more common than one would wish to be told in consultation that the therapist regularly answers the phone during sessions — a practice which is understandably very upsetting to the patient. Sometimes a patient tells me that she doesn't feel comfortable bringing this up with her therapist because he might be angry, or "he's so important and busy"; sometimes others report they have brought it up but the therapist doesn't change his behavior. On at least several occasions I have been told that the therapist has said to the patient, "I don't know why it should bother you; none of my other patients mind it at all."

I hear too that therapists often come late to their appointments and do not make up the time, end sessions early because of "emergencies" and the like. All of us are guilty of some of these lapses at certain times. The fact of the behavior is less relevant than the refusal to accept responsibility for what has happened, with the result that the patient feels, and often is, blamed for responding by feeling awful. It is crucial that the therapist acknowledges the power inequities as they emerge and negotiates with the patient toward some resolution that is reasonable for them both.

I particularly want to stress that all these instances of major disconnections, which are a function of the therapeutic frame, have a significant impact on the course of therapy, often long before the problem becomes apparent. Thus patients notice these power inequities and put a lid on their feelings about them because they feel so unentitled to their reactions and have such a need for the therapist; but at the same time they continue to distance themselves from him. Ultimately a major impasse or rupture develops, which may, at the time, appear mysterious to both

patient and therapist.

Interventions

I would now like to address interventions for those impasses, which for a variety of reasons, do not seem to move through the rhythms of connection and disconnection, but instead leave both therapist and patient feeling stuck. At such times some patients leave therapy abruptly and, in many such cases, both therapist and patient continue for some time to feel very wounded by the experience; in other instances the therapist acknowledges that the work has come to a standstill and offers to refer the patient to someone else. When the latter option is discussed candidly, it sometimes helps both therapist and patient come to terms with their limitations in this relationship and move on.

Another good and viable option in these circumstances is to invite another person into the relationship who can serve as a consultant to both therapist and patient. Ideally both people join together "to ask for help." Many times, however, it is either the therapist or patient who requests the consultation, but there is usually some degree of collaboration among all the parties involved. When either the patient or therapist resists and/or will not participate in the process, the effectiveness of the consultation is to some extent undermined.

Let us now return to the original group of patients I described on page 2, those whose therapy took such a dramatic downward course after what appeared to be a positive therapeutic experience over a significant period of time. These patients became intensely attached to their therapists, often feeling they could not exist without them; but they also felt betrayed by them since the therapists had promised so much at the beginning and then had backed off from the relationship. As a result, these patients became enraged and, at times, violent toward their therapists; the therapists found it increasingly difficult to tolerate the patients' demands and anger; and the patients found themselves more and more trapped by their own love/hate feelings.

Consultation

With this group the first step in an intervention was a consultation, which introduced another person into the picture with whom both patient and therapist could establish a relationship. Because the impasses seemed so entrenched, these consultations could not be limited to one or two sessions. Rather the consultation process required a longer-term intervention, a total of perhaps four to six interviews, covering a period of a month or six weeks.

The consultation process provided the opportunity to address the struggles both the patient and therapist were experiencing. The therapist could clarify the relationship for himself by ventilating some of his "unspeakable" feelings toward the patient. The patient could better understand her therapist by having another person to look to as a source of help. Helping the patient verbalize as much as possible all her grievances about the therapist allowed her over time to bring them back into the therapy. For some of these patients it was the first time they could begin to speak some truths about their experiences to their therapists. This process began the rebuilding of trust in the therapist and the development of the relational confidence that Jordan (1992) describes as part of the process of fostering relational resiliency.

It is crucial that the patient not see the consultant as someone who will take the therapist away from her, a frequent concern expressed in the initial consultation interview. In helping the patient talk about both the positive and negative aspects of her feelings toward the therapist, it is impressive how truly terrified she often is that the consultant might tell the therapist about her negative feelings and thus jeopardize a relationship that is so important to her. The extent to which these negative feelings are split off is also evident when one realizes how openly hostile these patients had often been to their therapists during this impasse stage. But certainly the "detoxification" of many of the thoughts and feelings about the therapist, once verbalized to the consultant, makes it possible for therapist and patient to talk more openly about what was hidden for so long.

I believe a major component of the consultant's task is to help the patient and therapist see the other person more in context and to become more aware of the nature of their relationship. This will help them to broaden their perspectives about each other and to appreciate more fully their different modes of struggling to stay in connection.

Of course the consultation is usually not enough to resolve the impasse, although in my experience the therapy does move more smoothly once the consultation has begun. The consultation is, however, just the beginning of the process of diluting the transference, as it gives the patient the experience of talking to someone other than the therapist, with some benefit. It also communicates to the patient that the therapist encourages and fosters other relationships, something not typically experienced in their own families.

The therapist, at the same time, feels less alone as she has someone to talk to, and less burdened since she knows that there is someone else who can also be helpful to the patient. Working with this group of patients, whom I would describe as seriously traumatized by sexual and other significant abuse, often requires other treaters and modalities to prevent further impasses and to counter the hopeless and helpless feelings often aroused in the treaters.

In some cases the consultation process may be sufficient to help therapist and patient move back on course and no other intervention is necessary. However, in those instances of protracted and serious impasses, introducing other therapeutic relational opportunities serves to prevent future serious impasses.

Thus at the end of the period of consultation, the consultant can recommend that the patient continue to see her therapist but also see another person who can function as a cotherapist; an alternative to this cotherapy model is to refer the patient to a group. The cotherapist may continue to work with the patient through the course of therapy or see her intermittently or on a more time limited basis, or even become over time the only therapist working with the patient. Which path to take is not always evident at the time of the consultation. The particular role of the cotherapist can be negotiated with the patient and her therapist (e.g. cognitive behavioral interventions, clinical administration, or other therapeutic tasks).

What this form of intervention does is to encourage both therapist and patient to ask for help, to value the enlargement of relational opportunities, and to acknowledge each other's vulnerabilities in this difficult relationship. By adding another person's perspective, both parties can move into a more mutually empathic relationship. This movement often requires that the consultant help the patient to consider other constructions (from those developed in the past) of the meanings of the therapist's empathic failures, such as lack of sensitivity to power differentials.

The therapist also needs another person's perspective to acknowledge the changes in the patient over the course of therapy. This is particularly true in those therapies which have lasted a long time. That is, the therapist often holds on to some earlier view of her patient, even when she, the patient, has demonstrated considerable movement in her own growth. Thus, the therapist may not sufficiently appreciate the patient's increased ability to tolerate painful affects and her newly acquired competencies. The patient, in turn, realizes at some level that the therapist does not see her as clearly as she once did. It is often very moving, for both therapist and patient, when the consultant shares her view of the patient in the "here and now." As caretakers, therapists may sometimes feel more comfortable with their patients' vulnerabilities than with their competencies; yet therapists are usually gratified when they can see the progress their patients have made.

Expanding relational opportunities

In addressing therapeutic impasses all along the continuum from episodic to more entrenched stalemates, we need to move out of the blaming mode to the empowering mode for both patient and therapist. As we appreciate and respect the fact that impasses are inevitable in all therapeutic work, we need to foster models of support that, as Jordan believes, facilitate mutually empathic connections and strengthen relational resilience (Jordan,1992). Such models avoid the intensely ambivalent attachments that patients and their therapists can develop.

As a consultant, I see that part of my task is to help both therapist and patient appreciate the different (as well as similar) kinds of vulnerabilities each brings to the therapeutic relationship. I try to encourage the patient to develop a stronger voice, through practicing with me, and to bring that voice back into the therapy by communicating more about how the impasse has affected her and how she perceives her therapist. If I have access to the therapist too, I do the same with her.

One woman I saw in consultation told me how enraged she became when her therapist misunderstood her. I wondered with her if she could imagine that her therapist might feel intimidated by her when she started her critical assaults. At first this felt like a completely foreign idea to her, since her therapist loomed so large and seemed so intimidating to her. When she next saw her therapist and quoted what I had said, the therapist was able to affirm this observation immediately, and the patient was able to start seeing her therapist as human and vulnerable too.

In the same way, I can convey to the therapist the extent to which his patient was devastated by certain reactions or lack of reactions to something that mattered very much to her. Very often the therapist is surprised to hear of these reactions because of some of his own issues and/or because the patient has been unable to speak more openly to him. In my experience, most therapists are responsive to this new information and are motivated to change their own

attitudes and style.

In this discussion I am reminded of the analogous work that Steve Bergman and Janet Surrey do in their workshops with couples (1992). In the face of impasses in relationships between men and women, the workshops provide opportunities to talk more openly with others who are not caught in the impasse, namely either Janet or Steve, or other members of a same gender group. This opportunity legitimizes turning to others for help and, in the process, speaking in a stronger voice of one's own as well as gaining a broader perspective about the other. More importantly, this workshop, like the consultation, can help all those involved in impasses to learn more about each other and to respect the nature and quality of their relationships. In these settings mutually empathic negotiations can begin to move from impasse to mutual empowerment.

Patient and therapist vulnerabilities

I think it is very important for the consultant to help both therapist and patient appreciate what kinds of vulnerabilities each brings to the therapeutic impasse. The patient's vulnerabilities are easier to identify, namely that she is intimidated and fearful of exposing those secret thoughts and feelings which she experiences as "bad" and "dangerous." She believes that if she revealed her true feelings and thoughts she would be criticized, wounded, and rejected. In the face of any sign of confirmation of these fears, such as the therapist's silence, noncommittal stance, misunderstandings, and personal preoccupations, these vulnerabilities are both intensified and more deeply hidden.

The therapist, in turn, is under enormous pressure, from the culture at large and the profession in particular, to be expert, to always know what to do, and to help his patient move out of her current pain and difficulties into a more adaptive place. When the patient is in acute distress and at a loss about how to resolve it, the therapist may attempt to reassure and rescue the patient, often promising more than he can reasonably deliver, considering the constraints and limitations in the relationship. As we have seen, this situation often results in the therapist withdrawing as the patient requests more involvement with her; simultaneously the therapist feels guilty and ashamed since he recognizes that he has made some errors in the process.

The profession does not encourage acknowledging such feelings, sharing them, or asking for help. As the patient feels more and more hopeless, the therapist feels hopeless too, as well as burdened, in the face of demands that he feels he cannot fill. These vulnerabilities, especially when hidden and disowned, contribute to the therapist's sense of failure and greater distancing from the patient. The consultant can meet with patient and therapist individually (and sometimes together) to help legitimize these vulnerabilities so that the therapist can accept them as understandable and sometimes inevitable. The consultant may also give permission for, as well as actively encourage, enlarged relational opportunities for both patient and therapist.

The main point of this paper is that impasses are inevitable, and therefore we need to learn more about how to move through them. It is also of paramount importance to know when impasses cannot be resolved and when therapy has become harmful and sometimes clearly destructive to the patient.

We know that in abusive relationships in general, the person abused often holds on to the relationship because she may be too terrified to move out of it, thinking it is all she has. In the therapy relationship too, patients hold onto powerful attachments to their therapists, even in the face of deep disappointment, betrayal, and other violations. In such cases the consultant needs to respect the power of the relationship on the one hand, and to serve as an advocate for the patient in helping her move out of the destructive, harmful therapeutic relationship, on the other.

In less dramatic instances of harmful therapy, a gradual process of moving out of it into a new therapeutic relationship is the preferred mode of intervention. In other instances where the harmful effects are more extreme, the consultant can help the patient leave the therapist in a relatively short period of time. The unfinished business of grief and mourning obviously will need to be addressed with the new therapist.

Conclusion

In bringing a relational perspective to therapeutic impasses, we discover how inevitable they are in the course of therapy and how their resolution can lead to growth and change in both therapist and patient. I believe the paradox of connections/disconnections helps us understand the dynamics of these impasses and guides us in our efforts to move the therapy out of impasse and into more authentic relationship.

This perspective must necessarily move us out of the blaming mode and into the empowering mode. In not pathologizing therapeutic impasses, we give

permission to both therapist and patient to ask for help without feeling like failures and blaming themselves. Most important is the need to value the enlarging of relational possibilities for both patient and therapist, so that in the face of episodes of disconnection between them, neither feels so at risk of being left alone and abandoned. The consultation is one model of support to both therapist and patient, but other models are the use of cotherapists as well as various kinds of groups for therapists and patients.

A relational reframing of therapy in general and impasse in particular stresses the need for an ethic of mutuality in the therapeutic encounter, with a profound appreciation of how much patient and therapist have in common. This conceptualization means rejecting the power-over model of therapy with its view of the therapist as expert and the patient as "the troubled one", "sicker" and "more disturbed".

I would like to close with Harry Stack Sullivan's definition of the therapeutic relationship: "Two people, both with problems in living, who agree to work together to study those problems, with the hope that the therapist has fewer problems than the patient" (Kasin, 1986, p.455).

Discussion Summary

After each colloquim presentation, a discussion is held. Selected portions are summarized here. At this session, Drs. Jean Baker Miller, Robin Cook-Nobles, Judith Jordan, Suzanne Slater, and Janet Surrey joined Irene Stiver in leading the discussion.

Slater: I think the ideas expressed in this paper present a profound challenge to the therapist. As therapists we have to agree to do therapy on such an authentic, mutual basis, and we have to agree to do this in maybe fifteen to twenty-five relationships simultaneously. The temptation then to take those clients who are "entertaining," and don't appear to be demanding and needy, can be compelling. We need to be vigilant about this tendency as well as not to underestimate what it takes for us to do our work well.

Jordan: I think it's so important to look at the shame of the therapist when the therapy feels stuck; at such times both parties move into isolation, and they don't feel they can get out of feeling stuck. The first step is for the therapist to acknowledge her sense of distance and then try to make the connection happen again. It must be very relieving for the client to have that reality acknowledged by the therapist.

Surrey: I think one of the hardest things for the therapist to acknowledge is anger. This raises the big question of what kinds of feelings is it ok for the therapist to express. Therapists' feelings of anger are inevitable yet are very problematic. Therapists are often ashamed of their anger and disown it, yet patients are keenly aware of its being there. In another way, we therapists often encourage our clients to express their anger, but we don't always like it when they do.

Question: I was struck by your phrase, "paradox of connections/disconnections," and I think of my own experiences as a therapist. Recently a client said to me, "I haven't heard a thing you said in the last five years!" I was struck at that moment as I realized that she was finally allowing that part of herself to say "I can't hear you if you're too close or too real." Her simple acknowledgment of that was very powerful. It was at first very jarring since I thought we were connecting and what was happening is not what I thought it was.

Stiver: I think that's a very good example of what happens a lot in therapy, although not often verbalized. But I also don't take what she said too literally. That is, I think she was saying, "Now I can begin to hear you." But probably she heard some things you said all along the way and that both hearing you and not hearing you made it possible finally to hear you in a new way and to feel free to tell you more of the truth of her experience. This decreased the distance between you.

Jordan: I was thinking how much in situations of impasse clients push the therapist out of role playing. Therapists role play a lot and it's amazing how many of our clients put up with it; certain clients won't. I think the impasses you described force the therapist out of role play into real connection.

Stiver: I agree. The traditional model of therapy is indeed a form of role play — all the ways we have been taught to be, such as, not to show our feelings, be a blank screen, behave as if we have our lives in order and as if we understand the client at all levels and at all times. These are the therapist's ways of distancing, of being "out of relationship."

Question: You've been talking about psychological forms of connections, but what about the physical forms of connection, that is, touching, hugging, how do they fit into the paradox of connections/disconnections?

Stiver: I think as therapists we need always to be careful of the ways we can communicate our feelings, and I think it may be more precarious when we move into the physical realm with our clients. Physical connection can easily be misunderstood and

frightening, and we know it has also been seriously misused. At the same time physical contact can also be a natural expression of affection, warmth and connection — like touching a hand or helping ground a person who is terrified. However, we need always to be alert to the dangers inherent in physical contact for our many clients who have histories of physical and sexual violations.

Cook-Nobles: We need also to take a cross-cultural perspective. In certain cultures if you don't respond physically it may be experienced as distancing and rejecting. In cultures where nonverbal expressions of connection are familiar, the therapist who does not respond may be experienced as disconnecting.

Question: As you talk of therapist and client moving closer by being mutually empathic and struggling together, how do you see the future? How will we determine who qualifies to be a therapist, who is strong enough to do this work? In the therapy you're describing, the lines are often crossed in the mutuality of the relationship. You're sort of saying to the client that she has to be empathic with the therapist. The therapist is no longer functioning as a leader. How do we know if the therapist is the stronger partner?

Stiver: The therapist has certain responsibilities and tasks. The same person can be a client in one situation and a therapist in another, and her tasks and responsibilities shift accordingly. Our hope is that the therapist is experienced and trained. I believe the model of therapy we are talking about requires a different kind of training from what most of us have had.

Slater: I think what we are asked to do as therapists is extremely complex. We are talking about a relationship being mutual without equal focus on each person's needs; yet, when the therapist is emotionally present and authentic, some of her needs have to come in. But certain lines, such as expecting clients to take care of the therapist, cannot be crossed. Our training falls short of addressing these issues. People can also misunderstand the relational approach as giving permission to the therapist to express her personal needs, or that it's a fifty-fifty relationship. That is not what we mean.

Miller: I think the therapist has a great deal of responsibility. Her purpose is to try to advance the relationship so that it becomes more mutually empowering, but that can never be in the direction of exploiting another person. I certainly agree with all the things that have been said, including helping therapists become less isolated in their own lives. I think that is our best hope and protection. But I think all therapists need a great deal of training and help, certainly initially, but also all through their lives. Therapists have the responsibility to see that they get that training, and the fact that their responsibility is very different from the client's can't ever be forgotten.

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