Work in Progress

Movement in Therapy: Honoring the "Strategies of Disconnection"

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Abstract

The paradox of connections/disconnections is at the core of the process of therapy, which is characterized by a series of connections, disconnections, and new connections. When the therapist is empathic with both sides of the paradox, she can have a more profound understanding of how terrifying it is for people to express their yearnings for connections and to relinquish their strategies for staying out of connection.

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Studying women's lives has led us to a new perspective on psychological development. For example, starting from women, Jordan and Surrey have explored the concepts of empathy and mutuality and proposed that the basic processes of optimal psychological development are mutual empathy and mutual empowerment (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Trying to discuss mutual empowerment more concretely, we've described it as composed of at least five beneficial components: an increased sense of zest or well-being that comes with the precious feeling of connecting with another(s); the motivation and ability to act right in the relationship as well as beyond it; increased knowledge of oneself and the other person(s) involved; increased sense of worth; and a desire for more connection beyond this particular one (Miller, 1988).

Accordingly, this work is leading us to explore our ideas about therapy. We would define the goal of therapy precisely as mutual empowerment that includes these same elements. However, therapist and patient have to grapple with the tendencies that they each bring that interfere with mutual empathy and mutual empowerment. These tendencies follow from those experiences in childhood and in later life that occur whenever a relationship has been hurtful, disappointing, dangerous, or violating — that is, disconnecting and not mutually empathic nor mutually empowering.

In the face of significant and especially repeated experiences of disconnection, we believe that we yearn even more for connections to others. However, we also become so afraid of engaging with others about our experience that we keep important parts of ourselves out of connection; that is, we develop strategies for disconnection (Miller, 1988).

Thus, we see psychological problems as centered in this fundamental paradox: in our deep desire to make connection, we keep large parts of ourselves out of connection; we develop a repertoire of methods that we come to believe we absolutely need which keep us out of real engagement (Stiver, 1990a, 1990b).

It is striking to us that in their work on adolescent girls, Carol Gilligan, Annie Rogers, and their colleagues arrived at almost exactly the same statement. They have beautiful data to show that at adolescence, girls begin to keep themselves out of relationship in order to try to make relationships in the usual ways available to girls in this culture (Gilligan, Rogers, & Tolman, 1991).

In a paper titled "A Relational Reframing of Therapy" (Miller & Stiver, 1991), we said that we see all the problems of therapy as manifestations of this central paradox and that this paradox translates into the central framework to guide the therapist. We also understood "resistance" in therapy as an expression of a person's belief that it is too dangerous to be in connection so that she *must* stay out of connection. This approach helps therapists to stay empathic with both sides of the paradox.

We also proposed that what really makes for change in therapy is that the therapist *can feel* with the patient — that is, *is moved* by the patient — and the patient is then *moved* by feeling the therapist *feeling with her*. This is mutual empathy in its therapy form.

Some people find the idea of mutual empathy very perplexing. We're suggesting that as the therapist really "gets with" the patient's experience, something happens — in the therapist. She is changed. If the patient can feel this happening, feel the therapist move in this way, then something very important occurs. It means that she, the patient, has had an impact on the therapist just because of her feelings and thoughts. This can be very hard for the patient to believe because of her past experience. But if she can begin to believe it, she will be moved. She has seen this in the therapist's experience; she had been empathic with the therapist.

Other relational theories

There are many complexities along the path of mutual empathy and mutual empowerment, and we will elaborate on just one of them. First, we would like to suggest briefly our views about other current psychodynamic theorists who emphasize relationships. At present we find the work of Mitchell, Forshage, and others connected to the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis (Mitchell, 1988; Skolnick & Warshaw, 1992) and Stolorow and his group (Stolorow, Brandchaft, & Atwood, 1987; Stolorow & Atwood, 1992) close to our work in many ways. However, there are major differences. These writers certainly emphasize empathy, but the reason for empathy is the therapist's and the patient's greater understanding of the patient. They do not think of mutual empathy nor see mutual empathy and mutual empowerment leading to both therapist's and patient's engagement in a growing connection to each other as the central process of therapy.

These writers do not take into account what is wrong with relationships in this culture as they have been and still are, especially the whole factor of power. Whenever one group has more power than another to determine what goes on in relationships, then relationships are in great danger of not being mutual and, therefore, not optimally growth-enhancing.

These relational writers' basic concepts do not arise from an analysis of gender. The men creating the concepts do not consciously work from a specific examination of their own experience as men in relationships, and their formulations do not evolve from an analysis of women's lives. This point is particularly important, since women have been the "carriers" of relationships for our culture — more accurately, the carriers of growth-fostering relationships.

From these basic differences, others follow. We hope they will be apparent as we talk further about the actual process of therapy.

The flow of therapy

All relationships — even optimal relationships – proceed through periods of connection to disconnection to reconnection. This would be true inevitably. At times this engagement will flow relatively smoothly, and at other times one or another person will feel unheard, not understood, not valued, diminished, disappointed, hurt, angry, and/or a number of other feelings. If, however, both (or all) people involved are able to continue to "represent" at least some of their feelings and if both can continue to try to "be with" or hear the other's experience, then they can proceed toward a reconnection — or more

accurately — a new connection.

It is not merely a reconnection, i.e. going back to some good old place. When this process occurs, each person and the relationship inevitably move on to a new level, to more than they were before. Of course, this growth to a new level does not go on every minute of life, nor always at the same rate for all people involved. Incidentally, children, especially, force adults to confront the need to grow. Their more "original" expression of feelings and needs are always facing us with the challenge of moving out of our old patterns — or our old strategies for disconnection — if we are to engage with them as they put forward their experience.

We see therapy, too, as a process of moving into disconnection and then new connection. Indeed, a way to describe therapy is to say that it is a special place designed to work on disconnections (which is why it can be so hard) and to work on learning to move through to new connections (which is why it can be so fulfilling and enlarging for both or all of the people involved).

It seems fair to say that therapy, by definition, — any therapy of any theoretical orientation — should be a process of a person bringing more and more of herself into relationship with another person (or persons in the examples of group, couple, or family therapy). As therapy proceeds, this means including those parts of herself that she had believed she could not possibly bring into relationship with anyone. It felt absolutely impossible because it felt as if the result would be absolutely devastating.

We want to emphasize this point. We are saying that in the face of the threat of expected disconnection, something different can happen; something new can occur. A person can find that by being more herself — being in her own feelings more — she can also be *more connected* to another person. This is the wonderful part of therapy.

This movement into more connection is also the part that leads into the hard parts of therapy. Therapy threatens the person's strategies for disconnection. The person begins to change from the "strategies" she's developed for staying out of relationship. As she shifts away from these strategies, she also moves further toward a greater sense of her longing for authentic connection. This longing, however, makes a person feel very vulnerable. It *is* a very frightening place to be.

Perhaps we should clarify a point here. We know that women talk often about wanting relationships and wanting close relationships, but we are saying that in therapy the frightening aspect is longing for *authentic* relationship based on the fuller truth of the woman's experience.

Honoring the 'strategies for disconnection': Empathy with both sides of the paradox

We want to elaborate on the strategies of disconnection. Especially, we want to emphasize their great importance, rather than seeing them as defenses that the therapist hopes to get rid of as quickly as possible.

Probably the most profound fears in therapy arise from the fear of giving up these strategies of disconnection. While the original terrible things that have happened to people lead to horrible fears, it is now the prospect of relinquishing these strategies that seems so utterly terrifying. This is so because the strategies seem so absolutely essential for psychic survival. To be without them feels as if it will put a person into the most dangerous and exposed position without the only means she's been able to construct for managing at all (Stiver, 1992). It can feel as if a person is being pressured to give up those ways of feeling and acting which promised some power, some strength. This is in contrast to the more optimal relationships in which a person's feelings and thoughts are the sources of strength and impact. In such relationships, other people should resonate with them and respond to them.

We want to emphasize, too, that these strategies were ways for staying out of connection because the only relationships that had been available were in some fundamental way disconnecting and violating. In many instances, they were deeply destructive. There was good reason to develop the strategies.

Often the strategies can be seen to represent ways of not capitulating, of holding out. Thus, they stand for a kind of authenticity. They can be, as we said in our earlier paper, life-saving or mind-saving methods which people have developed under great duress. Often people are saying to the therapist, 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," or, "I won't go along with or capitulate to your demands or to reality as you define it," (Miller & Stiver, 1991).

Here, Carol Gilligan and her colleagues have illuminated how all girls have to face the basically destructive forms of relationship imposed on them in their development, especially at adolescence (Gilligan, Rogers, & Tolman, 1991). If they are in relationships that violate their very being, there is great validity in the girls' resistance. Such resistance is to be deeply respected.

In this sense many women can find in therapy the valuable parts of themselves which they had not been able to bring into the only kinds of connection that are offered to women.

A woman with multiple personalities dramatically illustrates the authenticity contained in these strategies. Her main personality was very likeable and compliant. One of the other personalities was an adolescent boy who was very angry, threw things, wouldn't contract for safety, and made life very difficult for the treaters. This personality carried the anger and the non-compliance. It was very important that the therapist feel empathic with this part of this woman as her only expression, so far, of her outrage at the violation she had experienced.

Thus, we are talking about the major point that therapists must be empathic with these strategies, with the feeling of great need for them, and also of how terrifying the prospect of being without them feels. Sometimes therapy can become stuck because the therapist cannot be fully enough empathic with the need for one or another of these strategies and often of their many-sided complexities. As therapists, we fall into thinking of them as getting in the way of our agenda.

For example, I thought that a woman, Eve, probably needed to recognize her grief about the loss of her mother, but she seemed unable to do so. From what she had told me about her family, I felt that I understood a lot about Eve's feeling unable to bring these feelings into connection. I also felt that I would be empathic with the sadness if she expressed it. It was only when Eve said that the prospect of anyone seeing her feeling sad made her feel like a totally ugly creature, like some kind of slimy bug found crawling in the mud, did I see more fully how revealing sadness would have felt in her family. I didn't see Eve this way at all. So I said to her something like, "Now I can feel much more how awful it feels even to think of expressing sadness." It was probably not whatever I said but that something was moved within me by the image Eve painted that changed the feeling between us. I think that helped Eve to believe that I could be with her in her feeling the need for her strategies, and it helped to add to her belief that I would also be able to be with her when she moved away from them and could express her feelings more directly.

Thinking about these strategies of staying out of connection in this way can make a big difference in our whole attitude and approach. We can feel a new kind of respect and honoring — even admiration — for some of the strategies women have developed for staying out of connection, even as we believe they are making problems for the person herself and for the therapist. Most important, this approach can help us to stay empathic with this side of the paradox, that is, the very side that is militating toward staying out of connection.

In saying this, we want to emphasize that it is not only a question of "understanding" the strategies but also a question of the therapist really being able to "get with" the feeling of them. This combination of thought and feeling makes the difference; it makes the therapy move.

Respect for the strategies of disconnection is important because these strategies are usually the parts of therapy that make the most trouble. It is the part in which many patients can seem most off-putting or angry-making. They are the parts that lead therapists to label people as manipulative, narcisistic, entitled, and the like — the kind of labeling that allows the therapist to stay out of connection and does patients a great deal of harm. (Incidentally, this approach is not to be confused with the paradoxical interventions used by some family therapists. We hope that will be clear.)

Illustrations

Ruth

A period in therapy with a young woman in her 30s, Ruth, may help to illustrate these points. Ruth came to therapy with several issues. She was very competent in her work but had some problems there. She also had a number of physical symptoms. She had several affairs with women which had all ended for reasons which weren't very clear but which Ruth described as always including a gradual decrease in passion and an increase in irritability, leading to her lover leaving her.

She had a very clever, articulate, witty way of

talking, often using ridicule and contempt in speaking of the many people she criticized. This manner was hard for me to take at times. I felt put off, ineffectual, and also critical of her contemptuous approach. I felt particularly so when I felt this fire turned on me, though not directly — yet. However, I didn't believe it would be helpful to be critical. As a result, I probably used a strategy for staying out of connection — which was to be more silent. However, I did think I was sensitive to Ruth's strategies for staying out of connection and felt that I was able to be empathic with them some of the time.

Ruth had initially described both parents as loving, often very involved with the children, doing fun things with them at times. However, it was becoming clear that her father was probably a heavy and consistent drinker without her ever having recognized this before. She remembered her mother as "doing things" with her at times, but it was also becoming apparent that there were important times when her mother was psychologically "not there" for her. She was beginning to put these thoughts together, along with recognizing that her mother was probably depressed and preoccupied with attending to her father a lot.

One day, she was talking about what it would have been like to raise questions about her father's drinking in her family and realized that it felt, even now, like an absolute impossibility. She said no one would tolerate hearing it and in fact would turn on her and attack her. She began to get the sense that she may have been caught up in the family's denial and secrecy about this whole topic.

At the same time, Ruth spoke of remembering a specific time when she was ill, really wanted her mother, and her mother was not there. She spoke of being able to feel that longing and of feeling terribly alone, frightened, and humiliated to even think about feeling the desire and feeling her mother's non-response.

From the way she spoke, it was clear that this was an important step. She spoke haltingly, without any of her cleverness and wit. As she talked of her longing, she spoke with much more fear. I was very moved and felt that we were really moving.

At the next session, Ruth seemed totally back to her old style. She conveyed none of the very moving emotion of the prior session. I felt pushed away and less connected. But she did bring a dream. The dream was that there was a terrible explosion in a house. Ruth knew that a child was in the house, and she was struggling through the house to reach the child. She had a sense that other people were there too. She managed to reach the child, who was lying unconscious. Now, however, no one else was there.

Ruth and I discussed the dream and did talk about the feeling that an explosion would have occurred in her family if she had talked about what probably was going on. Also she felt she would be badly hurt if she stated her experience, and then there would be no one there to be with her. Perhaps she had learned to become "unconscious," to not know the trouble in the family. However, she herself did search for the hurt child and did attend to her. I raised the possibility that the dream may also portray Ruth's fear that I, too, would not be there with her when she needed me, when she was feeling vulnerable, alone, and bereft.

Ruth discussed all this but without much feeling. Despite the important content, the session was quite dull by contrast with the very moving prior session. However, I felt that Ruth's having the dream, remembering it, and bringing it in conveyed the other side of the paradox and were attempts to stay connected. Simultaneously, the explosion image in the dream taught both of us how fearful it felt to move further into the feelings about the family's denial as well as the recognition that her parents had not been with her in some important ways.

Also, Ruth probably was beginning to feel that I could be with her when she talked about these fearful feelings. She just couldn't proceed without having a chance to recognize more fully how frightening it was; without making more certain that I knew how fearful it was; and also that I could take these feelings — feelings that she had to assume must have been so terrible if her family couldn't be with her in them.

Within a short time Ruth returned to her growing recognition of the ways her parents hadn't been there. However, the pattern of following this moving connection with periods of clever, non-feeling conversation repeated many more times in various forms. At these times, I had to deal with the disappointment I felt when I thought that Ruth and I were moving along and then found Ruth back to her old style. I would feel immobilized and without impact, as well as shut out and not connected. But both Ruth and I were able to keep finding the ways to

a new connection.

However, I wanted mainly to talk about the dream because it so nicely illustrated the paradox and helped me to really "get with" Ruth's strategies for staying out of connection. It told about the reasons for retreating from connection even as the dream itself was a way of moving toward connection. It helped me stay in connection. The image of the explosion helped me feel more deeply how terrifying it was to see and speak the truth of Ruth's experience in her family. The picture of the hurt child helped me feel with Ruth those terrifying feelings of being so hurt and with no one there to respond.

The dream images helped me even when Ruth would return to her strategies. I suspected that as I was moved more, Ruth was moved more and was more convinced I could be with her. I think this helped me to drop more of my strategy of silence. This made it possible to move to new connections even as we moved out of connection repeatedly.

This story illustrates a situation that was not easy but did not have many of the more complicated features that can arise in trying to be empathic with the strategies for disconnection. We will now consider a situation of added complexity.

Sally

Sally came to see me after she had broken her leg in a skiing accident and had become seriously depressed. I had first met her 13 years earlier, when she was 17. At that time she was also depressed, as well as guilty about "sleeping around." She had described herself as a very good student and superb athlete. She was clearly very competent and proud of her independence. Although popular at school, she felt isolated and had no close friends.

I had learned very little about her family at that time. Her mother was alcoholic, and Sally took over many of the household tasks. She rarely mentioned her father, whom she described as very rigid, controlling, and often angry. Her counter-dependency was particularly striking, and she said her parents would be very disapproving of her asking for help. She believed her family would be horrified to learn of her sexual promiscuity, since they were very religious and proper.

Although she was appealing and responsive, I had always felt uneasy about how much I really knew about how bad she was feeling. For example, I was surprised to learn that she was seriously considering suicide. Also, after more than a year she told me about periodically cutting herself. In looking back I see how much she stayed out of relationship through her pleasant social manner and her highly developed counter-dependency. We did a lot of work around her ability to tolerate better her need for others and to gain a greater acceptance of her sexuality. She did improve over a period of three years as she became less isolated and depressed. In college she pursued a career in accounting and was an active member of the college tennis team. She was no longer sexually promiscuous and was able to establish a relationship with a young man. She was very much in love and happy when we agreed to end our therapy.

When we met again, she was 30 years old and living with a man she had met three years earlier, but since her accident their relationship had become more problematic. The fracture had been severe, and she had already undergone several surgeries and had been immobilized for some months. During this time she began to have flashbacks of sexual abuse; she recalled her father molesting her between ages 6 and 9. She remembered too that at age 9, when she finally told her mother about the abuse, her mother called her a liar. Her father came into her bedroom that night, raped her, and told her he would do it again if she ever told anyone. But he did stop the abuse. Although she could convey the horror of these flashbacks, she was very disinclined to talk about them. Still the very fact that she could tell me about them suggested that she was feeling more connected to me than in our first encounter, and I did feel more connected to her.

In contrast to the energetic, active woman I remembered from before, she seemed passive and disengaged. In addition to her broken leg, she was preoccupied with somatic complaints, aches, pains, and a chronic cough. Although she seemed pleased to be seeing me again, she was having major interpersonal difficulties everywhere else in her life, especially with her orthopedist, physical therapist, and the other physicians she was seeing.

She became increasingly isolated, and I was the one person whom she felt was on her side. I began to get calls from her doctors, who were frustrated and perplexed in their work with her. They all felt that once her leg was better she would be able to resume her tennis and other activities, which were important

outlets for her and had been very adaptive in the past. But what became increasingly apparent was that Sally was deliberately sabotaging efforts to get better. She was using her leg prematurely, often stamping and pounding it, not doing exercises and the like. She cancelled physical therapy appointments and would get into struggles about methods of treatment. Sally claimed she was simply expressing her frustration about how long it was taking to get better and how incompetent her doctors were. She insisted that she was very anxious to get well.

I believe that Sally was feeling increasingly connected to me, and I was becoming the only person whom she felt she could count on. But this was terrifying to her, which may have intensified her sabotaging behavior. What seemed even more troublesome was her resistance to go back to work. She had been an outstanding member of the organization, and the company's good health benefits covered most of her medical and psychotherapy expenses. Since the accident, however, her performance was declining. She often called in sick. Her latest evaluation indicated that her job might be at risk. Her depression worsened, which she attributed to how badly everyone was treating her. There was also a significant increase in her suicidal ideation, and even more disturbing was that she was very uncommunicative about it.

I found myself becoming increasingly frustrated, fearful that she would hurt herself and jeopardize her own physical and psychological recovery, her job, and all the benefits that were crucial to continue her treatment. As I began to join her boyfriend and doctors in urging her to show up for work and to attend to her leg, she became more angry and difficult with me as well. I felt more and more helpless, angry, and fearful. Thus, she began to distance from me as she intensified her strategies which moved both of us from connection to disconnection.

My understanding at that time was that Sally was "playing out" old relational images. Because she believed no one would be responsive to her yearnings for connection, they were expressed with hostility, which pushed people away, and thus confirmed her expectations and fears that no one would be responsive to her and everyone would consistently disappoint her. This is the kind of pattern which keeps old relational images entrenched and so difficult to modify.

In the language of more traditional approaches, one might say she was "regressing" and her therapist and treaters had to be careful not to encourage this "regression." Instead, they needed to help her to become "more responsible." It became increasingly apparent, however, that the more she was urged to become more "responsible," the more she dug her heels in and would not move.

One day she said to me that she was surprised to hear herself tell her boyfriend, "I really don't think I want to work anymore." Then she added, quite gleefully, "Boy, you should have seen the look on his face." At that moment my whole understanding shifted. It was the first time she *spoke*, rather than acted out, her wishes to give in to her longings to be taken care of, to not have to work so hard. Both sides of the paradox were illustrated by her yearnings for connection, through sabotaging the healing of her leg on the one hand; and by her strategies to keep others at a distance through her angry demands, on the other.

Although the statement to her boyfriend was provocative in the same way as her acting out, she was being more authentic when she owned her wish to give up all those strategies she had used to gain approval but to stay out of connection. As I could see more of what it had been like for her and resonate with her deep yearnings for the care she had never had, I could begin to empathize more fully with the enormous dilemma she faced. It was terrifying for her to acknowledge her yearnings more openly, since her old relational images informed her that she could not expect that anyone could respond to them and, indeed, would abuse her if she allowed herself to be vulnerable. I was then able to give up gradually *my* strategies of distancing, which were largely a function of my fears that I would not be able to help her.

I felt much more connected with her as I developed a sense of how hard she had always tried to be sensible and competent and how alone and unrecognized she felt when no one noticed that. Something truly shifted in my capacity to be moved by her and to convey that back to her. Later I was able to come back to my sense of her gleefulness in describing her boyfriend's reaction. I told her that I guessed it gave her some pleasure to say out loud what she may have wanted to say for some time, namely that she sometimes got tired of working so hard. I said that it made me feel more hopeful whenever she was able to risk expressing her true feelings and thoughts. She

began to talk with much more emotion about how scared she was since she broke her leg, scared that she couldn't be in control anymore, and how terrified she was that no one would put up with her, help her when she needed someone. She began to see that she had developed these relational images very early, when there either was no response or a violating one, to the expression of her painful feelings and thoughts. These images dominated her, without her having any clear awareness of the assumptions and expectations she carried with her into all relationships. Her survival strategies which emerged in the settings in which these images surfaced continued to distance her from others.

My empathy with her desperate need for her "off-putting" strategies and with her terror of giving them up helped me tolerate her more difficult behaviors. Sally was, in time, able to see how much she was jeopardizing her own welfare by her strategies of disconnection in the face of her longings for connection. (Over time also, in that context of increased trust, we could proceed to address the powerful impact of her abuse history.)

From disconnections to connections

Using the two examples of Ruth and Sally, we would like to illustrate what we believe the therapist needs to *do* to move the relationship from disconnection to a new form of connection.

What the therapist *does*, and more particularly, *how* she does it, is profoundly determined by her attitude toward the process of therapy and the relationship with the patient. We noted earlier that the basic paradox is characteristic of all human relationships. Thus the therapist, too, has to struggle with her longings for connection and her strategies for staying out of relationship when she becomes fearful of exposing her vulnerabilities.

Traditional models of therapy protect the therapist from exposing her vulnerability and support her strategies of staying out of connection. For example, the emphasis on the therapist's objectivity and neutrality allows her to keep distant from both the patient and from her own feelings. Presumably, the therapist's ability to help the patient is eroded when the therapist is too open to feel the patient's pain and when she is deeply moved by this pain and the courage it takes to express it. This behavior has been labeled as the therapist's "over-involvement" with the patient, with the danger of a "loss of boundaries" which, in turn, leads to negative therapeutic reactions, particularly regression.

As noted earlier, the therapist's major task is to be empathic with both sides of the paradox and to communicate this to the person with sensitivity and respect for how safe or how vulnerable the patient feels at different stages in the therapy. Of course, we all realize how much these strategies, although helping a person feel stronger, interfere with the person's life as well as the therapeutic relationship. While empathic resonance with the yearning for connection is usually easier for the therapist, it is much more demanding, as well as essential, that the therapist express empathy with the person's modes of distancing that hide these yearnings. In fact, the strategies a patient uses to resist connection are often very trying for the therapist, who may then mobilize *her* strategies of disconnection at the very times when respect for the person's "resistance" is most crucial. This respect must be combined with understanding how the therapist's strategies get in the way of the patient's as well as the therapist's growth.

The cases of Ruth and Sally illustrate our perspective from different points on the continuum; yet the therapeutic attitudes, issues, and processes are similar. Ruth's strategies included her denial of her deep disappointment in her parent's inability to be there for her in the way for which she longed. In light of her father's "drinking problem" and her mother's significant preoccupation with it, neither parent could be sufficiently responsive to Ruth. Her denial of their lack of availability protected her from an awareness of how disconnected from them she really felt. Thus, she did not have to feel her disappointment and her yearnings for connection with them. Through maintaining the myth of a loving family, she was unable to let herself or them know how alone she felt.

Ruth carried one set of relational images that portrayed an idealized family and served as a kind of survival myth to guard against the pain of acknowledging the truths about her family. To acknowledge those truths would only alienate her from family members whom she so needed to be there for her; but to *not* acknowledge them kept a large part of herself out of relationship at the same time.

Another strategy which kept her therapist at a distance was Ruth's attitude of contempt and ridicule. It was hard for her to be empathic with Ruth when she

was so contemptuous. Instead, Jean felt critical of Ruth and became more silent, which was *her* strategy of distancing. Ruth's difficult stance reflected, however, more of the truth of her experience than her Pollyanna description of her parents. Through empathy with Ruth's need for these strategies of denial and contempt, Jean understood how terrified Ruth was of facing her deep disappointments in her parents. As a consequence, she had become cynical of all relationships. As Ruth began to see her family more realistically, she also came in touch with a deeper level of sets of relational images, namely that it was dangerous to speak the truth, to represent the reality of her experience in her family. In turn, as Jean began to get a better sense of the truth of Ruth's experience, she began to be very moved by Ruth's disappointments and fears. Ruth's movement and change then became more evident. Also, Jean's empathy with Ruth's fear of giving up her strategies helped her to stay connected when Ruth withdrew from her again.

It is often at these junctures, where the person begins to move toward connection and then needs to return to old strategies, that therapists tend to become discouraged, feel pushed out, and mobilize their own strategies of staying out of relationship — a pattern which may lead to serious impasse. In this instance, Jean, through empathy was able to support Ruth's need to return to her old strategies. As a result, Ruth was more in touch with the truth of her experience, which made it possible for her to create her dream and bring it into therapy. Visual images, such as those in dreams or those sometimes evoked as the person brings telling vignettes into the therapy hour (such as the hurt child in Ruth's dream or Eve's self-image as a slimy bug), often have a much more powerful emotional impact on the therapist than do verbal communications. As Jean became more open and moved by Ruth's struggle, Ruth became less afraid of moving on into more connection.

When Sally returned to therapy after breaking her leg, this was the first time her strategies of counter-dependence and an action mode were not going to work. The critical point was that for years she had avoided awareness of her yearnings for connection, since she was so afraid that if she did need anyone, no one would be there. Now with her injury and without the resource of her old strategies, she was forced to face her longings for connection. Such longings were terrifying, and she had then to mobilize new strategies of resistance. Since at a deep level she carried the assumptions, based on her relational images, that no one would respond or attend to her unless coerced to do so, she angrily tried to control and force others to do what she wanted. These techniques, however, served to antagonize those she most needed. These are characteristic strategies of those we often call "help-rejecting," people who feel helpless but are afraid to reveal their needs for others. Thus, their very demands for help are expressed in an angry and aggressive fashion. These techniques provide an illusion of being in control and getting what one wants, but they only serve to intensify feelings of disconnection and alienation.

These new strategies were evident in the ways Sally sabotaged the healing of her leg, acting out her helplessness. Through her angry and demanding style she alienated those to whom she most wanted to turn. These behaviors expressed her "authentic" resistance to accommodating to others, her rage at how people had let her down, violated her, and her powerful wishes to stop working so hard, to be so sensible, and to be independent.

I experienced her sabotaging of her leg and her antagonizing her treaters, friends, and me as signs of how angry she felt about needing people. Failing to "be with her," I tried to persuade her that everyone wanted to be helpful to her. Further, I became caught up in trying to help her see that she was jeopardizing her health and her job. I could not keep in touch with how terrified she was of relinquishing her strategies, which would leave her feeling powerless and out of control. My own strategies of distancing were then called into play, as I assumed the role of the expert who would tell her what to do for her own best interests. Thus, my frustration and my sense of urgency to get her "to change" her behaviors only made matters worse, and I distanced increasingly from her. At some level I think I wanted a return of the old counterdependent Sally who took care of herself, was so reasonable, and was accommodating. I was not very comfortable with this angry, rebellious person, frustrating all my good intentions to help her get better.

It was only when she told me indirectly that she did not want to work anymore, in a way which felt like a momentary revelation combined with an odd affect of gleefulness, that something powerful shifted

in me. These are the big moments in therapy, those "turning points," when the person makes a new step in representing more of her experience and the therapist "catches on" and tunes in to the underlying affect. At that moment, I was very moved by a new emotional awareness of how burdened she felt all of her life, working so hard to do what others expected, but always keeping herself aloof and out of relationship. She had never dared to express how fearful and helpless she felt nor how she longed to be able to turn to others for some sense of authentic connection.

As I was able to identify the legitimacy of these feelings, stay with her terror of her sense of helplessness, Sally became more present, and I felt less disconnected from her. (As with the experience with Ruth, the patterns of moving in and out of connection, as we worked on these issues, were very evident.) Sally would become more suicidal and more difficult to engage after a more genuine encounter. But as I could appreciate and empathize with this process, we could continue to move back again and again into connection. Later she could tell me that the experience of being heard and seen in her pain and terror allowed her to begin to hope that she did not have stay so disconnected and alone in her life.

The key component in this process of moving from disconnection to new connections is the therapist's empathic resonance with both sides of the paradox in the patient and in herself. This resonance moves the patient to begin gradually to bring more and more of herself into the therapy relationship. It is essential that the therapist stay with the person's terror of giving up her strategies. Ruth's terror of facing the truth of her parents' unavailability to her, which was already becoming more apparent in therapy, was powerfully communicated in the explosion image in her dream. Although Ruth talked with little affect as she conveyed that image, the therapist's responsiveness to its powerful meanings was key in the process of moving the relationship from disconnection to connection.

Sally's terror was even less apparent under her more aggressive, angry, and demanding manner. But when she could begin to expose her yearnings to give up all her efforts to be so self reliant, even if communicated in a provocative fashion, I was moved to a new understanding of how hard it had been for Sally to put up this aggressively demanding front and never reveal her vulnerabilities. As I stayed with Sally's terror that no one would be there for her if she needed someone, Sally began the movement toward a new form of connection.

Conclusion

We would like now to summarize the main points in this presentation. What does the therapist *do* to help move the relationship? What are the central features of the *process* of reconnection in therapy? What are the *consequences* of this process?

What does the therapist *do*?

We want to stress again the importance of the therapist's attitude toward the relationship and what she believes is "healing" in the therapy encounter. This is an attitude of openness to the other person's emotional experience and its impact on the therapist's own experience.

The *process* of therapy

We place the paradox of connections/ disconnections at the core of the process of therapy. This process is characterized by a series of connections, disconnections, and new connections. When therapists are empathic with both sides of the paradox, they can have a more profound understanding of how terrifying it is for the people they treat to express their yearnings for connection and to relinquish their strategies of staying out of connection. They are so afraid of being powerless and out of control without these strategies. Here we would like to stress again that "to be empathic with" does not mean valuing the strategies themselves; often these strategies can be very hurtful to the people who so rely on them. Sometimes they may be destructive to other people as well. But what is healing in therapy is when therapists are moved by the images and stories which convey *why* a person so needs these strategies to survive and how dangerous it feels to give them up. The focus of the therapeutic task is to move the relationship from connection, through periods of disconnection, to new forms of connection.

The consequences

In addition to the five good things that we have described as following those relational interactions characterized by mutual empathy, we would add that the person begins gradually to bring more and more of

herself into the relationship and, thus, feels more authentic in her interactions. She also begins to experience a new way of being in relationship, a way which allows her to expose more of her sense of vulnerability. She will then have a greater freedom to express her yearnings for connection without feeling helpless, and her strategies of staying out of connection will inevitably decrease. To feel safe and have an impact on another person no longer seem dependent on maintaining these off-putting strategies. The person will also have greater confidence in her capacity to bear her feelings, knowing that she need not do so alone. This leads to an enlargement of relational resources in her *life*.

These consequences are not always easy to come by, as we all know. For them to be sturdy and lasting, they need to happen for both the patient and therapist. This is a humbling experience. We need to acknowledge how very hard it is to do this kind of therapy; to be open to our own and our patients' experiences; to struggle with our own strategies for staying out of connection whenever we feel vulnerable, criticized, and inadequate; and to hold on to the belief that what we are doing and how we do it will ultimately make a real difference. With those we might call our most difficult patients, we have constantly to be alert to the extent to which people have been profoundly wounded in past relationships and how much courage it has taken for them to survive, often by using the very strategies that make them so difficult, i.e., frustrating, enraging, or troublesome.

In this difficult work we often lose our way. We lose sight of the empowering impact for all of us, when the people we care about are able to listen to us, to be moved and deeply affected by our efforts to make some authentic connection with them. Many of us, particularly women, do know the truth of this insight, but it has not been acknowledged in the culture nor in our psychological theories as the central moving force of therapeutic change.

When we feel most at a loss in doing this work, we tend to adopt those "male models" we have learned in our training of how things change; we try to find the perfect interpretation which will suddenly transform everything; or, we take on the role of adviser, trying to fix things; or as we become more angry and frustrated, we start to formulate and confront these people's "manipulations," "projective identifications," and "help-rejecting behaviors." These are all ways to distance and disconnect. Instead, let us hold fast to the truth of our experience and our hope and faith in the power of empathic resonance with our patients, colleagues, friends, and lovers.

Discussion summary

A discussion is held after each Colloquium presentation. Selected portions are summarized here. At this session, Drs. Judith Jordan, Julie Mencher, and Janet Surrey joined Drs. Miller and Stiver in leading the discussion.

Question: How do these ideas hold up with women of racial or ethnic groups other than EuroAmerican?

Miller: We don't know in any profound sense. It's really up to women of other cultures to say. I'll state my view, although I cannot offer "proof" for it. I believe that in all cultures women have "carried" the whole part of life concerned with providing connections for everyone. It's not just connections; it's providing growth-fostering connections. In this sense, women's lives are similar in all cultures.

The exact forms that connections and disconnections take vary in different cultures. In addition, if your cultural group is oppressed by another culture, there are profound relational effects for everyone in both cultures. Thus, women in each cultural group have to describe their particular experience, but I would propose that this model would apply.

Those women who have worked with it find that it helps in describing their experience. For example, Clevonne Turner wrote two working papers on African American women, and Joyce Kobayashi wrote about Japanese culture.

Mencher: Effective cross-cultural therapy rests on the therapist being open in the way Irene and Jean describe, especially when she, the therapist, is ignorant or has gaps in understanding of the patient's culture. She also has to be open to being vulnerable about her own cultural background.

Surrey: Different cultures have different strategies for disconnection. You could say that when therapist and patient are from the same culture, it may be harder for them to see the strategies they are using.

Question: I think that self psychologists may value empathic failures because they are the points at which the therapist can see and respond to the patient

at the level s/he needs. Do you see it the same way?

Stiver: Yes, if patient and therapist then can become more mutually empathic and move toward more connection. Whenever we're not perfectly attuned — which is always — then if the patient can tell us something and we can move with her, we will become more connected. For example, with Sally, I hadn't understood enough until she said something that helped me reorganize my way of being empathic with her. Those are the moments of real change — when we haven't yet understood enough and we're still staying in there with the person.

Jordan: These are the "golden moments." They occur often. The crucial issue is can we, as therapists, stay in connection when we feel as if we're floundering, letting someone down, missing the point? That really is a challenge. Therapists have a great need to be competent and to be in control. Yet this is a profession where we don't feel either of those very often.

Surrey: I believe that the self psychologists speak of "optimal frustration" in therapy that leads to building "transmuting internalizations." We don't think it's the empathic failure or frustration that is helpful but the movement toward connection that can follow if there is a willingness of both people to see their part in what's happening. If both people can do that and can make shifts and try something new, that's really healing.

Question: I have noticed, especially in the case of rape, that clients often return to a strategy of disconnection after a previous movement into a new connection with me. Is that what you are saying?

Miller: Yes. I also think that is when the therapist may get discouraged and feel as if she were being ineffectual. It's very important to realize that with movement toward connection, fear often follows, and with the fear you see a grasping on to these old strategies.

Question: In your experience of disconnection, do you get nervous that you will move into an impasse? Do you reach the point where you share with the patient your frustration about what's going on?

Stiver: Yes to both questions. It can be important at times for the therapist to share her frustration but not in a way that's accusatory. If the therapist is communicating her frustration as a release for herself, this will not be therapeutic; if she is sharing it because she believes it will help the relationship, then it may really move the therapy forward. What the therapist can say is, "Something important is happening between us. We're both feeling stuck and finding it difficult to move. It might help if we could each share what that feels like." This can begin the process of moving out of that impasse to more connection.

Miller: We're saying two things. First, disconnections are to be expected repeatedly, both in life and particularly in therapy, because it's a special place for working on disconnections. So that's to be expected. During those periods the therapist can feel various degrees of discomfort and frustration. But secondly, we are also saying that when the therapist stays empathic with the person's need for her strategies of disconnection, then the therapist and patient can begin to reconnect. It isn't always that you experience great frustration or get into a major impasse. As Irene has suggested, probably the reason that you do get into major impasses is that when there is a disconnection and then the therapist does something that distances her from the patient, then this moves both people farther out of the relationship, rather than farther in. That's Irene's hypothesis of what makes for major impasses in therapy.

Jordan: By acknowledging the frustration (of course, not saying, "You are frustrating," but rather, "This is frustrating,") in that statement and in that acknowledgment, you're actually in the process of moving back in connection, rather than farther out.

Surrey: It is also getting into the "we" of the relationship. When the therapist expresses her frustration about what she is feeling about the relationship, she is saying, "*We* are experiencing this together," as opposed to staying in a state of separateness, moving into oneself, and not moving back into the "we" of the relationship.

Question: Along these same lines, having an awareness of that pattern of connecting and disconnecting, are there times when rather than talking about it afterwards, the therapist could predict the likelihood that disconnections will occur?

Miller: Yes, it can happen and can be very helpful.

Stiver: Sometimes the pattern gets played out more obviously in a person's relationships outside of therapy, and you can begin to see more clearly together how the strategies of disconnection are

expressed. The therapist can begin to name and empathize with the person's terrors of connection in these other relationships, so that when they begin to show up in the therapy relationship, it would be reasonable to expect that they will be followed by some form of disconnection.

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