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The Terribly Hard Part of Relational Psychotherapy

Your Writer Is in Trouble!

I'm ready to write this chapter and I want to write it, but I've been stopped in my tracks by an uncanny turn of events. I find myself in one of those difficult passages I just promised to write about: I'm trying to get through a painful model scene with my therapist. It began two chapters ago, and I was hoping it would be over by now. I don't know how I'll get through it. I'm thinking that maybe this time I will have to leave therapy. More of me thinks not, as I remind myself that I've been through these hard times before and I've come out all right.

That's exactly what this chapter is about—getting through hard times like these. But if I don't know whether I'll get through my own trouble, how can I write the chapter? I tell myself, "Just speak in your therapist's voice." From my therapist's chair, I'm always more confident (though never sure) that a client and I can find a way to work through difficult interpersonal feelings. But to speak in that voice now, I'll have to dissociate from what's going on for me. My writing will be here and I will be elsewhere. I'd rather not enact such falseness in a chapter that's supposed to be about honesty and integration.

So I have decided to begin this chapter from inside my current experience and find out if that can take me to what I need to say to you, my readers. Just now you might be wondering why I'm still in therapy, since I'm an older, experienced therapist. Or maybe you understand that relational therapists are uncommonly committed to becoming as clear as possible about their own organizing principles and relational processes. In any case, let me make a brief case for any therapist being in therapy at any time.

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In the first place, since therapists are ordinary humans to whom painful things can happen, we need as much help as anyone does to work through difficult times. Second, the job demands large reserves of emotional

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presence and resilience, and since therapists can't talk about their work at home or with friends, we often bring the trouble stirred up by our work to our own therapy. In a more personal way than a supervisor or consultant does, a therapist attends to our feelings of confusion, frustration, or depletion.

Third, most of us therapists take up the work because we know something about emotional pain and psychological dissonance from the inside. Many of us were parentified children in troubled families. Emotional attunement is second nature to us, and we thrive on providing the empathy we once longed to receive. But this means, too, that we live somewhere on the continuum of relational trauma, and also, then, on a continuum of dissociation. A good connection with a therapist can keep us in touch with what we feel, essential connectedness that enhances our daily lives and keeps us grounded in the face of all the emotional complications of doing relational therapy.

And finally, of course, we therapists are in therapy when we still feel bad from the inside. In the business of helping others feel better, we are perhaps more optimistic than some about our own chances of being helped. We believe in the process, and so we keep trying.

For all of these reasons, I have been in several different rounds of therapy over the course of my career as a therapist. The only reason good enough to keep me in this current therapy is the hope of feeling better because of it. I doubt anyone stays with the terribly hard part of relational therapy unless it's to try to accomplish something worth the risk. That's my purpose in my current therapy. Now I will tell you what's happening there.

The Story behind the Trouble

Not long ago, after completing the opening chapters of this book, I was beginning to feel quite excited about writing it and I said so in a session. My therapist not only empathized with my feelings, he also seemed to think that the book was a valuable project that could make a worthwhile contribution to our shared field of work. He seemed genuinely interested. A few sessions later, I brought him a photocopied draft of the first two chapters of the book. He thanked me and told me that it might be a while before he had a chance to read them. My heart sank. After I left the session I knew that I had to get those chapters back—to undo my asking as soon as possible.

I got my chapters returned to me, unread, at the beginning of the next

I got my chapters returned to me, unread, at the beginning of the next session. Then I began to try to talk about what had happened. A model scene was clear to me. I had dared to hope that my analyst's interest in my

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work was genuine and that he shared my excitement about it. But in his response I'd heard no excitement, only polite self-protection, with maybe a subtle tone that my request was a burden. Then I was filled with shame for having asked. I knew at once that I had asked for far too much; the only time he owed me, of course, was paid-for time in session. I had made a terrible and humiliating mistake. It was as if I had been caught asking him to put a childish drawing of mine on his fridge.

I tried to say all this, but his silent listening felt like a cold, critical void. I ran stuck and fell silent myself. I hated having to talk to him about what I felt; it completed my humiliation. I told him, "Shame is like a burn, a bad burn. And talking about it is like having to strip the dead skin away so that it can heal." I wanted him at least to hear how horrible I felt. I felt flattened and grief-stricken, though I didn't know what I had lost.

In the first days after this rupture, I went for long walks, trying to calm myself. Slowly I did grow calmer, and I began to get my feet under me. My equilibrium returned as I was able to think that I didn't need his approval. I didn't need him to share my excitement. My book was an adult project in the real world, and what mattered was to do it well and find a publisher. I would do that. He would never hear about the book again until it was a finished project. Or, if it turned out to be a failed project, he would never hear about it again—period. I could feel myself gathering up my angry humiliation and using it as fuel to keep my project going and thus to keep myself going. Indeed, that was the move I had been making from the very moment when I knew, "I have to get those chapters back."

I know that from the outside my feelings look like a huge overreaction to my therapist's expectable, reasonable response to my request. That in itself is embarrassing. But those feelings may be more understandable if I provide some background that explains why this simple interchange was actually a potent model scene for me.

My father was a theologian in a religious tradition that did not allow women to be leaders or thinkers. This might not have mattered a lot to me, except that as his oldest child, I identified with him and couldn't help but want to follow in his footsteps. Ours was a complicated relationship, because there was also deep trouble in his personal relationships with women, especially the women he loved. And so I tried to find a place with him as a pseudo-son. I learned from him how to hammer a nail, paint a room, drive a mowing tractor, shoot a rifle, and pitch a tent in the rain. I developed, during the years of listening to his preaching, a passion of my own to put words together in ways that would make people think. But I was never invited into my father's study.

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In my second year of university, I wrote my first philosophy paper, and I brought it home to him in hopes that he would read it. He never

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mentioned it again to me. Weeks later I found it lying crumpled behind the couch. As I understand my own history and how it stays with me, that philosophy-paper model scene is itself a condensation of many earlier experiences that convinced me that what I felt and had to say as my own person didn't matter much to my father. What did matter was whatever he wanted me to think, feel, say, and do. He was easily troubled, easily angered, and I learned very young to do whatever I could to keep him happy. I also learned that I should never ask for too much from him—or from anyone. In fact, I shouldn't really ask for anything; I should always just be grateful for what I had been given.

And now, as an adult with that history, I have chosen to be in therapy with a man who is not just my senior but also a psychiatrist trained as an analyst. This puts him well "above" me, for although I work as a psychotherapist, I am a social worker by profession—one of the feminized professions well down in a mental health hierarchy dominated by mostly male psychiatrists. In my professional life, I have lived in the shadow of the tall towers of psychoanalysis, but I have been barred from the castle. Or so it seems sometimes. As an academic, I have written about psychoanalysis, but I am outside the fraternity, I believe, and always will be. And part of that is by choice, because I don't want "them" to own me. I want to think and speak for myself. Yet my complicated interest in psychoanalysis is like tilting at windmills, or so my organizing principles say. It will amount to nothing. I could just as well have tried to be a woman theologian trying to speak my truth in my father's patriarchal religious tradition. (Or I could just as well have tried, as a very small child, to resist his powerful need to control my feelings and shape my being in ways that would mirror him.)

This was the fraught relational context in which I became brave enough to talk to my analyst about my own place in the world of relational psychotherapy. After countless tests of his empathy, including careful repairs of previous misunderstandings and ruptures in our relationship, I was secure enough to risk it. I could dare to say to him that maybe what I had to offer was valuable even if it wasn't psychoanalysis, that maybe my writing could say something that was both quintessentially me, in my own voice, and also useful. I had reason to hope that this particular man/psychiatrist/analyst might see that my ways of thinking and feeling, of being and expressing myself, were worth something just as they were. I wanted my *self* to matter in his eyes—and in his feelings, I think.

That's how much was riding on my casual request that he read what I had written about the work we had in common. In retrospect I can see that the situation was far too fraught for my needs simply to be met. The situation

situation was far too fraught for my needs simply to be met. The situation had to shatter—so that I could experience what it was all about. I thought that if only he had responded with just the right degree of enthusiastic

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pleasure when I gave him my writing, then all would have been well, even if he hadn't been able to read it for a while. But that response would have just kept the model scene moving, fraughtness intact, toward some other moment when his response would fall short of my hopes. I doubt he could have kept on being "perfect" enough to protect us from the implosion of shame that happens at the heart of the model scene I am reliving with him. That shame is too large a part of my life experience, with too many trip wires running off in every direction. Furthermore, the situation I set up seems, in retrospect, uncannily calculated to bring the old model scene to life between us. The implosion of shame was hardly an accident. I must have known that I would see some hesitation if I asked him to read a long piece of my writing on his own time and right before his holidays. As I have said to him bitterly since, "I knew better."

Readers might well wonder, "Why did you do it then?" First of all, I didn't knowingly choose to do it. I chose my small action, of course, but I didn't see the large picture with its quality of model scene before I chose, or notice the clues that I might be setting myself up for shame. It seems I was compelled to set up that particular old/new scene and risk the shame. Something drew me, an unchosen "why." I think it was a compelling hope, just out of my awareness, that my therapist's positive response to me would wipe out that whole other system of self-with-other feelings and meanings that had been constricting and tormenting me for years. I believe that I thought, without consciously thinking it, "If I set it all up again and he is the exact and perfect opposite of my father, I can at last be free." There's a powerful logic there, and in fact, in very small, imperfect increments worked out over time, that's exactly how relational psychotherapy makes space for change.

But the model scene in which I don't matter is far too powerful and too thoroughly entangled in my personality to destroy with one blow. I can't vaporize the fraughtness; I need to feel it. As I was saying in the last chapter, integration means to reconnect with the core self-with-other events and feelings that are at the heart of relational trauma. And that's a third answer to the question, "Why did you do it?" I guess I needed to reconnect with a part of myself who has been too painfully humiliated to reach out or to be embraced. I'm not sure I want to know her now or that she wants to be known. For in that split-off relational world where she lives, others have no time or space for her. She feels like nothing, a nobody, to them, and then she feels greedy and disgusting for wanting more. That's the core relational truth at the heart of my model scene, though the scene takes the shape of an effort to change that truth and the inevitable failure of that effort.

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Other scenes are clustered around that relational truth but further from the center and more protective of it. I could mention winning a prize, when

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I was six, for the second highest marks in my class, and my bewildered surprise at my parents' pleasure. And then the penny dropped: "Oh, *this* is how I can matter!" My father didn't read that philosophy paper of mine, but I finished my philosophy major with honors. I can feel myself doing it again, typing away at this project, looking for a publisher, determined to get it done in spite of my therapist.

The last time I saw him I said, "I'm bigger than whether this therapy turns out okay or not. I can leave it if I have to. And it feels really good to say that. My life, my *self*, is bigger than this. You can't destroy me. I will survive. No, I'll do better than survive."

Bravado. But also a way to keep my balance—to keep from falling into that powerful self-with-other fragment of not mattering, that pit of shame. After a lifetime of practice, I do it well. I also know it's only a second-best solution. But it might be all I have, and if so, it's far better than nothing.

I imagine readers wondering, "If you can see all of this so clearly, why aren't you over the shame already? Why do you have to keep playing your game of 'I don't need you'?" To tell you the truth, I don't know for sure. I think it's because I feel all alone in this. I wish insight were the cure. I wish that just the repetition, the powerful experience of "old" feelings surging through me, a catharsis of pain and grief, would release me. I wish there was something I could do to change how I feel. Even writing doesn't help.

Although I can't see my way out, I'm not without hope. My hope is that I won't be alone in this forever. I can't feel that it's happening yet, but maybe if I keep on telling my therapist what I feel, I'll begin to know that he's still there. That would help. And maybe if I'm calmer I'll be able to make those brief, careful visits to that unbearably humiliated little girl and find out that we can survive the contact.

But my feelings go back and forth, up and down. Right now I can't shake the conviction that my therapist is against me. Whatever he says is dangerous; his voice makes me angry and afraid that I'll lose my shaky balance.

Yet I still want to keep on hearing from him. I want the danger to wear off. I want to be able to survive that contact, too, especially the part where my unbearably humiliated self is right there before his eyes.

Right now that's what I can't stand. I want to be very far away.

But I keep coming back, because I believe in the slow, patient work of integration. Surely the feelings will become less intense with each visit to the site of shame. Bit by bit, acknowledged and respected, the danger will diminish. My therapist can't be a parent I never had; he can't even complete one perfect gesture to right a wrong done to me. But he will keep offering many small and imperfect, but consistent and intentional moments of

ing many small and imperfect, but consistent and intentional moments of understanding, and they will help me find my way back to the security of the relationship.

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That's the theory. The problem is that I still can't *feel* that he understands.

But as I've said, I still want to hear from him. I want those moments of understanding again; I miss how they feel. In spite of everything, it must be true that I still trust him, because I'm counting on him to hear, without giving me defenses or explanations, how I hate being with him, how I despise what I feel, and how I wonder whether I can ever trust him again. As the danger wears off, perhaps I'll once again feel his understanding and my trust.

I can say all of this hopefully, but I can't imagine how my next hour of therapy will feel much better.

A Way Through

In fact, after I had written those words of mixed-up feelings and guarded hope, I spent most of the next session locked in a shamed, angry silence. I had made a terrible mess for myself, it seemed, and nothing I could say would help—yet he still waited for me to speak. By now this felt almost like a taunt to me, a mockery of my helplessness: Surely I could do this analysis properly and find what I needed to say! Clearly I was just nursing a childish tantrum! But I couldn't speak these thoughts; I could only retreat further.

Finally, after six sessions, two before and four after a holiday break, my analyst took the initiative to say, "I think it might help if we went back and talked about what happened." I wondered why he had waited so long to intervene, to say something. But I remembered my angry, scared reactions to any words from him in the very first sessions after the rupture; perhaps he'd just been waiting for time to ease things a bit. I could also imagine that he had been offering his silence as open, nonintrusive acceptance while I was experiencing it as cold disconnection and a taunt.

By this time I couldn't go directly back to talk about what happened. First I needed to say what was silencing me now: "I feel stupid about not being able to talk because it's like I got myself into this trouble and I should be able to get myself out. But I can't."

He said it made sense to him that I couldn't talk: "It's clear to you, partly because of what your history tells you, but also because of things that have happened between us, that I won't listen to you or understand you."

"Yes," I said. "But it's worse than that. You'll be angry and disgusted, too."

"All the more reason, then, that you can't talk!"

Then I felt safe enough say, "What I can't get over is that picture I have of myself asking you to read stuff I've written. It makes me so ashamed

of myself asking you to read stuff I've written. It makes me so ashamed. Because I shouldn't have asked. I was asking you to spend time outside of the time I pay for."

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"Well, first of all," he answered, "this relationship isn't limited in that way. It has its own meanings and feelings, and it stirs up new feelings like wanting something. There's nothing wrong with asking for something extra. You just might get it. It was good to ask—a positive step for you."

This did not feel fine at all, even though I knew what he meant. "No, there has to be something very wrong about wanting and asking because of how I feel afterward. Asking makes me feel that there's something really wrong with me."

"Then there must have been something in my response to your asking that made it go wrong for you," he suggested.

"When you said you wouldn't be able to get around to it for a while, then it seemed that it was a burden and a chore, and I shouldn't have asked."

He noted the irony that in trying to prevent my disappointment about a delay in his reading, he had disappointed me much more deeply. He asked what kind of response would have been more what I needed. I had thought about that. "If only you had been *excited* to get it, like I was *excited* to give it to you—then I don't think it would have mattered how long it took you to read it." But I told him the rest of my thought, too: that the situation was just too fraught and probably had to shatter, sooner or later.

He disagreed about the situation having to shatter. Was he just trying to keep me from still making it my own fault? Someday, in another kind of space, I'll ask him whether my concept of "fraughtness" makes sense to him, whether he agrees that sometimes what's being worked out between two people is so loaded with disowned stuff from the past that it *needs* to "go wrong" and break open—so that the disowned stuff comes clear and new integrations can start to happen.

Now that we were talking, I could tell him how I was using my humiliated anger to fuel both my writing and my determination to get my work published in the real world. "That's a good plan," he said. "But there's just one wrinkle in it. When you come in here, you still feel bad about yourself."

"Exactly!" I thought. "So how *will* I feel better about myself? Not until we work this thing out between us!" That didn't seem impossible anymore, but I still had my doubts. Remembering the intensity of my reactions still made me flinch with shame. His long silence had made the shame worse, and somehow that silence had felt intentionally shaming.

I began the next session by asking him why he had waited so long to suggest that we talk about what happened. I told him my idea of why: that in his mind the best way to do analysis is for the patient (me) to do all the associating. The analyst shouldn't have to help the patient. It would be second-best analytic work if I were to be helped—bailed out of my own

second-best analytic work if I were to be helped—bailed out of my own mess, as it were. I should be able to get myself out of it. (This isn't what I believe about my own work with clients, but insofar as analysis is somehow

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different from "ordinary" therapy, perhaps this would be part of the difference: "No being helped!") As I spun out this theory, I could see how it echoed the basic model scene: In the given nature of things, I'm inferior to him (in this case as an ordinary therapist is inferior to an analyst); if he thinks of me, it's with some kind of disgust or derision; and my best efforts won't change what he thinks.

He heard me out and then asked if I'd be interested to know the real reason why he waited so long to suggest that we talk about what had happened. Yes, indeed, I was interested! "I really thought you would never want to go back to it again," he said. "I thought it was so painful, you wouldn't want to touch it."

I was stunned. How could he think that? Didn't he know me better than that? Don't I always try to talk about hard things? As I reminded him at once, in my family of origin nothing can ever be talked about, and that's just horrible. Feelings build, tension mounts, nerves fray, and even if it all goes underground, there's no chance of easy, friendly closeness. Against that background, for someone to say calmly, "I wonder if we could talk about what happened," is an amazing relief. How could he not know that? He didn't answer that question, and it still puzzles me. Maybe he was operating from organizing principles very different from mine. But it was enough that he gave me a reason for his silence. Our difference may be puzzling, but once spoken it's not such a threat. We can move ahead anyway.

Moving ahead, I needed to tell him that I had begun to write the two of us into Chapter 5, and that I might just keep us in the book. I felt that if I didn't talk to him about it, the writing would become a secret, silent presence in our work together, and I didn't want that. "And if you're very good and ask nicely," I added, gently mocking both of us, "someday I might let you read what I've written about you." I quickly admitted that this was a sly way to draw attention to unresolved trouble between us. "I'm sure that I will never again ask you to read something that I've written!"

"You'd have to be completely convinced that I was interested and wanted to read it before you could ask."

"That's right," I said. "And I really can't imagine that happening."

"But you're playing with the idea," he replied. "With that bit about if I'm good and ask nicely." I had to grant him that, and I was glad he understood my playing.

When I looked about for other unresolved bits to talk about, I expected to find the shame I had felt about the intensity of my reactions and feelings. But it was gone. Had it vanished once I knew that his silence hadn't been to shame me? All I could know for sure was that in this calmer, more

been to shame me? All I could know for sure was that in this calmer, more connected self-state, I found myself satisfied with the way I had seen our relational trouble through. "It's like when I play a sport," I said. "I always

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play hard; I want to do it the best I can. That's how I feel about this therapy: I like that I do it hard. I like that about myself."

Suddenly I had a brief vision: a little blue book in my hand and then in my therapist's hand. I knew what it was. "It was my book, all finished and published," I told him. "If it got that far, then you might look at it; then it would be important enough to matter."

"I'd be willing to watch you score goals but not watch you play."

"Right. And you sure wouldn't want to watch me practice!"

He laughed, and in that moment I liked the feeling between us. Then the session was over.[1]

Comments

Six relational theorists could have six quite different opinions about what happened between my therapist and me. I'm in no position to make a final statement. I'm including the story in this chapter because it illustrates some important points I want to make about how to understand and manage those times when therapy feels relationally terrible to your client and also, then, to you.

First of all, although I was able to stay in therapy, my strong, consistent feelings were: "I hate how I feel; I hate what you're doing to me (even if you don't mean to); this relationship is hopeless; I'm bitterly angry, and I want out!" I want you to know that I truly could not see my way through. As a relational therapist, you need to understand that such intense hopelessness, rage, and despair can be held within a constructive therapeutic process. Those feelings can all be completely true for your client—and yet not the end of things.

If you can know this with relative calm, you will provide fundamental safety and security for your client, even as she despairs and rages at you. Your quiet confidence in the process of working things out between you will probably help her decide to stay with the process rather than leave it precipitously. Although leaving might promise quick relief, she may also sense that it wouldn't be good for her to end therapy with one more retraumatizing experience of a painful model scene. Intuiting that these are the stakes for her, she needs you to trust the process on her behalf when she can't.

Second, I want to emphasize that a difficult time like this is only part of a much larger process of relational therapy. I wouldn't have gotten through it—or even dared to get into it—without having spent a long while developing a relatively secure and resilient relationship with my therapist.

developing a relatively secure and resilient relationship with my therapist. I expect that the benefits of getting through it will emerge only slowly in our ongoing relationship now that the crisis has passed.

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Although working through these kinds of relational ruptures can be a very important part of the larger therapy process, I'm not suggesting that it's the most important or most powerful work to do in therapy. Most relational psychoanalysts, including self psychologists, would say that working through breaks and impasses is crucial if change is to happen in therapy. It seems that feminist self-in-relation theorists would make these repetitions of negative experience secondary to developing healthier, more positive self-with-other patterns in therapy. I lean toward the former position: these negative self-with-other model scenes are invaluable when they play themselves out so strongly because they make plain exactly what's getting in the way of healthier, happier relationship. When they appear, they make possible the conscious integration of previously dissociated feelings and meanings. This process clears the way for developing more positive self-with-other patterns.

But in the end, the point about the therapeutic value of relational ruptures may be moot. Nobody, neither client nor therapist, would ever intentionally instigate them. They just happen sometimes. Then, whether a certain client's therapy is rife with relational turmoil or it happens only rarely and quietly, it's crucial to her entire therapy project that the two of you find a way to deal with the trouble honestly and thoroughly every time it comes up.

And finally, I want to make it clear that dealing honestly with relational trouble and thereby getting to the other side of a negative model scene doesn't all by itself "fix" anything. I imposed an arbitrary ending on my own story because it didn't tie itself up neatly; nothing was finished or fixed for good. I know I will never again ask my therapist to read something I have written—at least not on his own time. What about that happy ending, then, where I finally give him my writing, he likes it, and I am never again afraid or ashamed? If I can't have that, what was the point of going through all that angst?

The point is that something has changed and is changing. The connection between my therapist and myself fells lighter and less fraught than it was before. What happened? I reconnected (unwillingly!) with a tightly wound bundle of humiliated feelings, and I did so (hating every minute of it!) in the presence of someone who offered steady patience and understanding. I survived to tell the tale. I can talk about wanting and shame more freely in therapy; it's not such an unspeakable secret. And it's a good bet, I think, that outside of therapy, I won't have to work so hard to avoid situations where shame might break through. Nothing has been fixed; nothing is finished. Instead, new possibilities open up, new chances to be

nothing is finished. Instead, new possibilities open up, new chances to be in the world with more entitlement, ease, and freedom. My happiness is not guaranteed, but I can live with that "ending."

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How Do These Bad Experiences belong to Good Therapy?

It's time, now, to step back a few paces and set my story within a larger context. My telling of it assumes that these relationally hard times belong to good therapy, but I should clarify that they belong only to good *relational* therapy. In some kinds of therapy, relational ruptures cause nothing but trouble. When a mode of therapy carries no mandate to explore and work through the relational dynamics between client and therapist, the work usually stays "cooperative"—played out as a comfortable exchange between the therapist's benign, helpful authority and the client's compliance. In this context, if relational trouble happens, a client probably does well to get out of the therapy. If he stays, he will either bury the trouble, which will sabotage his therapy work, or he'll embark on a struggle to find out whether it's he or his therapist who's doing therapy wrong. That kind of win-lose situation can only replicate a destructive relational model scene for a client, and one which a nonrelational therapy can't turn toward constructive learning.

In short, only a relational perspective makes therapy a safe enough place for working out relational trouble between client and therapist. Let's review the main points of that perspective. First, as a relational therapist, you understand that the bad feelings about himself that a client brings to therapy have their origins in how he experiences himself in relation to others in his life. Second, you expect that as the therapy relationship becomes more significant to your client, these very fears and anxieties will come to life between the two of you. Third, your therapeutic intention is not to change how your client interacts with others, but rather to help him experience the meanings and feelings of his interactions more directly, and always with compassionate understanding for his subjective experience and the dilemmas of his life. You know that his lifelong principles of self-protection will soften only in the warmth of compassionate empathy, and that only then, as his organizing principles slowly change from the inside out, will he start to experience new kinds of connections with others.

But it's this compassionate empathy that, in the therapy relationship, also draws your client into more painful dilemmas than he had ever anticipated. As he spends time with you, he begins to glimpse and desire emotional goods he had long ago given up. He begins to enjoy interested, sympathetic attention, he wants to be known and remembered for exactly who he is, and he longs to matter deeply to someone, to be special. At the very same time he is certain that these wants will be denied or turned against him so that he'll end up even more disappointed and humiliated for

having wanted. He "knows" this will happen because it's a self-with-other experience that has formed his way of being in the world. As he lives on

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this knife-edge of anxiety in therapy, he alternates between careful retreat and daring to try for new experience. As I did, he might dare to ask for something he would never have asked for before.

And then sometimes the worst does happen. The doom falls, just as he knew it would, and he finds himself swamped by helpless rage and bleak despair. The shame he's been dodging and masking out in the world has exploded, full force, in this relationship. The self-loathing voices are loud in his ears, and he takes desperate measures to silence them. Why does the worst happen sometimes? Not because the client brings it on himself, but rather, because you, his therapist, are a human being who doesn't always get exactly what's going on between yourself and your client. On certain days, you might be just tired or distracted, or maybe what your client is talking about is hard for you to hear for reasons that have nothing to do with him. But in any case, you fail to pick up his cues that tell you what he needs right now. And because of the intentional intensity of the therapy situation, this "miss" of yours suddenly stands in for all the misses he's known in his life and all they've meant to him about being "too much" or worthless or forgettable.

Once again I'm suggesting that in the relational therapy situation, there's probably something inevitable about these "misses" and ruptures of understanding that spin you and your client into unwitting replays of painful model scenes. To say they are inevitable is not to say that they are your client's fault or your fault. For the client, the inevitability of being misunderstood isn't due to his neediness or sensitivity; nor is the inevitability of your failure to understand him due to your own unresolved issues. Simply put, misunderstanding belongs to the humanness of the therapist–client exchange. That's not good and it's not bad; it's just life.

Talk of reactivated model scenes and organizing principles suggests that what the client brings to the therapy relationship is what makes it go wrong. But a relational therapist knows that when things go wrong in therapy, *something happened* in the therapy. In my story, though I might still suspect (given my organizing principles) that what happened was that I asked for too much, my therapist insists that "what happened" was set off by his response to my legitimate asking. I was doing fine, he says, feeling stronger, hoping for new things, even daring to ask for them—something like a small child learning to walk on her own. But then, as he puts it, he happened to put a chair in my path. When my particular desire and striving met his particular response, what happened was a rupture in our relationship.

In traditional psychoanalytic psychotherapies, my therapist would be expected to examine his response for signs of "countertransference" feel-

expected to examine his response for signs of "countertransference" feelings that motivated his response to me. The point would be to neutralize those feelings and "clear the field" for my feelings. But in a more relational

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therapy, the point of such self-scrutiny is that he is able to accept his part of what happened between us as inevitable, expectable, or understandable, and to stay engaged in the relationship. This approach to countertransference is counterpart to the redefinition of transference that relational theory proposes.

A Relational Definition of Transference

In traditional psychoanalytic theory, transference is the patient's projection of his own internal conflicts on the blank screen of his therapist's personality. It's a psychic action separate from the countertransference the therapist might counterproject, based on his own unresolved internal conflicts. Each person launches and receives psychic messages and influences from a bastion of isolated individuality. In a relational view, by contrast, when any two people are together, two subjectivities or complex senses of self, with their respective organizing principles, are being elicited and regulated by each other. Each subjectivity is intimately involved in the shape and feel of the relationship and in how each experiences self and other in it.

Therefore, as the relationalist Lewis Aron argues, any analysis of what's going on in therapy must be an analysis of the relationship, not just of one person's contributions to it.[2] "Resistance" to therapy is a client's legitimate self-protection against aspects of the therapist's personality that feel threatening to her. Likewise, her so-called "negative transference" is an interpersonal event—an integral part of all the ways she and her therapist, with their respective organizing principles, mutually construct and regulate their relationship.[3]

From a relational perspective, transference and countertransference are the idiosyncratic ways through which a certain client and therapist attempt a relationship as best they can. As Stephen Mitchell puts it, transference is both contextual and constructed: it's the client's response to particular interpersonal circumstances, and it's produced for a particular purpose. Though it may be based on past experience, the prime purpose of transference is to provide the client a point of entry into this relationship. Likewise, countertransference is the (largely unconscious) form through which the therapist tries to reach the client, using her own experience as a way to enter the client's story.[4]

With this relational perspective in mind, it's clear that when things go wrong in therapy, it doesn't make sense to explain it first of all in terms of what the client is bringing from her past. It makes far more sense for the therapist to ask her client, "What just happened? Where am I misunder-

therapist to ask her client, "What just happened? Where am I misunderstanding you? What did you hear in my response to you?"

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The language of transference applied to such normal interpersonal events serves to remind us of the intentional intensity of the therapeutic relationship, the power it has to hurt or heal. The relational therapist Donna Orange suggests the word *cotransference* as a way both to honor the intense complexities of the therapeutic relationship and also to emphasize that therapists participate with clients in the intersubjective field or "play space" of the therapy conversation. In that space, she says, the organizing activity of the client and the therapist are two faces of the same complex, ongoing dynamic between them. Neither activity needs to carry the negative connotations associated with both transference and countertransference.[5]

As therapists, we all know that sometimes the complex dynamic between client and therapist becomes painful in ways that aren't resolved; the therapy relationship self-destructs. In traditional terms these failures are blamed on unmanageable negative transference: the client's expectations and responses are destructive distortions of reality. More relationally minded traditional therapists admit to a transference–countertransference impasse: They just can't get past their own defensive reactions in the face of impossible demands or relentless anger.

Radically relational theorists have a different perspective. They note that client and therapist are always communicating from different organizations of experience as they try to make sense together. When either person feels threatened by the other's organizing of their mutual experience, protective operations appear. If the client feels misunderstood, pathologized, or demeaned, she may respond by shutting down, "getting worse," or attacking the therapist's competence. Feeling ambushed and helpless, the therapist may try to regain control by "diagnosing" the client's self-protections as resistance, negative transference, or something deeply wrong in the client's psychological makeup.

When a client's feelings are interpreted as a distortion of reality, she has two choices. She can give in and let her reality be wiped away. Or she can fight back—against her therapist's belief about her, her therapist's reality, which is threatening to erase her own reality. This is how the stage is set for a transference–countertransference crisis and a downward spiral toward relational impasse. Each person has to insist on her own organization of experience to prevent being erased by the shaming judgment coming from the other.

Things wouldn't disintegrate so badly, however, if the therapist could recognize the core of experienced, subjective truth within the client's hurt

recognize the core of experienced, subjective truth within the client's hurt and angry feelings. To do so, the therapist has to believe that whatever the

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client feels, it's not a distortion of reality. It *is* reality—the client's real feelings about something that's actually happening right now in the relationship between the two of them.

Of course we don't want to be implicated in our client's distress, especially when we feel, "I didn't do anything! I don't deserve this! *I'm* being misunderstood!" But radically relational theory tells us that we will be surprised at how well things can turn out if we put our own truth on hold long enough to listen for and then believe the truth that our client is telling us.

How Does a Relational Understanding of Transference Help a Client?

What does this relational revision of transference, and especially of negative transference, mean for a client in relational therapy? It means that when he feels you've misunderstood, criticized, belittled, or ignored him, you want to hear about it. He can be confident that "good work" means talking honestly about what he feels in the therapy relationship, even if the feelings are disturbing. It means you'll listen not in order to map his psyche, but because you believe tending well to relationship is essential to anyone's well-being.

A relational revision of negative transference means that it's safe for a client to speak his disgruntled protests, his pointed questions, and his contrary thoughts. "Safe" means that as his therapist you won't blame, shame, or pathologize him for what he feels and says. Instead, you will work with him to find out where the two of you are at odds, paying special attention to where you missed his cues about the kind of response or understanding he needed. If relational ruptures are, indeed, the product of "cotransference," or the interaction of your client's and your own relational organizing principles, then whatever is happening cannot be your client's fault, alone. In fact, it can't be anyone's fault, alone. Any two people can be "organized" so as to miss each other, scare each other, and set each other off in all kinds of unpredictable ways. That's life—in relationship.

What happens to the past in this revision of transference? It doesn't disappear, for as we've seen, the past can be alive and powerful in the present; whatever matters from the past is operative in here-and-now organizing principles. A question remains, though: Do clients need to make conscious links between past and present? Do clients need to understand the historical roots of their side of transference in order

understand the historical roots of their side of transference in order to integrate the dissociated experience it embodies, accept their emotional history, and grieve their losses? Or is it enough that clients have

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an in-depth experience of healthy relationship that reworks destructive relational patterns?

These are important questions, and it's important to answer them in a way that doesn't make us choose between insight and experience (just as we don't have to choose between past and present). We can hold it all together if we track the sequence of processes in relational therapy. In my own story, I wished very hard that just making contact with my humiliated self would be my cure. But the breakdown of the dissociative wall—connecting with the pain of both then and now—could not make me feel better. Reexperiencing trauma, even in the form of negative transference, is not in itself helpful. Integration and healing happen only when the new/old traumatic feelings are understood in a new relationship, and can thus be laid to a better rest.

As a relational therapist, you prepare space for such integration by taking good care of the therapy relationship from the beginning. After a client reconnects with traumatic relational experience in her relationship with you, you concentrate time and energy on understanding her experience and reworking it in depth and detail. Relational therapy knows that the bumps and grinds of life and the therapy relationship will produce plenty of new/old memories, transferences, feelings, and thoughts to integrate, but unless there's a new relational way to be with it all, nothing will change in how a client can feel and think about herself.

In a nutshell, it's good news for your client when "negative transference" is reinterpreted as a process of mutual regulation, or cotransference. It's good news, first, that the trouble she thought was only inside her and coming only from her painful past is actually something that's happening right now between her and her therapist. It's even better news that the trouble that's happening right now isn't just her fault, her distortion of reality: The two of you are doing it together, somehow. But the best news of all is that since you're doing it together, you can probably find a way to understand what you're doing and then do it differently together. That's how your client will be able to get to the other side of painful old model scenes with you. That's how the therapy holds open space for new organizing principles to emerge. That's how insight and experience, past and present, become woven together into a new reality.

In an evolving relational process that sometimes seems to have a life and a mind of its own, relational therapy becomes first a place where a client feels better as she feels understood, then a place where she sometimes feels worse than ever (but finds herself, in the end, still understood), and finally a place where new interpersonal confidence can emerge, along with new

a place where new interpersonal confidence can emerge, along with new insight and self-integration—providing a sturdier, more durable kind of feeling better.

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Hard Times from a Therapist's Perspective

A relational revision of negative transference changes a therapist's job description. You don't get through an impasse by helping your client take responsibility for her feelings and own her projections. But neither is it your job to take responsibility for what happened. The whole notion of taking responsibility shifts when transference is no longer a matter of "your baggage" and "my baggage," but rather a matter of mutually constructed relational dynamics. Now "taking responsibility" looks not like admitting to fault, or even to "baggage," but like keeping yourself honest and open to the other person in the relationship. It's with this sense of response-ability that you can own what you have done in the relationship without feeling defensive and guilty about the effects of your unintentional mistakes and omissions.

In this spirit, you won't shrug off what's happening by putting it on your client or her "transference." You won't try to explain it away by talking about your good intentions. Instead, you will move toward and lean into what's happening. You will do your best to step inside your client's negative experience of you, even "wearing" the hurtful intentions and feelings she attributes to you in order to understand how the relationship feels to her. All the while that the two of you are trying to get through this hard time together, you will keep checking in on her ongoing experience of you.

The therapeutic tasks I've just described add up to a very tall order. This work is not easy. Depending on the nature of the model scene you and your client are enacting, the relational truth you inhabit together can be quite painful. Any of these phrases might capture who you are to a particular client in a given moment:

- You're going to think badly of me for what I'm saying now. No, you *are* thinking badly of me.
- You don't have problems like this; your life is perfect. Next to you, I'm a real loser, and I hate telling you this loser stuff about my life.
- Sure, you understand what I'm saying, but you don't really care.
- If I tell you my secrets, you'll use them against me later. You'll bring them back when I'm vulnerable.
- When you add something to what I say, that means I have to think what you think. You want to take over my thinking.
- You congratulate me, but you're really pushing me away. All that matters is how I perform.
- If I do well, it's really something about you—you're the therapist who made this possible. It's your success, not mine.

who made this possible. It's your success, not mine.

- You're feeling sorry for me. That means I'm pathetic. You think I'm pathetic.

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- If I believe you care about me, I'll find out differently later and be terribly humiliated for having been gullible. Humiliating me will feel good to you.
- If I get close to you in any way, you'll hurt me, use me, in ways I can't even imagine. I don't know what's going to happen, but the threat is real, all the time.
- If I start to count on your understanding and need you, you'll feel like I'm clinging; you'll scrape me off with disgust.

Of course, your first impulse will be to disagree with any such conviction the moment you hear it. Even if you only sense it, you'll want to prove yourself otherwise. This isn't what you feel toward your client! This isn't who you are! This just isn't the truth, and furthermore, being in a relationship shaped by such a truth feels ugly. Doesn't your client need to understand that you actually feel something completely different?

Reassuring your clients that you care for them and accept them seems like a natural approach to take when emotional convictions as negative as these emerge in therapy. As a relational therapist, however, when such feelings start to surface, you will do something that doesn't seem natural. Rather than disagreeing with your clients' distressing experiences of you (and rather than trying desperately to be such a good therapist that the distress will disappear) you will try to understand how it feels for them to be in those painful self-states and to have such troubling fears and dire expectations of you.

Here you are counting on one of the most counterintuitive but reliable principles of relational work with relational problems: There's little chance that you can change a client's negative experience of you directly. None of your reassurances will make any difference. But if you consistently understand that experience from your client's point of view, eventually you become not only the one who is feared and mistrusted, but also the one who understands your client's fear and mistrust. And that's the pivot point for change. For your client, to have her negative feelings simply accepted and understood is a very particular and unexpected form of being understood, and it's the first move in building a different kind of relationship between your client and yourself. I'll illustrate this counter-intuitive principle with a vignette from my practice.

A Story from the Therapist's Side of Relational Trouble

One day a quite fiercely independent, professionally successful, and rather

One day a quite fiercely independent, professionally successful, and rather lonely client (I'll call him Dave) was telling me about one of his recent accomplishments. Earlier in the session he had been talking about making

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better interpersonal connections in his life, something I really hoped would happen for him. So I responded to his story of achievement by suggesting that eventually he'd be able to feel both accomplished and connected with others; he'd be able to "put it all together." Dave went quiet then, but it was close to the end of the session and I didn't know anything was wrong until he came back the next week.

Then he was so agitated he couldn't sit down. He told me that after the last session he'd been so angry he'd gone straight home to his own backyard, where he ended up hurling snowballs at the back of the house. Dave knew exactly what I had done to make him so angry. My "suggestion" of putting it all together totally undercut the good thing he was trying to tell me. I had told him that his good thing wasn't good enough, that it wasn't, in fact, good at all, because it wasn't up to my standard. "What's the point of telling you something good about myself, if you're just going criticize!" he said. "It's like you're telling me there's something wrong with being proud of myself! Okay—it *is* wrong! These voices in my head keep telling me I'm stupid, I'm childish, so I deserve this. I want to smash something. I feel like smashing *myself.*"

At least Dave had learned in the process of our work together that whatever his feelings were, I wanted to hear about them—especially if they were about what was going on between us. "Negative transference" had just come to rolling boil in that room. Now what would I do? How would I respond?

I'll leave the immediacy of the scene for a moment to compare how different theories of transference would lead me to respond to Dave in different ways. If I worked with a classical definition of negative transference, I might have said to him, "I understand that's what you feel I did to you, and that it's very painful. In fact, I did something different, and that's how we know that these powerful, painful feelings are coming from somewhere else, probably from somewhere in your past. I'm wondering if these are familiar feelings, whether you've been here before—perhaps with your mother or your father."

If I worked with a more progressive, interactive view of transference, I might have said, "I can see how my suggestion felt critical to you. That's a very plausible construction of what my words meant. But there were other ways you could have heard me, too. So I wonder why you understood me in that particular, very painful way." In other words, I'd admit that Dave's feelings didn't come from nowhere, but from something I really did. Yet I'd emphasize the power of his past to construct our interaction in this particular way.

particular way.

In a more interpersonalist mode of working with transference, I might have said, "It's hard for you that out of a whole session, what stays with you

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is something that feels critical and undercutting. As we've noticed before, all you can do at a time like that is withdraw, taking your anger away with you. But I think something is changing for you, too—you've come back to tell me about it. Maybe now we can get a bigger picture of your options." My point in this mode is that there's something limiting about Dave's interpersonal style, but it's getting less constrictive. My ongoing task, as an interpersonalist therapist, is to engage with him so that I can let him know, without blame, how his style works. This is a potent way for Dave to learn how to expand his relational repertoire.

But I'm a relational therapist who actually thinks more in terms of organizations of experience than in terms of transference. And so I accept the truth of my client's experience. Dave had been feeling expansive and I had punctured his golden bubble with a sly criticism. Now he needed to hear, "Yes, that's what I did to you," as he struggled to cope with the intensity of his reactions. Disturbed and shamed by that intensity, Dave needed to know that his reactions made sense. That's where we had to begin. I knew that.

And yet, after Dave's opening explosion, I found myself trying to explain what I had been intending to do in the previous session, hoping Dave would understand that I had been trying to help, not hurt him. Fortunately, he had the gumption and the relational honesty to say to me, "I can't hear that from you right now."

"No, of course you can't," I said, and I brought myself back sharply to the work at hand. I wanted to say I was sorry for what I had done, but I knew that an apology wouldn't help either. It would be just one more way for me to try to feel better, to get my goof behind us. What we needed, instead, was to be right in the middle of all the trouble my mistake had caused. First of all I had to hear the trouble, and I had to hear it thoroughly and well.

I learned that there were two kinds of trouble—what was between us and what, as a consequence, Dave was suffering on his own. Cut off from supportive connection with me, he kept deriding himself for his own stupidity. Then he would counter this self-loathing with what he called a swift kick in the butt: "Forget it. Don't be such a loser. Get on with things." Dave was sleeping poorly, and he spent his days in a funk, trying not to snap at colleagues. As he told me how bad things were, I listened carefully, encouraging him to say more and hoping that my responses would let him see that I took his distress seriously.

Dave had to tell me forcefully and in detail how horrible he was feeling, and he had to be sure that I got it. That took one session. Only after

ing, and he had to be sure that I got it. That took one session. Only after he knew he'd been heard on that score could he return, in the next session, to the "scene of the crime" in order to try to learn more about what had

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happened. He was calmer now, and we could go directly to his experience of my lapse and walk through it slowly. Dave said that it had been such a shock to him. He had come to trust that I would be on his side, and then I wasn't.

I noted what a risk he had taken, just to tell me that he was feeling good about himself. It was an unguarded, hopeful, open moment. I agreed that I had, indeed "set him up for it" by being a good listener. I had led him to believe that it was safe to be proud of himself with me—and then WHAM! I had delivered a betrayal of that new, tender, fledgling trust. And for all those reasons, this was a serious injury, I said.

As Dave grew more confident that I wouldn't disregard or belittle his experience, he could tell me more. In the third session after the rupture, he mused, "It's like you want me to be good, but not too big for my britches. It's like my being good should make you feel pleased about yourself—'Look what I made happen here!' But it can't be different from what you want. I have to be *your* kind of good. And you want me never, ever, to show you up. You've gotta keep me in my place, keep reminding me who's boss, who really knows things around here."

That's when he made the connection, "When I left that bad session, when I was throwing those snowballs as hard as I could, I felt like I used to when I'd show something I made to my dad. He always found something not quite right with it, something to improve. And I'd just want to destroy it, crumple it up, smash it."

I saw the connection: "I did to you the same sort of thing that your dad did—I undercut you in the guise of being helpful."

"Yes! And for the same reasons."

"Because I don't want the competition," I ventured (wearing what he was attributing to me). "But it's more complicated than that, isn't it? There's a double message coming from me: 'Grow up, be strong like me. But you'll never do it right.'"

This fit for Dave. The accuracy of my understanding mattered, but the huge relief was to be understood from inside his own experience. The symptoms that had followed the rupture between us—anger, irritability, anxiety, depression, self-loathing, and sleeplessness—faded rapidly. And then our relationship began to feel much more trustworthy and secure than it had felt before the break.

I understood this as follows: during the repair of the injury, Dave was having two experiences of me at once: the hurtful one, which we worked to understand as fully as possible, and the experience that I was completely committed to understanding him without protecting myself at his

pletely committed to understanding him without protecting myself at his expense. This latter experience was now eclipsing the first one. However, Dave will always have a realistic memory of getting hurt by my clumsiness,

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which might happen again. But we can deal with it if it happens; Dave knows that, too. This is another sign of a more complex, resilient, and differentiated relationship, a relationship being performed differently between us.

Final Comments

For Dave and me, this episode was only one part of a long process of relational growth and change. We couldn't have gotten through it without having first developed reliable mutual rapport, and the outcome of the episode was a subtle but profound strengthening of mutual trust that we can now carry forward. The episode was generated not by Dave's pathology, but by an interaction that went wrong between us. *Something happened.* Drawn by the experience and promise of empathic understanding, Dave took an important relational risk. And then I failed to understand what was going on between us and what he needed from me. His risk and my failure created a compressed version, a "model scene," of a very important aspect of his relational life, and it stirred memories of times in his formative years when he had been misunderstood and undercut in similar ways.

By itself, Dave's sudden, painful connection with disowned feelings and memories wouldn't have helped him. What he needed was to feel his hurt in a relational context that was radically different from the one where the original hurt had been inflicted. As soon as I realized that Dave was injured, I knew it was critical that I, the very person who had hurt him, do all I could to understand how he felt and what had happened to him. It was this steady intention to understand him that made this a different relational experience for him. When his hurt feelings mattered, they were no longer overwhelming or shameful. He could live with them more easily. He could explore their history and their meanings. He could let them go, too.

But what about my feelings? Before I end this chapter, I should at least ask the traditional questions about my "countertransference." Why did I respond to Dave's sense of accomplishment by suggesting that he could be both accomplished and connected? Probably because I like being with him better when he's "connecting." I want him to experience a fuller, richer relational life. I was disappointed when he fell back on his achievements in order to feel good, and perhaps a bit impatient, too. Probably I felt a twinge of envy at his professional success, so that my words were, indeed, intended to "keep him in his place" as he suspected.

to "keep him in his place," as he suspected.

Now it's good that I know about my tendencies to want certain things for my clients, to be impatient, or to feel envious or inferior sometimes.

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It's important that I monitor those tendencies so that I don't throw around a lot of impatience and competition in my therapeutic relationships. On the other hand, those tendencies are part of me. If I interact as a whole human being, eventually they may emerge. I just have to be ready to deal with the effects of my human fallibility, called "countertransference" in this situation.

A more dangerous kind of countertransference occurs as unthought responses to a sudden rupture in therapy. Who likes to make a mistake? I'm a therapist, making a life's work out of helping and caring; I *hate* to be experienced as an inflictor of pain. It's appalling to see an apparently small "miss" become so hugely destructive. These are the most critical countertransference moments. How do I manage my guilt or anger or despair? How can I avoid pitting my own reality against my client's reality? When things go so wrong, how can I not worry non-stop or throw up my hands and walk away? I can't escape these questions, for it's relational therapy that I do. That means I'm really in these relationships—when they go well, but also when they go badly.

If you're a relational therapist, it's not a problem that your feelings are present and invested in the therapy you do; in fact, your emotional presence is an essential part of what you offer. But it does matter a great deal how you "perform" your feelings in therapeutic relationships, especially when there's trouble. You have to decide what to put aside and what to use. Whatever you use has to be helpful both to the client and to your relationship with him. If you focus on understanding your client's experience as fully as possible, you may have a rocky ride, but you will probably come through the trouble together. The personal feelings you had to put aside may not dissipate, but then you make some time to air them gently with yourself or with a colleague.

This may sound like a convoluted process, but it's not so different in structure from what good parents do. Parents, too, strive to be emotionally present, available, and genuine, and at the same time they contain and manage their feelings in ways they believe will be best for their children. Relational therapy didn't invent the use and management of self for the good of the other. Relational therapists borrow the self-for-other wisdom that good parents, mentors, teachers, and spiritual guides have always counted on, and they turn it to a very particular purpose: using self to counter the effects of their clients' toxic self-with-other experiences.

All of us in therapy, clients and therapists alike, want never again to taste the bitterness of toxic relationship. It's our heartfelt desire not to have to go through rotten times with each other. If we're lucky, it won't hap-

to go through rotten times with each other. If we're lucky, it won't happen often. But when it does happen, we have reasons to hope that getting through these hard times honestly and together will be worth the trouble.

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Notes

1. When I had finished this story about us and knew I would keep it in the book, I brought it to a session for my therapist to read. I didn't want to write behind his back. The request to read on my time felt fair and safe to me. When he had read it, he said that although he doesn't always like how he's seen as a therapist, he didn't mind being this therapist.
2. Aron, *A Meeting of Minds*, 82.
3. Ibid., 127, 77.
4. Mitchell, *Influence and Autonomy in Psychoanalysis*, 146.
5. Orange, *Emotional Understanding*, 67–68.

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6

The Wonderfully Good Part of Relational Therapy

Wonderful Ordinary Goodness

"Wonderfully good"—that's a bit over the top! How does something as natural and unpretentious as relational talk therapy get to be wonderfully good? It happens when people who have rarely felt happy with themselves or comfortable with other people start to feel better in ways they never expected. Feeling an everyday kind of good is a strange new experience for them and it can be quite a wonderful surprise.

Many of us take this kind of feeling good for granted. We know what we do well and what people like about us. We have a sense of belonging with family and friends. We've found a productive place in the world and expression for our creativity. Our values match up with our lives.

When life is good, our relationships are working well. We give and receive understanding. When there are problems, we talk about them; when we're hurt, it's safe to be angry. With this kind of security with others, we feel balanced within ourselves. We're able to bounce back from disappointment. Losses are painful, but we can let others help us grieve and recover. We're able to accept our failings and mistakes, and we've learned that laughing at ourselves can help. On the whole, we're content with who we are.

Such goodness is ordinary. It doesn't depend on social status or material wealth. We don't have to be stars or heroes or saints, rising above the hurts, conflicts, and confusions of everyday life. But we are able to be here, okay in ourselves and connected with others. This unremarkable well-being is exactly what has always eluded our anxious, depressed clients. When they came to therapy, all they wanted was relief from feeling bad. They couldn't imagine what "good" would feel like; they didn't even know to hope for it. But with no fireworks or grand illuminations, no sudden breakthroughs

But with no fireworks or grand illuminations, no sudden breakthroughs or transformations, this wonderful sense of well-being has sneaked up and surprised them.

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This everyday kind of "wonderfully good" is in counterpoint to the terribly hard part of relational therapy we've just discussed. The painful feelings of those difficult times may be connected to traumatic model scenes, but they, too, are stirred up by everyday failures of empathy and understanding. When relationship goes wrong in everyday ways, the pain is no less bad for being ordinary. Likewise, when relationship goes right in ordinary ways, the well-being it brings can be unexpectedly wonderful.

The Connection between Hard Times and Good Times in Therapy

Both the hard times of the last chapter and the good times of this chapter are set in motion by a relational therapist's empathy. When your main concern as a therapist is to understand what your client means and how she feels, she starts to believe in her own perceptions and emotions. She begins to feel not so isolated, not so angry and sad, and she gains some genuine, respectful empathy for her own struggles. As her relationship with you becomes more and more important to her, she brings forward more of who she is; she lets herself make contact with experiences and emotions she usually keeps well hidden, even from herself. As she does all of this, she begins to realize that not only does she feel safe in this relationship, sometimes she also feels a new kind of frightened. Your empathy has invited her to be more open and vulnerable than would normally be comfortable for her. The risk she's taking scares her. Something tells her that this is going to go wrong.

As we saw in the last chapter, sometimes these fears are realized when a therapist who has been consistently present and understanding suddenly fails to be there or to get it. Such breaks are painful and they matter a lot because there's so much riding on the relationship. In this chapter, we will spend more time exploring just what is riding on the relationship. The interpersonal ruptures that can make relational therapy terribly hard are only part of a much larger process that in its essence offers to understand, respect, and to a significant extent meet a client's most basic needs for emotional well-being. This larger process may sometimes include dramatic ruptures and repairs, but overall it is made up of many small, repetitive moments when a client's expectations of getting hurt are surprised by something good instead.

It all starts with needing. From infancy through old age, we all carry legitimate emotional needs with us every day. The circumstances of many clients' early lives taught them, however, that emotional needs can't be

clients' early lives taught them, however, that emotional needs can't be met, and so they tried to squelch them. Such needs remain a very important component of adult life—needs to belong, to matter, to be respected

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and honored for one's uniqueness, to express and create, to have feelings received, to feel safe and secure. But clients who squelched their emotional needs in childhood don't know how to find or even feel what they need now. They are likely to think that such "neediness" is childish and shameful. If some of those needs should start to come up in their relationship with a therapist, they're sure trouble will follow.

It's important that you understand how these ordinary, good needs cause such trouble for your client. Since he squelched his needs in childhood, they may indeed turn up in childlike forms at first, longings to be special, close, and beloved. For him, that's appalling. Even so, since they have been squelched for so long, the needs he detests may have a lot of urgency about them, which also heightens his anxiety. As a child he had good reason to decide that needs were the problem and should be silenced. If he hadn't needed, nothing would have hurt him. That empty hurt feeling became an "I'm bad" feeling. Now, in the principles that organize his psychological life, wanting and needing are tightly linked to shame.

Since the first session of his therapy, you have tried to meet this client's needs for respect, support, and understanding. And from the beginning, his response to your offer has been thoroughly entangled in model scenes and organizing principles that tell him that he can't trust this goodness, that wanting good connection is a stupid mistake. The problem is that he *does* want it—more than he knows.

Your empathy wakes up his strong self-with-other needs, but it takes a while for these new feelings to take shape and move from the shadows into his awareness. But when he starts to feel both the good and the bad, the promise of nurturing, enlivening connection and the fearful shame of wanting it, it's more than he can feel all at once. His feelings alternate between hope and dread. It's almost inevitable that after he has felt good for a while—connected, understood, self-respecting—something "bad" will happen to cause disconnection. Then wanting feels futile and dangerous, and he feels empty and stupid again. Though some of these breaks can be large and distressing, as the last chapter illustrates, most of these misses and worries are relatively small and can be talked through in a session.

Once, for example, one of my clients berated herself for not knowing ahead of time that a certain man was going to cheat on her. I tried to undo her self-blame by saying, "You know, it's really not your fault when you get fooled by a man who's manipulative and devious."

She looked stonily at the floor. "You do this," she said. "You tell me something isn't my fault, and then I feel powerless."

Clearly I had missed the emotional point of her story. "Ah," I said, "I see

Clearly I had missed the emotional point of her story. "Ah," I said. "I see what you're saying. You should be able to tell in advance because then you would have more power in the situation."

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She looked up and nodded and went on from there. She had corrected my "miss," bringing my empathy back to her experience, and now she would think and feel her way through this issue in her own way, with me paying attention to what *she* meant. (In our relationship, too, she was learning that she could have the power she needed.)

Another client often asks me toward the end of a session whether her talking has been too much for me. We have explored what lies behind her question: her conviction, nailed down in a childhood home of chaotic abuse, that others are either too fragile or too distracted to hear her. Therefore, she feels like she doesn't matter and shouldn't be heard. That's what turns up again and again. But when she asks her questions, it's important that I scan myself, too. If I have been a bit distracted by personal worries, or I haven't had a good night's sleep, it's important that I say so, simply and briefly. Because if I don't, she'll still sense that something is off between us, and she will take that to mean that something is wrong with her. That's how subtle a "miss" can be.

When these inevitable misses and worries happen in a therapy that's working well, talking them through brings your client back to the positive side of needing and connecting. Each talking through and reconnecting reinforces her belief that this relationship is safe and that it will give her more than she's hoped for before. Just to be able to say "I'm worried what you're thinking," or "You're not getting it," is more than she thought possible at first.

And then, as she continues to talk about her problems and feelings, she will become aware of some new edge of anxiety in the relationship with you. There's something else that she wants from you, perhaps, and she knows she can't have it. Or she's sure you're thinking something bad about her. Or there's something new she wants to tell you about herself, and she's sure you won't like it or even understand it. Whatever the problem is, it's another chance for her to talk her way through bad feelings and back to good connection. So it goes, over and over, and the cumulative effect is a relationship of more complexity and security, and also more possibility for interesting, good surprises.

Two Dimensions of Transference: Self Psychology

Robert Stolorow and George Atwood, theorists of an intersubjective version of self psychology, call this oscillation between hope and dread in therapy a shift between two dimensions of transference. Your client's fearful

therapy a shift between two dimensions of transference. Your client's fearful expectation and experience of repeating the past is *repetitive transference*. Laid down as psychological organizing principles, repetitive transference

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appears over and over again in many guises, and it needs to be met by countless counter-repetitions of your understanding. These repetitions, important instances of a consistent empathic connection, help engender the good relational feelings that self psychologists call *selfobject transference*. According to Stolorow and Atwood, these two kinds of relational feelings, this *repetitive transference* and *selfobject transference*, are not two separate kinds of transference, but rather two different dimensions of one complex transference that develops and changes over time between client and therapist.[1]

Repetitive transference was the topic of the last chapter. In this chapter, to explain how relational therapy builds lasting emotional well-being, we spend time with selfobject transference. Self psychologists believe that as a client comes to understand how his repetitive transference plays out, he will come to understand how his psychological organizing principles make sense of his interpersonal experience for him. This is the most significant aspect of his "unconscious" for him to investigate in therapy.[2] But while he is doing this, and also in the quiet, comfortable spaces between bouts of uncomfortable work with repetitive transference, something ultimately more important is happening for him. His shaky, insecure, fragmented self is being strengthened through selfobject transference.

Some self psychologists drop the word "transference" from their description of the client's positive experience and simply speak of a client's selfobject needs and selfobject experiences. Not only do the client's emotional needs deserve respect and understanding, they also deserve to be met as well as they can be within the limits of the therapy situation. Howard Bacal calls this therapeutic stance *optimal responsiveness*.[3] He and Kenneth Newman suggest that therapists provide selfobject experiences by doing the following:

- Attuning to clients' affective states
- Validating clients' subjective experience—including identifying with the "rightness" of their perceptions
- Providing affect containment, tension regulation, and soothing
- Sustaining or restoring a client's weakened sense of self disrupted by selfobject failure
- Recognizing each client's uniqueness and creative potential[4]

Good Experience as "Selfobject Transference"

Simply put, a selfobject experience is a self-with-other experience that feels supportive, enlivening, comforting, freeing, and life-enhancing. Your

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experience of the other's being with you feels so "just right" that you hardly notice it. Think of how you feel most good in yourself when you're with a close friend. Think of the prototype of that experience—a lively, confident toddler who doesn't realize that her security and happiness are being created for her moment by moment by the people around her. Her selfobject surroundings allow her just to be herself—to explore, do, feel, relate, grow, and develop in her own way.

Sadly, some children don't receive much concentrated attention to their needs, and some receive some kinds of it and not other kinds—for example, lots of safety and protection, but not much admiration for the child's accomplishments, or lots of pride, but little companionship or understanding. If a client has such gaps in his relational experience, they may lead to what self psychologists call *deficits in his self experience*. A large part of his therapy can be a repair of those deficits, which will give him a second chance to develop a cohesive, competent self in secure relationship with others. The therapist provides the selfobject experiences the client uses for such repair. In order for the repair to "take," the therapy relationship has to have significant intensity, an intensity summed up in the word "transference." When there is enough intensity, the selfobject dimension of the therapy relationship can put into motion major changes in what a client expects and experiences in the rest of his life.

Heinz Kohut, the father of self psychology, identified three major forms of selfobject transference. In *idealizing* transference, the client needs to feel connection with and protection by someone good, strong, and wise, someone he can trust and hope to emulate. A *mirroring* transference is structured by the client's need to be noticed and affirmed in his strengths, ambitions, and creativity. He needs someone to admire and smile, to back up his dreams and plans. An *alter ego* or *twinship* transference focuses on an essential alikeness between client and therapist. "Being like" is an important kind of belonging; it counters feelings of being alone and alien in the world.[5]

In a textbook on self psychology written after Kohut's death, a close colleague, Ernest Wolf, identifies three more important needs to be met within a self-sustaining selfobject ambience. In a *merger* transference, the client needs the therapist to be exactly attuned to every detail and moment of her experience. An opposite kind of need leads to an *adversarial* transference; here a client can assert difference toward someone who will take a firm opposing stand but who will also continue to be supportive, responsive, and affirming of the client's self. A third kind of need is for *efficacy* in relationship. A client needs to know that she has an impact on the therapist and can evoke the kinds of responses that will help her.[6]

and can evoke the kinds of responses that will help her.

To this list of selfobject needs and transferences, Stolorow and Atwood add what they call *self-delineating* selfobject transference. This transference

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takes shape with clients whose early experiences of misattunement and invalidation have left them with a very tenuous sense of self. They have a shaky hold on their own perceptions and opinions. They feel their emotions as bodily sensations, but they can't put their emotions into words or symbols to make sense of them. In the therapy relationship, a client with this kind of amorphous, chaotic self-experience will depend on the therapist's responses to give form and words to what he feels until he begins to have a durable sense of being present as a feeling self in his own right.[7]

What Does Selfobject Transference Mean for Your Client?

The language of selfobject transference summarizes important aspects of the everyday goodness a client can experience in the relationship with his therapist. The most basic kind of well-being is a client's confidence that his existence is valid, that his feelings make sense, that his thoughts can withstand others' differences of opinion, and that his unique self is recognizable and durable over time. If he is one of those survivors of relational trauma who has lived with many kinds of dissociation, his quest is to know: "I am here and I am me."

In the chapter on trauma, we saw how important it is for you, as this client's therapist, to attend carefully to all the many scattered details of his experience, becoming for a while a container of pieces too painful for him to manage. Through your here-and-now attention to all of his thoughts and feelings, he begins to recognize a self at the center of his fragmented experience. In time, he becomes able to integrate these past and present fragments into a reliable sense of "This is the road I've traveled to be here. This is who I am now." In the language of self psychology, his selfobject experiences with you help him delineate a self.

If that's where your client is coming from, self-delineation is just the beginning of the good experiences possible for him; there's much more that he missed out on. Likewise, for clients who have a clear sense of self but don't like that self very much, therapy offers a wealth of positive experience that touches in some way what they have profoundly missed. What selfobject experiences haven't happened for them?

Perhaps a client has missed the sense of someone who is always close by when he needs her, someone to help calm and soothe whatever trouble he's feeling. Another client may miss someone who is strong for her in ways she's not, someone capable and wise. With this someone to back her up, she can feel strong and capable herself.

can feel strong and capable herself.

A client might need someone who sees exactly what's good about him. Her smile of approval has no strings attached, so he can take it in: "Yes,

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that's me. I can shine. It's good to be the best I can. She likes what she sees, and so do I!" Or a client might be desperate for a best friend, a soulmate, someone who sees the world just like he does. When the two of them are doing things side by side, he knows he belongs in the world.

Another client might be missing somebody who's glad to hear the strong things she has to say, who enjoys taking her on. She wants someone who can play as hard as she likes to play, someone who's not scared of bumps and knocks. Then she can be as assertive as she wants to be—and safe, too, with him.

These are selfobject transferences in the language of everyday wanting. In their simple forms, they can sound like childishness exposed. Perhaps that's why it's so hard for clients to admit to themselves and to you that these are, indeed, the experiences that they crave. It's up to you to be confident that all of these desires, in various forms, belong not only to healthy infant and child experience, but also to healthy adult relational experience.

Does it matter if you put the name "idealizing transference" on your client's deepening trust in you, or "mirroring transference" on how much it helps him when you smile at his success? What matters most is that your client is having those experiences. But it might also be useful to have a concept about what's happening, because it's more complicated than a cure by kindness. When good selfobject experiences accomplish "healing" or change for a client, they do so by influencing his organizing principles. What's helping him is a change in how his relational experience can be processed, or a change in his self-structure, as some self psychologists would say.

Now it's true that clients don't have to be able to see or understand such changes to profit from them. On the other hand, self-understanding usually strengthens the process of change. Here's where the idea of transference can be helpful; it allows both you and your client to step back a bit to see what's happening. Together you can acknowledge that your client is feeling better not just because you are a nice person, but because of specific new kinds of interactions taking place between you, interactions that have the power to change how he feels about himself.

Relational therapy may be most effective when new experience is accompanied by a client's new insights about how his self-with-other system works. Just as important as the insights is his experience of working with you to make sense of what's happening. These experiences of understanding together add context and depth to his experiences of getting relational needs met. "Transference" is a word that reminds both of you of the intentional work you're doing together: you're allowing deep, important needs

tional work you're doing together? you're allowing deep, important needs to emerge in the therapy relationship, along with all the conflict and trouble they may cause him. In the midst of these complex, powerful experiences,

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you're working together to find words and meanings for them, so that your client comes to understand more fully: "So this is how my system works!"

Other Developmental Stories

Self psychology says that therapy should be a sustaining selfobject milieu for your clients. Through selfobject experience a person comes to feel like a delineated, cohesive, and vital self, a self-respecting and contributing member of the human community, supported in her ambitions and affirmed in her values. But self psychology's story of how a self develops is a speculative one worked out from therapists' experiences with adult clients. There are other interesting stories about the power of relationship in human development that begin, instead, with infant and child studies. I'll look briefly at some of them because they, too, support the idea that a relational therapy can help repair developmental damage clients have suffered, and thus help them experience a new sense of well-being in the world.

Attachment Theory

Mary Ainsworth and John Bowlby have identified three main patterns of attachment between infants and caregivers.[8] A caregiver's consistent availability and sensitive responses to a child lead to *secure attachment* and the child's confident ability to venture out and explore. In *anxious resistant/ambivalent attachment*, the child doesn't know for sure that the caregiver will be available and responsive—sometimes she is, but sometimes she disconnects or disappears. The child tends to worry about separations, cling, and be anxious about exploring the world. When an inconsistent caregiver also rebuffs the child's advances, an *anxious avoidant attachment* is set in motion. Eventually this child avoids contact in order to hide her needs, and she masks her anxiety and anger with self-sufficient competence.

After the first two or three years of a child's life, Bowlby says, these patterns become habitual, or "working models" of how all significant interactions work. A securely attached child will update her working models as she grows because of the free communication between herself and her parents. She can move on to more mature forms of secure attachment as a base for more mature forms of confidence and exploration. Since an insecurely attached child lives in a less communicative, responsive environment, her working models of attachment are likely to persist unchanged, first with

working models of attachment are likely to persist unchanged, first with her original caregivers, and then with others, even when they treat her quite differently than her original caregivers did.

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Working models of attachment are similar to what I have called *self-with-other organizing principles*. Bowlby holds out the hope that although change becomes more difficult as we age, there are always chances that our working models of attachment can be influenced for the better. When working models of self-with-other aren't held too tightly, life experience can continue to alter them to match new relational life situations. But the more anxious and insecure a working model is, the more likely it is to be rigidly repetitive of early experience. Here therapy can help, Bowlby says.

Therapy becomes a new attachment in which a client's working model of attachment can be subverted, if ever so slowly. How can this happen? In healthy parent–child relationships, working models change through what Bowlby describes as free-flowing, warmly personal conversation, laced with feeling. This is the kind of conversation relational therapy works toward. In the beginning stages of therapy, a client may be afraid to bring much of herself forward. But each time she does, there isn't the disinterest or rejection she anticipates. Slowly she finds she can speak more freely of herself and her feelings. Even difficult times of misunderstanding eventually prove the reliability of this new model of attachment. New security gives the client a base for new explorations and undertakings. And all the while, this new working model of relationship is becoming more exportable to other relationships in the rest of her life.

Attachment theory offers this picture of the developmental repair therapy can make possible for clients. It suggests that a secure base will allow them to explore life with more confidence. But beyond that, the "goods" are all in the negative: clients won't feel so anxious, angry, or depressed. For a more positive description of the "goods" of healthy development and redevelopment, we next look briefly at the work of Daniel Stern and Joseph Lichtenberg, whose theories on childhood development are linked with relational psychoanalytic theory.

Daniel Stern

Stern describes four different kinds of relatedness that emerge in sequence between an infant and her parents and that then carry on into the child's adult life: (1) *emergent relatedness*, (2) *core relatedness*, (3) *intersubjective relatedness*, and (4) *verbal relatedness*.[9] Each kind of relatedness develops as an intricate matching of cues and responses between parent and child; each requires an infant constitutionally able to give and respond to cues, and a parent who can do the same, offering

to give and respond to cues, and a parent who can do the same, offering nonintrusive, interested, consistent, and relatively accurate attunement to the child's signals.

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Emergent relatedness is the self-with-other system within which an infant sorts and cross-matches perceptions and stimuli to make patterned sense of the world, especially of her social world. This emergent domain of relatedness and of self carries on into adulthood as capacities to learn, to manage stimulation and anxiety, and to make contact with others.

Core relatedness is the relationship between the infant's energy and excitement patterns and her parents' responses to them. Through responses rich with matching and complimentary energy, parents provide a reliable context in which an infant can experience core senses of self such as agency, affectivity, coherence, and continuity. More importantly, she comes to experience a balanced well-being in this core sense of self, an equilibrium that depends on her parents' interactive presence with her. Later in life, the domain of core relatedness has to do with how well a person can use various relationships to maintain a cohesive, balanced, resilient sense of core self.

In intersubjective relatedness the focus of the infant–parent relationship moves to the sharing of subjective experience. In interactions between two selves, parent and child, meanings and feelings are communicated and understood. Affective attunement makes this sharing possible. Parents' capacities to attune and to empathize determine, in large part, what kinds of affective experiences can be safely included in the child's sense of self, and they influence the feeling tones of the child's self-states. Throughout life, the domain of intersubjective relatedness is the "place" for the giving and receiving of empathy and understanding and thus for maintaining self-esteem and comfortable self-states.

For Stern, verbal relatedness is the beginning of the possibility of false relatedness, for a child can be spoken to and taught to speak in ways that deny what the child's body and emotions tell her is really happening. Everything that is not included in this social world of language becomes either "private" or "disavowed" or "not-me" experience, according to Stern. In adulthood, these experiences that lie outside of what's socially sanctioned often generate feelings of inauthenticity, anxiety, and alienation. But if one can share the private experiences and integrate the disavowed and "not-me" experiences of one's life, verbal relatedness can become a domain in which one is known and affirmed as contradictory and imperfect, but also as a unique and valuable self. It's clear that this could be a job for therapy. In Stern's scheme, however, the therapy relationship is able to touch and shape each kind of adult relatedness, not just verbal relatedness.

In Stern's terms, a client's secure therapy relationship can sometimes take the form of emergent relatedness, helping him make better contact with the world and turn some of his life's chaos into patterns he can man-

with the world and turn some of his life's chaos into patterns he can manage. As core relatedness, a client's being with his therapist will support the dynamic balance of his core senses of self—his emotions, will, and agency,

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and who he feels himself to be in space and time. In the domain of intersubjective relatedness, emotional attunement and empathy will broaden and deepen a client's sense of who he is "inside" and invite him into the positive feelings of interpersonal sharing and connection. And as verbal relatedness, therapy makes space for conversations that bridge the gap between who the client knows himself to be and the social self he believes he must present to the world.

Lichtenberg and Motivational Systems

Joseph Lichtenberg proposes a theory of structured motivation (instead of a theory of structured self) as a way to explain the behavior of infants observed in their natural surroundings and also the behavior and feelings of adults in therapy. He says that human motivation is best conceptualized as a series of systems designed to promote the fulfillment and regulation of basic needs, which he sorts into five categories: (1) the need for psychic regulation of physiological requirements (for food, warmth, and sleep, for example), (2) the need for attachment and affiliation, (3) the need for exploration and assertion, (4) the need to react with aversion, either fight or flight, when in danger, and (5) the need for sensual and sexual enjoyment.[10]

Exchanges between parent and child give each of the child's motivational systems its robustness, contours, limits, and feeling-tones. The parent's feelings are a powerful regulator of the child's experience of his own motivations. If, for example, a caregiver responds to exploration with encouragement, the child will explore more confidently and his exploratory system will be strengthened. If the responses to a child's attachment strivings are warm, reaching out to others feels good to him, not shameful. If there is a blank in caretaker response when it comes to a child's sensuality and sexuality, he will be limited in this area of self-knowledge and self-expression.

Parent–child interactions that are loaded with feeling become clustered together in what Lichtenberg calls model scenes. In therapy with adults, as we have seen, model scenes turn up as stories, dreams, and memories that represent emotionally loaded formative experiences from infancy, childhood, adolescence, and earlier adulthood.[11] In Lichtenberg's scheme, the model scenes that emerge in a client's therapy will be linked to the ways in which caregivers responded to his basic needs, which in turn shaped the motivational systems through which he continues to try to stifle or take care of those needs.

care of those needs.

Sometimes the therapy process can show a client new ways to take care of those needs: the therapy room may become a place for a special kind

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of relaxed well-being; in your presence, a client may explore previously forbidden areas of feeling and new ways of being with another person; a client may learn to assert himself in therapy, and to fight back or withdraw in useful self-protection if you inadvertently hurt him. The client will not only be having these new experiences, he will be talking about how his motivational systems work for him both in and out of therapy. Talking about them when they're "hot," that is, when he's embroiled in a model scene in which he is working to get the best outcome he thinks he can have, has significant power to change how his motivational systems work for him, especially when that kind of talking is embedded in ongoing self-reflection within a supportive selfobject relationship.

The Boston Change Process Study Group

In 1995 a group of infant and child clinicians and researchers, practicing psychoanalysts, and analytic theorists (including Daniel Stern) came together in Boston to study the question of how change takes place in psychotherapy. They intended to develop a model of change that would be based on infant research and that would explain the "something more than insight" that produces change in therapy. Thus their work attends more to questions about dyadic process than to questions about the structure of self or of motivation. The group explores the interactive, mutual, nonlinear processes that organize an infant's emotional states and also his sense of how to do things with intimate others, a kind of knowledge that the group calls *implicit relational knowing*. Then they make links between these processes and processes of change in therapy.[12]

All clients bring implicit relational knowing to the therapeutic relationship, the Boston Group says, a knowing that profoundly affects the quality of their relational lives inside and outside of therapy. Therapists bring their own implicit knowledge about relational procedure. Over time, then, a client and therapist will find themselves "getting along" in a way that's influenced by both partners' implicit relational knowing. In itself, this can lead to change for a client. How so?

Just as a parent can provide a mental/emotional context for expanded and more complex states of shared consciousness with a child, so a therapist can engage with a client in ways that produce for both of them an expanded sense of how they can be in this relationship. The therapist brings to the relationship ways of interacting that the client might not have known about. At the same time the client is bringing challenges into the

relational system that require the therapist to expand his own repertoire of understanding and response. As the client–therapist relationship expands,

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new forms of agency and shared experience become available within it. These new patterns of organization can also be put into operation in other relationships.

The Boston Group believes that changes in implicit relational knowing are what produce the important changes in therapy that can't be attributed to insight. Such changes come about through unplanned events in therapy. In an improvisational mode of talking and being together, "now moments" happen between client and therapist. These are the moments when something new could emerge that would change what both client and therapist know about the possibilities of relating to each other. If now moments are handled in a way that fosters a "specific moment of meeting," the relationship does change (if ever so slightly), and the implicit knowing of each partner is altered by the new and different intersubjective context between them. They then return to "moving along" in therapy, a process consisting of many small matches–mismatches, ruptures, and repairs that put the new shape of implicit knowing into play—until another "now moment" offers new possibilities for expanding their shared and individual consciousness.

The Limits of a Self-For-Other Perspective in Therapy

The genius of theories that connect adult emotional health to infant development is that they recognize that "health" or "good experience" is more than what remains when conflicts are worked through in therapy. Developmentally minded therapists don't focus on treating disease or dysfunction so that clients can return to "normal." They understand that psychological health or emotional well-being is itself an interpersonal creation. They know what effective parents, teachers, mentors, and coaches know: it takes artful, intentional, caring activity to provide the interactive contexts that sustain many different kinds of good learning experiences for those who count on you to help them develop.

However, self-for-other relational therapy needs the check and balance of a self-with-other perspective. Seeing the therapist as only the provider of reparative experience seriously limits a relational perspective. In the first place, the assumption that the therapist's empathy is only a means through which to meet the client's needs shifts the therapist away from mutual presence in relationship. Too much focus on providing what her clients need blocks a therapist's ability to be a real other person engaged with her clients.

Therapies that script the therapist as just a provider may also subtly patronize a client. The client knows that she is an adult in therapy. If

she thinks about her organizing principles for attachment, achievement, and taking care of herself, she knows that they are woven into her adult

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personality. They make her who she is now, and she can't go back in time to undo them, no matter how well her therapist might meet her needs. Furthermore, she doesn't want to feel like a perpetual victim of her childhood history.

This client needs a therapist who is as present *with* her, here and now, as she is a provider of empathy *for* her. A self-with-other focus offers therapy in which it's very clear that a client is not a regressed child or a victim, but rather an active explorer of how relationship works for her right now and how it could be different. In such therapy, she will do this exploring *with* you, her therapist, and you will be challenged to explore your own experience, too, and to resist using your empathic expertise as a subtle escape from the immediacy of the relationship.

In this mode, a client explores her unfulfilled neediness as desires that are completely appropriate in here-and-now adult relationships. Her problem is that powerful anxiety has twisted these desires into opaque impossibilities. The point of her therapy is not that it will meet her needs, but that she will have the chance, here in therapy, to come to terms with both her legitimate adult desires for connection and the longstanding anxiety that turns them into trouble for her. It's useful for her to feel and understand her anxiety in terms of her history, but liberation comes as she finds the courage to accept her adult desires and to act on them in new ways.[13]

The "Goods" A Self-With-Other Perspective Offers

With its developmental and intersubjective emphases, self psychology is both a self-for-other and a self-with-other therapy. Interpersonal/Relational psychoanalysis also contains both themes, but it puts a stronger emphasis on the current, mutual dance of self with other. Aron and Mitchell describe positive outcomes in therapy not as a self becoming stronger and more cohesive, enjoying enhanced capacities to self-right and self-reflect, nor as changes in organizing principles or in motivational or self structures. Instead, they speak of meanings that client and therapist negotiate about what's happening between them, and of the larger, related meanings that these two partners in therapy co-construct and that turn out to be pragmatically useful narratives of the client's life experience.[14] "Pragmatically useful" means that therapy has generated a sense of self and relationships that a client feels to be important, meaningful, and "authentic," that is, deeply his own.[15]

If a client's life is stuck because old constraints keep foreclosing possi-

If a client's life is stuck because old constraints keep foreclosing possibilities for new experiences, one could say, as Mitchell puts it, that his life is stuck because of a failure of imagination. His therapy relationship is where

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new things can happen to prime his imagination, things invented neither by you nor by him, but brought to birth by what happens between the two of you and what might happen next.[16] These new things might feel good or they might not; what matters is that they will feel meaningful and authentic to him, and that they will be windows for his imagination and pathways to further important movement—the opposite of his habit of shuttered, constricting "stuckness."

This more philosophical version of relational psychoanalysis doesn't focus on easing life's pain with empathic understanding. It invites a client to embrace the inevitable clashes and tragedies inherent in human life. It resonates with an existential sense of the conundrums of everyday experience, which at best become creative dialectic tensions to live out with courage and imagination. In this view, the meanings that a client makes of his life experience are not only constructed in relationship with others (especially his therapist), they are also dialogical meanings, that is, though they belong to him, they are also shareable with others in the human community. Sharing dialogue moves a client beyond the limits of victim and dominator positions in social relations, and it enhances his ability to enjoy the meeting of minds.[17]

Jessica Benjamin's feminist definition of intersubjectivity highlights self-*with*-other. First she insists that psychoanalytic discourse must treat women as full subjects, not just as love/hate objects for male subjects. She goes on to argue that all relationships should be "intersubjective," that is, products of negotiations between persons who mutually recognize one another as subjects. Benjamin is saying that intersubjectivity is something more than the situation created when two or more subjectivities share a field of existence. (This is the field theory of intersubjectivity developed by self psychological intersubjectivists like Stolorow, Atwood, and Orange.) Benjamin reserves the term *intersubjectivity* for the mutual recognition that can be negotiated between any two subjects, including child and parent. In this kind of intersubjectivity, neither subject exists for the other; each partner is engaged in mutual and reciprocal processes of asserting self and recognizing the other's self-assertion.

Benjamin highlights the necessary instability of such intersubjectivity as it makes space for aggression, competition, and the inevitable breakdowns and repairs of recognition that happen in the course of a relationship. The demands of empathy become conflictual when empathy must run two ways. Domination of one person by the other is always a possibility. But relational analysis is doing its best work, Benjamin proposes, when it helps its analysands develop the capacity for achieving and sustaining the "inter-

its analysands develop the capacity for achieving and sustaining the "inter-subjectivity" of two-way recognition. The other side of this work is helping analysands develop capacities to contain and work with what happens

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when intersubjectivity breaks down—with the internal tensions generated by clashes of wills and frustrated aggression, and with fantasies of reversals and reprisals.[18]

The women of the Stone Center also speak to the ideal of mutuality in relationship. They believe women have special capacities for empathy and recognition, while linking aggression to masculinity and patriarchy. In their version of relational therapy, the development and exercise of women's ways of connection become the paradigm for all healthy human development and psychology. Thus self-in-relation therapists concentrate on connecting with their clients. Like the other relational therapies we have considered, this model is also a psychodynamic therapy. Relational experiences between client and therapist, condensed in transference feelings and relational images, generate insight about relational patterns. Stone Center theory maintains that this combination of experiencing connection and developing insight will produce change in clients' current relationships and in their well-being.[19]

The Stone Center theorists place most emphasis, however, on what happens within the therapy relationship itself, which they characterize as mutual, as Aron, Mitchell, and Benjamin do. "Self-in-relation" is the primary human reality, they say; autonomy and independence are fantasies. Insofar as a therapist must put the client's subjective experience at the center of the therapy, therapy can't be fully mutual. Nevertheless there can be real connection, respect, emotional availability, and openness to change on both sides of the relationship, and therapy can help this experience of mutuality to deepen and grow.[20] In this way the therapy relationship produces for both partners what Miller and Stiver call the five components of empowerment: "zest," action, knowledge, worth, and a desire for more connection—five powerful, in-relation "goods."

Zest in-relation is the opposite of isolated depression. Zest happens when people feel they have a meaningful effect on one another, and then they feel more empowered to take further action. A therapy relationship that's working well will stir such energy in both you and your client. From all this meaningful interaction comes a great deal of knowledge about each other and about how the relationship works for you.

Friends who enjoy mutual relationships feel like they matter more in the world when they have mattered to each other in their interchange. Likewise, when therapy works well, even you as therapist will feel that your presence has been important. What matters more in therapy, of course, is that your client's sense of worthiness increases as she feels your honest, interested engagement with her. It's no surprise that she would want

est, interested engagement with her. It's no surprise that she would want more of this connection. Your client's relational life improves as she acts on this desire not only with you, but also with her partner in an intimate

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relationship, with friends, and even with people beyond her circle of close connection. All of these positive outcomes of therapy flow from what goes on between you and your client.

Although these interpersonalist, dialectical, and feminist versions of relational therapy differ in their expressions of philosophy, politics, and ethics, they agree on this point: The well-being or the "goods" that therapy produces are primarily self-with-other phenomena, even though they emerge in the context of a therapy that is clearly for the client.

What If Your Client Falls in Love with You (or You Fall in Love with Your Client)?

As you read about these benefits of intimate connection in therapy, you might wonder: What if these positive feelings in this intense interpersonal relationship lead to falling in love? Well, the truth is that falling in love happens in many kinds of therapy; it would be no surprise that it could happen especially in relational therapy. As you listen to your client, you are consistently warm, attentive, and responsive. She shares her mind and heart with you, and you are there for her week after week. In this situation, a certain kind of falling in love is almost inevitable—she will develop a heightened awareness of your ways of being with her; she will experience intense feelings of various kinds when the two of you are together, and she will have many thoughts and fantasies about you when you're apart. Some of those feelings and fantasies may be romantic and sexual. That's natural, too.

As adults we know that feelings of emotional intimacy often lead to desires for physical and sexual intimacy. We also know that having those feelings doesn't mean that a person has to act on them; responsible choice is always possible. So it is in therapy. But there are special considerations when a client falls in love with you. First of all, although a client's loving feelings are fine and often helpful to her therapy, under no conditions is it fine or helpful for you to respond to those feelings with a romantic interest of your own. You may feel loving and sexual toward her, but if you act on those feelings, you are taking advantage of your client's vulnerability in the relationship—a clear breach of your ethical responsibility to her. So says every code of professional ethics for psychotherapists.

That being said, let's return to how it might be helpful for your client to fall in love with you, and to how you can respond with her best interests in mind (whether or not your own feelings are involved). Falling in love is just one more instance of the emotional intensity that makes relational

is just one more instance of the emotional intensity that makes relational therapy effective. It can be described as a particular kind of transference, often called "erotic transference." In its negative, repetitive dimension, your

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client might fear that her love will be mocked or rejected, or, on the other hand, that her love will be snatched greedily and then twisted to abuse her. In the positive, helpful dimension of erotic transference, her experience of having her love welcomed respectfully can lead to new depths of self-respect and stronger capacities for safe, mutual connections with others.

So although falling in love is not to be acted out in therapy, if it happens, it's best for your client not to hide it from you. It's your responsibility not to become entangled, either positively or negatively, in her feelings, but to listen to them carefully in order to understand her world and her feelings more fully and deeply. In short, it's your job to receive her loving feelings, and all the conflicts around them, with the same empathy you bring to anything else she talks about.

Thus, if your client falls in love with you and is anxious and ashamed about the situation, you can reassure her that this is a natural thing to happen and quite common in therapy. As you help her find ways to talk about her feelings, she learns, once again, that there's nothing wrong with who she is and how she feels. The relationship expands to contain more interpersonal reality, and her capacity to love becomes more available to her for growth beyond therapy. The two of you will probably be surprised how easy this talking turns out to be, and how simply okay it is to let these feelings be part of what's happening now in this relationship.

Please note, however: if you find yourself having strong, persistent romantic and erotic fantasies about a client, whether or not the client has expressed loving and sexual feelings toward you, you must get yourself to a supervisor or therapist you trust and try to understand the meaning of your feelings—not only in the context of the therapy, but also in the context of your own personal life. As a relational therapist, you will have been trained to enter into emotional intimacy that you don't mistake for falling in love. If you're making that mistake now and feeling the pull to cross a professional ethical boundary, chances are that something is wrong or missing in your personal intimate relationships.

What about Dependency?

The good feelings of therapy also give rise to another kind of fear, fear of dependency. We've come up against understandable forms of this fear elsewhere in this book. Clients who were never able to count on their parents to support them will fear starting to count on you, because they expect that you will only disappoint them in the end. As we've seen, these repetitive fears need

will only disappoint them in the end. As we've seen, these repetitive fears need to be treated with repeated gentle empathy. But there's another kind of "fear of dependency" I'd like to address now, and it's not really a fear, it's a judgment.

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Sometimes clients are advised by well-meaning friends and loved ones not to rely too much on a therapist for support and help in daily living. Such reliance, they're told, will not diminish with time. It's a dependency trap induced by therapists to line their pockets or feed their egos. Sadly, in therapy as in any profession, there are a few bad apples. Some therapists are poorly trained, less than competent, or even unscrupulous, and some of them do manipulate their clients into long-term dependent relationships. But people who are deeply suspicious of dependency don't usually discriminate between good and poor therapy. To them, it's all suspect.

Behind such suspicion is the assumption that dependency is the unhealthy or immature opposite of independence, that in optimal development we grow out of dependency and into autonomy. All relational therapies undermine that assumption. The core project of the Stone Center theorists is to turn that assumption upside-down. They argue against a dependence/independence dichotomy, for the two kinds of being-with are completely intertwined in interdependent social relationships, they maintain. Wishing or pretending to grow out of the human condition of interdependency, like denying one's own vulnerability and emotions, is a recipe for relational and psychological disaster.[21]

What's more, the Stone Center says, dependency on others can be both healthy and appropriate; it's just a fact of interpersonal life that sometimes you have to count on others to help you cope with things you don't have the experience, time, or skill to manage as well for yourself. Other times you are the lender of help, expertise, and support. The "helping" themes and moments of relationships become unhealthy only when one person needs to keep another person subservient or powerless in the relationship. Otherwise, dependency is normal and growth promoting. In Stiver's words, dependency allows you to experience yourself "*as being enhanced and empowered through the very process of counting on others for help.*"[22]

Stone Center theorists would tell your client that it's not just all right for her to count on you for your responsive understanding, it's the only way to grow. Self psychology, too, refuses to see normal psychological development as movement from dependence to autonomy. That movement, says Kohut, is impossible, for human beings never outgrow their need for selfobject connection. Instead, our healthy development is the story of our growth within sustaining relationships between ourselves and others, and these selfobject relationships themselves keep developing as we rely on them in ever more complex and meaningful ways.[23]

When you are in a self-*for*-other mode of relational therapy, you provide a healthy relational environment that alters a client's self with other

vide a healthy relational environment that alters a client's self-with-other experience. He will grow not out of dependency, but into modes of dependency that are more reciprocal, empowering and useful to him in his life.

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As he makes peace with how much he needs to depend on others for his everyday well-being, he'll be able to recognize how much he has to offer, too, in healthy interdependent relationships.

A self-*with*-other mode of relational therapy seems at first glance less vulnerable to a dependency critique. In this mode, you are less a provider of good experience than a partner in a challenging project. But the project depends first on developing a relationship deep and real enough to bring to life your client's most painful ways of being with others, and then on all the work it takes for the two of you to find a better way of being together. From the outside, all this investment of time and energy can look like dependency, too. However, though a client may come to count on this relationship for an intense kind of engagement he's known nowhere else, the word for this intense, shared adventure of discovery is hardly "dependency"!

In fact, the responsible practice of any relational psychotherapy *protects* clients from dependency that would belittle or control them. As therapist, you enter a therapeutic relationship fully aware of the power a client invests in you and of the responsibilities that go along with it. Her "dependency" is voluntary, and she enters into it for reasons that both of you respect. You know that many relational powers will be awakened in your work together, and you intend to welcome them openly and to make sense of them as best you can. The therapy is *about* what happens between you, and your commitment to that work is your client's first protection against unhealthy dependency in therapy.

A second protection happens throughout the therapy process: relational therapies put the dynamics of the therapy relationship on the table and keep them there. There's nothing about the therapeutic relationship that can't be noticed and questioned. So if your client is feeling in any way trapped or belittled or "too needy"—that's exactly what she needs to talk about! As her therapist, you stay alert for clues of such feelings, you ease her way into talking about them, and you respond with receptive understanding. Then your client can find her way back to active partnership in your ongoing interdependent relationship.

"I Almost Smiled at You Today!" (A Story about Ordinary Goodness)

This chapter has been about the ordinary goodness relational therapy offers. To end it, I'll tell a story from my practice that illustrates most of the accounts of ordinary relational well-being we've looked at so far.

"Kim" came in one day and sat silently for a few moments, as she often

Kim came in one day and sat silently for a few moments, as she often did. Then she said, her eyes on the floor, "I almost smiled at you today when I came in the door." I was puzzled. It wouldn't have been the first

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time she had smiled at me in session. Yet this seemed important and hard for her to say. What did it mean to her? What was going on between us that she *almost* smiled at me? Having worked with her for almost three years, I knew she would explore those questions with me. It took a few sessions, but together we came to understand a certain kind of "goodness" emerging for her—tentatively, along with anxiety.

Thinking like a self psychologist, I had learned over the years that Kim needed careful mirroring from me—responsive facial expressions, understanding sounds, and short sentences that summed up what I was getting. Neutral silence from me told her that I was disinterested or not even present—which meant that she was wasn't worth being with. However, when she could feel my interest, she felt a sense of connection with her inner thoughts and feelings and a sense of mattering both to me and to herself.

Kim also made twinship connections with me, checking out books I'd read and movies I'd seen, enjoying our shared interests in baseball games and golf lessons. She longed to experience herself as "normal," as "belonging," and less like an alien on earth. As we grew into liking to be together, Kim felt less like an outsider in the rest of her life. It wasn't surprising, then, that she could smile more easily with me.

But what mattered here wasn't just any kind of smiling; it was smiling *"as I came in the door."* I thought about Kim's attachment history. She experienced both parents as emotionally detached, which explained why I had to be so present to her. Since they never shared what moved them or mattered to them, Kim never had a chance to feel essentially or deeply like either of them. This deficit generated her need for twinship with me. But what in her history made it dangerous to smile *as she came in the door*?

In Bowlby's terms, her working model of attachment was insecure and avoidant. She had experienced not only detachment from both parents, but also rejection when she reached out. As she mused on this, she said, "Well, my dad had those paranoid tendencies, so from him it was like, 'What do you want from me?' And my mom was so self-conscious, it was like my knowing her was going to expose her somehow. My wanting to connect just scared them both, I guess. It still does!"

We had noticed an insecure avoidant pattern in stories Kim told: how she'd sometimes cross the street not to have to say "Hi" to someone; how the more she liked and admired certain people, the less she was able to speak to them. With me she was always pleasant and respectful, and social smiling was part of the package. But I knew that she held back, expecting very little from me, as if afraid to offer too much or want too much.

very little from me, as if afraid to offer too much or want too much.

In this context, I could understand that smiling at me as she came in the door would be an enormous risk for Kim to take. As she explained,

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"Then it would be just me in your face, saying, 'Here I am! Smile back! Or *something*!' It seems like way too much to ask. I'll be in trouble for sure." The trouble she anticipated, I thought, would be that sting of an aloof non-response and the sickening slide into shame that would follow, a sequence she knew well in her bones, if not in her conscious mind. But on the other hand, after almost three years of my consistent, attentive responsiveness, something was getting through to that insecure, avoidant working model of attachment. She'd had the *impulse* to smile. She told me about it! She was thinking about it from every angle.

In terms of Stern's domain of core relatedness, Kim needed to find out whether I would match my energy to hers, or whether preoccupation with my own needs or my own depression would leave her stranded with her "up," interactive strivings, and then disorganized and alone with a struggle to regain her equilibrium. In the domain of intersubjective relatedness, the question would be more about whether we could share the feelings and meanings of our inner worlds. Would she see in my eyes and in my face pleasure about our connection, anticipation of taking it further and deeper into knowing each other? Or would she see "Stay away from me!"—an echo of her father's fear of being used or her mother's fear of exposure?

"I almost smiled at you today!" was a moment full of goodness because new RIGs, new sequences of interactions, were jostling for space with those old RIGs. Already our interactive core relatedness had helped Kim experience a self of more lively, balanced energy. Already our intersubjective relatedness had helped Kim experience the value of her inner world, with its uniquely interesting thoughts and feelings.

In Kim's moment of almost smiling, attachment–affiliation was the motivational system most operative. Despite their emotional detachment, her parents must have provided enough warm, affective response to her infant attachment needs to activate that system well. The good news is that her urge to make friendly contact has survived, in spite of the forces that regularly squelch the urge. As she came through my door, whatever happened—something she saw in my face or manner, linked with an expectation of rejection—activated a secondary motivational system, aversion. To protect herself she shut down her impulse to smile. The ability to self-protect is also good. But the therapeutic good about all of this, according to motivational systems theory, is Kim's new ability to notice the "model scene" quality of what happened and thus move beyond ongoing unconscious repetitions of the scene.

The moment of almost smiling was a "now moment" that Kim turned into a moment of meeting by telling me about it. As we shared the mean-

into a moment of meeting by telling me about it. As we shared the meanings of an almost-smile between us, something shifted in how we each knew each other, and we could hope that Kim's sense of the possibilities of

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relationship, her "implicit relational knowing," might have been deepened and expanded through that meeting.

So far everything we've understood about the goodness in Kim's almost-smile are goods that the therapy relationship has given Kim: a more cohesive self, a better working model of attachment, RIGs that better support Kim's vitality, the retooling of one of her motivational systems, the expansion of her implicit relational knowledge, and, through all of this, new capacities to reflect on how her self-with-other systems work for her. All of these "goods" accrue to Kim, thanks to consistent self-*for*-other interactions. Does her story also illustrate the power of self-*with*-other to develop "goods" located in the relationship?

Well, in Stone Center terms, there was "zest" between us when Kim spoke of almost smiling. A shared smile wasn't yet possible for *us.* As we explored our dilemma, we came to a better understanding of each other and of ourselves in relation, and then we each felt more secure and worthy. As these mutual experiences deepen in therapy, we can expect more well-being within the relationship.

From a more interpersonalist perspective, "I almost smiled at you!" was a flash of imagination, a thought unthinkable before, something new between Kim and me after a long time of the same old thing going on between us. We may never know how our work together released that impulse into Kim's awareness, but now that it's between us, many "small" things are changing. Now, instead of just being sure that her advances will be trouble, Kim wonders, "What if my smiling at you means something to you I'd never expect, something I don't even know about?" Possibilities expand, with new fears and new excitement—and for me too. I wonder, "Will she ever actually greet me with a free, spontaneous smile? What would it be like to feel that smile—and to smile back? What might we discover then?"

Kim says, "My smiling at friends feels different now. It means different." She doesn't know what it means, exactly. She doesn't know where this "smiling" (more reaching out to others with more expectation of friendly response) will take her in the world. We don't know where reciprocal smiling might take us. We haven't even done it yet! But we can feel between us the satisfaction of something old and stuck giving way to something much more warm, alive, and moving even when we just talk about what smiling (and not smiling) means. Making this meaning together feels good. "We-ness" feels sturdier; the give and take of conversation works better; mutual enjoyment and mutual vulnerability have become more possible between us.

between us.

Does this growth facilitated by relationship or this intense mutuality of relationship mean that Kim is dependent on me in an unhealthy way? In

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the session after Kim "almost smiled" she told me, "I bumped into a friend on the street. I saw her coming and I kept walking straight toward her. I said, 'Hi, Donna! How *are* you?' Like with *enthusiasm*! I felt like I meant it. It felt good." Kim listed all the ways she had been putting herself forward a bit more in her life. "It's about expecting that when I put myself out there, sort of in their faces, they won't find me a bother," she explained. "Maybe they're actually happy to see me." Then she got scared. "But I'm not sure about that. What if I'm wrong? That's the risk I take if I smile at you. So I don't. Not yet."

If Kim were dependent on me in an unhealthy way, our relationship wouldn't help her expand her strength, vitality, and sense of self-worth in connection with others. My "support" would keep her weak, scared, and small. But that's not what's happening. Instead, Kim is trying out new ways of being in the world at the same time that she's trying them out with me. In a situation of unhealthy dependency, Kim and I would duck away from challenging questions about what's going on between us in order to keep things the same. But we're not doing that. Even now we know better than to impose closure on this almost-smiling episode. It doesn't matter whether we smile at each other in the end. What matters is the change set in motion by the question, "What's going on between us?" Dependency is a closed loop; genuine relational therapy sets in motion interactions that move outward, opening up relationships and the selves who live them. It asks questions that don't have endings.

Therapies, however, do have endings. And beyond the endings waits the final proof of this "goodness" pudding: Does the well-being last when the therapy is over? That's a question for the next chapter of this book.

Notes

1. Stolorow and Atwood, *Contexts of Being*, 82–83.
2. Ibid.,34.
3. Bacal, ed., *Optimal Responsiveness.*
4. Howard Bacal and Kenneth Newman, *Theories of Object Relations: Bridges to Self Psychology* (New York: Columbia University Press, 1990), 229.
5. Kohut, *How Does Analysis Cure?*, 192–194.
6. Wolf, *Treating the Self*, 124–126.
7. Stolorow and Atwood, 34–35.
8. Mary Ainsworth, *Patterns of Attachment: A Psychological Study of the Strange Situation* (Hillsdale, NJ: Lawrence Erlbaum Associates, 1978); and John Bowlby, *A Secure Base: Parent–Child Attachment and Healthy Human Development* (New York: Basic Books, 1988), especially Lecture 7, "The Role of Attachment in Personality Development," 119–136.
9. These four domains of relatedness and their connection to clinical issues are summarized in Stern's

The Interpersonal World of the Infant, Chapter 9, "The 'Observed Infant' as Seen with a Clinical Eye," 185–230.

10. Lichtenberg, *Psychoanalysis and Motivation.*

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