Chapter 3

New Developments in Relational–Cultural Theory

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THE BIRTH OF A THEORY

The Relational–Cultural Theory of women's development is rooted in the groundbreaking work of Jean Baker Miller, who proposed a new understanding of women's development in her book *Toward a New Psychology of Women* (Miller, 1976). In 1978, Miller, a psychoanalyst, along with three psychologists, Judith Jordan, Irene Stiver, and Janet Surrey, began meeting informally to reexamine developmental psychology and clinical practice as it pertains to women (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Their twice-a-month meetings were the beginning of a collaborative theory-building group that led to the birth of a revolutionary approach to understanding psychological development.

In 1981, Miller was appointed as the first director of the Stone Center at Wellesley College and the theory-building group found an institutional home, allied with the Stone Center's mission to study psychological development and the prevention of psychological problems. At the Stone Center, the theory group initiated a series of colloquia in which they, along with other scholars and researchers, explored the complexities of women's development. Over the last 20 years, the proceedings from these colloquia and other presentations have been documented and published as over 100

"works in progress." These works became the core writings that describe the fundamental concepts of the theory that has become known as Relational–Cultural Theory (RCT).

Today, many of the core ideas underlying RCT are articulated in several books (Jordan, 1997; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller & Stiver, 1997). These ideas suggest that all growth occurs in connection, that all people yearn for connection, and that growth-fostering relationships are created through mutual empathy and mutual empowerment. In particular, Miller (1986) described "five good things" that characterize a growth-fostering relationship: (1) increased zest (vitality), (2) increased ability to take action (empowerment), (3) increased clarity (a clearer picture of one's self, the other, and the relationship), (4) increased sense of worth, and (5) a desire for relationships beyond that particular relationship. These *five good things* describe the outcomes of growth-fostering relationships, that is, the outcomes when growth occurs through mutual empowerment and mutual empathy: we grow not toward separation, but toward greater mutuality and empathic possibility.

In addition to describing the benefits of growth-fostering relationships, that is, connection, RCT explores the impact of disconnection, recognizing that disconnection is an inevitable part of being in relationship (caused by empathic failures, relational violations, injuries, etc.). When, in response to a disconnection, the injured (especially the less powerful) person is able to represent her feelings and the other person is able to respond empathically, experiences of disconnection can lead to a strengthened relationship and an increased sense of *relational competence*, that is, being able to effect change and feeling effective in connections (Jordan, 1999). However, when the injured or less powerful person is unable to represent herself or her feelings in a relationship, or when she receives a response of indifference, additional injury, or denial of her experience, she will begin to keep aspects of herself out of relationship in order to keep the relationship. In RCT, this is referred to as the *central relational paradox* (Miller & Stiver, 1997). In these situations, the individual will use a variety of strategies—known as *strategies of disconnection* or *survival*—to twist herself to fit into the relationships available, becoming less and less authentic in the process (Miller, 1988). This is similar to the pathway that Carol Gilligan traces for adolescent girls who keep more and more of themselves out of relationship in order to stay in relationship (Gilligan, 1982; Gilligan, Lyons, & Hanmer, 1990). This pathway leads to failures in growth-fostering relationships, accompanied by diminished zest, empowerment, clarity, worth, and desire for connection. Within this context, one's natural yearning for connection

becomes a signal of danger; the individual comes to dread the vulnerability necessary to fully engage in growth-fostering relationships.

Therapy based on RCT involves the ability to work authentically with the client's disconnections, to rework relational images (images that shape our expectations of relationship), to bring people out of their sense of isolation or shame and help them move back into healthy connection. This therapeutic process requires creating awareness of relational patterns and disconnections, helping clients to transform strategies of disconnection, which are blocking their ability to participate in healing relationships.

While RCT was initially developed to understand women's psychological experience, it is increasingly being used to gain a better understanding of all human experience, including men's experience. Special attention is being paid to examining the importance of difference, particularly difference informed by imbalances in power and privilege. RCT is the foundation for a growing body of research on depression, trauma, eating disorders, substance abuse, chronic illness, mother–daughter relationships, and lesbian relationships, as well as issues of racism, sexism, heterosexism, classism, and a multitude of other psychological and social problems (Hartling & Ly, 2000).

TOWARD A RELATIONAL PARADIGM OF DEVELOPMENT

Traditional theories of development were constructed around a core belief in the ascendancy of individualism and separation. From its inception, the field of psychology attempted to emulate the "hard" science of Newtonian physics that proclaimed the salience of material, separate objects (the atom or molecule) secondarily coming into relationship (Jordan, 1997). Ironically, Newtonian physics, which has shaped much of the thinking in science and psychology, has been challenged and replaced by modern physics, which emphasizes the primacy of relationships. Nevertheless, individualistic, "separate-self" models of development—modeled after Newtonian physics—continue to dominate the field of psychology and are perpetuated by Western and U.S. values of autonomy, separation, individualism, boundedness, and self-sufficiency (Cushman, 1996).

The Stone Center theory group, which has grown in size and diversity, continues to question separate-self models of development, especially for women. In particular, they recognize that the traditional psychological notion of the "self" is a highly spatial metaphor, connoting separation, boundedness, protection from a threatening context or milieu (Jordan,

1997). By holding up the separate-self standards of independence and autonomy as endpoints of development, women and others are frequently judged as deficient or inadequate. In the field of mental health, this has often led to pathologizing women's behavior and development (e.g., women are too needy, too emotional, too dependent).

Looking beyond the bias in psychological models that privilege independence and self-sufficiency, RCT focuses on the process of growth and differentiation within relationship, the expansion and elaboration of connection, as well as the movement toward increasing mutuality in relationship. Dominant theories have tended to emphasize the formation of intrapsychic structure as the foundation of well-being, suggesting that healthy development is the capacity to function independently. These theories often imply that the individual is an empty vessel to be filled by a "good mother" or others, leading to the ultimate outcome of being able to "stand on one's own two feet." In contrast, RCT suggests healthy development occurs when both people are growing and changing in relationship. When individuals are engaged in a mutually empathic, mutually empowering relationship, both people are becoming more responsive in fostering the well-being of the other and of the relationship itself; both people are growing through connection. RCT proposes a shift away from a one-way, individualist model of development to a relational model of mutual development.

RCT THERAPY AND PRACTICE

RCT emphasizes health, growth, and courage, and points to a new understanding of human and individual strength: strength in relationship, not strength in isolation. Isolation is seen as the source of most suffering, while the process of creating mutual empathy and mutual empowerment in relationship is seen as the route out of isolation. In therapy, mutual empathy and mutual empowerment evolve out of the client seeing, knowing, and feeling her or his impact on the therapist, on the relationship. Unlike traditional approaches that extol the practice of nonresponsiveness, neutrality, and nongratification, RCT suggests that it is important for clients to learn about their impact on others, which begins with learning about their impact on the therapy relationship. If we accept the premise that a client's sense of isolation and strategies of disconnection arise in the context of nonresponsive, nonmutual, disempowering relationships, then healing occurs in the context of a respectful, safe relationship characterized by empathic responsiveness.

Mutual empathy lies at the core of this healing connection. This is not reciprocal empathy; it involves the client seeing, knowing, and feeling that she has moved the therapist. The client has had an impact: she has learned that she matters and that she is relationally effective. This is a relationally corrective and restorative experience for the individual who suffers from a history of chronic disconnection or nonresponsiveness from important caregivers.

The responsive engagement of the therapist is crucial to the healing process in therapy. This engagement is not the same as therapist reactivity; it is therapeutic authenticity, which involves *modulated responsiveness*, not knee-jerk reactivity. Modulated responsiveness is informed by *anticipatory empathy*, anticipating the possible impact one has on another and *caring* about that impact. As all clinicians know, therapists and clients have different responsibilities in the therapy relationship. A therapist assumes the greatest responsibility in a therapy relationship by performing a role that carries with it the obligation to uphold professional ethical and legal guidelines. These guidelines inform the therapist's practice of modulated responsiveness, anticipatory empathy, and authenticity.

Authenticity in a therapeutic relationship is not about total spontaneity or unmitigated self-disclosure (Miller et al., 1999). It involves trying to bring more and more of one's experience into connection, with constant awareness of the possible impact on the other person. For example, being authentic in any relationship, especially a therapeutic relationship, involves clearly stating one's limits (e.g., "I'm not comfortable with that way of interacting. I'm sorry if that is hard for you but you need to know my limits"). Authenticity requires a person to take responsibility for describing the conditions in which one can meet the other person in relationship. This is different from suggesting that the other person is somehow deficient, needs limits imposed upon her, or that her request for a certain type of interaction is necessarily indicative of pathology.

The concept of *boundaries* is pertinent to the discussion of authenticity and mutuality. Often people misinterpret authenticity and mutuality, suggesting that the relational–cultural model espouses self-disclosure or gives permission for total spontaneity. Rather, RCT questions the seemingly innocuous concept of boundaries because it arises within, supports, and reinforces the model of a separate self, which suggests that one must protect oneself from relationships, that safety and well-being ensue from constantly armoring oneself with invisible barriers. Traditional conceptualizations of boundaries carry implications of the self always existing within a dangerous

environment, a self that needs protection from, rather than good connection with, others.

Another way to think about boundaries is as places of meeting, exchange, and maximal growth. Instead of fortifying boundaries, the emphasis in RCT is on (1) clarity in relationship (e.g., this is your experience; this is mine), (2) the right to say "no" and to exercise choice in deciding what one will share or do, (3) the importance of stating limits (e.g., "I can't do this in our relationship because it makes me uncomfortable"), and (4) redefining boundaries as places of meeting and exchange, rather than as walls of protection against others. By observing these four conditions of engaging in relationship, we essentially honor growth and safety through connection, not through separation or imposing power over others. Moreover, RCT concepts—such as authenticity or mutuality—are practiced within a context of relational clarity, a context in which boundaries are places where people meet to grow through connection.

Social/Cultural Disconnections

Another key component of therapy based on RCT is the recognition that disconnections as well as opportunities for growth occur not only on the individual or familial level, but also at the sociocultural level. Societal practices of categorizing, stereotyping, and stratifying individuals have an enormous impact on peoples' sense of connection and disconnection (Walker, 1999, 2001; Walker & Miller, 2001). Racism, sexism, heterosexism, and classism impede all individuals' ability to engage and participate in growth-fostering relationships. RCT suggests that therapists must be aware that different forms of unearned advantage and power accrue to different categories of identity. For example, being middle class, white, or heterosexual carries with it all sorts of unearned privilege in a society that values these characteristics over others. bell hooks's notion of "margin" captures some of the dynamics of this distribution of privilege and advantage (hooks, 1984). Those at the center hold the power of naming reality, the power of naming deviance and norms, and often hold the power to eliminate the possibility of open conflict with or challenge from those who are forced to the margins. The exercise of dominance and privilege suppresses authenticity and mutuality in relationships, limiting and interfering with the formation of growth-fostering relationships. These sociocultural dynamics inflict disconnection, silence, shame, and isolation on marginalized groups. These issues must be in the forefront of the therapist's work with a client.

Thus, the central tenet of RCT in therapy is that people develop through and toward relationship, which occurs within and is influenced by a cultural context. Above all, RCT asserts that people need to be in connection in order to change, to open up, to shift, to transform, to heal, and to grow.

GROWING PAINS AND POSSIBILITIES: RESPONDING TO CRITIQUES

An important part of developing a robust theory is exploring and responding to questions and criticisms. Criticisms offer theory builders the opportunity to clarify, adjust, and ultimately strengthen their work. One criticism of RCT is that it offers an essentialist portrayal of development. This argument implies that one's biological sex determines fundamental, internal, individual attributes (e.g., "women are naturally more relational"). The theory builders have never intended to suggest that women are "by nature" more relational, empathic, or nurturing. Jean Baker Miller's (1976) original work clearly delineates the power of context and the power of a patriarchal culture, which has assigned women the primary responsibility for supporting and maintaining the relationships necessary for everyone's growth. Her work is profoundly sociopolitical and social constructivist. Miller's book clearly describes gender as a socially constructed variable, largely framed by power dynamics. She states:

> A dominant group, inevitably, has the greatest influence in determining the culture's overall outlook—its philosophy, morality, social theory, and even its science. The dominant group, thus, legitimates the unequal relationship and incorporates it into society's guiding concepts. . . . In the case of women, for example, despite overwhelming evidence to the contrary, the notion persists that women are meant to be passive, submissive, docile, secondary. (p. 8)

RCT explicitly elaborates on the role of power in the development of social identity and articulates the ways in which sociopolitical/cultural factors lead to disconnection, disempowerment, and isolation (Walker, 2001; Walker & Miller, 2001).

Another criticism of RCT is that it reflects the biases of the initial group of theory builders, who were white, middle-class, heterosexual, educated women. Recognizing that their perspective was limited by centrist

privilege, since the mid-1980s the original members of the theory group have been committed to bringing diverse voices into the center of theory building and to being as conscious as possible of their own biases and privilege, as well as the extent to which they participate in the dominant culture. Now, through the collaboration of an expanded group of theory builders (e.g., Jenkins, 1993a, 1993b, 1998; Rosen, 1992; Sparks, 1999; Walker, 1999, 2001), RCT has grown and offers an enlarged understanding of the diversities and commonalities among women from a wide range of backgrounds and experiences. There is not one psychology of women nor one voice, but many. Voices traditionally marginalized are now at the center of the theory-building group and the challenging dialogues on race, sexual orientation, and other issues of difference are shifting our understandings of connection and disconnection. While class is acknowledged as a crucial force in creating connection and disconnection, it remains one of the most difficult to address.

Those who have followed RCT over the last 20 years will note that enriching the dialogue has transformed the theory. For example, the theory was initially known as "self-in-relation" theory; however, ongoing conversations with collaborating scholars suggested that the original name continued to overemphasize an individualist, separate-self perspective. Consequently, the theory was renamed Relational–Cultural Theory. This is only one example of how the collaborative process through which RCT emerged requires that theory development remain open and responsive to new ideas, new research, and new voices.

APPLYING RCT: THE CASE OF M

M was an 18-year-old woman who had been seen in many treatments prior to her current treatment. She had been diagnosed by other clinicians as borderline, paranoid, and depressed. Previous treatments had ended with her firing therapists when empathic impasses developed, or they ended with therapists impatiently terminating with her because of her persistent self-mutilating and sometimes suicidal behavior. In the course of treatment, it became clear that a stepfather had sexually abused her. Her history was filled with episodes of an eating disorder, some substance abuse, and other self-destructive behaviors.

In the beginning of therapy she was very cautious; she had come to the RCT-based therapist because she had heard that the therapist was more "human" and "present" than other therapists were. But she soon found

fault with the therapist, who seemed too distant as well. She had great difficulty trusting the RCT-based therapist and would often become quite scared and/or rageful when the therapist "screwed up" by not understanding her completely. These disconnections were abrupt and painful. Her history was replete with abuse, lack of protection from caregivers, and violations of her sense of integrity. A supposedly trustworthy adult had abused her behind closed doors, and she had been silenced about her experience.

Therapeutic failures or mistakes emphasized to her that her new therapist was not 100% trustworthy, that is, the therapist might disappoint her, and, in response, her terror might catapult her into major strategies of disconnection and self-protection. The therapy situation itself felt triggering to her, inviting her to a place of psychological vulnerability with a supposedly trustworthy but powerful figure, all held behind closed doors. She frequently threatened to quit therapy and called other therapists to complain about her current therapist. Her substance abuse got worse when she felt threatened, as did her self-destructive behavior. Although she was on medication, a selective serotonin reuptake inhibitor, to stabilize her depression and to deal with some of her symptoms of posttraumatic stress disorder, psychobiological factors appeared to be contributing to her reactivity, which led her into feelings of greater disconnection (Banks, 2001).

In response to her client's struggles, the RCT-based therapist, very slowly, began to rework each empathic failure that had occurred in her relationship with the client. This meant that the therapist acknowledged her own relational imperfections and limits. And the therapist began engaging with the client to repair the relationship by examining the ways in which both people contributed to disconnections. Further, they explored the ways the client's reactivity to the therapist's limitations led to her isolation and her feeling that she was even more endangered. In other words, the therapist and the client began to rework the client's central relational paradox: the therapist honored the client's strategies of disconnection (recognizing that these behaviors had been essential to her survival) and at the same time held and facilitated the overall movement toward connection. The client was not forced to relinquish her strategies of disconnection before she was ready to or before she felt safe enough to risk the vulnerability necessary to enter into greater connection. The original wisdom and usefulness of these strategies for survival were also honored (she had to move into protective inauthenticity as a child in order to stay alive in an abusive situation). But, gently, slowly, the therapist invited the client to look at the patterns of her behavior that now led her to feel more frightened in her iso-

lation than she might have been if she had been moving into more connection. Working with mutual empathy, the therapist opened herself to being impacted and affected by the client (e.g., at one point the therapist felt tears well up when the client was crying about her helplessness and pain; in another instance, when the therapist empathically failed the client, the therapist let her client see that she was pained by her own mistake and apologized). As the client sees her impact on the therapist, she slowly begins to regain a sense of relational competence, a feeling that she matters to the therapist. It is with this attitude of respect and mutuality, joining with the client in empathic resonance, that the therapist supports movement out of isolation and back into connection.

In addition to facilitating her movement toward greater connection in therapy, the therapist encouraged her client to develop other relationships to help her regulate her fear of becoming too dependent on the therapist. Furthermore, the client was encouraged to voice her dissatisfaction and discomfort with the therapist whenever these issues arose, and she was encouraged to find ways to ground herself when her biological reactivity threatened to contribute to disconnections in relationship with others. In this way, the therapist and the client began to build authentic connection and what RCT refers to as *relational resilience*, which involves movement toward empathic mutuality, relational awareness, and relational confidence, the belief in one's ability to create growth-enhancing relationships (Jordan, 1992). Rather than something that resides within the individual, RCT suggests that resilience is relational and contextual. This conceptualization of resilience dramatically alters our understanding of strength, healing, and growth.

EMERGING RESEARCH: A RELATIONAL–CULTURAL REFRAMING OF RESILIENCE

As the literature, research, and applications of RCT continue to grow and expand (Hartling & Ly, 2000), one of the most promising and compelling areas of inquiry is the study of resilience. Although many investigations are grounded in individualist theories of development, much of the research on resilience points in a relational direction, suggesting that *resilience grows through connection* (Jordan, 1992). The following section begins a discussion of the research and offers a relational reframing of characteristics associated with resilience.

Resilience: Beginning with a Feminist Framework

Jean Baker Miller (1976) and other feminist scholars urge us to critically examine the theories and assumptions underlying many areas of research (Keller, 1985; McIntosh, 1988, 1989; Minnich, 1990; Stewart, 1994). These scholars highlight the effects of privilege, power, and biased perspectives (e.g., sexism, racism, classism, heterosexism, homophobia, etc.) that can distort the study of a wide range of human behavior, including the experience of resilience. When research is designed, developed, conducted, and interpreted primarily by members of a dominant group, these individuals will tend to define themselves and their values as the norm or ideal, concomitantly implying that members of subordinate groups are deficient or abnormal. Many years ago, Jean Baker Miller named this problem when she said that "the close study of an oppressed group reveals that a dominant group inevitably describes the subordinate group falsely in terms derived from its own systems of thought" (p. xix). With regard to the study of resilience, the strengths of women and marginalized men may be misconstrued or completely overlooked by research that covertly or overtly emphasizes the values and norms of the dominant group.

For example, in the 1970s, Kobasa (1979; Kobasa & Puccetti, 1983) described the construct of "hardiness" as an individual characteristic associated with resistance to stress, a form of resilience. Based on initial research, hardiness was defined as an internal characteristic comprised of three factors: (1) commitment: the ability to easily commit to what one is doing; (2) control: a general belief that one can control events; and (3) challenge: the ability to perceive change as a challenge rather than a threat. Over the years, hardiness has been used as a standard of stress resilience in men *and women*. However, today we realize that Kobasa's research had serious limitations that were not deemed significant in the past. The subjects of investigation in Kobasa's original study were white, male, middle- to upper-level business executives. While the qualities of commitment, control, and challenge (i.e., hardiness) may accurately describe stress resilience in this particular sample, these characteristics may not be the most useful indicators of stress resilience in women or others not represented in the study.

In other words, if women from a broad range of backgrounds had been the subjects of investigation, the researchers might have identified different characteristics associated with stress resilience. For instance, in her study of African American mothers on welfare, Elizabeth Sparks (1999) described relational practices (e.g., connection, collaboration, and community action) used by a marginalized group of women to overcome the corrosive effects of

poverty, racism, and being stigmatized as social scapegoats. By broadening the research population and taking a relational perspective—rather than restricting the population and focusing on individual, internal qualities or traits—researchers can make visible some of the relational, collaborative characteristics that may contribute to the resilience of many populations (Genero, 1995).

In response to the implicit limitations of much of the research, Abigail Stewart (1994) offers specific strategies for studying resilience in the lives of women, that may be helpful for examining the experience of other marginalized groups. She recommends that researchers utilize the following strategies to gain a more accurate understanding of the strengths exhibited by women:

1. Look for what's been left out.
2. Analyze your own role or position as it affects your understanding and the research process.
3. Identify women's agency in the midst of social constraint.
4. Use the concept of "gender" as an analytic tool.
5. Explore the precise ways in which gender defines power relationships and in which power relationships are gendered.
6. Identify other significant aspects of an individual's social position and explore the implications of that position.
7. Avoid the search for a unified or coherent self. (pp. 13–30)

Stewart's suggestions remind us to embrace the complexities of women's experience and begin identifying the features of women's lives that have allowed them to be resilient despite the social constraints imposed upon them. Her strategies offer us a feminist framework for exploring the research on the resilience of women and, possibly, the resilience of other subordinate groups.

A Relational Conceptualization of Resilience

The literature on resilience typically describes resilience in three ways: (1) good outcomes—the absence of deviant or antisocial behavior—after experiencing adverse conditions; (2) maintaining competence under conditions of threat; and (3) recovery from traumatic experiences (Masten, Best, & Garmezy, 1990). These definitions, combined with traditional models of development, tend to reinforce a focus on internal, individual personality traits associated with surviving adversity or trauma. Enlarging the dis-

course, RCT encourages researchers to examine the social, cultural, and interpersonal factors that impede or enhance one's ability to withstand or overcome hardships. An RCT view of resilience requires an analysis of the relational conditions that foster growth in the lives of those who have suffered severe disruptions, the conditions that allow people to thrive despite exposure to many forms of adversity. Hence, RCT expands and transforms conceptualizations of resilience to include understanding the dynamics of finding and moving toward mutually empathic, mutually empowering relationships in the face of adversity, trauma, or alienating social/cultural pressures—that is, the ability to connect, reconnect, and resist disconnection.

By shifting the focus beyond the individual, RCT promotes a broader perspective, which requires investigating the relational–cultural factors that influence one's ability to be resilient and to grow despite adversities. In particular, RCT attends to the influence of power in dominant–subordinate relationships and the experience of marginalized populations to determine how social/cultural systems of advantage or disadvantage may privilege or oppress an individual's ability to be resilient. Thus, an RCT-based conceptualization of resilience promotes a broader, richer, deeper inquiry into this complex experience.

Exploring Resilience: Individual and Relational Considerations

Over the years, researchers have identified numerous characteristics associated with individuals who have successfully overcome adversity or traumatic experiences (Barnard, 1994; Masten, 1994, 2001; Masten, Best, & Garmezy, 1990). While many of these characteristics are viewed as internal traits, these traits are clearly influenced by relational–cultural conditions and dynamics. Reexamining and rethinking the relational aspects of the characteristics associated with resilience moves us toward a new understanding of this phenomenon. The following discussion offers a relational analysis of six characteristics associated with resilience.

A Relational View of Temperament

Temperament is described as an internal, relatively stable, individual characteristic frequently noted in the research on resilience (Rutter, 1978; Werner & Smith, 1982). A well-known study of multi- and mixed-racial children living in adverse conditions on the Hawaiian island of Kauai suggested that "good-natured" boys and "cuddly" girls were more resilient than other children (Werner & Smith, 1982). But what are the relational–

cultural aspects of temperament? Rutter (1978) observed that children with adverse temperaments (i.e., temperaments characterized by "low regularity, low malleability, negative mood, and low fastidiousness" [p. 51]) were twice as likely to be the targets of parental criticism. He concluded that a child's temperament has a significant impact on the *parent–child relationship*, either protecting the child or putting the child at risk. In other words, temperament affects an individual's ability to participate in relationships that promote resilience.

Based on the Kauai study and Rutter's observations, one might conclude that children with adverse temperaments would always be less resilient because their temperaments would negatively affect their ability to attract, engage in, and sustain relationships. However, RCT requires that we also consider the cultural context in which a child's temperament is expressed. A study of East African Masai children found that those with difficult temperaments were more likely to survive extreme drought conditions (de Vries, 1984). The researchers theorized that these children were able to assert their need for (relational) support within a culture that values assertiveness. A relational–cultural view helps us understand that temperament has an impact on a child's opportunities to connect and gain access to resources that are necessary to facilitate her or his ability to be resilient.

Intellectual Development and Connection

Intelligence is another individual trait cited in the research on resilience. Although it is largely considered an internal, stable characteristic, Ann Masten and her colleagues (Masten, 1994, 2001; Masten, Best, & Garmezy, 1990) describe some of the contextual and relational factors that may explain the connection between intellectual development and resilience, including economic or educational advantages or having skilled parents. Analyzing the influence of relationships on intelligence, Daniel Siegel (1999) emphasizes that brain development is an "experience-dependent" process and that interpersonal relationships are the central source of experience that influences how the brain develops. Opportunities provided to children through relationships activate certain neural pathways in the brain, either "strengthening existing connections or creating new connections" (p. 13). According to Siegel, "Human connections create neuronal connections" (p. 85).

The brain is a dynamic living system, open to experiences primarily facilitated by relationships and constantly in a state of change. Although Siegel focuses on early brain development facilitated by the parent–child

relationship, his analysis begins to describe the interactive dynamic of mutual influence among individuals engaged in relationships that contributes to healthy brain development and function throughout our lives. Siegel's observations suggest that researchers should continue to explore the relational–cultural factors that foster intellectual development and healthy brain function, both of which contribute to one's ability to be resilient.

Self-Esteem and Social Esteem

Self-esteem is a generally accepted personality characteristic associated with resilience (Dumont & Provost, 1999); however, RCT brings to our attention some questions about this characteristic. Judith Jordan (1994) observes that self-esteem in Western culture is primarily constructed on a separate-self, hyperindividualistic model of development, which valorizes self-sufficiency and individual achievement over collaboration and connection. Further, traditional conceptualizations of self-esteem are often built on hierarchical comparisons in which one's esteem depends on feeling superior to someone else. Consequently, the process of building self-esteem can become an exercise in individual, competitive achievement. Within this context, those who subscribe to more collaborative and collective models of achievement may be viewed as lacking in self-esteem.

Traditional, individualistic constructs of self-esteem may have limited relevance to people of color. Yvonne Jenkins (1993b) offers a group-centered, relational conceptualization of esteem, which she calls *social esteem*. She suggests that "*for collective societies, group esteem is practically synonymous with the anglocentric conceptualizations of self-esteem*" (p. 55, original emphasis). Social esteem implies a group-related identity that values "interdependence, affiliation, and collaterality" (p. 55). For diverse populations in which the unit of operation is the family, the group, or collective society, social esteem is an essential part of healthy psychosocial development, and it may enhance one's ability to cope with adversity—that is, one's ability to be resilient. As with the characteristics mentioned thus far, RCT encourages researchers to take a relational view of esteem.

Internal Locus of Control or Mutual Empowerment

Internal locus of control (ILOC) is another individual characteristic associated with resilience, in particular resilience in the form of competence under stress (Masten, Best, & Garmezy, 1990; Werner & Smith, 1982). What is ILOC? According to Roediger, Capaldi, Paris, and Polivy (1991),

"Children who take responsibility for their own successes and failures are said to have an internal locus of control" (p. 352). This definition seems to decontextualize the issues of control and fails to recognize the realities of racism, sexism, heterosexism, or other forms of discrimination that affect one's ability to feel an internal sense of control. In fact, it would appear to be advantageous for the dominant group to persuade the subordinate group that they *should* have an ILOC, they *should* feel responsible for their lack of success and their failures. Obviously, it is easier to have an ILOC when one is a member of, and exhibits the characteristics of, the dominant, privileged social group.

A 1999 study challenged thinking about ILOC (Magnus, Cowen, Wyman, Fagen, & Work, 1999). The researchers compared stress-resilient (SR) white and black children to stress-affected (SA) white and black children and found a significant difference in the ILOC between the SR white children and the SA white children, but not between the black children. Based on their results, the researchers theorized that white families may emphasize individual control while black families do not because it might promote a false belief that one can control adversities such as racism and other forms of discrimination.

From an RCT perspective, it might be helpful to move away from the individualist language of internal control and move toward a more relational language of *mutual empowerment* or *mutual influence*. A sense of control comes from feeling as though one can influence his or her environment or experience; she or he has the power to take action on behalf of her- or himself and others, creating possibilities for change. Rather than seeking to achieve an internal sense of control over experience, perhaps individuals are more resilient when they are engaged in relationships that are mutually empathic, open, and responsive. For example, research suggests that responsiveness and mutual influence are essential features of successful marriages (Gottman & DeClaire, 2001) and that couples who engage in mutual support are more resilient when faced with economic pressures (Conger, Reuter, & Elder, 1999).

The Meaning of Mastery

Mastery is a term frequently used to describe the sense of competence associated with being a resilient person. Of all the concepts discussed thus far, the term *mastery* has some dubious connotations. According to dictionary definitions, Judith Jordan (1999) notes, " 'to master' is to reduce to subjection, to get the better of, to break, to tame" (pp. 1–2). She states that the

"mastery implicit in most models of competence creates enormous conflict for many people, especially women and other marginalized groups, people who have not traditionally been 'the masters' " (p. 2). Jordan's observations suggest that researchers might want to consider an alternative term and conceptualization of this quality. Nevertheless, how do people develop a sense of mastery or competence? In her research on resilience in children, Ann Masten and her colleagues (1990) identified three forms of activity parents can practice to develop competence or mastery in their children: "model effective action, provide opportunities to experience mastery, and verbally persuade children of their own effectiveness" (p. 432). Not surprisingly, these are relational activities, suggesting that mastery and competence grow through participation in supportive relationships. Once again, relationships are key in developing a sense of competence or mastery.

From Social Support to Connection

Obviously, social support is one of the most relational constructs identified in the research on resilience. The benefits of social support have been well documented in psychological and health research (Atkins, Kaplan, & Toshima, 1991; Belle, 1987; Ganellen & Blaney, 1984; Ornish, 1997). Yet social support, as it is defined in the research (Fiore, Becker, & Coppel, 1983), tends to represent a *one-way* form of relating, something that one gets from others. This is extremely different from the *two-way*, mutually empathic, mutually empowering, growth-fostering form of relating described in RCT as *connection* (Jordan, 1992). However, researchers have described some specific forms of social support that imply that these relationships foster connection.

Renée Spencer (2000) discusses a number of studies that suggest that a relationship with one supportive adult is associated with good outcomes when children are faced with various adverse conditions, including parental mental illness (Rutter, 1979), separation from a parent (Rutter, 1971), marital discord (Rutter, 1971), divorcing parents (Wallerstein & Kelly, 1980), poverty (Garmezy, 1991), maltreatment (Cicchetti, 1989), and multifaceted or a combination of risk factors (Seifer et al., 1996). In a study of over 12,000 adolescents, Michael Resnick and his colleagues (1997) determined that *connection* to parents, family members, or other adults is the most important factor associated with a reduced risk of substance abuse, violence, depression, suicidal behavior, and early sexual activity, regardless of an adolescent's race, ethnicity, socioeconomic status, or family structure. This seems to draw into question the traditional view that healthy develop-

ment requires progressive separation and independence from relationships or requires "standing on one's own two feet." Furthermore, although the research in Spencer's paper clearly articulates the importance of supportive relationships, these studies continue to reflect a one-way perspective, the effects of connection on one person (the child) in the relationship rather than the effects on both people in the relationship.

Engaging in relational behaviors to cope with adverse conditions may be especially true for women. Challenging the generally accepted theory that people exhibit a *fight-or-flight* response to stress, a recent analysis by Shelley Taylor and her colleagues (2000) suggests that women may utilize a *tend-and-befriend* response to stress. Women will engage in caretaking activities or the creation of a network of associations to protect themselves and others (e.g., children) from a threat—women exhibit a relational response to stress. Taylor et al. postulate that the fight/flight response may be inhibited in women by brain chemistry that reduces fearfulness, decreases sympathetic nervous system activity, and promotes maternal caretaking and affiliative behavior. Taylor and colleagues' analysis is supported by studies that show that women are more likely to mobilize social support in times of stress, they maintain more same-sex close relationships, they turn to female friends more often, and they are more engaged in social networks than men (Belle, 1987).

The tend-and-befriend theory provides us with a relational perspective on women's responses to stress yet it simultaneously raises some serious concerns. It is troubling to think that this new theory might be used to justify patterns of discrimination and social oppression of women, offering an overly simplistic biological explanation of women's behavior, akin to suggesting that women are by nature relational—that is, an essentialist understanding of women's behavior. It is troubling because, historically, biological explanations have been used as evidence of women's inferiority (Tavris, 1992). In response to some of these concerns, Taylor and her colleagues state:

> Our analysis should not be construed to imply that women should be mothers, will be good mothers, or will be better parents than men by virtue of these mechanisms. Similarly, this analysis should not be construed as evidence that women are naturally more social than men or that they should shoulder disproportionate responsibility for the ties and activities that create and maintain the social fabric. . . . Biology is not so much destiny as it is a central tendency, but a central tendency that influences and interacts with social, cultural, cognitive, and emotional factors, resulting in substantial

> behavioral flexibility. . . . some aspects of the tend-and-befriend model may characterize male responses under some conditions as well. (2000, p. 423)

These researchers acknowledge the limitations of their analysis and existing studies. They recognize that women have been the subjects of investigation in virtually all research exploring affiliation under stress. The lack of data about male subjects makes it impossible to know whether or not the tend-and-befriend model might apply to some aspects of male behavior. Although this theory offers some new possibilities for understanding a biological factor that may contribute to relational behavior, RCT suggests that relationships are highly complex, involving the interaction of numerous social, cultural, psychological, and biological factors that have yet to be explored (e.g., Banks, 2001).

Overall, studies of social support indicate that receiving support contributes significantly to one's ability to be resilient. Yet these studies predominantly focus on the experience of one individual in the relationship, exploring the one-way benefits of relating, such as assessing supportive parent–child relationships only from the child's perspective. In a recent paper, Ann Masten observes that many research models "do not accommodate the bidirectional nature of influence in living systems" (Masten, 2001, p. 230; see also Masten, 1999). She notes, for example, that "one study that found parenting to predict child competence, resilience, and change in child competence over time, also found that child competence predicted changes in the parenting quality over time" (Masten, 2001, pp. 230–231; Masten et al., 1999). RCT proposes that relationships that enhance resilience and growth are characterized by a bidirectional or two-way experience of *connection*, which involves mutual empathy, mutual empowerment, and movement toward mutuality, benefiting all people engaged in the relationship (Genero, Miller, & Surrey, 1992). By extending studies to include the outcomes for both or all people in relationship, researchers can begin to investigate how resilience grows through the dynamic of connection (Jordan, 1992; Liang et al., 1998).

THE CONTINUING GROWTH OF RCT

The study of resilience discussed in this chapter provides us with one example of the recent developments in RCT and illustrates how this theory can expand our understanding of the diversity and complexity of human

experience. Through the collaborative process of theory building established in the early years of its development, RCT continues to evolve and grow, offering new insights and new possibilities for research and therapy.

In 1995, the Jean Baker Miller Training Institute (JBMTI) was established at the Stone Center at Wellesley College. The institute was formed to provide greater opportunities for clinicians, scholars, students, researchers, and others—from around the country and around the world—to meet, discuss, and deepen their understanding of the many applications of RCT. Since its inception, the JBMTI has hosted intensive training institutes, workshops, courses, and seminars exploring the clinical, business, and community applications of RCT. In addition, the JBMTI works in alliance with a network of researchers who are utilizing RCT in various investigations of human experience. To date, the JBMTI, along with the Stone Center, has published over 100 papers and books that describe fundamental concepts, new developments, and wide-ranging applications of RCT.

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