Therapists’ Authenticity

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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.

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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.

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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