
What Changes in Therapy? Who Changes?

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Abstract

A central component of therapeutic change involves facilitating the capacity to move and be moved by the other. Another way of saying this might be that change entails experiencing a greater freedom of relational movement. The question of who and what actually changes in the process of therapy is the focus of the three vignettes that follow. They highlight, among other things, the recognition and acknowledgment of mutuality as an essential force within the relational matrix and the ever-changing landscape that this creates. Each of these examples of a change process bears, as well, a particular stamp of its own, and thus speaks to the unique personality of every therapeutic dyad.

Introduction

Jean Baker Miller, M.D.

The following papers offer clinical illustrations to suggest answers to the questions: What changes in therapy? Who changes? They formed part of a panel at the Learning from Women Conference sponsored by the Jean Baker Miller Training Institute and the Cambridge Hospital/Harvard Medical School Department of Continuing Medical Education in April, 2002. I introduced this panel by discussing some basic notions about the process of change and the obstacles to it on both the personal and societal levels. These ideas are published in a separate working paper, "How Change Happens" (Working Paper No. 98; Miller, 2002). However, some of the main points are summarized here.

Change is the essence of life. While it is most obvious in children, change is a necessity at all ages. It will happen inevitably. If we are ready to greet it, we can move to growth and joy; if not, we may encounter pain and trouble. Change toward growth creates pleasure; we feel most alive and zestful when we are moving in this expanding activity.

Growthful change usually occurs in interaction with others. People do not grow alone. According to Relational-Cultural Theory (RCT), change requires the ability to take in new experience occurring in these interactions and to construct new *relational images* (RIs). We have defined RIs as those inner constructions that we each create, often without awareness, out of our experience in relationships (Miller & Stiver, 1997). Beginning early in life we elaborate and complicate our RIs repeatedly. These images define what we expect will happen in relationships and also the meaning of this experience for our total selves, e.g., if we have had relationships that make us feel valuable, we carry over this meaning to make us feel worthy and confident in most realms

of life such as school, work, and the like.

We probably compare new experience to the RIs we've created to date. If our RIs are relatively flexible as well as rich and nuanced, we then modify them. If they have been reinforced restrictively and repeatedly—and with strong emotional threat or harm, especially with psychological isolation—we may build more rigid RIs. These will be much harder to change.

Among other concepts about change in RCT are the *central relational paradox* (CRP) and *strategies of disconnection* (SDs; Miller & Stiver, 1997). The CRP states that people yearn to participate in connections with others but to the extent that their relationships have been unresponsive and/or hurtful, they will keep important parts of themselves out of connection—those parts that they believe are impossible to bring into relationship. SDs represent the many, varied ways we all develop to keep out of connection. The vignettes described in this paper illustrate these concepts and others.

To consider influences on change, we have to look at the societal context. Patricia Hill Collins (2000), an African American sociologist, has written of *controlling images* (CIs) imposed on African American women, which Maureen Walker discussed in a recent paper (Walker & Miller, 2000). I believe this concept provides a valuable link between the social and psychological levels and can be extended to propose that we all live under CIs imposed by the dominant culture. However, CIs are different for each group in society. As we know, social groups are stratified, i.e., white upper-class men, white upper-class women, white middle-class men, and so on. CIs define for each group what is acceptable and what is not, what people can and cannot do. They exert a powerful impact on how we construct relationships, thus they heavily determine the RIs we create.

According to RCT, the most frightening human experience is psychological isolation. If severe, a person usually feels, along with isolation, a sense that she is the person at fault; she cannot be heard or understood; and she is powerless to change the situation. This is the meaning of “condemned isolation” (Miller, 1989). And this is a basic reason that change is so hard. While we may have many accompanying feelings, at bottom we fear that we will be rendered isolated and powerless. We fear altering our CIs, RIs, and SDs—those constructions that we believe we desperately need, that we think protect us from isolation. I believe this threat operates on our attempts to make change on both the societal and the individual psychological level.

The following vignettes sample some of the many

aspects of change in therapy. While RCT offers many guides to therapeutic change, its central tenet is that each therapy will be unique as it evolves out of the particular relationship between patient and therapist. Thus, these illustrations do not provide concrete advice on specific topics. For example, with the person discussed here, Natalie Eldridge discovered that more “active listening” rather than verbal interventions led to more mutual connection. With another person, the opposite may be true. In the third example, Wendy Rosen is responding to a unique situation and would not necessarily be involved in gift giving with another person. As always, the most important feature was the growth of authenticity in connection that emerged out of the interchange around the gift.

All of these papers seek to counter the myth that the therapist is not effected by the therapeutic relationship. She certainly is, but *the purpose of therapy is to help the patient*. The therapist has the responsibility to act so that the relationship moves in a direction that is growth-fostering for the patient. In doing so and in trying to meet the patient at the point of her or his needs, the therapist may grow too.

“Mary”

Natalie S. Eldridge, Ph.D.

Mary entered therapy in her early 30's to deal primarily with the task of coming out as a lesbian to her parents in the Midwest. She had moved to Boston about six months before in order to live with her current partner, Susan, with whom she had maintained a long-distance relationship for years. She described her history since graduating high school as one of distancing herself from her small-town roots and developing an urban lifestyle very foreign to her parents' experiences. While in a previous therapy in another city, she had come out to herself as a lesbian, but she kept this aspect of herself compartmentalized and hidden from her family. She did share her friendships and her work successes easily with them. This process of compartmentalizing actively reinforced her relational image that she maintained connection with others by not causing trouble and by being the adored little girl who is “bright, good, and nice.” However, coming out to her parents had moved to the front burner for Mary in response to her deep commitment in her current relationship and her desire to share her happiness and success in love with her family. Her significant anxiety about the possible consequences of coming out to her family reflected the