Work in Progress

Therapists' Authenticity

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Work in Progress is a publication series based on the work of the Stone Center for Developmental Services and Studies at Wellesley College, and it includes papers presented in the Center's Colloquium Series. *Work in Progress* reflects the Center's commitment to sharing information with others who are interested in fostering psychological well-being, preventing emotional problems, and providing appropriate services to persons who suffer from psychological distress. The publication also reflects the Center's belief that it is important to exchange ideas while they are being developed. Many of the papers, therefore, are intended to stimulate discussion and dialogue, while others represent finished research reports.

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At the Stone Center-Harvard Medical School/ Cambridge Hospital "Learning From Women Conference" in Boston, 1998, six members of the faculty of the Jean Baker Miller Training Institute at the Stone Center presented short pieces on this topic. Their remarks are reproduced here.

Abstract

An African American women, a lesbian, and others describe the complexities of this topic. Therapist authenticity does not mean that the therapist is reactive or totally disclosing. Instead, it means that the therapist is present, responsive, and real. Her actions must be based on the context of each relationship and on knowledge of the complex factors that foster the growth of an empowering relationship. Several clinical examples illustrate these points.

Jean Baker Miller, M.D.

Relational/Cultural Theory emphasizes therapist authenticity. In this, it differs from many traditional psychodynamic theories. But what do we mean by therapist authenticity? We will each offer a short answer to that question.

To begin to answer it, we have to set out a few basic notions. Working in a relational way comes out of a whole different therapeutic approach. It is not a model of the omniscient (and omnipotent) expert *acting on* a person, making interpretations about what's wrong with the "sick," "disturbed" patient. Instead, it is both people—or in group or family therapy, all people—participating in trying to carry out a creative act of countering the destructive effects of a patriarchal, "power-over" society and all of its many manifestations—recognizing that these conditions affect us all (Miller & Stiver, 1997; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991).

However, we believe that the therapist should have particular abilities, responsibilities, and knowledge—and the training to acquire these capabilities. What are these abilities? Most important of all, the therapist needs to learn how to participate in the therapy relationship in such a way that she facilitates "movement in relationship." How does she do this? If she is really present and authentic, she will be moved, i.e., feel with the patient's expression of her experience. If the therapist can make it known that she is moved, the patient will be moved, i.e., feel with the therapist feeling with her. The patient thus, has the very valuable chance to know that her thoughts and feelings do reach another person, do matter, and can be part of a mutual experience (Miller & Stiver, 1997). We think that this is the key source of change in therapy. It is so important because the basic trouble has been the disconnections the person has experienced, the disconnections in which the patient had little or no possibility of having an authentic effect

on the disconnecting relationship.

This is very different from training not to show any response in therapy. However, it requires very good training to express authentic responsiveness in a way that creates movement in relationship.

To be a little more specific, to facilitate movement in relationship, the therapist should know a lot about the strategies of disconnection. They arise out of disconnecting experience. We believe that the central desire of all people is to connect with others. But when people have suffered hurt, danger, humiliation, and many other kinds of disconnection, they continue to try to find whatever connections they can. Now, however, they feel they can do so only if they keep significant amounts of their experience and responses out of connection. This is what we call the *central relational paradox*. The methods people develop to keep parts of themselves out of connection are called the *strategies of disconnection* (Miller & Stiver, 1997).

Seemingly, paradoxically also, we believe that one of the most important ways to facilitate movement in relationship is to truly honor the strategies of disconnection. We must realize the deep reasons for these strategies and the fear or terror that people feel at the threat of losing them—even as we believe that they create the problems, i.e., they are the very obstacles to connection (Miller & Stiver, 1997).

We assume that the therapist knows how to work with the strategies of disconnection. That is her job. Authenticity, then, means that the therapist tries to be with the thoughts and feelings occurring in the relationship. It also means that the therapist tries to be with the movement toward connection, the fears of that movement, and the strategies of disconnection. She should be "in" this moment-to-moment interplay. She should try to convey that she has felt with the patient and raise questions when she hasn't, questions that will help them both move toward the mutuality we've described (Jordan et al., 1991). This moment-to-moment responsiveness is the most important part of authenticity.

What about the question of the therapist "disclosing" facts about her own life—or even her feelings? If such "disclosures" do not advance the movement in relationship, there is no place for them in psychotherapy. If they will advance the movement, or will help to convey that the therapist is honoring the strategies of disconnection, they may be important. If not bringing them in will interfere with the movement in relationship, then they may need to be brought in. This is where training and judgment—and often discussion with colleagues and supervisors—come in.

One brief example may illustrate these points. The question of my physical disability from polio comes into therapy with everyone with whom I've worked, although in many different ways and sometimes very indirectly. One example of this occurred early in therapy with a woman I'll call Constance. She never expressed any negative feelings. She said things like, "I hate complainers. What have I got to complain about? Some people have it so much harder."

On the one hand, I like and admire Constance's awareness of hardships in the world. But, this can also be a person's way of avoiding deep feelings of hurt, disappointment, anger, and other important feelings that she hasn't yet shared, that is, it can be a strategy of disconnection. I didn't know if Constance was trying to stay away from certain feelings; so I asked, "When you say that are you thinking about my disability? Do you wonder if I've had a hard time?" This may not have been what she was thinking. I, however, believed it was important to explore this possibility since it may have been a part of her strategies of disconnection.

As I have become more relational in my approach to therapy, I've become more open about my experience. Specifically, I have become more open whenever it is required to facilitate movement in the therapeutic relationship. Of course, this always depends upon where the relationship is during the course of therapy.

So my openness varies with every patient. In this instance with Constance, I said, "I had polio when I was very young and there were some hard times. I, too, know that people endure much worse hardships in life. But I don't think we can compare these things. What hurts you, hurts you. And you have the right to experience that and explore how it affects you. So my polio and more extreme hardships don't negate anything you feel. Also, it's important that you feel able to bring this up whenever you want to."

The subject of my disability comes up repeatedly in different forms with patients. I watch for it, among watching for lots of other things. It comes up in the words people use, in their dream images, and the like. When I suspect that something personal, like my polio, is interfering with the movement in the relationship, I try to offer the patient an open, authentic response that may facilitate movement toward better connection.

To summarize, I want to emphasize that relational authenticity never means that the therapist uses therapy to meet her own needs. If I had a need to talk about my polio, I certainly shouldn't impose that

on anyone's therapy. But, if I suspect that my polio may be getting in the way of movement in therapeutic relationship, then the therapy needs me to talk about it.

We'll now move into more complex aspects of this topic.

Judith Jordan, Ph.D.

Relational authenticity in therapy is not the same thing as total honesty on the part of the therapist; it is about a *quality of presence* that contributes powerfully to healing in connection. The therapist's emotional presence is *an important source of information* for clients and *a resource for growth* in the therapy relationship. It's important for clients to develop an awareness of the impact of their actions and words on other people and on relationships. The therapist's authentic responsiveness contributes to a sense of relational competence as the client begins to experience him or herself as effective in moving or affecting the therapist. It also leads to the development of anticipatory empathy in the client; this involves learning how to anticipate how s/he affects and moves others. The therapist, in being engaged and authentic, gives important information about what impact the client has on her or him. Clients need to develop relational awareness, looking at interactions and learning what they contribute or how they affect the flow of the relationship. They need to ask questions like: "Where is this feeling coming from—is this about me or is this about you?"; "Are you bringing this into the session or have I affected you in some way?"; "Am I stimulating something in you in some way that I may not even be aware of?"; and "What am I contributing and what are you contributing to this interaction?" This leads to the growth of mutual empathy and relational awareness.

Mutual empathy, an essential component of authenticity, is the core relational dynamic that leads to growth in therapy. It depends on the client seeing that she or he *has an impact* on the therapist. In order for the person to know that s/he matters, that s/he influences or moves us, s/he needs to see and feel the therapist's response. This clearly goes against rules about neutrality, nondisclosure, or nonresponsiveness held by many traditional therapists. Also, in order to grow we all need the sense of connection that arises in this flow of mutual empathy. I would suggest that this process changes over time in therapy and my authenticity as a therapist changes over time in working with somebody. We're building a relationship in which trust is growing both ways. Both therapist and client develop increasing trust based on our shared history of movement through connection and disconnection. This opens the way for more relational authenticity.

In discussing therapist authenticity, I want also to make the distinction between relational responsiveness and reactivity. Reactivity is impulsive, entirely spontaneous, and based only on the internal experience of one person (e.g., I feel angry, I just have to express it regardless of the context and the responses of the other person). Relational responsiveness involves a consideration of context and concern about the possible impact of our actions or words on the other person and the relationship. Therapeutic responsiveness also includes the intention to be of help to the client. Therapist authenticity is always informed by that intention.

In the course of therapy the therapist also develops a kind of anticipatory empathy which allows an informed, considered responsiveness quite different from "knee jerk reactivity." Anticipatory empathy is based on the history of the relationship, a knowledge of the client, and working hypotheses about what the client and the relationship need at this time. It is practiced with the aim of empowering the person and the relationship. It involves a great deal of clinical judgment and sensitive attunement to the client's responses. Anticipatory empathy moves the relationship and increases the sense of connection. It contributes to and arises within an atmosphere of care.

If the therapist is responsive to the client, the inevitable disconnections that occur all the time in therapy will lead on to new connection. In fact, in the reworking of disconnections, connections are strengthened and transformed (not merely repaired) and the relationship develops a stability and trustworthiness that allows further growth to occur. This is where the real work of therapy happens, in navigating and transforming the inevitable disconnections.

In our model, the source of pathology is *chronic disconnection*, not just disconnection; and, chronic disconnection results from the nonresponsiveness of one person (particularly the more powerful person) when disconnections occur within the relationship. Consequently, nonresponsiveness of a therapist is not only not helpful to most clients but it is actually hurtful to many. Conversely, within a context of relational responsiveness, the client learns that he or she can be effective in relationship, that he or she matters. These empathic moments provide the building blocks for a sense of relational competence. Depriving clients of this information impoverishes the therapeutic work. Moreover, for people who have been particularly wounded by unresponsive others in

the past, this nonresponsiveness signals *a kind of danger* that can lead to withdrawal, isolation, and re-traumatization.

Boundaries: I also want to address briefly the question of boundaries. When we talk about authenticity, many people say, "Well what about the 'boundary issue.' Isn't it important for therapists to maintain their neutrality, their boundaries and not reveal or disclose too much of themselves or their reactions?" Perhaps we ought to clarify what is meant by "boundaries." The boundary concept is about safety, clarity, and privacy. It potentially includes the capacity to authentically represent one's needs and feelings in a context that holds some promise of mutuality.

It is essential in therapy that the vulnerability of our clients is protected, particularly by making sure the therapist is not using them to meet his or her own needs. It's also important that we recognize the therapist's legitimate right to maintain his or her own privacy, and it's essential to clarify the origin of the feelings and thoughts which emerge in a therapeutic encounter—what belongs to the therapist and what belongs to the client. These are all key elements in what is usually covered in the notion of "keeping the boundaries."

By suggesting that therapy involves mutual empathy and the practice of authenticity on the part of the therapist, we are not suggesting that therapists simply engage in an ordinary social relationship with clients. The above discussion of reactivity versus relational responsiveness points to that. The therapy relationship is intentional and professional. Its aim is to help the client. The therapist's energy and thoughts are directed toward helping the client effect a change in his or her life.

The therapist and the client are in particular roles which suggest different kinds of participation. There are power differences. The therapist's role is to facilitate the development of relational awareness and to assist the client in meeting his or her goals. The therapist also belongs to a profession that sets standards of care; protective limits for both people are crucial to this relationship. Respect, clarity, and responsibility on the part of the therapist for the well-being of the client capture for me the values that are often tagged with the word "boundary." Therapist authenticity requires these qualities. It does not involve total self-disclosure and usually it does not even involve disclosure of factual information about the therapist's life, although in the example that Jean just gave that was clearly a very important sharing.

I am reluctant to use the boundary metaphor and language, however, because it connotes a spatial metaphor of "self" experience (in a "separate self" paradigm) which emphasizes the importance of protection from an impinging context, personal or otherwise, and thus obscures the importance of a *boundary as a place of meeting*. Redefined, boundaries would suggest movement, differentiation, and connection. Perhaps if we could think of boundary as a place of meeting rather than an armored dividing line, protecting against an impinging outside world, this concept would make more sense in a relational model.

For me, the current boundary metaphor partakes of the dominant paradigm of "a self" resisting influence, demarcating spheres of influence or control in order to establish "power over" others as a way of ensuring personal safety. It is important to remember that "self" is a metaphor. There is no such thing as a "self." The bounded self is a metaphor built on a model of separation rather than connection. In contrast, I believe that safety and psychological growth arise in good connection, not in the experience of self-sufficiency, autonomy, and boundedness. Growth-enhancing relatedness depends clearly on respect, clarity, the capacity to represent one's needs and feelings, and an expectation of mutuality. In meeting others authentically, in engaging in growth-fostering relationships, we create a sense of personal meaning and value.

Having said all that, I think it's important to reframe the concept of boundaries and identify specifically what about the concept is useful in therapy. The way it is currently used is too often unexamined and, I think, rather flip. I offer the example of a supervisor saying to a supervisee when she reported she had passed a box of Kleenex to a sobbing client, "Where were your boundaries?!" I've heard many examples like this. There's a "boundary police" mentality that gets going, pushing therapists subtly in the direction of a separation model, which includes therapist nonresponsiveness. This mentality comes from a model in which separation equals safety. Instead, we believe that growth-fostering connection builds safety. This shift from a "separate self" paradigm to a relational paradigm makes the current boundary concept problematic.

What do I think is useful about the boundary notion?

1. *Clarity*: It's important that each person's experience is clear and each person knows whose feelings and thoughts belong to whom. It is important to help clients know and express their feelings and needs more clearly. This leads

to better connection with one's inner experience and better connection with others. And it is important to develop clarity about which relationships are mutual and growth-fostering and which are not. In the latter case, it is important to assist people in disengaging from destructive or abusive relationships.

2. It's important that the therapist assume appropriate responsibility for the protection of the clients' *safety* and for the relationship.
3. The therapist should *never use* the client to take care of his or her own needs. This is most clear in the area of sexual exploitation, but it's true in many areas.
4. Both therapist and client have a *right to privacy* and *self-protection*. Learning how to say no to other people and feeling one has a right to say no or to state one's limits is very important for everyone but especially for people who have been violated in relationships. Both the therapist and the client must feel safe enough to stay in the relationship.

I want to underline some language there. As a therapist, I talk about *stating* my limits rather than *setting* limits on the other person. This feels honest and authentic. If I tell a client I cannot handle five phone calls a day from her / him, it's too much for me, that's authentically stating my limits. The need for the calls on the part of my client may be totally legitimate, but I can't meet that need. So, I state that and I say, "You do need to be in contact with me. It is, unfortunately, impossible for me to be there as much as you need. I'm sorry about that. But we need to do some problem solving around this. How are we going to deal with this together?" This is using my *real* response in the relationship to provide some information and to stimulate some collaborative problem solving together.

Both people in a growth-enhancing relationship are moving toward representing their own needs with an expectation of respect from the other. In the therapy relationship it is primarily the needs of the client that are attended to but the therapist also has needs for safety, self-care and the right to state certain limits. Both people must have the right to say no, to state their limits, as well as to seek responsiveness in the other person. How this occurs in therapy will depend on certain role constraints and the importance of keeping the client's well-being at the center of all decision making (this is where clinical judgment is crucial). Part of being an adult in a relationship is learning to respect the other person's feelings, limits, sense of privacy, and even flaws. Respect and responsiveness feel like a better route to genuine and mature relatedness than creating a therapeutic relationship with one "powerful," "in charge" person setting limits on, or placing boundaries around, an "out of control" other who must be reined in by force or superior power. Unfortunately, the concept of boundaries is too often laden with power inequity and, therefore, does not support the client in her or his empowerment or in the development of new relational awareness and patterns.

It is important for the client to learn to grapple with yearnings and needs in the face of another's inability to meet them; and it is important, although difficult, for both therapist and client to learn to hold the tension of these encounters. It is important for each person in a relationship to learn to respect the other's vulnerability. In addition, it is important to learn to move into relationships anchored in both self-empathy and empathy for the other. Much can be learned in the course of such struggles and their exploration in therapy. Significant personal growth occurs around the development of relational awareness which, I believe, is facilitated by the therapist's authentic, relationally responsive presence.

Irene Pierce Stiver, Ph.D.

Authenticity is ever-evolving, not achieved at any one moment—it is a person's ongoing ability to represent herself in relationships more fully. Mutual engagement in growth-fostering relationships is the very process that leads to the creation of a relatively safe context in which a person can risk revealing her personhood. While we would generally see strategies of disconnection as ways of moving out of authenticity, of not being free to represent oneself, at times these strategies can express a person's truth in some indirect and displaced form.

For example, a patient of mine often rants and rages at members of her family who hurt her and disempower her. Her fury is understandable and legitimate, but her angry outbursts take a form that pushes everyone away (including me). She is seen as "the bitch," yet she is the only one in her family who expresses the rage that all of them must experience. Often this rage spills out to other settings where it is not as legitimate (and in therapy), but it is still a truth about her experience.

I couldn't figure out how to get to these issues without invalidating her feelings. I addressed them by finally saying something like, "When you tell me about such-and-such, I really feel how enraging that was for you; yet, I keep wondering if you feel any relief when you get angry—whether you think that

you really have expressed how you feel and know it's legitimate?" When she could see she felt worse, not better, after an angry outburst, we could move into more mutual, authentic exploration.

The therapist's efforts to represent herself more authentically facilitate the process of movement toward mutuality. When I feel less authentic, less empathic with my patient, I do not feel connected to her/him, and the patient does not feel very connected to me. As a result, I become more inhibited, silenced, and uncertain about how or what I feel and how or what I want to share. When this occurs, I ask myself: What seems to be interfering with my feeling safe enough to be responsive and what is interfering with our relating in a genuine, authentic way?

In these moments, I have felt least able to authentically represent myself, and least free to express a whole range of feelings and thoughts that I do not think are "good." For example, at that moment I may feel angry, judgmental, anxious, intimidated, as well as ashamed and uncomfortable about my experience. When this has happened, I become afraid that if I speak some truth about my feelings and perspective, without carefully phrasing what I want to say, I might be doing something harmful to my patient. Furthermore, I am very fearful that if I speak my truth about what I am experiencing, my patient may disconnect from me and I would feel cutoff and alone.

During these difficult moments, we therapists often lose faith in the process of how to move from disconnect to new, better connection. This keeps us stuck. I want to suggest that when we feel disconnected, we need to exercise greater effort to bring more of ourselves and our experience into the relationship, to feel more present and engaged—even if it means risking a period of disconnection. It may sometimes be a big risk since the patient may feel hurt and/or not understood in response to the therapist's sharing. The work then is to find ways to move from the disconnection to better connection; but, we need faith that the process usually works when we create a more mutually empathic, authentic context while we are trying to transform the rupture.

When I am in that non-authentic space, I need to listen carefully to the ways in which the patient is responding to my lack of "good enough" engagement. I find that if I do listen carefully, the patient will often say something authentic that gives me the opportunity to move into more mutual and authentic connection, as in the example I'll give in a moment.

So both the therapist's taking the risk by moving into authenticity and the patient's taking the risk to convey what she is experiencing (and the therapist hearing that message), can move both of them into more connection. However, when I'm in the midst of a major disconnection I forget what I truly believe, which is: when the therapist hangs in there with empathic resonance throughout the worst periods of disconnection, things do begin to move—at least most of the time.

To sum up: authenticity is a process in movement—we move in and out of more or less authenticity as a consequence of the relational dynamics. Sometimes disconnections in the relationship are an immediate consequence of a therapist taking the risk to express more authentic feelings, but also sometimes they are the consequence of not expressing the truth. When I can appreciate how much a patient's strategies of disconnection contain a truth, I am more able to find something authentic to say which helps move the process into more mutual engagement.

A clinical vignette illustrates some of these issues. I was seeing a woman in her fifties (whom I will call Linda) whose mother was then in her late eighties. Linda had a long history of grievances about her mother—for not ever listening to her, for always lauding how wonderful her brother was who rarely visited or called, for not apparently recognizing what her daughter had accomplished, and especially for past threats to disown her when she married a Jewish man.

I could easily empathize with all these experiences, and I did, but the mother was quite elderly—and living alone in another city. Linda was becoming more gutsy in general, in therapy and life, that is, becoming more authentic, expressing more of what she thought and felt about what was happening in all of her relationships.

In the past Linda and her family had always invited her mother to join them on holidays; someone would pick her up and bring her to their home. Now Linda was refusing to facilitate her mother's visits or to pick her up. She said her mother was perfectly capable of taking a bus. In addition, if she and her mother went out to lunch, she was furious if her mother did not offer to pay (the mother was on a small income and Linda was very well off).

So here is my patient representing herself more fully than ever before. (Prior to this new behavior, Linda would withdraw, drink heavily, and be overly accommodating to her husband, mother, children, and so on.) Now she was speaking more of her truth and was proud of it. I found I could not mutually engage with her perspective; yet, it was clear that she thought

I would be pleased at this progress and proud of her speaking up and "expressing herself."

I would listen, not say much, but wanted to say something authentic like, "Oh come on, your mother's 88! And on her own. Of course you're angry with her, but can't you find more generosity of spirit?" Which, of course, I didn't say. After one of these sessions in which I was quite silent, she said, "I guess I got a D in mothers." So maybe I was more authentic than I thought. Her capacity to say that to me allowed me to move and begin to engage more mutually with her and to say at least something more authentic.

I said, "I guess you picked up something about my attitude and it has been difficult for me to convey it to you. I understand the reasons you're so furious at your mother. I also understand that you want to let her know how much she has hurt you in the past. But, I think when you don't seem to take into account that she is old and alone, you end up feeling worse about yourself. It keeps your relationship with her stuck in the past even as you have tried so hard to change it." This opened up her pain about doing what she was doing. We could engage more mutually in trying to understand together why she did not want to give up this behavior; simultaneously, we could engage in understanding how bad this behavior felt. Over time this relationship evolved amazingly well.

In such relatively non-mutual periods in therapy, I feel cut off from my own experience and disconnected from myself and the patient. I was in touch with my age as a contributor to my distress at Linda's treatment of her mother. In addition, images of my own mother at 87 certainly got in my way and silenced me (I would say to myself something like, "This is your issue—keep quiet."). Nevertheless, with the help of Linda's response, perhaps to my giving her some authentic message, I finally found one authentic thing to say.

In supervision, when I am not so directly engaged and when this kind of disconnection or an impasse occurs, when the therapist feels unable to say "the right thing" and feels distant and cut off, I always ask, "Can you think of one authentic thing you *can* say?" While this may sometimes cause more disconnection before it moves on to new connection, the therapist feels more real and more mutually engaged and then movement often can occur.

Maureen Walker, Ph.D.

About five years ago, I had a patient whom I will call John. I was working in a university counseling center and when John needed a therapist, my number came up. We did not choose each other. John came into my office, propped himself in a chair, crossed his legs, and announced that he had come in for some *feedback*, but that he didn't expect very much good to come out of our conversation. He went on to say, and I quote, that he was like any "white, conservative, male Republican. [He wasn't] one of those people who expected somebody else to solve [his] problems." John was quite efficient, economical, and effective in his speech; he had used just four words to let me know what he thought of himself, what he expected of the process and of me. (I must say that I felt totally outclassed in the moment. Because of all of the things I thought about him, no four words would have expressed them.) I think of this particular patient because those first few moments with him typify the impact of a non-relational culture on relational authenticity. John and I shared the legacy of living in a stratified culture, where people are not just different, but where judgments of better than and less than are imposed on those differences. Using the coded language of this culture, we were able to traverse the territory of those differences without ever leaving our psychic home. In other words, old relational images could remain intact, and neither John nor I had to risk fuller representation with each other. We were also engulfed in the unnamed shame of an unjust power differential—where people on both sides of the inequality live with a certain amount of mistrust, numbness, and fear.

Disclosure: I did not like John. Had I met him on an airplane, I would have changed my seat. However, in the therapy office different standards apply. The dilemma that I felt in the moment was how to take care of myself; that is, how to hold onto not only my sense of professional competence but also my personal integrity and how to act in his best interest. As an African American women with diverse and extensive clinical experience, I was invested in my image of myself as a culturally competent, politically astute therapist. That image, however, was framed in a cultural context of dominance-subordination, and it left me with two options: fight or flight. To fight might mean that I would level him with some sharp retort or scathing political commentary—rationalizing that anyone who was so politically obtuse was ripe for shaming. At the very least, such a response would have allowed me to turn the tables and reassert my professional dominance. After all, I had been taught that I was *supposed* to be in charge of the session. I knew, however, that that would have been a very harmful response. Adding to the weight of this awareness was my felt sense that anything that I might

say in this moment of mutual mistrust could have implications far beyond the therapy room. It had the potential to contribute to either the healing or the further deterioration of the larger culture. Fortunately, we are guided by ethical principles that remind us that our first obligation is to do no harm. If I could not, with any sense of authenticity, offer John warm positive regard, I could at least do no harm. And at that moment, doing no harm translated into one of my favorite strategies of disconnection: when in doubt, get out. I immediately started to think about how I could get John out of my office and preserve my image of myself, if possible in less than the allotted fifty minutes. I was frantically trying to identify one of my colleagues who ideally, would be a better "match" for John, or failing that, somebody who just owed me a favor.

Fortunately, the session did last for fifty minutes, and I was forced to really grapple with my commitment to authenticity—to being honest, caring, and principled. I found myself asking two questions:

1. What would it mean to risk fuller representation of myself with a client whom I did not like and with whom I felt unsafe? Everything in my professional training had taught me that my job was to be less anxious—read: more powerful—than my client. Although my professional culture gave me "power over" John, in the dominant society which provided the larger context for our interaction, John indeed was more valued and had "power over" me. That place of historical and contemporary marginalization is not safe territory for me. It is a place where my competence is questioned. It is a place where the collective relational images of the dominant culture hold sway: where unless I *prove* that I am somehow different (i.e., disconnected from other people who look like me), I could be prejudged of everything from laziness to stupidity to promiscuity. It is very important to own here that adding insult to cultural injury was my own sense of shame at my capacity to be wounded.
2. Under these conditions, what would constitute "good enough" disclosure? What I discovered during those first few moments was that the "power-over" model of relationship, whether rooted in my professional culture or the larger dominant culture, left me with an either/or dilemma: being open to John would have felt like erasing myself. Without being able to articulate the specific responsibilities that constitute therapist authenticity in the moment, I knew there had to be a way to communicate more of the truth than either of those options held.

Although the words rang hollow on my ears at the time, I said something to John about how the decision to talk to me must not have been an easy one, and we were able to move on. It wasn't much, but it was good enough. It was enough to allow him to move on and enough for me to feel that I had not abandoned or betrayed myself. In retrospect, it was the "one true thing" that Irene Stiver (I.P. Stiver, personal communication, April 20, 1998) described in her reflections on skills for authenticity.

In less than ten minutes I found myself listening to a man describe his pain as he tried to "balance" his homoerotic fantasies and sexual longings with his attempts to live out a "straight" facade in a corporate context. As we moved deeper into his narrative, I was able to authentically express my sadness at what he had come to see as his personal unworthiness; I could sense his fatigue and feel the burden of inauthenticity in his own life as he had to work harder and harder to keep more and more of himself out of relationship with important people in his life. He was living every day in that place that Jean Baker Miller (1988) refers to as "condemned isolation." There was a lot of movement and mutual growth over the two years that we worked together. We laughed and strategized together as he prepared to talk with his girlfriend, whom he described as a religious fundamentalist, about his sexuality. We decided that his wanting to take her to see *My Own Private Idaho* was at least as ineffective as her wanting him to join an evangelical congregation as a "cure." In sum, this relationship became very important to both of us.

Reflections on the Vignette

John came into my office desperately yearning for, but deeply terrified of, connection of any kind, let alone a cross-racial encounter. His strategy of disconnection was to represent himself as a tabloid headline, using emotionally charged language designed to trigger reaction rather than engagement. He knew (probably instinctively rather than consciously) that to initiate our meeting with assertions of race, gender, and political affinity in a culture stratified along those same lines would lessen the possibility that either of us would build or sustain a connection.

My immediate instinct was to feel unsafe, and I found myself floundering in a sea of historical anger and ancient hurt. My strategy of disconnection was to immediately armor myself with old relational images

of white, male, conservative Republicans. To protect myself from the wounds of yet another racist encounter, I decided in less than two minutes that I knew his story without ever hearing his narrative, thus keeping intact the relational images in which I had previously found safety. In that place of personal and professional vulnerability, it felt safer to respond to John as an abstraction, as a tabloid headline.

Five Critical Learnings About Authenticity

I use this vignette because it illustrates five critical learnings about authenticity.

1. Jerome Frank (1991) talked about faith in the process as a nonspecific healing factor. Neither John nor I had much faith in the process during those first few moments. I think for me that loss of faith masked my fear of vulnerability. This fear is especially potent in a non-relational culture that rewards *invulnerability and power over another* (Jordan, 1997). What I learned from John about how to be a better "therapist-person" was that "good enough" authenticity was not possible without accepting the gift of mutuality. I think it's important to distinguish between mutuality and sameness. We were not the same, although John and I both knew the pain of being on the "less than" side of a cultural inequality. Mutuality for us meant loosening our hold on the relational images in which we both took refuge. In that way we were both "closeted" and needed to "come out" to relationship with each other and to ourselves in a way that would allow our images to shift.
2. To risk authenticity in a non-relational culture is to recognize relationship as the bearer of cultural shame. We live in a culture that creates vulnerability through differential valuing and then shames vulnerability by locating the pain within one individual or the other. As Judy Jordan mentioned earlier, projective identification erodes authenticity. In other words, it felt safer to see John as the source of my anxiety and vulnerability rather than to examine the images and meanings that I had internalized as a result of living in a hierarchical culture—to interrogate those with my own shame and anxiety about vulnerability.
3. This differential valuing also means we bring to cross-cultural relationships not only a physical self, but also a collective-historical self by means of the relational images that we hold of self and others. Because those images have provided the illusion of safety in a "power-over" culture, we may become deeply invested in them. For example, to the extent that my images provided me with a pre-formed set of expectations and relational possibilities, I can anticipate threats and thus armor myself *against* connection and mutuality. It is important therefore to recognize that relationships across stratification are rife with living and active images that can undermine even the most deeply felt yearnings for connection. It can be as if the actual persons in present time are reduced to spectator roles as the vested relational images spar with each other. As we examine our investment in and our connection to those images (collective-historical self), our capacity for self-empathy grows and allows for expanded knowing of self and other. As I grew in my capacity for self-empathy, I was able to be more fully present with John; I could embrace his impact on my life. As John grew more alive and trusting of himself, he was able to witness his impact on me. He was able to know that I deeply cared about his life. This process of mutuality, by definition, was neither unidirectional nor linear.
4. Self-empathy interrupts denial in a non-relational culture. One of the signal features of non-relational culture is that those persons who collectively represent dominance reserve the right to name reality, thus distancing marginalized people from their own experience. Under such conditions it is difficult to embrace and to develop empathy for the totality of one's own experience, irrespective of whether one then chooses to *disclose* it. From my "power-over" location in the culture of therapy, I felt freer to name my anger and indignation at John than to acknowledge the historical pain and vulnerability that our relationship exposed. Movement in the relationship was directly contingent upon my ability to be empathic with my own vulnerability and to remain connected to all facets of the emotional paradox that relationship across stratification holds.
5. What threatened authenticity in my relationship was that my efforts to disconnect signaled my resistance to mutual impact; the resistance was expressed in my need to establish and maintain power over this person while keeping my images intact. The challenge for me to facilitate a relationship that would allow John to come to know and represent himself in his totality and in his particularity: white, male, gay, Republican, perhaps even conservative, not better than nor

less than, but culturally different from me—and for me to accept him in his fullness: a white, male, gay, conservative Republican could help me *become* and *represent* more fully who I am.

Janet Surrey, Ph.D.

I would like to look at some particular dilemmas that arise around the therapist representing herself in the therapeutic relationship. Many of these dilemmas are recurrent themes brought up by experienced clinicians working in the Relational/Cultural Model. I describe this aspect of the relational development of therapists as working with the therapist's voice; the "I" voice of the therapist in the therapy relationship.

I, as a therapist, am not here as simply a disembodied presence, a reflecting or projective mirror. I am present as a person with voice, first of all embodied (e.g., I have to miss sessions for illness or surgery; I am tired or I have a headache today).

I am here with a particular social identity (a unique combination of privilege and oppression) and a cultural location (by race, class, gender, ethnicity, sexuality, etc.). All of these get negotiated in every therapy relationship in unique ways.

I am also present with my own particular history, temperament, strengths, weaknesses, vulnerabilities, and my own particular limits and limitations (both personal and professional).

I bring with me my own life context—family, children, professional identity, spirituality, politics, interests, and life commitments. It is interesting and significant that these are often some of the primary reasons particular clients seek me out as a therapist.

I need to represent all these conditions and work with them as they become relevant in the moment in any therapy relationship.

I am also open to growing and changing. Every relationship creates new challenges, questions, and possibilities, with constantly evolving issues of how I (or any therapist) represent myself. Sometimes these flow with very little struggle, sometimes they are very complicated. Some of the ongoing questions I continuously work with moment-to-moment are: How much of my experience do I speak? How? When? Why? What is the impact of not speaking? What about information about me that is not my choice to share as when a client reads something I've written or when I have to tell something of enormous importance in my life, such as I'm going to China to adopt a baby or I have to cancel a session because my father is seriously ill? How do therapists determine how much to share? How do we deal with major events in *our* lives as they enter therapy? For example, a therapist with metastatic breast cancer came to see me around the process of working with her clients during the last months of her life. Her concern and work to be present but not intrusive in these relationships was incredibly thoughtful and inspiring.

How much do I share responsibly my own experience, life dilemmas, learnings, and stories? How do we make the choices that these will be helpful in fostering the client's growth? How do we assess this?

What about a client who is unusually sensitive to my own level of presence—who deserves to know when (and sometimes why) I am distracted, have low energy, or am stressed? How much do I explain? When does this become intrusive?

When working on impasses in therapy how much do I share my feelings in the relationship? We know some of our clients already know a lot about us, but how open are we to "owning" and working with our own difficult or complicated feelings?

How much can I risk? Those moments of truth, when the therapist trusts the client and takes the risk to reveal something difficult about herself, often stand out in a client's memory as a key turning point in the relationship. But, sometimes these moments can be hurtful to the relationship. How much trust and history is there within the relationship to get through these difficult interactions? And, is there really any "safe" place to hide in the end?

We are constantly working with such dilemmas—and often a particularly difficult issue or feeling needs to be talked through with a colleague before one can share responsibly with the client. All of us need ongoing supervision or a peer supervisory relational context in our lives. Sometimes, depending on the history and trust in the relationship and time available (as in longer term therapy), we can take more risks to be open. In general, I would say that in my own development as a therapist, I am much more likely to try and find a way to bring these dilemmas and my interior musings into the relationship—that is, into the "We."

A significant aspect of our responsibility as therapists is to monitor our self-awareness and to grow in our ability and competency to represent ourselves and to *care for ourselves* in the context of the therapy relationship. Dilemmas around authenticity involve conflicts or tensions between different responsibilities—including to ourselves—all encompassed in the larger, overriding task of fostering the client's growth.

One client, who was struggling with infertility, wrestled for two years with whether or not she really

wanted to know if I had children. I did not leave that totally up to her but rather tried to look together to see what her knowing, or not, might mean in the relationship to *both* of us. What was authentic and connecting was the struggle to find our way together and not necessarily (in this particular situation) the actual facts of my life. When this client found out a few years later that I was going to adopt my first child, she was truly moved that I had given her the space and time to think through together what had been best for her and our relationship.

The kinds of issues most troubling for me are acknowledging feelings I have in the relationship, which I worry about sharing or about which I feel shame. These raise dilemmas for me of protection verses authenticity, that is, protecting the client (or perhaps myself) versus telling the truth or rather finding a way to be authentic, as Irene has stressed.

As I describe these dilemmas, I am struck by their resonance with themes I have been writing about regarding the mother's voice in mother-child relationships, as these have been culturally constructed. The mother's "I" voice, her representing herself in the relationship with her children, has historically been seen as dangerous or intrusive but may actually be central in fostering real relational development in her children. Relational dilemmas center around how two voices in dialogue can move toward greater mutuality. Such dilemmas come to the forefront when I feel anger, judgment, fear, hurt, or despair in the relationship and when these are not just fleeting emotions but have some real significance.

To begin with anger—I have grown much more comfortable about receiving a client's anger than I am in responsibly representing my own. I still struggle with old images of anger as destructive rather than as a source of positive energy for change. Furthermore, I do not carry many inspiring relational images of healthy anger in therapists. Sometimes when I need to own my momentary reactive anger, I may say something like, "You are right. I do sound irritated, but at the same time I am in touch with a larger understanding about why you may need to push me away." We *are* asking the client to be with us, with our feelings, and to appreciate their impact on us. When I feel judgmental, it usually passes, but if it persists, I believe the client may need this acknowledged. In effect, I am saying that I, too, am human and have a range of feelings and can keep working with them in the service of the relationship.

If a client hits a vulnerable place, either intentionally or unintentionally, I realize that I often feel shame about these feelings. I still hold some image of the therapist as invulnerable or always capable of putting aside her personal reactions. Intellectually, I know that this is not true, but I still feel it is very awkward to work with these reactions when they come up for me in therapy. I am aware that these feelings often arise in the face of the client's strategies of disconnection, and this framework often helps me to find an empathic stance within which I can express my own reactions. However, sometimes it is really just my buttons that are being pushed because of who I am, not simply because of the client's behavior.

A big dilemma for me arises when I am feeling trapped in a therapy relationship. Sometimes it is just a temporary feeling: "I want out; I don't want to be here; this is just too hard; I can't find a way to move." However, sometimes it is really a larger issue of discerning if the therapy is helpful, if I need help with staying in the relationships, or if I need to let go. This is very different from simple countertransference, although countertransference may be a factor. These can be thorny questions. For example, when and how can a therapist decide and negotiate a break or termination of therapy, not simply for the client's welfare but for her own? These questions touch on important issues of our own self-care—questions to be honestly and responsibly negotiated in the therapy relationship.

Part of our responsibility in the therapy relationship is to take care of ourselves so that we can be present and responsive, whether this has to do with taking vacations, time for self-care, personal growth, working to balance our lives, working with vicarious trauma, and the like. This is difficult when our needs or choices are clearly not immediately in the client's interest although they may well be in the interest of the relationship, which includes the client.

Sometimes self-care in the relationship involves discerning when I feel abused or frightened and need to represent or change something. And, sometimes therapists simply need to acknowledge and own their vulnerabilities, limitations, basic values, or concern for the "bottom line" to be able to work productively. For me, the most difficult dilemma arises when my needs really are at odds with what I feel is best or right for the client. For example, when I went away for a three month maternity leave, I know this was particularly hurtful to some clients. If the issue is something less than an obvious priority or necessity, how do we negotiate this responsibly? What are the limits and the dimensions of our "promised" availability? Our accountabilities? How do we actually work out such deeply conflicting responsibilities in the relationship?

An experienced clinician consulted me recently

to discuss a situation which was very troubling and confusing for her. For a number of years, she had been working intensely with a very fragile client whose mother had died during the client's birth. The client was pregnant with her first child and had expressed to the therapist that, for the first time, she felt she could count on the therapist to be there and not abandon her when she had the baby. The therapist appreciated the meaning of this in terms of the particular event she was facing (giving birth) as well as in terms of the client expressing her need and trust in a very new way.

Closer to the client's due date, the therapist suddenly was offered the opportunity to travel far away to participate in an event with enormous meaning and importance to her. It would mean being away for three weeks, including during the client's due date. The therapist felt she needed help to think through what to do. She felt torn and knew she wanted to take this opportunity for herself but could not imagine disappointing the client in this way. In the therapy relationship, she found herself unable to be clear and hold onto her own conviction, she started doubting herself, and she could not speak about the situation.

With a lot of support from me and other colleagues she decided to go and finally told her client that she would be going away. The client felt terribly betrayed, became extremely angry, and depressed and stopped eating. The therapist then wrote her a long letter describing how difficult her decision had been, how terrible she knew the client would feel and how much she hoped they could hang in together and deal with this. The next two months were devastating as the client felt her worst nightmare had been reenacted. She expressed a lot of anger, but, over time, also felt that her therapist had really acknowledged her and the importance of the relationship. She also appreciated the therapist sharing the details of her decision and could understand the importance and meaning of the trip to the therapist. This impasse has had a relatively positive outcome so far.

We know, however, that this is not always so. I saw the therapist, the client, and their relationship grow enormously through this time. The therapist sought consultation to gain clarity on her own dilemma. She was then able to make a clear, honest statement to the client with awareness of the potential impact and with a passionate commitment to stay and grow together through the disconnection.

These dilemmas can be extremely painful and complex—often the stuff of which hard and real relational growth can, but not always does, happen. The call to authenticity is a great challenge. It raises many lively and some painful questions that make it imperative to create opportunities like this to examine together how to move constructively within the relational paradigm.

Natalie S. Eldridge, Ph.D.

Ethical Dilemmas Raised by Conversation on Authenticity

In listening to our conversations about authenticity in the months preceding this conference, I began to consider some of the ethical dilemmas that moving toward authenticity raises in our work:

1. How do we maintain our responsibility for the therapeutic relationship and our responsibility to protect the client; and yet, move away from a hierarchical, or paternalistic, stance in the relationship?
2. When our own emotional response takes us out of connection with the client and when acknowledging that response could be experienced as intrusive to the client, how do we decide what to do? Irene's case was a beautiful illustration of this.
3. From an ethical perspective, what is therapeutic safety? When is it "safe enough" to take some risks? Safe for whom? And when is too much safety potentially harmful for the client as well as to the quality of the therapeutic relationship?
4. Finally, new ethical questions emerge from this conversation about what constitutes abuse, negligence, or avoiding harm. If we allow clients to assume that all our feelings and reactions in the therapy room are about them, can we increase the potential for client shame, or burden the client with our inauthenticity? Judy has illustrated this well.

Focus on the Context

We cannot answer these questions here; in fact, I do not believe there are universal answers. Rather, faced with these dilemmas, ethical clinical choices must arise from a careful consideration of each therapeutic context. These are some of the questions that might help us consider a specific context:

1. Who are we protecting in a given situation: the client, the relationship, or ourselves? Which is most relevant in this particular therapeutic context?
2. How much risk can we take? Do we have the time within the relational context to "hang in

there" and deal with the fallout of a relational risk? Some of the contextual factors to consider include the strengths and vulnerabilities of both the client and the therapist, the stage of the therapy, and the history in the particular therapy relationship of negotiating empathic failures. Sometimes we have little data on the contextual factors, as in Maureen's case, where issues of authenticity arise in the first meeting.

3. What is our relational context as a therapist: do we have a community of colleagues and consultants that can help us to hold these dilemmas and make context-relevant, sound ethical choices? Sometimes there are elements of context we cannot see from inside the therapeutic relationship.
4. For me, ethical dilemmas involving authenticity often arise when I feel particularly inauthentic in a therapy relationship and when I am uncertain how to move back into authentic connection. Disclosure or acknowledgment sometimes is the way to move, but not always. If it is in the service of the relationship with the client and in the service of her healing, then it can be useful, as in the case Jean discussed concerning bringing up her disability in the therapy. However, if disclosure is in the service of reducing the therapist's anxiety only and is done before the client is ready to hear it, then it may be harmful both to the client and to the relationship.

Illustrative Vignette

As a lesbian therapist, I find I must decide with each client how to manage information about my lifestyle. Often, it is not relevant nor an issue, but when it becomes an issue in the midst of a therapy, it can be distracting and it can move me out of connection until I resolve it.

For example, I had worked for a few months with a 20-year-old African American woman who was lonely, shy, and frustrated at her lack of dating experience with men. Our differences in race and in age were self-evident from the beginning of therapy, and she had shared a certain safety she felt in these differences. She was making progress in using the therapy to rehearse how to connect with others, and she was beginning to build an external support system. I was completely unprepared when she arrived in crisis one day because her brother had come out as a gay man to her family, and her parents had disowned him. She felt both betrayed by her brother for not telling her earlier and betrayed by her parents for forbidding her to contact him. She was struggling to understand his sexual identity in complete isolation and spoke of how she had never known anyone who is gay.

For her, this revelation changed nothing in the therapy relationship, while for me, a dramatic shift occurred. I suddenly felt very inauthentic with her and became distracted by my own anxiety. Was I betraying her by not disclosing my sexual orientation? How likely would it be for her to inadvertently find out this information from someone else in the university community? If she knew I was a lesbian, would she feel compelled to disown me? The shift in the relevance of my sexuality to the therapy relationship created a dilemma for how to move back into healing connection with my client.

What to do?

First, I held on to the frame of therapy built thus far in our relationship, concentrated on shifting my attention from my anxiety back to what my client was saying and just plain held on until the end of the session.

Next, I tapped into my professional relational context. Luckily for me, this included both colleagues at the University Counseling Center with whom I frequently discussed cases and it included a peer supervision group made up of lesbian therapists from various settings. As I reviewed my dilemma and sorted out whom I was seeking to protect from what, I saw that a disclosure about my sexual orientation might have eased my immediate anxiety about keeping something from her as her brother had done. Yet, it became clearer that disclosure would not relieve her of the sense of betrayal she had concerning her brother and may have distracted her from understanding the meaning of this relationship with him. The major concern for the therapy remained my disconnection from her in the therapy; I had become temporarily less present, less authentic, and I did not want this to persist.

Discussion of the case itself reduced my anxiety, and I was able to shift my focus back to the client's sense of abandonment and disconnection from her brother for whom she felt great affection. My work with her was around supporting her explorations into peer and dating relationships. It also involved exploring her perceived loss of her brother, which was a devastating blow to her growing confidence.

In reviewing the context of this particular therapy relationship, I thought about the brief duration of our work and our anticipated termination in four to five sessions at the end of the semester. I considered our particular relationship history and

noted little focus on empathic failures thus far. As I refocused on the client's needs at that time and the power in our relationship to create an environment in which she could move and grow, any consideration of a move to disclose my sexuality to her dissipated. Rather than identifying with the brother, who was disowned and cutoff because of being gay, I realigned myself with the client.

I felt sad that, at the moment of the intimacy of learning something significant about her brother, my client had been cut off from the potential of greater connection by her parents who were seeking to protect her from an unknown threat. I felt compassion for the conflicting loyalties she felt, which left her with the perception of an impossible choice of either disconnecting from her parents or disconnecting from her brother. These are things I could share with her—that moved us into greater connection around the relational issues that brought her into therapy. I moved back into an authentic connection with her for our remaining sessions.

Conclusion

The ethical processes involved in resolving the kinds of dilemmas raised by our presentation today are complex. Some therapists have oversimplified and vastly misinterpreted the subtle but significant ways we are redefining therapy or, as Jean puts it, our attitudes about therapy. However, it should be clear to all that authenticity does not equal self-disclosure. Mutuality does not mean that the therapist's needs are equal to the client's needs in the therapy relationship. Rather, ethical clinical choices about how to move toward authenticity emerge only from careful consideration of each therapeutic context, which includes understanding the intentionality or purpose of the therapy, analyzing the power dynamics that influence the specific relationship, and exploring the strategies of disconnection of both the client and the therapist.

References

Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins Press.

Jordan, J. (1995). Boundaries: A relational perspective. *Psychotherapy Forum*, *1*(2).

Jordan, J. (1997). Relational therapy in a non-relational world. *Work in Progress, No. 79*. Wellesley, MA: Stone Center Working Paper Series.

Jordan, J., Kaplan, A., Miller, J.B., Stiver, I., & Surrey, J. (1991). *Women's growth in connection*. New York: Guilford Press.

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

Miller, J.B., & Stiver, I.P. (1997). *The healing connection*: *How women form relationships in therapy and life.* Boston: Beacon Press.