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Challenges to Connection

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Challenges to Connection

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Abstract

Exploration of patterns of disconnection and transforming reconnection is central to therapy. Therapists must be especially aware of their own contributions to disconnection; defensiveness, imposition of control rather than empathic responsiveness, overreliance on individualistic models often lead to disconnection on the part of the therapist. Patterns of violence and trauma in the culture create a context of disconnection for both therapists and clients.

Challenges to connection are challenges to mutuality. What are the forces—intrapsychic, interpersonal, and societal—which threaten the flow of mutuality? Empathic and relational failures are inevitable; movement in and out of mutual connection is the norm, not the exception. It is only when people become rigidly stuck in relational patterns which limit growth and cause pain that we worry about the failure of mutuality and relational resilience.

Power, dominance, entitlement

In order to create mutuality, we must be open to influence, to being emotionally "moved," to being vulnerable (Jordan, 1986). All too often people move into illusions of self-sufficiency, control and power dynamics to manage the inevitable and often frightening experiences of vulnerability and uncertainty in life.

Denial of vulnerability and movement into a power/control mode can lead to a relational pattern of entitlement, self-preoccupation, and failure of empathy in one person and accommodation, compliance, and silencing in the other. While giving the appearance of connection, inauthenticity and a deep sense of disconnection prevail (Miller, 1988; Miller & Stiver, 1991; Stiver, 1990). At its extreme, we see this pattern in many abusive relationships—particularly in trauma and sexual abuse of children: a powerful person violates a vulnerable, dependent child and silences the child's experience with physical or psychological threats. Furthermore, there is a pernicious combination of denial and blame. The crazy-making message from adult to child is: this *isn't* happening, and *you* caused it! Only the adult's needs are honored. The needs of the child for love and protection from a responsible and concerned grown-up are ignored. At the core of trauma is isolation,

helplessness, and powerlessness. Judy Herman has noted "traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system for self-defense becomes overwhelmed and disorganized" (1992, p. 35).

Society, power, and gender

Unfortunately, patterns of entitlement and accommodation, carried to their extreme in trauma, form the core of much of our normative gender socialization, particularly in adolescence. Alfred Adler wrote in 1914, "male domination is the severest illness of our social organism" (Griscom, 1992).

Hilary Lips, writing on women and power, suggests that our cultural conditioning tells us "women are supposed to defer to men, to be nice rather than tough, to be supporters rather than leaders" (1991, p. 10). In adolescence there is massive pressure for girls to accommodate and to accept others' definitions of reality, particularly around sexuality, anger, and power. A girl's experience of her body and sexuality is typically subordinated to the boy's needs; the imperative of male sexual entitlement warps a boy's experiences at the same time that it objectifies the girl (Jordan, 1987). Simultaneously, girls become very vulnerable to shame in adolescence; women typically are most ashamed about physical attractiveness and failure in interpersonal relationships, areas over which they may have little real control (Lewis, 1992). And unlike men, who become angry when ashamed, women become depressed and disempowered.

Self-blame and isolation

While subordination can be created with direct exercise of violence, as in abuse and battering, it is also more insidiously enforced with shaming and creation of pervasive images of "the good woman," who, in Virginia Woolf's terms, is "intensely sympathetic . . . immensely charming and utterly unselfish" (Quoted in Heyn, 1992, p. 145). The subordinate is then shamed when she doesn't match the cultural ideals of gender appropriate behavior. Shame disempowers people; it severs trust in the self and others. It leads one to a painful place of isolation, where one feels there is no possibility of empathic response from another person. In shame and self-blame one cannot mobilize the relational resilience necessary to move painful disconnection into transformative connection.

Patterns of resilience in therapy

An abusing family and a traumatizing society share a destructive pattern of violating vulnerability and actively silencing and moving people into a place of shame, immobilization, and isolation. Denial of this pattern is also rampant. Finding empathic possibility where none existed before is the single most important step in moving out of the silence and separation of shame and trauma.

In therapy that provides a context of respect and safety, the client can begin to look at these patterns of disconnection and at the failures of mutuality, and reestablish movement back into connection. The rigidities of relational and self-images begin to shift. An important path toward this larger movement is through exploration of patterns of isolation, stuckness, and nonmovement in the therapy relationship itself. We need to learn particularly from those moments when there are shifts toward and away from connection. I try to be especially sensitive to what Jean Baker Miller (1988) calls "condemned isolation"—powerlessness, shame, and self-blame—in both the person I work with *and* myself. This is part of moving toward an ethic of mutuality suggested by Carter Heyward, Jan Surrey, and myself (Heyward, Jordan, & Surrey, 1992). An awareness of, and acknowledgment of, the therapist's movement into disconnection becomes especially important, since in those moments we lessen the opportunity for reconnection through empathic repair; further, with trauma survivors these breaches may evoke a sense of abandonment and retraumatization. As Judy Herman notes "trauma impels people both to withdraw from close relations and to seek them desperately" (1992, p. 56). Irene Stiver has illuminated some of these paths to disconnection in her paper on therapeutic impasses (1992) and Jean Baker Miller (1988) has pointed to a central paradox of connection. Here I will explore briefly several routes to disconnection on the part of the therapist: 1) defensiveness; 2) the failure of a relational perspective, with overreliance on individualistic and intrapsychic models; 3) the intrusion of what I call outside judges or old supervisors; 4) the difficulty of staying present with anger and conflict; and 5) the imposition of control rather than empathic responsiveness. I present these, not as a way to judge, or even eliminate, them but to suggest that if we can compassionately recognize and acknowledge our patterns of disconnection, we can then be more present to work on transforming the

pain. And we lessen the probability that our shame about disconnecting or failing our clients will lead to denial, isolation, and impasse.

Defensiveness in the therapist

Although our training is meant to assist us not to respond defensively, we all carry our own vulnerabilities and wounded places into our work. Thus therapists are sometimes unwitting participants in creating painful disconnections and possible retraumatizations. One common place of difficulty for many therapists is with the ability to recognize and explore the pain produced by our own empathic failures or insensitivity. A young therapist reported a session in which a client, after much anguish about sharing a very painful and personal poem she had written, had given it to the therapist at the end of the session to read before the next session. In the intervening week the therapist completely forgot about the poem. The client walked in and said, "What did you think?" The therapist reported feeling a sense of confusion and then sickness as she realized she had forgotten the poem. She first simply said, "You mean your poem? I haven't gotten to it yet." The client dismissed its importance, and began talking about some event at work about which she had no feelings. The therapist felt more and more awful and disconnected and sensed the client was losing touch with herself and the therapist. Finally, the therapist commented, "You know you said it wasn't that important about my reading the poem, but I think it *was* important and I feel terrible that I let you down." At that, the client broke into tears of deep pain and spoke about her vulnerability in having shared the poem and her hurt that the therapist didn't seem to care about her. This often painstaking, mutual working through of disconnections and reconnections in the therapeutic relationship creates both increased understanding of relational patterns and a more vital, resilient connection.

Failure of relational perspective

The difficulty of holding the tension between connection and disconnection sometimes leads us out of a more relational attitude and into defensive use of concepts like transference, projective identification, and resistance; or we pathologize with diagnoses, overemphasizing the extent to which the problem arises *only* from the client's past experience rather than in the "here and now" relationship with us.

One client I was working with, Susan, was very attuned to variations in the quality of my presence; she could pick up the tiniest nuances in my voice that indicated stress, which to her suggested I would be less present for her. She alternated between vociferous rage at me and silent withdrawal; these reflected both her basic *yearning* for and fear of connection with me. In her withdrawal, I later learned, she became preoccupied with what she might have done to drive me away. In her rage, she was clearly protecting herself from the potential abuse she feared from me when she felt I was disconnected. Initially I tried to direct our understanding to the reasons for her "overreaction" to my levels of stress, using a model of transference which located the source of *our* disconnection only in the abusive relationships of *her* past. I soon learned that Susan felt I was saying *she* was the problem, as her stepfather had done when he viciously assaulted her. Or, she felt I was being defensive like her alcoholic mother who denied she was completely inebriated when there was no doubting it. Often now, when I notice that there is a bit more stress for me and I see her beginning to move into angry withdrawal, I comment, "This is one of those times that you may pick up that I'm a bit more stressed out. You may feel I'm not fully here for you. In the past that has sometimes led to your feeling like something bad or awful in you caused me to move away from you. We need to keep an eye out for that pattern now." Disclosure of my limitations, or personal contribution to certain painful patterns of disconnection between us, has never failed to relieve her or to strengthen our connection. Incidentally, it does not stop her anger . . . she can still be mad at me for not protecting myself and our relationship from these intrusions of outside stress. When I don't admit my part in the interaction, however, she is thrown into the despair of overassumption of blame or the tendency to ragefully see the other as a dangerous perpetrator.

Outside judges

Our capacity for connection may also be tested when the images that we hold of ourselves of being caring, understanding, and helpful therapists are challenged. Furthermore, supervision which is often carried out with an attitude of shaming leaves us especially vulnerable to the actual or imagined judgments that other professionals may make about us.

Several years ago when I was beginning to struggle with the diagnosis of "borderline personality," feeling that it was a potentially hurtful and pejorative diagnosis but still not comfortable with totally rejecting it, I was working with a very intelligent young woman, Betty, who was exquisitely sensitive to the not so hidden negative implications of this diagnosis. And she had let me know that she had been injured by being called this in the past.

In the beginning of treatment she often found it necessary to cut herself, which sometimes led to trips to the local emergency room. As you can imagine, once there, she was not treated with a great deal of understanding or respect. And the psychiatrists on call were often equally annoyed at me—there was a clearly shaming, blaming tone, an implied question about why I couldn't control my patient better. Early on in this scenario one psychiatrist, in a phone call from the emergency room, said he wanted to confirm her diagnosis, "Clearly borderline, right?" Not wanting to get into all my dilemmas about the diagnosis, and feeling as if my credibility as a good therapist was already on the line so I better at least *act* like I knew my DSMIII-R, I wearily, and probably in some exasperation, said, "Yes." I was unaware that he then turned to Betty, who was in the room, and said, "Borderline, just as I assumed."

Next day Betty came in and said "Did you call me borderline?" I froze. Should I remain silent, or subtly blame the victim by asking "You're afraid I would betray you." For a moment I even considered pretending innocence and blaming the psychiatrist—"He said *that*?!" Finally, I said yes I had. There was a look of hurt and rage as she exploded, "How could you!" I clearly owed her an explanation, and I said that I thought probably I had been frustrated with her and acknowledged that she must feel like I had sided with what she called "those jerks in power" and forsaken her. I added that I thought that was a bad way to express my frustration and that she had a right to feel hurt and angry at me.

While she was initially deeply upset with me for betraying her in that way, she also quieted down more quickly than usual and commented it would have been much worse if I had tried to lie or shift the blame to her in some "slimey" way (one of her favorite words about me early in treatment). Because I did not deny a very painful truth, she felt I was giving her the message that I thought we could handle some difficult things between us, including hurt, anger, and conflict. Retrospectively she also commented that she found my vulnerability in that moment palpable and surprisingly reassuring. She could see that causing *her* pain caused *me* pain. In this moment, we were both quite vulnerable; as therapist I was alert to wanting to protect her (and myself) but at the same time I had to bear the burden of having injured her.

To me this vignette exemplifies one of the primary tasks of therapy: acknowledging, tolerating, and learning from the inevitable tension that arises as we move between connection and disconnection. Viewing the disconnection with interest, rather than with judgment or shame, paradoxically brings both people closer to the possibility of connection. Locating the source of pain brings energy back into the interaction. The things we cannot name and share isolate us. In this situation, we both could have spun out of connection entirely, entrenched in our most closed and shut down places. The difficult task of learning to stay in connection, open to the other in hurt and anger, but also protecting ourselves from injury, is one of the main tasks of development; it is one of the main tasks of therapy.

Another difficulty arises when certain guidelines of treatment are put forward that create conflict for us either because we are given conflicting messages about what constitutes good treatment, or, what we are told is "good treatment" is at variance with our own inner convictions of what is healing. A beginning therapist reported to me that she had had an upsetting session with a client following a meeting on risk management with her outpatient team; at that meeting she felt the message given was that any visible emotional involvement on the part of the therapist constituted a dangerous boundary violation. When she subsequently found herself tearing up as her client began to talk about the terminal illness of her adolescent daughter, the therapist could think of nothing but keeping herself from crying. She could barely hear what the client was saying and felt totally unable to connect or be helpful. This was completely at odds with what had been a responsive, mutual interaction between this therapist and client in previous sessions. The client canceled the following appointment and fell into a deep depression, feeling she was being too self-pitying in her preoccupation with her daughter's illness. The therapist felt anxious and incompetent and blamed herself for being too emotional; in the face of the message she had received from her team, she felt she had to learn to be less

expressive and not so torn between her own responsiveness and "good clinical practice." Both people felt isolated and self-blaming. Together the therapist and I explored the appropriateness of her response of sadness and how sharing that, rather than becoming preoccupied with controlling it, might actually have been very affirming and useful for her client. She was then able to take this up with the client in the next session and was able to reestablish the sense of empathy and connection. We all face the larger task, however, of coming to terms with the institutional issues, and the increasingly legalistic tone of some of the risk management literature.

On a lighter note, another beginning therapist reported to me that a patient was speaking about a very painful event in his childhood, and the therapist began to feel tears coming to her eyes. The patient noticed the tears, and probably her discomfort with them, and said "Quick, pinch your nose!" The therapist felt confused and apparently looked puzzled because the patient then went on to say, "You're about to sneeze, right? That's what I do when I'm about to sneeze and I don't want to. I pinch my nose." Later, with this same patient, as he was speaking about being tucked into bed at night by his grandmother, tears again came to the therapist's eyes. This time she was stifling a sneeze, but the patient noted these tears and said, "Oh, you're going to cry. You must have experienced something like this when you were little."

Therapy is about learning—mutual learning. Importantly, it involves becoming aware of our relational patterns and learning how we participate in creating them. The therapist is not *the expert*, a person who once had problems but, who, having gone through her/his own personal therapy or analysis, has it all figured out and is beyond the ordinary suffering of human life. Therapy depends on the capacity of both people to endure a sense of mystery and not knowing, and to hold the tension of vulnerability.

Part of therapy is also about empowerment, helping to create a sense of power and confidence. Much of traditional therapy can be disempowering: fitting people into diagnostic categories, mystifying the role of the therapist, providing hackneyed interpretations, explaining all emotional engagement between therapist and client as manifestations of transference and countertransference. I was thinking about the term "resistance" used by Freud and now by Carol Gilligan. In typical therapy, resistance suggests that the therapist is the one who knows what the patient needs to talk about and address; in Gilligan's notion, political resistance indicates the importance of the individual retaining her or his own knowledge of relationship and the world, rather than surrendering that power to another person or process (Brown & Gilligan, 1992). In relational therapy we explore self-with-other.

Difficulty staying present with anger

Therapists need to be respectful of the difficult way that truth is often kept alive. For instance, the self mutilation of the abuse survivor, which we find so difficult to deal with, may be a powerful exercise of resistance to being silenced. The rage that bursts out may be an effort to communicate and protest against objectification, cruelty, and violence. Therapists need to respect the anger that comes from hurt and seeks justice. At the personal level, we can see how anger helps heal, and we can find ways to bring this into our struggles to stop the patterns of abuse and trauma that the culture encourages and allows.

In therapy, staying in connection around anger is difficult. Beth was a survivor of chronic physical and sexual abuse who came to me after having seen twelve other therapists. Early sessions were filled with painful, angry silences. Sometimes in desperation, my need to do something would get the better of me, and I would suggest that something about this current situation was coming from her past. Inevitably, she experienced this move on my part as assaultive. She would wail loudly, without words, and often call later to say she was going to kill herself. After several months, my failures produced outbursts of rage, rather than silence and suicidality. At best, she screamed at me; at worst she picked up objects in my office that she threatened to hurl. She then progressed to telling me in icy and certain terms that I was torturing her. Now, although we are still struggling with the combination of fury and helplessness, the pain is much less silent and indecipherable than it was. She continues to feel I have let her down more than she thinks a good therapist should, and she lets many people know this. She recently said, "You know I've developed the most incredible sensitivity to violence in my life. And you could say I'm overreactive to the dumb and insensitive things you say sometimes. But they really *do* violate me and you really need to hear that."

Beth's loud protest about violation is *essential* if she is to develop the capacity for real connection with

me. It honors her pain and her right to protest. She learns I can validate and survive her anger. But, perhaps more important, she is learning that we can build a relationship together that can tolerate, and even be strengthened by, an expression of self-protective anger. The courage to be in conflict is fundamental to the development of authenticity and mutuality. Recently she has begun to be curious about the intensity of her reaction to me. And we both are working to understand our parts of the cycles of disconnection/isolation and immobilization. Rather than emphasizing only her overreaction or transference, I must first validate her exquisite sensitivity to my way of distancing and setting up barriers. This validation assists her in her effort to know and name her own current reality, something that she struggles with on a daily basis. Our work is allowing her to transform old relational patterns that led only to isolation and despair. Recently some lightness appeared in her criticism of the quality of my responsiveness when she reminded me of a saying in AA—"take the cotton out of your ears and put it in your mouth."

While the concept of transference is useful to understanding how past relational patterns enter into current relationships, it can be used at times to suggest that the *entire* source of disconnection is in the client and in the past experiences of the client. This interpretation protects the therapist but it can also stop therapists from examining the subtle ways we exercise privilege or power, the ways that we are insensitive, the ways *we* disconnect.

Control versus responsiveness

The client needs to be respected and responded to and not controlled by the therapist. It is particularly important for trauma survivors to feel interpersonally effective and able to have impact on others. Kernberg referred to this as "keeping the therapist under control" (quoted in Herman, 1992, p. 136), which I suspect has more to do with the therapist's need to be in control. Where treaters need to be *in control* rather than *in empathy*, the treatment is often in trouble. This does not mean that limits aren't set regarding what is useful, acceptable, or tolerable in the therapy, but I think that is best done in terms of the therapist stating his or her personal limitations rather than in terms of the so-called boundlessness of the client's needs. Real safety in a relationship of mutual concern and empathy eludes both participants when therapists assume an adversarial stance or move into overcontrol. As another abuse survivor noted: "As I see you learning how to be with me and how to self-correct, I can be less vigilant with you. When I'm vigilant, I feel terribly isolated and I only have an illusion of safety. Like when something goes wrong here in this relationship, I feel like I've been abused again but I also feel it's something about me that produced it . . . something about me that drives people to hurt me or move away from me. When you take responsibility for your part in our difficult times, I don't feel like I'm the problem."

Emotional connection is established through responsiveness, often in sensing the empathic presence of the other person. In mutual empathy we experience ourselves as affecting and being affected by another. When we feel empathy from the other person for our experience, it provides a palpable sense that we influence and emotionally touch the other person. You can see my responsiveness to you, in my eyes, in my face, and hear it in my voice. In empathy I am present, vulnerable, open, responsive, and concerned. This responsiveness goes against the edicts to protect oneself from the impact of another person, part of our cultural overemphasis on separation and control. Crucial to the therapist's engagement is the everpresent effort to take into account, and care about, the way another is going to be affected by what we say or do—a kind of anticipatory empathy or empathic concern. This is at the heart of the therapy exchange.

Therapy is, very importantly, about bearing feelings together and bearing tension together. It is about bringing frightening, shameful affect into connection and finding that someone can be with you as you try to do that. The goal is to shift and transform fixed patterns of isolation, immobilization, and denial. Mutual emotional responsiveness is central to this effort. The therapist is not simply "emoting" with the client, but, in a relationship which is primarily devoted to the client's wellbeing, there must be engagement and "considered responsiveness" on the part of the therapist. This aspect of the relationship allows the client to begin to explore her capacity to move and influence another person as she explores her own inner reality. When, as therapists we relate in a spirit of power and control rather than with empathy and respect, we at best impede this exploration. For those clients who are trauma survivors, we run the greater risk of retraumatizing them.

Social

The context for our work as therapists is that we live in a society where control often manifests itself as violence and in which a disproportionate amount of violence is directed at women by those with whom they are in primary relationships. Those women who speak up about their abuse are blamed; and the culture supports women in their self-blame—what were you doing there, why did you wear that, you must have wanted it, why didn't you leave?

What we saw in the Anita Hill-Clarence Thomas hearings was a replay of what happens each time a woman has risked moving from silence to utterance regarding the ways she has been victimized by the system and by particular men. She was subject to a vigorous effort to discredit her and shame her: she was seen as "sick, delusional, lying, ambitious, a woman scorned, she asked for it, why did she stay?"

Beverly Greene has noted that "traditionally Black women have been blamed for the family ills and stress which are in fact caused by institutional racism" (1990). This is a dynamic that prevails for most nondominant groups (Coll, Cook-Nobles, & Surrey, 1993). To individualize and pathologize problems of the nondominant group lessens the probability that the necessary social change will occur. For women, for people of color, for lesbians and gays, for most marginalized groups, we must assume that the dominant culture implicitly endorses some violation of our vulnerability and has some investment in our isolation from one another. We *are* to be silenced.

This culture gives many signals that women are not safe, on the street, in their homes, in their primary relationships with men. One million eight hundred thousand husbands in the United States batter their wives; every day four women in this country die of being beaten (French, 1992; *Time*, January 18, 1993). When questioned about what each sex feared most in the other, women responded, "that a man would kill them." Men responding to the same question said: "a woman might laugh at them" (Heyn, 1992, p. 238). Twenty-two to thirty-five percent of all visits by females to emergency rooms are for injuries from domestic assaults. Battering women during pregnancy causes more birth defects than all the diseases put together for which children are usually immunized (*Time*, January 18,1993).

Carolyn Ramsey, executive director of the Massachusetts Coalition for Battered Women Service Groups, herself a former victim of battering, stated in the *Boston Globe*, March 7, 1993, "Domestic violence boils down to control, controlling a person's behavior through intimidation, assault, ultimately weapons." The article reported that David Adams, executive director of Emerge, a counseling service for batterers, did a study of men who batter and those who do not. "Batterers felt more entitled to sex and more entitled to take their own bad moods out on their wives." In the same article, Christine Butler, director of the Suffolk Battered Women Advocacy Project noted: "Men's sense of entitlement is engrained in society."

The *New York Times* (March 20, 1993) reported on the entitlement of eight high school students in the middle-class suburb of Lakewood, California who were in custody accused of raping or molesting scores of girls as young as ten in a gang competition to accumulate "points" for sexual conquests. Almost more disturbing than these practices was the backlash following the arrests among some residents who essentially argued that "boys will be boys." And the father of one of the arrested boys commented, "Aren't they virile specimens?"

Resistance, as used by Carol Gilligan (Brown & Gilligan, 1992) and Annie Rogers (1993), may be an especially important factor if we posit that this society is functioning in a traumatizing way for many girls and women. Many women's "symptoms," then, may be seen in part as efforts to resist the societal pressures to succumb, to be silent and "nice." They may represent resistance to having one's vulnerability taken advantage of, or resistance to becoming a sexual object. In our therapy, these resistances may show up as difficult challenges to our capacity to stay connected with often defiant, or at best noncompliant, clients who are asking us to be different than we were taught to be in doing therapy. We are invited to be more real and more vulnerable, and more involved than traditional guidelines suggest. These brave women, who are also in real confusion and pain, can sound the alarm to us of what is so wrong with so many families and with so many institutions, including therapy, in our culture. We have to follow the courage of the survivors we are working with and take the risks to change the larger system—the therapy systems and the social systems.

We might wonder if it would be possible to help all girls become bicultural vis à vis a sexist culture in the way that Beverly Greene suggests blacks have learned to exist in both white and black culture (1990). Could we teach girls about sexism the way black

mothers teach their daughters to be savvy about racism, so that they can live as safely as possible in a racist culture?

As therapists we cannot continue to pathologize individual adaptation to socially destructive patterns. Therapy should not become a part of the problem by suggesting that most pathology lies only in the individual and that the solution is therefore directed only at the individual. We should not become a part of the problem by reinforcing the isolation of women from one another. Change must occur at both the personal and social level (Jordan, 1992).

Toward solutions

Women joining with women is one of the most potent forces for social change and healing that I can think of. While it is important that we can come together to share common pain and support one another, it is also important that we share new visions and become part of a larger movement for social change and respect. When the *political* is *personalized*, what lies at the heart of trauma is never dealt with; this includes sexism, racism, heterosexism, classism, and acceptance of dominance and power as legitimate interpersonal strategies. We come together not just as victims or healers but as people who are *moved* by experiences of abuse and vulnerability to transform these abuses in individuals and the culture at large.

In order to move in relationship, at a personal and social level, we must be able to change not just ourselves but the relationships that we engage in (Jordan, Kaplan, Miller, Stiver, Surrey, 1991; Surrey, 1984). As Jean Baker Miller has noted, if we cannot change relationships women will "twist themselves to be acceptable in unacceptable relationships" (1988). There is a danger that therapy which only attends to the intrapsychic will abandon women on that twisted path. There is a danger that pathologizing women's relational commitment as "codependency" or "masochism" or "self defeating behavior" serves a similarly pathologizing and disempowering function.

Moving out of victimization

While acknowledging the pervasiveness of victimization and trauma for many women, we are not encouraging the adoption of a victim identity where one's pain is validated and one simply lives with it. Rather we are interested in empowering women to move into healthy, mutual connection where victimhood can be transformed. But we must also look at the ways that a system based on male dominance will constantly serve to erode the confidence and movement out of victimhood. One client recalled that her abusive father would *inevitably* punish her with rape whenever she began to feel more "full of herself." Sexual dominance is at the core of rape, battering, and incest.

To move out of being a victim and being victimized, one must feel the presence of validating, encouraging relationships. We must help each other disconnect from destructive relationships and move into good conflict. Violations of relationship lead to anger; we need to help women find ways to use this anger to safely begin to change the violating relationships and structures. It is not easy for women to be in anger; but again this is *not* just an intrapsychic quirk of women. There are many messages in the culture that confuse, demean, and punish our anger. As therapists we can use our own "empathic anger" to push for social change, rather than simply dismiss our reaction as countertransference. Rieker and Carmen note that in treating trauma survivors there is often a turning point when the "rage is experienced not as meaningless but as a response to cruelty" (1986, p. 369). Anger *can* be the first step toward justice.

Adrienne Rich noted in her poem *Hunger*, "until we find each other, we are alone." Finding each other is neither quick nor easy. First we must find our diverse realities and truths; then we must stay open to each other's experiences and to the experiences we create together; and finally we must keep our hearts from closing down when uncertainty and vulnerability loom large. Together we need to forge the courage to be in good conflict, to expect social change, to have our passion and our vision acknowledged. I also believe women do all society a favor by increasingly, vociferously, and even angrily challenging the usefulness and wisdom of an individualistic, competitive ethic that gives too much permission to the abuse and violation of all people. In closing, I turn to the wonderful, resilient wisdom of Audre Lorde who said: "My anger has meant pain to me but it has also meant survival, and before I give it up I'm going to be sure that there is something at least as powerful to replace it on the road to clarity" (from *Sister Outsider*, quoted in Behar, R., 1993).

Discussion Summary

After each colloquium lecture, a discussion session is held. Selected portions are summarized here. In this session

Drs. Cynthia Garcia Coll, Natalie Eldridge, Jean Baker Miller, Irene Stiver, and Janet Surrey joined Dr. Jordan in leading the discussion.

Miller: Are you saying that in therapy whenever there are disconnections there's a high probability that the patient will believe it's her fault, especially if she's a patient who has been abused? And further, that the path is for the therapist to first of all engage with the disconnection, to speak of the disconnection, and then to search together for what's involved in it?

Jordan: I think there are two steps: one is the naming and acknowledging of the disconnection; and the other is the assumption of joint responsibility as well as a joint engagement in looking for the reasons for it. If you think about traditional therapy, the disconnection is either not addressed or it becomes part of a backdrop of the already existing disconnections of silence and neutrality. I think that often leaves many clients in a place of tremendous isolation where they can't work on and understand the realistic piece they may have contributed to the disconnection. Nor can they see the part the other person has played. It's a very disempowering process ordinarily.

Question: In the age of managed care, I was wondering what kinds of dialogues have been going on with you folks . . . about the limitations and maybe even some positive things. What I'm hearing is that you see therapy as happening through engagement and ongoing relationship, and I was wondering if you have any thoughts about shorter therapies.

Jordan: It's a really important question and it's one that's coming up increasingly. I think as a community we need to take some action in terms of educating the providers and consumers. We need to try to stop some of the ways we are being managed and our clinical judgment is being preempted. I worry a lot about the effects of managed care. To take a more positive stance, it's possible that some of this could serve as a push for us to think creatively about ways we can use some of our models of relational engagement in a shorter therapy. We traditionally think of a relational approach as being more long-term, and certainly with trauma survivors I can't imagine how we can really shorten that process. But I do think we partly need to take it as a challenge.

Stiver: Managed care often gets in the way of the relationship because the therapist can spend much time and effort on if rather than on listening to the client. Often the therapist worries so much about whether the therapy can proceed that she distances from the patient. I've seen that happen. I've experienced that preoccupation myself. And although the client may be preoccupied also, it's often misunderstood. I have seen some major impasses develop because this has not been acknowledged as a problem. The therapist feels she is trying to do her best to try to advocate for the client, yet, at the same time, the focus is away from the relationship and the issues at hand. It's important to remind ourselves all the time about the impact this issue has on the work we do. And again, I think it's important to name it wherever possible and talk very forthrightly about it.

Question: I'm wondering what your opinion is of the false memory syndrome and about the increasing frequency with which children's testimony about sexual abuse is being discounted in the courts on the grounds that it was erroneously obtained by the interviewers by leading questions, etc.

Stiver: I think it's an issue that we are all responding to. It is very much a reflection of a serious backlash in response to the enormous recognition of the prevalence, of epidemic proportions, of sexual abuse. Having started out as an experimental psychologist I know the difference between contrived situations which test for something and what we're talking about in real life. Those of us who sit with people who talk about their abuse know in the deepest way possible the truth of that experience. These researchers have discovered in the laboratory that you can make suggestions to people that influence their memory. I'm sure that you can, but I don't think it's relevant at all to the issue at hand.

Surrey: I would speak to the whole phenomena of the telling and the believing and the speaking about abuse that's going on right now. I agree that we are going to see a lot of backlash to that. Part of the false memory syndrome movement is about support groups for families and parents. It's also about these therapists who are supposedly putting terrible ideas in family members' heads. There can be other difficulties. I certainly hear of people coming in saying they've been told they are abused because they have all the symptoms of abuse. That feels very painful to me. There are some therapists' wrong practices we need to learn about.

On the other hand I feel that we are trying to come to terms with our own histories. All of us have to search out our own histories. It's a collective

process—a collective revolution. I don't think of it as hysteria or contagion or anything. I think of it as a collective process of trying to remember and trying to put this into place. And we have to see it as beyond the individual. We're all engaged in this revolution.

Jordan: One of the most troubling things about "the false memory" movement is that it puts real victims into a position of being doubted and shamed. Only now are women coming out of the silence that has been imposed on abuse for hundreds of years. And even now we know that with rape, with therapist abuse of patients, with all forms of abuse, the percentage of victims who come forward to speak about it is tiny. A very small percentage of rapes are reported and only two to four percent ever are successfully prosecuted; it is the same with therapist abuse. It seems to me that suggesting that there are all these false claims of abuse really serves to silence people. Even if there isn't a clear intention to do that, the effect will be to push women back into shame and back into silence. And that is tremendously troubling. This cycle of silencing has happened before. The victims are inevitably injured by it.

Question: What can we all do as therapists or incest survivors or friends or family? What can we do so that this backlash does not push us all back into the silence and isolation?

Stiver: Bringing it up in public places every time we can is important. When the Carole Tavris article on this topic appeared in the *New York Times Book Review*, it was amazing the letters that poured out reflecting the outrage that all of us feel; they published just a few of them. And I think we have to work very hard not to be silenced. At every opportunity—at workshops, doing the work we do, supporting the people that we see—we absolutely do not back down. We need each other. You never can fight alone. Join with each other and constantly be speaking about it, and do even more social activism—more systematic social activism.

Question: I hear you reformulating the paradox that Jean Baker Miller and Carol Gilligan talk about, that if you stay in relationship with the institution you work for and the supervisors who tell you how to do it, you have to step out of relationship with your clients. And that if you stay in relationship with your clients, with them empathically, you have to develop resistance to the institution. I'd like to hear about practical ways that you do that resistance yourself.

Jordan: I personally do it by having the support and input of valued and respected colleagues, people who share a certain understanding of what is healing in therapy. I think that you are pointing to something very important and very troubling. It's not that we're always at odds with the mainstream guidelines of therapy or with our particular institutions, but we sometimes do take a stance that is different from them and that places us in some position of vulnerability. Therapy is not built on one scientific, proven technique for helping people. As professionals, it becomes terrifically important to feel that you're sharing the work you do with other respected colleagues and professionals who are also trying to move the edge of psychotherapy so that it meets the needs of the people we're working with. We do not want to get mired in serving the legalistically defensive needs of the profession and the institutions. But you can't do it alone.

Stiver: On a slightly positive note, I do think the toothpaste is out of the tube. Judy Herman talks about cycles; before this backlash she was hopeful that there was such a recognition of abuse that we couldn't possibly get silenced again. She writes it as a hope. I still think it looks that way. It's just so prevalent; to push it under the carpet is no longer possible. The other thing that Judy Herman talks about is that those people who are victims of abuse often heal through being socially active, through resistance, and through fighting the system. I think that groundswell can make an enormous difference; through people speaking the truth about their experiences and becoming activist as part of their own healing and contribution. We as professionals have the responsibility as well of raising consciousness of what's going on and what the dangers are.

Question: I've noticed over the years that you've pointed to examples from your own practices. Would it be helpful if people in your audiences also supplied you with examples of some of the material you're discussing?

Jordan: If you're providing an example of someone else, you'd have to get her permission. But if it's your own experience, we would be interested. Thank you for the thought.

Miller: It would be very helpful. Just send them to the Stone Center. The permission to use them is essential. Thank you for thinking of that.

Question: This question is about social activism. What is a way to get moving? There is often a lack of interest that I think is resistance. What's a way to take

the step from a group that's aware but not vocal, to a more vocal aspect. How do you get past the apathy?

Eldridge: Resistance from a system can intimidate us but it also creates a lot of opportunity for creativity and underground organizing. Another thought that comes to mind is that there are often more public issues that can rally the voices of your group—for instance, talking about the debate about false memories or the prevalence of sexual abuse. I know in my workplace the Bean-Bayog case raised a lot of consciousness because people who were really concerned about that case brought it up and kept talking about it. Sometimes it's easier to bring a public issue in to get at the dynamics in your workplace or your group.

Coll: The way I think about it is if it's a woman's issue, it's everybody's issue. In thinking about health care reform, a lot of the decision making about healthcare utilization is made by women. It was interesting when we had the ecological summit. Much of the discussion of ecological problems came down to women's fertility issues, women's educational opportunities, and related issues. Women's problems become everybody's problems.

Jordan: A part of what you're asking is how to bring women into their voices and into their courage. And I think that happens through a sense of connection and not through a "macho" notion of separate courage and standing up alone. Women become empowered in groups, and women within the group begin to get in touch with their collective courage that allows their voices to come forward. That helps them move toward social action.

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