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# **Work in Progress**

## **How Change Happens: Controlling Images, Mutuality, and Power**

Jean Baker Miller, M.D.



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# How Change Happens: Controlling Images, Mutuality, and Power

**Jean Baker Miller, M.D.**

## **About the Author**

*Jean Baker Miller, M.D., is Director of the Jean Baker Miller Training Institute at the Stone Center, which is part of the Wellesley Centers for Women at Wellesley College; and Clinical Professor of Psychiatry at Boston University Medical School. She is the author of *Toward a New Psychology of Women*, co-author of *Women's Growth in Connection* and *The Healing Connection*, editor of *Psychoanalysis and Women* and author of many papers.*

## **Abstract**

*Change is inevitable but it can go in a positive direction toward growth or in a negative direction. Extending Patricia Hill Collins' concept of controlling images (2000), we can see how these images interact with relational images and strategies of disconnection to obstruct growth on both the societal and the personal level. In therapy, change is defined as movement-in-relationship toward better connection; and increased connection leads to growth. Several aspects of therapy that lead to deeper and wider connection are explored, especially increasing the patient's power. Prior versions of parts of this paper were presented at the Jean Baker Miller Summer Training Institutes in 2001 and 2002 and at the 2002 Learning from Women Conference sponsored by the Jean Baker Miller Training Institute and the Harvard Medical School/ Cambridge Hospital in Boston, Massachusetts.*

As therapists, we're "in the business" of change—change for the better. That's our goal. Another word for change for the better is growth. Change is the essence of life. It is most obvious in children but it is a necessity through all of life. Change will occur inevitably but it can go in a positive or a negative direction. Further, I believe change toward growth creates pleasure. We feel most alive and zestful when we are engaged in this expanding activity.

## **Change and Relational Images**

I'd like to explore the use of Relational-Cultural Theory (RCT) to further our understanding of change and its difficulties. Growthful change occurs as we encounter new experience, and this new experience usually happens in interaction with other people. We do not usually grow and develop in isolation. I think growth requires the ability to modify our relational images or to construct new ones. To do this, we must open ourselves to the influence of others. We've defined relational images (RIs) as the inner constructions we each create out of our experience in relationships (Miller & Stiver, 1997). We begin to construct them early in life, and we modify and develop them repeatedly. They define what we believe will happen to us. Not only do they portray what we expect will happen in relationships, they determine the meanings of this experience for our total conception of ourselves. For example, if our relationships have made us feel valuable, we will tend to carry this belief over to most realms of life, in school, work, or others. For the most part, we do not construct these images consciously.

To take in new experience in a growthful way, we probably compare the experience to the RIs we've created to date, again not usually consciously. If our relational images are relatively flexible, we may then modify them. However, if they have been reinforced very powerfully, and especially with threats of

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isolation and condemnation, we will build more rigid RIs. They will be much harder to change.

For example, a little four-year-old girl, Lucy, was very curious and gleeful. For their own reasons her parents couldn't join her in these interests and joy. She began to develop the image that when she pursued her interests no one would be there. As time went on, this RIs became rigidified into, "Whenever I pursue my interests, I will be isolated." As happens when a child feels isolated, she also developed the belief that something was "wrong" with her if she landed in this dreadful place.

Another child may be more fortunate; she may find other people, a teacher, a grandmother, or other relative who can join her in her interests and joy. She may be able to alter some of her RIs or create some new contrasting images. Perhaps she will be in conflict.

## Societal Context

Therapists working with people in marginalized groups cannot think about what will help people to change without thinking about change in a larger context. For example, they can't think that things are fine for African American youth and they should just adapt to the status quo. Or that working-class youth face no obstacles but their own.

Many therapists didn't consider a need for societal change for the dominant group until they were challenged by their disciplines to become culturally competent. For others, the women's movement opened up the whole question of the norms held out for white women. This elucidation has led to questioning the norms for people of both genders and the whole construction of gender. More recently, led by marginalized women, feminists have begun to explore the intersection of race, class, and gender.

In her book, *Black Feminist Thought* (2000), Patricia Hill Collins, a sociologist and one of the scholars leading the exploration of this intersection, has suggested the concept of "controlling images." Maureen Walker referred to this idea in another paper (Walker & Miller, 2000). I find this concept provides a valuable link between the social and the psychological. Collins discusses the controlling images (CIs) inflicted on African American women. Several other authors have also discussed them, including Elizabeth Sparks in a paper on African American mothers for example, "the Mammy," "Jezebel," or, more recently, "the welfare queen" (1998).

I believe the concept can be extended to all the groups that society creates. Society also defines some

groups as better than others. Working-class people can be portrayed as dimwitted, burly, uncouth, brash, and the like. White women have been described as either Madonnas or whores. In Hispanic traditions the Virgin Mary image has been very powerful.

Controlling images define who and what we each are. They determine what is acceptable and what is not, what people can do and cannot do. They exert a powerful impact on how we can act and how we construct relationships. Consequently, CIs create the framework within which people make the kinds of relationships that go into the construction of RIs. We fashion RIs in the immediate interactions in our lives. They form the psychological constructions we then carry in our minds, often without awareness. But the RIs are very determined and in many societies constricted and limited by the CIs. We are often not fully aware of the operation of CIs, although members of marginalized groups may be more conscious of them than members of the dominant group.

Collins (2000) defines all of the controlling images as lies, falsities. Although false, they exert a powerful force holding people of all groups in their place, that is, resisting change. Therefore, CIs can induce people of both privileged and non-privileged groups to believe that change cannot and should not occur. For example, white women were led to believe that they must adhere to the dominant group's image of the good heterosexual woman or they will fall to the level of "those other people," the "bad women," the "Jezebels," the "sluts," or the "dykes." They will sink into these "degraded groups."

But it is more complicated. While CIs affect us powerfully, people also create forces resisting them. These resistances may arise from two major sources. One is the truth of their own experience, which differs from these falsities. For people in marginalized groups, their group culture may reinforce these truths and convey different traditions. For example, African American people know a different story about African American women, or Latina women know that they are not docile victims. However, it can be complex for people to hold on to their truths when bombarded by the CIs.

Second, particularities within a person's immediate development may counter the CIs. For example, while a working-class family may convey to a child that s/he can't aspire too much, a parent may, in the very immediate way s/he relates to the child, convey that s/he is most precious and valuable. This attitude can form a base for the child's ability to counter restrictive images.

In sum, our society, and certainly others too,

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constructs groupings of people, maintains that some are better than others, forces CIs onto people, and reinforces them powerfully. It thus creates a whole framework of thinking in terms of “better than” and “less than,” which is a mentality we all internalize to varying degrees. Such societies are geared to reinforcing the *status quo*. They do not build into the very workings of society a good way of learning how to “do change” well, to live in a process of change. Yet we all have to.

### Threat of Isolation

What happens when we try? We have proposed that the most frightening human experience is psychological isolation (Miller, 1988). If severe, a person usually feels, along with isolation, a sense that s/he cannot be heard or understood, cannot affect the others around her—that is, she is powerless. Along with this experience is the sense that you, yourself are the reason for this. We’ve called this terrifying experience “condemned isolation.” (Miller, 1988).

While not all threats of isolation are as horrifying as this, we all experience some degree of them. As a result, we all try to stay out of vulnerability and risk. In the attempt to do so, we create the “Central Relational Paradox” (Miller, 1988). We deeply desire and need connections but we become so afraid of what happens when we attempt to connect with the people important to us, that we keep large parts of ourselves out of connection. Those are the perceptions, thoughts, and actions that have seemed unacceptable or dangerous in the relationships surrounding us in our development. We develop what Irene Stiver called “strategies of disconnection” (SDs: Miller & Stiver, 1997). Sometimes they are strategies for psychological survival. Again, most of this process goes on outside of our awareness.

To be open to change to new and unknown experience always potentially threatens our strategies of disconnection and our old relational images. We developed these strategies in the attempt to avoid isolation and the RIs portray our fears about the worst things that can happen in relationships. Thus, change threatens us with isolation along with powerlessness without the strategies that we believe we need and that we cling to so desperately. In sum, the big threat is isolation—and the big answer is connection. We have to keep finding the meaningful connections that will help us to encounter all of the vulnerability and risk we face in trying to change and grow. But what if we can’t find the ways to become more connected? This is where therapy can come in. It is a way to help

a person whose particular combination of CIs, RIs, and SDs is interfering with her ability to change.

### Change in Therapy

Overall, therapy means “movement in relationship” toward better connection. This connection will make it possible for a person to change her restrictive CIs, RIs, and SDs. But to do so, she does have to encounter “the new.” In this case it is the therapist who is the bearer of new experience.

In the past, we’ve tried to describe some of the main processes in therapy that lead to change (Miller & Stiver, 1997). I’ll summarize them briefly:

1. The therapist must be able to “feel with” the patient and the patient must “feel the therapist feeling with her.” In saying this, we include the thoughts that go with all feelings. This is mutual empathy as it occurs in therapy.
2. The central guide at all times is that the therapist should be aware of how connected or disconnected she feels.
3. The therapist must “honor the patient’s strategies of disconnection.” She must recognize the powerful reasons for their existence, often born out of great pain and fear. Not only must she know this, she must be able to “feel with” the patient’s deep need to cling to them.
4. Through this work, patient and therapist can come to understand the CIs, RIs, and SDs, how and why they come into play and feel so essential.
5. As a person brings more of the truth of her experience into the relationship, she finds she has become both a stronger, more developed person and also more connected to the therapist and eventually to others in her life. That is, she discovers a reversal of the *Central Relational Paradox* (Stiver, Rosen, Surrey, & Miller 2000; For a description of the Central Relational Paradox see Miller & Stiver, 1997).

Of course, there is much more to be said about each of these points but I want to emphasize three additional possibilities. First, I believe that in addition to feeling that the therapist feels with her, a patient has to feel that change matters to the therapist and that she, the patient, matters to the therapist. It’s very hard for a person to attempt all of the vulnerability and risk of trying to disrupt her CIs, RIs, and SDs if the other person is sitting there trying to act as if it doesn’t matter.

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I believe the relationship, and the patient, and change in the relationship do matter to the therapist. Traditionally, therapists have been encouraged not to show it or even admit it to ourselves. This differs from pressuring someone that she must change or change in the way the therapist wants or needs for her own psychological reasons. Such pressure is especially dangerous if the therapist is not aware of her own motives.

It is also different from the therapist not understanding and respecting each person's pace or, again, honoring her strategies of disconnection. It is about the therapist's real desire for the patient to reduce her suffering and distress and to grow and enlarge. It is also about the growth the therapist will inevitably experience when they both are engaged in mutually-empowering movement.

This leads to the next point: change requires mutuality in movement. If growth is to occur in any relationship, both—or all—of the people involved have to change. For example, a child must change and grow; to foster that growth the rest of the family has to keep growing. They, too, learn and enlarge as they change to meet the child's growth. Sometimes this growth is easy for parents, sometimes it is much more difficult and anguishing.

In the larger society too, subordinate or marginalized groups are the ones who most need to create change but this growth usually requires that the dominant group change as well. This is the hardest part. To take a relatively easy example, if women make changes in the workplace so that they gain more flex-time, men may have to adapt to working at an altered schedule. Ultimately, the men often find that such changes benefit them, too, and benefit the whole system, as Joyce Fletcher and her colleagues elucidate in their work (Fletcher, 1999; Rapaport, Bailyn, Fletcher & Pruitt, 2002). The whole system changes and enlarges. As we know, some systems are much more difficult to change and necessary changes are still to come as in the civil rights movement, workers' struggles, the women's movement, gay liberation, and others.

As we can see clearly in these examples, mutuality does not mean sameness or even equality. The child and the parent grow in different ways and at different rates. It is similar in therapy. The patient comes seeking change. For this change to occur, the therapist has to keep changing, for example, to meet the need for empathy with each thought and feeling as it arises, to understand and feel with each phase of the strategies of disconnection, and the like. Most of all, we need to move into those places where we feel

vulnerable and at risk if the therapy calls for it. Again, this is the hardest part.

Perhaps a brief example will illustrate this notion. In doing therapy, I found it particularly difficult whenever I felt like didn't know what to do or when I felt like I was not doing enough. I believed that I must understand *everything* about therapy and apply it appropriately. This idea was certainly reinforced by the CIs in my medical training.

With one patient, Pam, I kept feeling I was failing miserably on all of these counts. She wanted to be able to make relationships with other people and kept losing the few she made. She was a very demanding and critical person and appeared totally unaware of how she put people off. I had tried everything I could think of and we were getting nowhere. I was feeling helpless, not good enough, angry with her for making me feel this way, and then, as Maureen Walker has pointed out, ashamed of all of these feelings. Now, I was occupied with myself and, therefore, disconnected—thus, according to all of our precepts, doing the worst thing possible.

One day, after Pam complained again, I said, without really planning to, "You know I feel helpless." I was immediately very frightened. A doctor never says such a thing. More important, I believed that in most instances it is a terrible thing to say to a patient. It will make her feel utterly despairing. Thus, I was certainly moving into the unknown. I didn't know what would happen except that she would say, "That's because you're not a good therapist," and stomp out of the room. What Pam did say was, "Well, now maybe you know how I feel."

Now, I certainly felt much more involved in the next moments and so was she. She came around to saying she couldn't imagine I ever felt helpless. Here I am such an established professional. I said I often did and so did other people I knew. But I also really had faith in this process and that people working at it together can keep finding ways to move. Incidentally, her response was interesting because I had said many times, "I know it's so hard to feel so alone." I certainly meant it. That may have helped someone else, but it hadn't helped her enough.

Later, it emerged that part of what was keeping her stuck was this false image of me as so successful and accomplished. It was contributing to her fear of risking movement into some of the deeper vulnerabilities involved in her problems. How could she reveal her most despised parts of herself with such an elevated personage? Of course, it was also making her feel as if the impasse was all her fault. We were able to move on in our work together.

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How did I grow? I learned, once again, that I don't have to know and do everything right. Instead, the main thing is to stay in the immediacy of the moment-to-moment movement of the relationship. Sometimes the way to do that is to put yourself at risk, to move into something new, even if in a small way. Of course, therapists should do so with thought and practice and should do something more considered than what I did here. The aim clearly is not to be careless or thoughtless.

We don't have to be able to predict and control everything. We can't do that anyhow. We do have to keep getting training and help from colleagues so that we are as knowledgeable and skillful as possible in what we do. Most important, we have to feel able to deal with "what happens next," to engage with whatever ensues, especially if we have made a major error or failure. This is where the most important work usually occurs. Sometimes, it is not as bad as our own CIs, RIs, and SDs have led us to fear. At best, we find that we are able to connect in new and enlarged ways.

Incidentally, this example may suggest projective identification. That is not the point I want to make. Pam was very conscious of feeling helpless. I would focus, instead, on the ways in which patient and therapist can find moment-to-moment movement toward better connection and also that this movement is mutual.

## Power

The third and more overriding point about change in therapy concerns the recognition of the importance of the patient's effect on the relationship and on the therapist. This notion is really implicit in the first point in the above list of recommendations for therapy—that is, that the therapist must feel with the patient and the patient must feel the therapist feeling with her. If this occurs, the patient must have had an effect on the therapist and on the relationship. However, we have not examined this effect thoroughly. More specifically, I'd like to explore the obstacles to movement-in-relationship that occur when the impact of the patient or the therapist turns to "power-over" forms of action rather than mutual empowerment.

We should note that the field of psychology has left the whole issue of power relatively underdeveloped. Alfred Adler raised it early but he was soon cast out by Freud and so was the whole topic.

Why is this issue so important? Actually, we and

others are really saying that all psychological troubles arise because we haven't been able to effect the important relationships in our lives. We couldn't reach the other person(s) or couldn't bring about change in something that hurt. Even as infants, we affect our relationships as recent research has demonstrated. For example, Edward Tronick has produced striking videos that show infants trying to relate to their caretakers (1998). If the caretaker does not respond appropriately, the babies try several times more, but if a response does not occur, they turn away. These videos seem an amazing portrayal of exactly what we're talking about. The infant desires and seeks connection. When it seems impossible, s/he turns to disconnection, isolation. Of course, the strategies of disconnection become ever more complicated as the person goes on in life.

From earliest life, then, we should have an influence on the relationships in our lives just because of our thoughts and feelings. They should matter. Others should respond to them (which doesn't mean agree) and care about them. This is basic to the possibility of participating in relationships: if you are not having an effect on the relationship and the other people in it, you cannot really be participating in the relationship.

Thus, in therapy people have to regain a belief that they can have an influence on their relationships, beginning with the therapy relationship. Therapist and patient each affect the other and each must recognize and acknowledge this effect. Judy Jordan has written about this topic in her work on relational competence (1996). I am exploring the topic from the perspective of power.

There are additional immediate reasons why this matters in therapy. It is terrible to be in a room with someone and to feel one can't have an effect on her/him. How can you be safe? It's as if you are totally at the mercy of the other person. This point may relate to the point Amy Banks made that people suffering with chronic post traumatic stress disorder (PTSD) sometimes find it unbearable even to be in a room with a therapist (2000). She suggests that they are triggered to have the sort of brain chemical reactions that began when they were powerless when confronted by a perpetrator.

Traditionally, therapists have been encouraged to demonstrate that patients had no impact on them – that is, to not react to patients' thoughts and feelings. Therapists called on Freud's dictum that the analyst should display an "even hovering attention." At its best, this advice admonished therapist to be nonjudgmental and not to "reward" or encourage one

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of the patient's utterances over another by showing more of a reaction to it. Some writers, even recently, have spoken of this attitude of giving patients this freedom and scope as a loving stance.

Instead, I believe this stance can lead to what is then labeled "acting out," as the patient attempts to elicit the therapist's response. Further, patient and therapist do inevitably affect each other. The point is to recognize this influence and to move in relationship toward effecting each other in ways that are mutually empathic and mutually empowering. Incidentally, Irene Stiver described an observation that she and many others who do many consultations know, that patients know accurately a great deal about their therapists' reactions. They have usually not told their therapists because they also pick up the notion that they should not be aware of what is going on (personal communication, 1991).

Patients are always trying to have an effect on their therapist. If they can't do so directly, their attempts will come in the form of strategies of disconnection. Some strategies may not look like attempts to have an effect, e.g., silences, intellectualizing, talking off the point, attack, anger, criticizing the therapist. There are many more. These strategies are also uses of power in that they prevent the relationship from moving, they create obstacles to movement. They certainly affect the therapist, but all of these actions are usually not conscious attempts to wield power.

On the therapist's part, she possesses more power than the patient as detailed below. Even so, there are times when the therapist feels threatened and not safe. Many of these instances follow from the controlling images we develop about ourselves as therapists, as Maureen Walker suggested (2001). This is what was happening to me in the example with Pam above. Therapists' CIs may include having to be all knowing and always competent. (Our RCT, if misunderstood, runs the risk of adding even more CIs such as we should be all empathic, all understanding, and the like.) These therapy CIs usually build on our particular cultural CIs and RIs such as believing we had to take care of everything, to solve all the family's problems, and others.

Threats to our CIs usually occur when therapy is not going well, often when we feel the patient is explicitly or implicitly making us feel pressured to make something improve or solve something. A good example of this kind of a moment occurs in the teaching video, entitled "*Martha*," that Judy Jordan and a trainee role-played (Jordan & Lesses, 1998). They were trying to portray a disconnection. It began

when the "patient" was pressing Judy to come up with a solution to her immobilization. Judy made a suggestion and the patient became very angry and sarcastic.

At these moments of disconnection I believe that we, as therapists, can ask ourselves the question: "Is it important to try to repair the relationship or is it important to try to repair some image of myself? Further, when we try to recoup some image of ourselves, we tend to fall back on some maneuver that is a power-over attempt. For example, in the video, Judy might have said, "I see you're angry. I am just trying to help." On the surface seemingly innocuous but indeed very disconnecting and a true put-down.

Why do we fall back on a power-over maneuver? Because that is what we learn in our culture. As Maureen Walker has captured it so well, "It is our default position." Because that is how our society is structured and how we all tend to respond. It can happen in a split second and usually without our awareness. Thus, the whole power-over mode of acting enters the therapy room. In this sense, we can see therapy as a realm in which we are trying to learn a new way of relating, different from that of our dominant culture.

In the example with my patient Pam, she saved me from the attempt to try to repair my images by making it easy for me to say that I often felt helpless and, most important, she also made it possible for me to affirm my belief in this process. The latter helped me counter the discouragement I had introduced.

Judy's response in the video illustrates a much better way of moving into connection. Judy says that she felt the patient didn't like what she (Judy) said, and it made her (the patient) angry. "And I felt bad," says Judy. This response led them back into very good movement. Note that this is not therapist's authenticity for the sake of "disclosure." It is an authentic statement that moves the relationship into connection. Further, Judy tells the patient that she cares about her and about the relationship. The patient has an effect on Judy and it matters to her.

This video also portrays a growing point for the therapist as well as the patient, that is, it illustrates mutuality. Such moments lead us to stretch, to do something new, not because the patient is there to help us grow but because we have tried to move the relationship toward better connection, toward the goal of therapy. When we participate in that process, we also grow. None of us get it right all of the time and on the spot. We do get second chances, and sometimes third and fourth.

Even to ask the question, "What am I trying to

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repair here?" may help us to move to a new track. It can create a pause in our automatic response to repair our own images. We will return to this point in the next section.

After working on this talk for a while, I realized that this section is really spelling out in a little more detail some of the specific components in *Impasses* that Irene Stiver wrote about in her paper on *A Relational Approach to Therapeutic Impasses* (1990). In that brilliant paper, she said that *impasses* occur when the patient feels disconnected from the therapist and the therapist follows by disconnecting from the patient. The therapist is usually not aware of what's happening initially. It makes me happy to be carrying forward her work in this way.

## What To Do?

What to do? The answer lies in working toward increasing the patient's effect on the relationship and toward the patient's and the therapist's recognition and acknowledgment of that effect. As a first step, we can recognize how the whole therapy arrangement augments the therapist's power. We and others have written about this (Miller & Stiver, 1997); so I will just review some of the features. The patient is the person coming with problems; she is in the supplicant position. To be in this position immediately makes her feel "one-down" in our culture. While this should not be true, it is how people are made to feel. We don't have good models of a helping relationship that is respectful and empowering for the help seeker. Our difficulty in finding a word for the seeker reflect this situation. We have struggled over not liking either the words, patient or client for years and have not found a good word in our common language.

The patient comes to the therapist; she is stepping into the therapist's domain as Wendy Rosen said (2002). Once there, the therapist sets the whole frame, it is usually quite rigid and not to be questioned. The patient is supposed to be more exposed psychologically, more vulnerable. She is always in the "helpee" position, never the helper or equal contributor; this situation usually makes a person feel inferior and less empowered. Very often the way we present ourselves leads patients to feel less powerful. For example, we appear as professionals, often of high status, all knowing with all of our problems solved as Judy Jordan says (1998).

Most important the patient usually feels she cares more than the therapist. In truth, we may matter more to patients than they do to us. However, as discussed above, patients and our relationships with them also

do matter to us although traditionally, we have not let them know this. This situation may create the most important power differential of all. The person who cares the most usually feels at a great disadvantage in power. Further, this feeling usually leads to serious shame, which then increases a person's sense of powerlessness, silence, and difficulty representing her experience.

As in transference, patients can see the therapist as similar to those powerful people in the past whom she would not be able to affect, to reach. But the therapist has more power and status, in fact, in the present. This power differential will become more complex if the patient is from group defined as "lesser than" but the society.

Thus, the therapy situation, itself, tends to increase a patient's strategies of disconnection because of this power difference. Traditionally, therapists have talked of therapy creating dependency but have not considered extensively the creation of powerlessness.

Further, structural factors in reality may operate to give the therapist significant real power over the patients' lives, for example, in institutionalized patients and in some managed care arrangements. Elizabeth Sparks made this point about her work with adolescents remained to an institution by the court. Her suggestion is to acknowledge the truth and to honor the fact that she is struggling with these reality constraints (2001). Denying and mystifying power is the worst course and one that we know is common to those in power-over positions.

## Initial Session

Having recognized this major power differential, what steps can we take? We can very consciously work to make this differential clear and to increase the patient's power. This action can start with the very first interview with steps like the following: We can explain how we work and ask what the patient expects. Sometimes people expect something very different and it is best to discuss that. Second, we can explain the conditions in which we can work. We can say, "You tell me what you'd like" and try to meet the patient's conditions. When we can't, we should be honest about it.

As part of the way we work, we can explain that this work depends on a dialogue, an interaction based on mutuality, with words like, "I can't possibly do it alone." This kind of mutual engagement may be different from what the patient is accustomed to in other healing situations. Cultural characteristics may enter here and the therapist may have to deal more extensively with the differences from the patient's

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expectations.

It is important to urge patients to ask questions and to say that asking them truly will help the work. They keep the therapist more in touch with the patient's experience. We can say that we will answer questions when we feel able but may not do so if it makes us too uncomfortable. We can also ask the patient to tell us as the work goes along when we are not getting the point or not being responsive.

I'm sure we can think of additional suggestions. Although specifics are important, the most significant feature is that they convey an attitude of openness, of the therapist's desire to hear the patient, and wish to change when the relationship calls for it. They can create a tone that will help to increase the patient's influence on the work. This mode is very different from the old model of the expert "acting on" the patient.

## As Therapy Proceeds

As therapy proceeds, perhaps we should consider the possibility that another central guide may be that we act always to increase the patient's influence on the relationship and accordingly, to increase the patient's awareness of her influence. We might consider this focus another key goal that we should pursue throughout. Although considering it at all times, it may be especially important at the moments when we are feeling disconnected. Can it be that we, as therapists, have resisted the patient's influence and she's felt she had to turn to her strategies of disconnection. Or have we, as therapists, done something that is making the patient feel our excess power, perhaps without awareness.

To try to attend to this possibility, we can, again, first of all, try to be open to it. This openness may be most important when working with people of marginalized groups but it is important with everyone. Just being aware of these possibilities can change us. It changes what we're inclined to say next as opposed to blithely going on our way as if this possibility didn't exist.

Further, when we feel something is occurring that we may not understand, we can ask about it. For example, one patient was going through a very difficult period at her job. She was overworked, stressed and complaining about it. I felt her workplace was very unfair and I said something like, "That's so hard. You must be very tired." Empathic? No. (Note that the last comment is not a good thing to say ever. It is not wise to tell people what they must be feeling.) The exchange stopped for a fleeting

moment. I said, "Did I say something you didn't like." She said, "Oh no, of course not." However, this brief exchange did open up a possibility that she became able to talk about later. It turned out that in her family she had to accomplish everything perfectly and do so while always looking healthy and beautiful. To accomplish this feat gave her some power and influence with parents whom she often felt was out of reach. My comment made her feel drained of her accustomed source of effectiveness in relationships but asking her about her reaction felt like a first step in opening up a very charged topic. At the time she didn't have clarity about it and neither did I. However, she later said that my asking created the first slight glimmer of light in a very obscure and confusing area. For the first time, she felt a small belief that this whole topic could even be talked about.

Another way patients can recognize their effect on the relationship occurs when we tell our responses. This kind of comment depends a great deal on the stage of the relationship and must be done with wise attention to what will help to move the relationship forward. The example from the video above is a very good one (Jordan & Lesses, 1998).

We can't always talk about the relationship directly because that is often one of the most difficult things for patients to do—and for therapists as well. Again, it can help just to be aware or questioning of our own feelings. We can also address this issue in ways that don't entail talking about the relationship directly, e.g., by asking a question such as, "Is there something I'm not getting now?" Thus, it's not always a question of telling our reactions as they arise but of using them to try to question whether a power-over dynamic is at play, one that the patient may not be able to get at. Jan Surrey made the point in discussing the *Martha* video that the patient may feel less powerful based on the status factors at play (2001). Martha sees Judy as a professional in a high status job compared to herself, who can't even get a job. Further, she sees Judy as thin, therefore much "better than" she according to the controlling images in this society. Jan makes the point that often a patient's anger and criticism can be based on such sources of power difference. Indeed, they can be understood as attempts at authenticity although the patient cannot state them directly. They may be a way of saying, "Something is wrong in this relationship." Jan adds that she learned this in working with patients and therapists of marginalized groups.

## Expertise

Since I have emphasized the importance of the

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patient's influence on the therapeutic relationship, a question may arise about the place of the therapist's expertise. Aren't therapists supposed to know and do something more than the patient does? Therapists absolutely need great expertise but it's a question of the *kind* of expertise—and the kind of expertise that offers the most safeguard against power-over actions. That expertise consists of the ability to participate in movement-in-relationship toward better connection, as stated at the beginning. This kind of expertise requires profound abilities; it is complex and can be very difficult. It requires extensive training and continuing help from colleagues. Further, the therapist has to have a grounding in knowledge of psychological functioning and development.

While the therapist requires this kind of expertise, the patient possesses certain kinds of knowledge that the therapist can never have. Only the patient knows what happened in her experience and how it led her to construct controlling images, relational images and strategies of disconnection—and especially, the clues to how she can move into better connection. She does not know all of this consciously but only she can supply both the steps and the obstacles to bringing them into the relationship and to changing them. She can gain access to them only as you work together.

In her study applying RCT to the workplace, Joyce Fletcher coined the term “fluid expertise” (1999). She meant that knowledge and ability can flow back and forth between and among workers; and between workers and supervisors. As one of the women she interviewed said, “No one knows it all.” Encouraging fluid expertise can lead to all workers becoming more empowered and creative.

The term applies to therapy and yet we're dealing with a more complex interchange. There are powerful forces keeping patients from knowing what only they know. Thus, the true expertise lies in increasing our ability to find the paths to both patient and therapist participating in the relationship so that it moves toward better connection. This increased connection leads to the patient bringing into the relationship more and more of her experience and becoming more able to examine her CIs, RIs and SDs. This, in turn, leads to more connection, which leads to bringing more experience into the relationship and so on in a spiraling interchange of growth.

## Conclusion

As therapists, most of us, I believe, want a world where everyone can change and grow. For that, we need to change whatever societal forces keep anyone

from growing. This is a tall order. Another concept of Patricia Hill Collins (2000) has helped me think about this tall order. She writes of the term, “visionary pragmatist.” She uses it to describe how African American women contributed to African American society beginning before the Civil Rights Movement. They played a major part in the growth and protection of their children, but not only their own children those of family, neighbors, friends, and in the neighborhood in general. They participated in the church and in other organizations and institutions. By the very way they lived, these women enacted a vision that went beyond the current situation.

These women contributed to the growth of people and institutions in day-to-day life even as they were aware of the power structure that affected them and even if they could not change the whole system. They were pragmatists. But they were living by a morality and a value system that was different and more advanced. They were living by a different vision. Many were ready to make greater change when that possibility came about, for example, Fanny Lou Hamer, Rosa Parks, and many others whose names most people don't even know.

I don't mean to suggest that privileged middle-class therapists of today are the same at all. But I do think we can learn from that concept; know the importance of holding a vision and finding ways to practice it even in current life, while building toward larger change. Indeed, I believe that if we are truly helping people to change and grow, we are inevitably moving in a way that counters the restrictive CIs of society.

Patricia Hill Collins' concepts may provide an additional example of how mutuality proceeds in a system. She evolved these ideas out of the truth of her experience as a woman of a marginalized group in this society. When people of marginalized groups tell the truth of their experience, they open up and illuminate the truth about the dominant group as well – and about the whole system. For example, we can see how controlling images affect everyone. They are not the same controlling image for all social groups but they help us see and understand the total society in a fuller and truer light. And this larger view can contribute to us all and to helping us make change in the system.

Despite dwelling on the problems of change, which we must continue to do as therapists—and as people who have a vision of a better world, I want to reiterate that I believe change—growth—is the most essential and exhilarating thing about living. All people are seeking it. It is our task to keep finding better ways to participate in this process.

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