A Relational Approach to Therapeutic Impasses

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About the Author

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Abstract

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

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

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

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

But more important, over the ten years since I first became interested in what I would now call therapeutic impasses, I have traveled a revolutionary path with my colleagues at the Stone Center. At that time, we had already begun meeting regularly, struggling to move ourselves out of traditional assumptions, techniques, and perspectives, when they did not seem to fit our clinical experience, that is, listening and learning from our women patients. We spent many hours examining the language of our
profession, with much of its pejorative connotations, language that is often objectifying, hierarchical, and pathologizing, as well as elitist, sexist, and the like. And we continue to struggle to find new ways and new language to talk about how we understand psychological difficulties and how to treat them. The work of Carol Gilligan and her colleagues has further enlightened my understanding over these years (Gilligan, Ward, & Taylor, 1988; Gilligan, Lyons, & Hanmer, 1990; Gilligan, Rogers, & Tolman, 1991).

A Category of patients

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

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

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

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

Formulation of impasse

I would like to summarize briefly how I understand the pattern I have been describing, in the context of a relational perspective. How did it happen that these women, who presented so positively to the therapist at the outset and appeared so motivated and responsive, began to look more and more harmed than helped during the course of the therapeutic process? I believe that these patients’ style of interacting in the beginning of therapy was a form of role play, which reflected a strategy to protect themselves against being wounded and violated in this new relationship. These women were, in fact, highly vigilant to the expectations others might have of them and were quite adept at figuring out how to win other’s approval and acceptance. They had developed excellent interpersonal skills that allowed them to give the impression of a higher level of adaptation than they experienced inside; they were very good at hiding their deep feelings of inadequacy, terror and profound distrust of all relationships. Their interpersonal skills concealed from the therapists the extent of their underlying distrust, ultimately leading the patient to feel misunderstood by the therapist and the therapist to feel misled by the patient’s presentation.

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