Work in Progress

The Conundrum of Mutuality: A Lesbian Dialogue

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All three speakers are members of the Stone Center Lesbian Theory Group, which also includes Wendy Rosen, Ph.D. Dr. Rosen's participation in discussions on this topic informed the development of these papers, but she was unable to be present at this presentation.

Abstract

Scholars from The Stone Center and others have, in recent years, persuasively articulated the need for therapists to work to construct more mutual therapy relationships with their clients. In these three separately written papers, the authors each address an aspect of implementing the concept of mutuality into the practice of psychotherapy, with an emphasis on the lesbian client/lesbian therapist dyad. Ms. Mencher's paper examines structural elements in the therapeutic relationship, and particularly explores issues related to the power and role differentials inherent in therapy relationships, the therapist's uses of herself, the construction of boundaries between the client and the therapist, and the management of complexities for lesbians in post-termination contact. Ms. Slater's paper addresses the development of intimacy in the therapeutic relationship and argues that lesbian client and therapist dyads engaged in working towards mutual (though unequal) therapy relationships do so in the presence of an underlying reminiscence to each one's experiences in forming lesbian love relationships. Specific aspects of the therapeutic relationship potentially colored by this association are identified. Finally, Ms. Eldridge's paper proposes that psychotherapists move beyond the traditional ethical code which provides only parameters about what to avoid and instead adopt a relational orientation to our thinking about ethical dilemmas. Ms. Eldridge outlines specific principles of ethical thinking from a relational orientation and offers practical suggestions for an ethical use of mutuality in psychotherapy. The author applies these principles to ethical issues common to lesbian client/lesbian therapist dyads.

Over the past decade, the Stone Center theory group has created a rich theoretical perspective on women's growth through connection, establishing that mutuality is a central hallmark of healthy relationships for women. Judith Jordan has developed and elaborated on the concept of mutuality and pointed to its importance in psychotherapy (1986, 1991b). In 1989, lesbian feminist liberation theologian Carter Heyward took an additional step to alert feminist therapists to the dangers of non-mutuality in most therapies (1989a). She challenged us to explain and correct the fundamental contradiction between the feminists' definition of what constitutes a healthy relationship and the reality of what characterizes a typical therapy relationship. We of the Lesbian Theory Group believe that it is no coincidence that a

lesbian pressed this challenge, since lesbian relationships outside of therapy fundamentally challenge traditional arrangements of power and connection, and since lesbians historically have articulated the radical edge of the feminist critique.

The Stone Center theory group has featured mutuality in psychotherapy as a major topic in virtually all of its work over the past four years on psychotherapy relationships. In such papers and presentations as Jordan's "The Movement of Mutuality and Power" (1991a), Heyward and Jordan's "Mutuality in Therapy: Ethics, Power, and Psychology" (1992), Heyward's and Surrey's workshops and trainings on mutuality, Miller and Stiver's "A Relational Reframing of Therapy" (1991), and the Stone Center's Cape Cod summer seminars, these theorists have questioned the traditional models. They have challenged the notion of the therapist as expert within a rigid, hierarchical structure of power over the client. Instead, they have struggled to define mutuality in therapy and have clearly endorsed the necessity of mutuality within the relational perspective's definition of what constitutes good therapy.

Other theoretical communities and groups of scholars and practitioners have been examining this issue as well. In the pages of *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, a (mostly male) community of contemporary psychoanalysts has been debating various challenges to traditional theory and practice. This community has been alternately referred to as "relational," "interpersonal," or "relational-perspectivitist" psychoanalysis. These discussions—such as Mitchell's (1988) and Aron's (1991) work on intersubjectivity in the analytic relationship, Modell's (1991) examination of the interplay of reality and transference, Burke's (1992) exploration of the use of countertransference disclosure, and Hoffman's (1992) and Tansey's (1992) questioning of the nature of psychoanalytic expertise—represent an exciting challenge to some of the most basic principles of analytic thought, an exploration that runs parallel to and often intersects with our own feminist debate here at the Stone Center.

The work of other feminist thinkers, such as Rogers' "A Feminist Poetics of Psychotherapy" (1991) and Bograd's "The Duel Over Dual Relationships (1992), has also enriched our exploration of mutuality in psychotherapy. Recent conferences on such topics as intimacy between therapist and client, boundaries in psychotherapy, and love in the therapy relationship indicate that many others in our field are thoughtfully considering the various issues related to mutuality in psychotherapy.

At this point, we in the Lesbian Theory Group have felt the need for the discussion to move forward, from advocating the importance of mutuality in therapy, to examining more closely how to incorporate mutuality effectively in treatment. We must turn our attention now to the various complexities that emerge from a more mutual psychotherapy. As we move from establishing the importance of mutuality to discussing how it is manifested in therapy, it is critical to include the many voices of therapists and clients—women of various ethnic, racial, and cultural backgrounds, women of various sexual identities, and women from various professional disciplines.

In this presentation, we will be introducing the voices of lesbians—to be precise, three white lesbian feminist therapists. We do so not merely for the sake of enhancing diversity or broadening the discussion, but also because we believe that lesbian therapists have always been required to wrestle with questions related to mutuality. We hope that our particular experiences will, therefore, not only broaden but also deepen our collective re-visioning of mutuality.

Once we agree that mutuality has an important place in relational therapy, many complicated questions emerge:

- What is mutuality in psychotherapy?
- Are there essential structural elements of therapy that determine whether and how mutuality is possible in psychotherapy?
- How can the treatment relationship maintain its unique and precious qualities while incorporating mutuality?
- Can mutuality exist without authenticity?
- What *is* authenticity for a therapist?
- What are the limits on authenticity and mutuality for the lesbian therapist who is not out to her clients?
- Is it possible to hold to traditional notions of termination and also believe in the importance of mutuality?
- What exactly are the clinical applications of mutuality in therapy? First, a few comments about our process as a group: In meeting after meeting over the past nine months, we struggled with these questions, often wondering if we were getting anywhere. Every time we tried to grab hold of some

meaty specifics about what mutuality actually is, our thinking turned to mush. We came to little more than an agreement that mutuality should be a goal of psychotherapy, with only vague generalizations about what that meant.

Our discussion of the boundary questions in more mutual therapy relationships edged us closer to genuine engagement. Disagreements surfaced among us as we discussed the use of self-disclosure, both as it relates to revealing personal information about the therapist and also concerning the therapist's expression of spontaneous feelings to her client. The group debated the optimal parameters for managing the inevitable entry of the therapist's needs into the therapy, and we discussed whether we can draw a line between the "real" relationship and the transference relationship. In some of our most lively meetings, we challenged each other's thinking on post-termination relationships, and we argued openly about when boundaries honor the client and when they allow a therapist to hide.

By the time we needed to put pen to paper, we had come to recognize that this is not a topic that lends itself to clear questions and concrete answers.
H
ever, we realized that we had reached a more complex understanding of the range of factors that must be considered each time we set out to move a therapy relationship toward mutuality. Our group had learned *how* to move beyond the facile generalizations, *how* to think complexly about mutuality, and *how* to make choices in a myriad of distinct situations.

Our discussions, and particularly our debates, have led us to the conflicts that pulled us deeper into relationship with each other and into our investigation of our topic.

Our paper consists of three sections, written individually, with input and critique from the other members. Except for this introduction and a brief conclusion, each of us will present our own thoughts and perspectives as we examine and develop a different facet of our ongoing dialogue about mutuality in psychotherapy. There are both overlaps and disagreements in the content of our papers. The combined elements of agreement and conflict reflect the success of our process, in which we have moved beyond the simplistic, to a deeper engagement with the conundrum of mutuality in psychotherapy.

Structural Possibilities and Constraints of Mutuality in Psychotherapy

Julie Mencher

Just as the Stone Center's relational perspective first affected me a decade ago, these recent discussions of mutuality have provoked in me an exciting and restful sensation of coming home. As I have listened to and participated in these discussions, I have heard the formal articulation and celebration of what I've found to be most healing in psychotherapy. I have gained a sense of the therapist as a real person, truly engaged and participating actively in the rhythms of discussion and silence, willing to talk about the relational process on both sides, acknowledging the real-life factors and circumstances of therapist, client, therapy, and community which both intrude on and enrich the treatment relationship. This is the person I aspired to be as a therapist, and this is the therapist who I tried to find as a client. (I will be using the word *client*, deliberately avoiding the use of the word *patient* because of its association to the hierarchies and power dynamics of the doctor/patient relationship.)

There were moments in recent discussions of innovations toward mutuality in treatment, when I had that 'of course' feeling and wondered, "Haven't we all been working this more mutual way for years?" While many clinicians have been engaged in a silent rebellion against nonmutual traditional methods behind the closed doors of our therapy offices, I, for one, have really felt the urge to come out from the therapy office closet—not merely to proclaim my own authenticity as a more mutual therapist, but also to formally describe, delineate, and honor a more mutual approach—so that future therapists won't have to hide behind closed doors.

Until now, my more mutual treatment approach has consisted only of a catalogue of mental snapshots, images of moments where my client and I have led each other off (what I have known to be) the beaten path of psychotherapy and into exquisite moments of intensity.

Mutuality in therapy—some anecdotes

- A client complained that in the previous session I had seemed uncharacteristically preoccupied and far away. I thought back to the day of our last session and remembered that there was a lot going on for me at that time. I said, "Thinking back on it, I realize that you're right, that I was preoccupied that day. I'm very sorry—it was a mistake for me to let what was going

on for me intrude on our time together." She thanked me for the apology and my candor with her. We moved on to another topic, but I still felt a loose thread of strain between us. I asked her if she felt there was more to discuss about my preoccupied state in the previous session, and she said yes but couldn't identify what exactly. I asked her if she wanted to know what was so engrossing to me that it took me away from her that day. She said yes, and I revealed that at the time I'd just learned of my cousin's sudden death in a car accident. She responded that she felt incredibly moved and close to me because I shared my loss with her, because I was willing to be so vulnerable, and that I treated her "like an equal." Without rushing in to take care of me or abandon her own feelings, she expressed her condolences and inquired if I was O.K. In hindsight, I understand how important it was that I validated the client's perceptions of me, explained my affective state, and revealed my own vulnerability to pain.

- When a client woodenly and mechanically described a horrific incident of being brutally raped by her father, I started to cry. Suddenly concerned, she said, "You look so sad and scared!" I agreed that sadness and terror were indeed what I felt, and we went on to try to recover her lost affect about the incest. Although (or perhaps because) this was a completely spontaneous reaction for me, my client experienced my nonverbal expression of affect, and I was unconsciously connecting with her most deeply repressed pain.
- A client I'd been seeing for several years came in one day and began to discuss an acquaintance of hers who is also an acquaintance of mine. Toward the end of our conversation, I flippantly made a remark warning my client about this other woman's untrustworthiness. Visibly stung, my client said, "Actually, I kind of like her." Immediately recognizing my error, I apologized for my offhanded remark and acknowledged that while my protectiveness toward her had an important place in our relationship, my judgments of people we both knew clearly did not. My client persisted, saying, "You *never* do stuff like that—why do you think you did that?" Because I felt as if I had initiated this role reversal, and as a result she had a perfect right to continue it to its conclusion, I agreed to take a moment to think about her question. I said, "The only reason I can come up with right now is that I'm feeling nervous today because I have my own agenda—something I'd like to bring up with you, based on my own need, not yours—something I know from our past experience that it's hard for us to talk about." We went on to discuss the issue of whether I could include case material from our therapy in this presentation, a question she'd had complicated feelings about before. Later on in the session, after she'd agreed to be included in my paper, she said, "I don't want to tell you what to do, but I think you should use *this*—our talk today—in your mutuality paper." In this session, the only relationally responsible response I could have had to my stumbling was to be willing to examine my own process as it was located in our particular treatment relationship, and to reveal it to her. In addition, the issue of my occasionally bringing my own needs to our relationship became explicit and available for discussion.

The imprecision and artistry of the therapeutic process often demands that we take risks in the moment that we only fully comprehend much later. With enormous reverence for the particularly powerful process of connection in the psychotherapy relationship, I think that much of how we grow through therapy is mysterious, unknown, or indescribable. I believe it is the unique qualities of the therapy relationship that create a context in which the mystery can work its magic, in profound and life-changing ways.

The structural elements of the treatment relationship

The following essential structural elements of the treatment relationship provide the basic context for its uniqueness.

- It is a time-limited relationship with a formal beginning and ending.
- The relationship is primarily and explicitly dedicated to the growth of the client, based on agreed-upon goals.
- There is a contract about when, where, how often, and how long to meet, but the therapist differentially wields power in determining this contract—usually the therapist determines time slots, usually in the therapist's office, usually by conventions of the profession, 50 minutes weekly.
- The client comes to the therapist because she/he is experiencing difficulty and asks for the therapist's help, based on clinical training, expertise, and experience.
- For the individual client, therapy is usually the only current therapy relationship; for the therapist,

this particular therapy relationship is one of many current treatment relationships (Slater, personal communication, 1992).

- The client shares much more information about his or her life than the therapist shares about his or her life.
- The therapist agrees to keep the relationship confidential, and the client is free to reveal it to others at will.
- The client pays and the therapist is paid.
- The therapist's communications to the client are supposed to be purposeful and are intended to further the treatment relationship; the client's communications to the therapist are virtually unconstrained.
- The therapist has the responsibility and the power to make recommendations to the client; the client has the ability and power to respond.
- The therapist operates within a broad professional context (including training, professional affiliation, ethics, and legal and licensing requirements), of which the client may or may not be aware.
- It is primarily the therapist's job to monitor and maintain the structural elements of each treatment relationship.

These characteristic elements of the therapeutic relationship are not incidental details; rather, they are essential factors which make this particular connection sometimes quite odd but always unique. I believe that these essential elements are what we have to work with, and work within—not get beyond.

Asymmetry and mutuality

We cannot ignore that these elements predetermine an inherent *asymmetry* in the therapy relationship. When we attempt mutuality within the context of asymmetry, we face the enormous challenge of traveling in two seemingly opposite directions simultaneously.

But maybe asymmetry and mutuality are not entirely mutually exclusive. In an attempt to delineate a relational approach to psychoanalysis, contemporary analyst Aron (1992) defines asymmetry as the dissimilar and unequal division of responsibility, roles, and functions within the treatment relationship. In contrast, mutuality (as he defines it) involves "how reciprocal the interaction and the experience of interaction are; that is, do the two participants mutually and reciprocally influence each other" (Aron, 1992, p. 482). Aron also states,

> The fact that the influence between patient and analyst is not equal does not mean that it is not mutual. Mutual influence does not imply equal influence, and the analytic relationship may be mutual without being symmetrical. (Aron, 1991, p. 33).

Burke (1992) wrestles with the question of how to implement this contemporary analytic goal, concluding that the therapist must constantly negotiate "a central dynamic tension between the mutual influence of the participants and the asymmetry inherent in a relationship that emphasizes understanding the motivations of only one participant" (p. 241).

While the concept of a dynamic tension between asymmetry and mutuality is extremely helpful in understanding how to incorporate mutuality into psychotherapy, I find that these contemporary psychoanalytic discussions are critically flawed in their lack of attention to the issue of power. These analysts' ability to conceive of mutuality within asymmetry depends on ignoring the power dynamics of the treatment relationship. The dimensions of asymmetry and mutuality do not merely represent drastically different directions in *technique*; fundamentally, they represent stark dichotomies of power, with asymmetry implying power differential and mutuality implying shared power. When we include an analysis of power in the psychotherapy relationship, I conclude that extreme allegiance to the asymmetry principle is disrespectful of clients, ineffective, and probably at the heart of most forms of therapist/client abuse; *and* I conclude that true mutuality is impossible within a treatment relationship that is intrinsically constrained by power imbalances and differentials. When we, as feminists, expose the structural, institutionalized power differential of the therapy relationship, our negotiation of that central tension between asymmetry and mutuality becomes ever more complex and challenging.

I believe that in psychotherapy *movement* toward mutuality is both possible and desirable, but that the actual achievement of mutuality is impossible within the asymmetry of power of the therapy relationship. When we acknowledge exactly what prevents true mutuality, we facilitate the relationship's movement toward mutuality. Only if we acknowledge the existence of the power differential, the hierarchies and

the boundaries, will the client feel we understand and experience each of our positions in the therapy relationship.

Movement toward mutuality

Our recognition of therapy as a relational context of unequal investment and unequal vulnerability lays the groundwork for movement toward mutuality. In traditional approaches, the hierarchy and rigidity of the roles of therapist and client are infrequently acknowledged and even less frequently challenged. Only at termination does the therapist share more of her or himself as a real person, in order to break down the hierarchy and move toward equality.

Within a more relational treatment approach, from its beginning the growth of the therapy relationship fundamentally involves movement toward mutuality. Movement toward mutuality involves fashioning the treatment not solely from theoretical constructs or clinical experiences; rather, we allow both ourselves and our clients to consider that the client may have the most expertise on her or his problems—and her or his solutions. We allow and encourage unequal but reciprocal impact and the expression of mutual influence.

The movement toward mutuality may be achieved by various means. The therapist's disclosure of personal information about her life is only one method—one I have found to be too easy to do and too difficult to use effectively. It doesn't involve much creativity on my part to impart information about my life; but the usefulness of that information is often doubtful. However, there are several other movements toward mutuality at our disposal.

- The therapist can be open to being affected and changed by the treatment relationship (Jordan, 1991).
- The therapist can express affect about the client.
- The therapist can disclose opinions about the client.
- The therapist can admit uncertainty or error, including fumbling and indecision; the therapist can propose tentative hypotheses, instead of delivering sure interpretations.
- The therapist can accept and validate the client's expressions of caring and concern for the therapist.
- The therapist can validate the client's accurate perceptions about the therapist.
- The therapist can tell the client what she (the therapist) has learned from the client.
- The therapist can refuse to take precautions to prevent the client from seeing the therapist as "a real person."

Movement toward mutuality, of course, requires attunement to the client's needs; the therapist must use these techniques selectively, as their impact will vary from one treatment relationship to another, as well as from one point in time to another with each client.

Parameters and boundaries

As we've opened the door to reconsidering some of our basic notions about psychotherapy, I've found that our discussion sometimes makes me quite uncomfortable, and I chafe at some of the more extreme challenges to the traditional structures of treatment. I find myself concerned that in the spirit of critique and movement toward mutuality, we are overturning some of the cornerstones that make the therapy relationship uniquely valuable. Sometimes, our discussion of mutuality feels as if we were on a slippery slope, where we end up sliding into making the therapy relationship just like all others. For example, I've heard such questions as:

- "If the therapist's expression of her feelings toward the client is helpful, why limit it to only certain feelings—what about jealousy, competition, sexual attraction—why not share those feelings with clients as well?"
- "If we aim toward mutuality, then why can't we convert the intense connection of the therapy relationship into a friendship after termination?"
- "If mutual responsiveness and impact is a measure of movement toward mutuality, then doesn't it mean that something is awry in the treatment relationship if the therapist *isn't* growing from it?"
- "Isn't the whole concept of boundaries outmoded in a more mutual treatment approach?"

While I agree that we must ask such questions in order to determine the outer limits of the treatment innovations we're considering, I personally do not answer them in the affirmative. I believe that the bizarre, distinctive features of the therapy relationship are what allow for a kind of freedom for the client to grow, in ways that other relationships do not. If this was a relationship just like any other, clients wouldn't be paying for it. The movement toward mutuality depends on *acknowledgment* of a power differential, a role differential, and certain hierarchies—it does not depend on the eradication of these asymmetries. Once

those parameters are established, mutually understood, and their limitations confronted, the client can use the treatment relationship in ways that she or he has not been able to engage in other relationships.

Further, I believe that boundaries remain important in psychotherapy. I agree that the hypervigilant guarding of ego boundaries has been used to protect the therapist, sometimes at the expense of the client, and to frighten therapists away from their own authenticity and creativity. I conceptualize the *useful* boundary in psychotherapy more relationally, as a boundary around the relationship that provides a container which protects the relationship, allows much freedom within it, and contributes to making the treatment relationship uniquely valuable. The relational boundary involves time boundaries, space boundaries, and psychological boundaries.

Likewise, I view termination within a relational frame: I do not view termination as a final ending, beyond which I will permit no contact. I believe that the connection lives on beyond the ending, either through internalization, or through the client's overt desire to touch base with me from time to time, or for me to remain available for further therapy. As Herman, Gartrell, Olarte, Feldstein, & Localio (1987) write, "neither transference nor the real inequality in the power relationship ends with the termination of therapy." Likewise, Hall (1984) recognizes the difficulties in post-termination relationships because of the "half-life of transference exceeding that of plutonium." Although in my termination grieving I am often tempted by my own wish to continue our connection, I believe I am always more valuable to my client as her therapist than as her friend.

Mutuality in lesbian therapist-lesbian client relationships

Now, how does being a *lesbian* therapist affect issues of mutuality? I think things become considerably more complicated in the lesbian therapist/lesbian client relationship. Dillon (1992) has commented that mutuality in treatment is especially critical with lesbian clients because lesbians experience great mutuality in their non-therapy relationships and therefore require nothing less in their relationships with us. In a cultural context where lesbians are largely isolated, invisible, and cut off from peer or ancestral role models, lesbian clients may look to lesbian therapists to fill this gap. As with any oppressed population, a therapist's adherence to traditional edicts about neutrality can be dangerously interpreted by the lesbian client: silent neutrality within a context of oppression may be interpreted as the therapist's collusion with the status quo of homophobia—"no comment *is* a comment" within a climate of oppression.

While these factors would argue for the need for increasing attention to mutuality in treatment with lesbians, there are additional elements which complicate the lesbian therapist/lesbian client relationship. In order for the therapist to be more mutual, she must be willing to express herself with authenticity. However, Natalie, Suzanne, and myself are among the fortunate few who are able to be authentic with our clients if it is clinically useful. But many lesbian therapists work in agencies or communities where they must guard the secret of their sexual identity from their clients, and this secrecy fundamentally and powerfully constrains authenticity and, therefore, mutuality.

In addition, working as a lesbian therapist with lesbian clients means that you live and work in a small-town atmosphere, even if that small town is the New York City lesbian community. Dual forms of contact with my clients is the rule, not the exception. The lesbian client who is talking with me about her deepest pain at four is likely to be dancing next to me at a lesbian bar at ten, or working out next to me at the gym on Saturday morning, or marching next to me at a political rally next week. My response to the inevitability of dual contact with my lesbian clients is to become more vigilant in protecting the relational boundary and preventing *dual contact* from turning into a *dual relationship*. This distinction often brings up complicated, mixed feelings about the limitations and unique qualities of our therapy relationship—and we work together in each treatment relationship to use our confrontations with the particular realities of therapy within the context of the therapeutic connection.

Contributions of the Lesbian Experience to Mutuality in Therapy Relationships

Suzanne Slater

"I got your name from the lesbian referral service at the women's center," began my brand new client. "I told them I wanted to find a lesbian therapist who could work with me individually and who does long term therapy." With this beginning, the frame for our new therapy relationship is already forming, based on

the acknowledgment that we are two lesbian women coming together to create a one-to-one, potentially close relationship with each other. Many of my lesbian clients know I am a lesbian before they come to see me. As members of an oppressed group, it is adaptive and often necessary for them to elicit this information about potential therapists before they risk inviting a therapist into their most private emotional worlds.

The first information exchanged between us pertains, then, to me, not to the client, and it is personal knowledge about me, relevant to my own relational and sexual life with women. Over time, whatever meanings this particular client will attach to my lesbian identity or to this commonality between us will emerge as we proceed and will differ from those of other clients. However, my client's knowledge of such personal information about me moves the connection beyond the bounds set forth in traditional constructions of therapeutic relationships and establishes that we are creating something outside of that restricted model of relationship. While heterosexual women therapists and clients may also discover their shared heterosexual identity, the all-female therapy relationship does not recall for them the same reminiscences of their lover relationships, and, in fact, specifically distinguishes the therapy relationship from the heterosexual lover relationships they form in their personal lives.

Even prior to therapy, lesbians gather experience in creating their relationships with no models of how *healthy* lesbian relationships should look. All lesbian relationships reflect a choice to move beyond social restrictions and invite both women to venture into clearly forbidden territory. Lesbian friendships, lesbian family relationships, collegial partnerships, and other lesbian-to-lesbian ties all demonstrate this independence, with the women looking to their own needs, desires, and individual priorities to shape their resulting bonds. Each relationship takes on the quality of an unfolding and unpredictable intimacy where the full emergence of the connection is jointly developed.

I will focus here on the parallels between lesbian love relationships and the therapy relationships formed between lesbian therapists and lesbian clients. I will suggest that the therapy relationship is intangibly influenced by both clients' and therapists' associations with each woman's experiences in her lesbian love relationships. This underlying nuance—or reminiscence—may be wholly or partially unconscious and ties the primary elements of the lover bond to some aspects of the structure of the therapy relationship. Parallels can be observed in the way lesbians frequently prioritize high levels of emotional closeness, in the way they create unique relational boundaries around the couple or therapy dyad, and in the contact some lesbians maintain with one another after the therapy or lover relationship ends. While much of the carry-over is specifically outside the sexual realm, I will recognize the potential presence of sexual attraction within this reminiscence, as well.

Lesbian identity and mutuality

All lesbians reach a critical crossroad. When two women find that fully entering into their closeness includes sexual and romantic feelings, women must choose between authenticity and conformity. Either the women can act on their authentic sexual attraction to each other *or* conform to powerful social injunctions against unrestricted intimacy between women—not both. By definition, lesbians are women who have faced this decision and have chosen to deepen their bond and go beyond the point at which society orders them to stop. Lesbian identity is achieved by prioritizing this desire for full and forbidden connection over complying with the imposed structure for the relationship.

Studies done by Loulan (1988), by Blumstein and Schwartz (1983), Peplau, Padesky, & Hamilton (1982), Eldridge and Gilbert (1990), Mencher (1984), and others have examined the relational features most central to lesbian couple relationships and have found that lesbian couples prioritize exactly those interpersonal elements which are most essential to the development of mutuality—empathic identification, a focus on emotional closeness, high expectations of self disclosure, and emphasis on relational equality. Partners commonly work to hone their abilities to negotiate both getting their own needs met and meeting the needs of another within the context of an all-female relationship. The couple continually balances identifying with each other as women, and as lesbians, while still differentiating between each woman's unique identity.

These components are especially conducive to developing a mutual relationship in therapy as well, where therapist and client share crucial personal commonalities despite their clearly distinct identities and roles. While in therapy, the focus is, and should be, disproportionately placed on meeting the client's

needs, movement toward mutuality is nonetheless enhanced and complicated by reminiscences of lesbian love relationships present in both women's lives. Client and therapist alike may be prepared to view each therapy relationship as an especially unique and uncharted exchange, looking to themselves to shape the complexities and boundaries of their developing relationship as a result of their experiences in constructing without models their own personal lesbian relationships outside of therapy.

Movement toward mutuality between client and therapist requires a rejection of traditional, nonmutual, male-defined models of relationship that bear partial similarity to the nonconformity required of lesbian women. As is true for lesbian lovers, the client and therapist reach a crucial turning point that can also be characterized as a choice between authenticity and social conformity. Either they can comply with the restrictions imposed in traditional models of therapy or venture into the still-controversial realm of collaboratively constructed therapy relationships. This choice serves as the clear point of departure from social convention. While lesbians are not the only women who value exclusively woman-to-woman relationships, lesbians have given these connections particular prominence in their lives, and have done so at tremendous social cost. Each lesbian brings to the therapy relationship a special seriousness about her connections with women and a desire to form genuine intimacy without the socially required participation of men. Therein, these lesbians demonstrate a commitment to the relational process at the expense of traditional social or professional approval. The two relational experiences, of being lesbian lovers and of being a lesbian client and therapist partnership, contain crucial parallels that can inform and shape the development of the therapy relationship. In therapy, these parallels may be manifested in a variety of ways, including a high level examination of the real (in addition to the transference-based) therapy relationship typical of some lesbian therapy dyads, a particular and mutual openness to negotiating how the therapist will and will not use self-disclosure in a relationship that began with a revelation of personal information about the therapist, and possibly also in a testing of boundaries on the part of some lesbian clients. In these and other ways, lesbian clients may be less likely to conform passively to a provided model for the therapy relationship and may expect to have input into the relationship's character and parameters.

Both lesbian lovers and lesbian therapy dyads striving for mutuality come up against a similar ambiguity when they opt for the uncleared path toward a more obscured but promising relational journey. Without maps to indicate how lesbian love or more mutual therapy relationships should look, both couples and therapy dyads are simultaneously burdened and freed up to construct their relationships virtually from scratch. While lesbians forming *therapy* relationships are guided by clearly different goals than are lesbians creating *couple* bonds, both invite the inevitable ambiguity that emerges when women allow their bonds to develop in their own unique way. Heyward (1989b) captures the essence of this relational unfolding in her statement, "Mutuality, like equality, signals relational growth and change and constitutes an invitation into shaping the future together" (p. 34). She continues, " . . . both people should be growing and changing in the relationship, mutually empowered to become more fully themselves with one another" (p. 35).

Lesbian couples must invest continual effort in this creative process—constructing their relationships according to their own needs and choices and monitoring their progress vigilantly. Frequently, lesbians are world-class processors, able to analyze at length (and occasionally ad nauseam) the most intangible of interpersonal dynamics. As Dillon (1992) has pointed out, lesbians are familiar with and open to relational complexity. Lesbians often view getting in there and working on their relational process as a source of closeness in and of itself. They may come to therapy equally prepared to examine the dyadic process emerging between client and therapist.

Constructing boundaries

In both therapy and couple relationships, lesbians must discover what boundaries are needed between the two women and also between the relationship and the outside world. Lesbians commonly respect the utility of relational boundaries, and they expend much energy in creating and preserving selected boundaries. Lesbians commonly cultivate lesbian-to-lesbian friendships that are highly mutual and also clearly nonsexual. Many lesbians skillfully navigate the particular complexities of forming nonsexual intimacy with one another.

Likewise, more mutual therapy relationships also demand particular boundaries. While movement

toward mutuality does involve transcending *traditional* conceptions of therapy relationships, these more mutual therapy dyads are not formless relationships where all boundaries are automatically discarded. Lesbian clients may come to therapy specially equipped to help select useful relational boundaries. However, unlike the situation in couple relationships, establishing and preserving those boundaries in therapy is a mutual but unequal exchange. The therapist assumes ultimate responsibility for boundary maintenance, frequently collaborating with her clients but not capitulating in disputes over needed relational limits.

In addition, societal homophobia imposes a continual need for lesbians to present their most intimate and private relationships either as nonexistent or as superficial to the surrounding mainstream community. Lesbian couples face pressures to hide the true nature of their relationships due to the very real dangers associated with coming out. Similarly, therapists deliberately keep the treatment relationship secret, resulting in the powerful duality of great intimacy behind closed doors and little or no acknowledgment that any such attachment exists in front of others. Lesbians in therapy may recognize this contrived but necessary pattern of interaction from their experiences in lover relationships. Because lesbian therapists and clients share what are usually small lesbian social communities, there is a strong likelihood that they will travel in overlapping social circles. They may, therefore, frequently be confronted with the need to enact a duplicitous exchange, where minimal head nods suffice as recognition of actually intimate, private bonds. The similarity to their lover relationships may be at times quite conscious for one or both as this familiar dance is repeated.

> Terry and Andrea didn't often go to plays in Springfield. It was one thing to be out together as a recognizable couple in Northampton, but neither felt the same safety being identified as lesbians in Springfield. Throughout the evening, they avoided touching and watched the crowd more vigilantly than felt comfortable. Part way through intermission, Terry spotted her therapist sitting in a nearby section of the theater. Clearly aware of each other, the therapist nodded to Terry in an acknowledging but understated way. Privately, Terry felt vaguely amused that two of the most important women in her life were here, and no observer would ever be able to tell.

Beyond termination

Lesbians' experiences in couple relationships also color their therapy relationships after termination. While heterosexual couples more frequently end contact with each other after they have broken up, lesbians frequently work to maintain connection after they are no longer a couple. This effort is based on the belief that relational bonds extend beyond the two women's roles as lovers. The basis for relationship is less wholly dependent on their lover status than is true for other kinds of couplings. Likewise, lesbians in therapy may challenge traditional conceptions of termination, where clients and therapists relinquish all contact with each other and avoid future connection of any sort. Lesbians' normative efforts to create post-break-up relationships with ex-lovers may inform their responses to the traditional prohibition against post-termination contact between clients and therapists. Hence, the lesbian therapy dyads may exhibit a wider range of post-termination arrangements between clients and therapists. Also, as Julie has mentioned, because the lesbian community is small in most areas, unplanned contact between lesbian clients and therapists after therapy has ended is quite likely, whether or not either considers this interaction desirable. This may actually limit the options for clients and therapists, as in practice a choice to have no further contact may be difficult to accomplish.

> "I can't believe I won't be back after seeing you every week for four years," my client commented tearfully. "I'll miss seeing you and being able to connect with you." My client and I knew we would be running into one another this very weekend, since both of us were invited to a small memorial service for a mutual friend. We both acknowledged the paradox of working to bring closure to our relationship knowing we'd be seeing each other again right away. It was too soon after this final session for us to have contact, and yet, neither would agree to forego the weekend's important event. How could I help my client fully experience this ending, when we both knew we'd repeatedly cross paths

before any time had passed at all?

Sexual tensions

Finally, it cannot be ignored that the commonality shared by lesbian therapists and clients is a sexual as well as a relational one. Within the intimacy and privacy of the therapy relationship, lesbian clients and therapists develop relational features which bear similarity to their love relationships. Specifically, client and therapist renounce overly confining relational boundaries, increase their collaboration in shaping their relationship, and prioritize the development of their authentic connection. Each woman knows that in their private lives outside of therapy this process has included sexual feelings. Heyward (1989b) has bravely articulated the sexual nuance in the development of mutuality in her statement, "Our sexualities are our embodied yearning to express a relational mutuality in which the tensions are sustained, not broken . . . There is remarkable erotic power in these tensions" (p. 33-34). Within a therapy relationship there is potential for this sexual tension at moments of relational breakthrough.

> For many weeks I could feel we were nearing a profound secret. My client's eyes studied me constantly, clearly looking for clues as to whether or not I would be able to handle the truth she was considering sharing with me. Finally, she found her moment and took the risk. "My best friend and I were secret lovers for twelve years," she said. "We would meet every night after our husbands went to work for the 11 to 7 shift, and we would stay together until they were soon due home. We'd set a clock to be sure to be back in our beds before they arrived home." The content of her secret surprised me only slightly and was not difficult to hold. The look in her eyes, however, gave me pause, as we sat silently in her moment of greatest exposure. My client shifted anxiously, uncomfortable in the silence that followed her disclosure. She knew she was suddenly more exposed, revealing a sexual truth about herself that filled her with both fear and shy excitement. The resulting tension between us felt distinctly sexual and I, too, was uncomfortable as I recognized that my own feelings had become sexually charged as well. At exactly this moment of revelation that she, too, is sexually involved with women, our own connection was being tested. We were both women for whom moments of great intimacy with another woman had in our lives become sexual. Neither of us could escape the unspoken fact that vestiges of that same blending of close and sexual feelings which were so welcome in our personal lives had subtly found their way into the therapy relationship as well.

In conclusion, while lesbian love relationships and lesbian therapy relationships contain critical and fundamental differences, lesbian client and therapist dyads engaged in working towards mutual (though unequal) therapy relationships do so in the presence of an underlying reminiscence to each one's experience in forming lesbian love relationships. The association between these two central forms of lesbian-to-lesbian connection occurs at varying levels of conscious awareness and is certainly not universal for all lesbians. However, lesbians bring unique experience to the tasks of redefining the boundaries between client and therapist, of welcoming relational ambiguity, and of making their connections with women primary at particular social cost. In addition, lesbian experience also informs clients' and therapists' approaches to managing the dichotomy of sharing great closeness behind closed doors yet hiding the relationship from others, of juggling complex realities related to their therapist-client contact after termination, and of recognizing the potential for sexual feeling inherent in the developing emotional connection. While nonlesbian therapy dyads may also achieve these relationship qualities, the association between lesbian experience and the tasks of developing genuine client-therapist mutuality offers a particular contribution to the wider discussion of therapeutic mutuality between women.

Mutuality, Psychotherapy, and Ethics

Natalie S. Eldridge

Why is ethics a key element in our discussion of the movement toward mutuality in psychotherapy? In our discussions, we found ourselves stumbling over the limitations of our more traditional conceptions of ethical standards of practice. At the same time, it became increasingly necessary to make a clear link between a defined ethical framework and our own movement toward mutuality in our practices. It is by this domain of ethics and professional identity that we

can distinguish between psychotherapy relationships and all other relationships in which we engage.

My thoughts on mutuality, psychotherapy, and ethics have been nourished by many people: Carol Gilligan (1982) and her colleagues' work on moral development, the work of both Laura Brown (1989, 1991) and the Feminist Therapy Institute (1987) on feminist ethics, Carter Heyward's (1989a) moving challenges in her papers here at the Stone Center, and the pioneering work of Melba Vasquez (1992) in voicing the importance of gender and ethnic diversity in training clinicians to practice ethically. I have been further stimulated and challenged by my involvement with the Stone Center Lesbian Theory Group.

From this rich context of feminist theory I want, first, to suggest a way for therapists to view ethics from a relational model. Next, I'll give an example of how this relational view can be useful in understanding the movement toward mutuality in psychotherapy. Finally, I will offer some cautionary suggestions for considering ethics in psychotherapy to those of us traveling in the uncharted territory between traditional views and not-yet-clearly formulated alternative frameworks.

Ethics from a relational frame

"Thou shalt not have sex with your client...."

"Thou shalt not have dual relationships with your clients...."

"Thou shalt not use therapy relationships for personal gain...."

Regardless of how the ethical codes are worded, most of us have been trained to conceptualize the ethics of our practice as a list of commandments, or rules. If the rules are broken, the result could be a compromised treatment for our client, negative judgments by our colleagues, and/or a legal suit brought against us. Some of the most agreed upon rules have been reified by becoming laws dealing with confidentiality, the duty to warn, and, in some states, sexual contact between client and therapist. Those "ethical practices" that have become laws are the most clearly understood and discussed in professional circles, because of the threat and enormous cost of legal liability. An orientation around rules is what Gilligan (1982) has defined as a morality of rights, where justice and fairness prevail—an orientation most pronounced in the moral reasoning of men. It is on this frame of morality that our legal system, and much of Judeo-Christian culture, is based. Gilligan (1982) compares the morality of rights with a morality of responsibility, where an ethic of care and relational considerations prevails—an orientation she discovered as she listened to women struggle with both hypothetical and real decisions. In a morality of responsibility, reasoning is based on weighing conflicting responsibilities to the various relationships in which a person is engaged.

The work of psychotherapy is certainly about care, and our ethical standards and codes do reflect underlying principles of care, such as our responsibility to do no harm to our clients (Kitchener, 1984, 1988). Yet the emphasis in our ethics training seems to be on what we should avoid, rather than what we can do, to ensure an ethical stance of doing no harm. We learn to avoid certain behaviors, but are not always provided with a theoretical frame that describes what it is about that behavior that makes it unethical or that helps us respond to the less defined, more subtle situations which can arise in our practices.

I am suggesting that while the effective practice of psychotherapy relies heavily on a morality of responsibility and care, our professional standards and codes of ethics are communicated to us largely within a morality of rights and justice, with the implication that fairness and universality should prevail. Although there are ethical imperatives which should be applied universally, I believe that some areas of ethical deliberation need a more complex and flexible kind of reasoning. It is the ethic of care, most pronounced as we listen to how women reason, that we need to understand more fully in order to apply an appropriate ethical frame to a relational therapeutic model.

A relational context in psychotherapy, and in our ethical thinking, allows for greater variability and diversity in our practices which, in turn, can reflect the needs of our increasingly diverse clientele. However, variability runs counter to a basic tenet of our training. We are taught to develop *universal* rules and standards of practice and to apply them with no variation to all clients. Indeed, if we vary our practice from one client to another, aren't we taught that we are risking a potential ethical violation through our own countertransference reaction? I have found this question arising often with colleagues and supervisees. My response is that we should indeed observe, and recognize, any variations in our practice from client to client. The goal, however, is not to ban all variation, but to question why there is variation

and if it is therapeutic. Where traditional thinking and a "fairness and consistency" model of ethics prevail, such a variation is suspect by its very existence. I suggest that we must take the next step and ask the relationally therapeutic questions of what is appropriate care for the particular client, for the particular therapeutic relationship, and for the given therapist? Could a particular response (such as silence and a neutral affect) be therapeutic with one client and abandoning with another? I think the answer is a resounding yes. Could a therapist's response (such as tears) be unthinkable (a clinical error) with one client and therapeutic with another? Absolutely. For example, I have found it therapeutic to sometimes share my tears with a client who is discussing a significant loss. With terminally ill clients, I have been moved to tears by the prospect of the loss of my client through death. Yet the client who is facing her own death, and finds everyone in her life dissolving into tears when she tries to discuss how she feels about dying, may need a different response from her therapist if she is to experience her process in a fuller way. It is a consideration of the relational context of each dyad, at each stage of the relationship, that guides the therapist about this ethic of care.

As we take a step deeper in negotiating mutuality in psychotherapy, we move beyond discrete behaviors, such as showing an emotional response or sharing a piece of personal information. At the base we find the psychotherapeutic frame and our responsibility as therapists to construct and preserve that frame.

Yet how clear are we about what that frame is? How do we each, personally and professionally, understand and experience the process of constructing and preserving this frame? In considering this question, I came up with a working definition for myself: The therapeutic frame is both an internal image and a set of concrete behaviors, held and acted on by the therapist and communicated, over time, to the client. Within the parameters of this frame, both therapist and client engage in a negotiation of intimacy and power that will maintain safety and a therapeutic climate for the healing and growth of the client. Various therapeutic orientations and cultural experiences affect how we, as therapists, might envision this frame. I believe the Lesbian Theory Group's particular views of the therapeutic frame, though not absolutely congruent among those in our group, are still informed in some common ways by our experience as lesbians, personally and professionally.

On a personal level, certain cultural factors emerge which have been discussed by both Julie and Suzanne. As lesbians, we are likely to have been relatively unconstrained by the heterosexual "frame" for couple relationships; instead we have negotiated normative lesbian paradigms of high-intimacy, shared-power relationships (Eldridge & Gilbert, 1990; Blumstein & Schwartz, 1983; Peplau, Padesky, & Hamilton, 1982).

On a professional level, unless we refuse to work with lesbian clients, or unless we deprive ourselves of lesbian community involvement and support, our social and political community is comprised of us and our clients. Therefore, we are challenged to find therapeutic and ethical ways to maintain a therapy frame that will neither deny the other contacts that may occur, nor be destroyed by them. I will use this dilemma of working within a small community to illustrate some principles of ethical thinking from a relational orientation.

Examples of relational ethics

Dual roles between therapist and client are specifically taboo in the professional codes of ethics, one of what Brown (1989) calls "the thou shalt nots." Since the traditional ethical stance of complete separation between personal and professional contacts is impossible for many lesbian therapists treating lesbians, the first step is to reframe and name our common experience. Berman (1985) has suggested the term "overlapping relationships" to describe those aspects of therapists' and clients' lives that will intersect within a small community, even when the therapist exerts great effort to avoid dual roles. If we begin with the premise that some overlap is unavoidable, we must go on to explore ways to delineate and maintain clear boundaries around the therapeutic frame in this more mutual therapeutic context. How can we embrace the predictable reality of overlapping relationships and yet avoid what is dangerous and harmful in the broader concept of "dual relationships"?

I would like to suggest several guidelines. First, we can recognize and validate the existence of overlapping relationships, to ourselves, our colleagues, and to our clients. Otherwise our own shame or denial of the existence of these "breaks in the traditional frame" will get in the way of conscious and thoughtful decision-making about how to maintain a

useful frame in this particular system. Jordan (1989) has written eloquently on the power of shame to destroy connection.

Second, we can be active in preplanning the ethical management of anticipated overlapping relationships. We can predict potential overlaps with clients at the outset and collaboratively set up norms with the client that will contain both boundaries and connectedness in such outside encounters. The Feminist Therapy Code of Ethics (1987) developed by the Feminist Therapy Institute is unique in addressing the concept of unavoidable overlapping relationships, and offers the following as one of its guidelines: "A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client" (p. 2). This suggests that we don't need to flee from the possibility of role overlap, but rather we are to take responsibility for making the first step toward boundary management.

Third, we can develop a more complex concept of the therapeutic frame than the traditional one. The traditional frame is what Brown (1991) has called an "abstinent frame," and is conceptualized as invariable from client to client, with any variations seen as breaks in the frame, and, thus, as opportunities for boundary violation. For example, within an abstinent frame, self-disclosure of certain personal information or emotional responses would be seen as a boundary violation regardless of the relational context of the particular situation. Similarly, within a different frame, a therapist who views self-disclosure as always valuable, holding it as a kind of ideal, may also fail to recognize the circumstances in which self-disclosure is clearly contraindicated. Mutuality must begin with a very clear focus on the particular cultural and therapeutic context of each therapy relationship.

As an example, all lesbian therapists must deal with the question of whether, when, and how to come out to clients. From an "abstinent frame," the therapist might choose never to directly come out to clients. But even if the therapist espouses a norm of never disclosing her sexual identity to clients, the client may uncover this information and may bring it to therapy. How does the therapist hold the therapeutic frame and deal with this intrusion of information? How does the therapist deal with this authentically? What harm could come from the therapist's failure to acknowledge her sexual identity? On the other hand, if a therapist holds a norm of always coming out to her clients, what happens if a client doesn't want to know? There are some clients who are simply not ready to hear this information and effectively defend against it by denying it, and there are those who, to their detriment, will hear it and feel bombarded by such a disclosure. The therapist who makes this decision on a clinical basis, case by case, must deal with the complexities of reviewing her therapeutic frame within the context of each therapeutic relationship. It is often more comfortable to stay in an abstinent frame than to deal with the demanding process of negotiating these complexities.

Fourth, the application of a feminist analysis of power in therapy can help us to clarify and set appropriate boundaries for the therapeutic frame. We can include the client's expertise in determining appropriate boundaries by providing options for discussion. At the same time, we must acknowledge that our power is not equal and not capitulate to the desires of our client when they differ from our own clinical judgment. I think my clinical judgment must be based on what the client wants, on what I think is best for the client, a*nd* on what I am comfortable with as a therapist and a person. Still, some boundary violations can be avoided simply by asking the client what will work best for her rather than making a priori assumptions from an expert position.

Finally, weaving an ethical framework into our training and practice rather than treating it as something we add on later will help us to develop a more integrated orientation to our ethical and theoretical understanding. Each of us has to begin by developing our own ethical code, in consultation with others and in a way that is congruent with the existing codes to which we have already agreed to abide. An example of how one lesbian therapist has woven an ethical code for herself is offered by Gartrell (1992) in her recent article on "Boundaries in Lesbian Therapy Relationships." Although others, including myself, would not necessarily come to the same decisions about our practices, Gartrell's clear delineation of her stance on boundaries provides a good example of the development of one therapist's relationally-responsible code of ethics.

Practical suggestions for an ethical use of mutuality in psychotherapy

1. Acknowledge and own the power we have as

therapists and the inevitable power differential between therapist and client that forms the frame of psychotherapy. Denial of our power is dangerous.

2. In reviewing our own practice and ethical standards, go beyond concrete do's and don'ts to ask ourselves "why" or "why not" about each behavior. This questioning practice can help to keep our ethical framework more conscious and aligned more closely to our theoretical orientation. It is easy to violate the spirit of an ethical code or standard without violating the letter of the code.

3. Therapist self-care is an ethical imperative. If we are not fairly consistent in caring for our changing personal needs, it will be very difficult (if not impossible) to prevent us from meeting those needs in our therapeutic relationships. A part of this self-care is recognizing the limits to our flexibility as we work with our clients. For those of us with large practices in a small community, there are very real repercussions if we vary certain boundaries with one client and not with another. Our clients talk to one another about their experience of therapy and what they know about us—a normal response for an oppressed group checking out levels of safety and struggling to create mutual models of relationships, including therapeutic relationships, that reflect their unique needs. The therapist would be wise to consider this broader context for her practice and assert the boundaries she needs in order to provide adequate privacy and consistency. This kind of self-care is particularly critical when the therapist is a member of the same extended community.

4. The last, and probably most essential suggestion, is to make ethics a relational process: consulting, questioning, discussing, disagreeing, clarifying . . . these relational processes help to heighten our awareness and capacity to create a living ethics for relational psychotherapy.

I leave you with more questions than answers about mutuality, psychotherapy, and ethics. I have suggested the complexities involved by highlighting a few of the interlocking pieces. We need to grapple with the combination of the need for some universal ethical imperatives and the importance of aspects that must be handled on a case-by-case basis. We must be careful not to replace traditional edicts with "relational edicts," not to substitute one set of "thou shalt nots" for another.

I believe that by integrating more of the voice of responsibility and care into our understanding of ethics, along with the voice of the "thou shalt nots," we can enrich our practices and weave an ethical framework more congruent with a relational model of psychotherapy.

Conclusion

In conclusion, once we, as therapists, have relinquished the security of an allegiance to asymmetry (at the expense of mutuality) *or* to mutuality (ignoring asymmetry), we find ourselves in the more complicated territory of engaging in the tension between these two seemingly opposed elements of psychotherapy (Burke, 1992). In this paper we have examined the challenges of engaging in this tension in each therapy relationship, in each session. Furthermore, the process of incorporating mutuality into psychotherapy involves always being mindful that each individual therapy relationship is firmly rooted in a tradition and structure of power, as well as being embedded within a broader context of culture and community. Raising questions rather than giving answers, we have tried to build a frame around which to negotiate a very complex topic and to add our voices to what we hope will be a continuing dialogue on the conundrum of mutuality in psychotherapy.

Discussion Summary

After each colloquium lecture, a discussion is held. Selected portions are summarized here. Drs. Judith Jordan and Irene Stiver joined in the discussion.

Question: I want to thank you for taking risks and addressing some difficult issues. To address one of Julie's examples: When a client picks up accurately that we are preoccupied in a session, how far do we go with that? Do we give her her money back?

Mencher: No, I don't think that we have to go that far. I think that interaction becomes part of the fabric of the therapy relationship. It's the reality of relationships of all kinds that attentiveness and attunement are not perfect. I think there's something to be gained in a client seeing that we are not perfect, and in using that in the therapy. I often say to clients, "Let's look at how it feels to you to learn that I'm not perfect." For some clients, it feels like an assault; for other clients, it feels like a welcome relief. It has to be negotiated in each particular relationship.

Jordan: I'd like to add that the client may get double her money's worth in the session—where the discussion of the "failure" can be incredibly

empowering and validating.

Slater: We need to distinguish between different kinds of preoccupation. When there is an event in the therapist's own life that makes it understandable that the therapist will feel called away, that's one thing. A different situation is when I find that with a *particular* client, I'm more likely to feel preoccupied than with others. In those cases, we need to examine what is going on in the client, or in that particular treatment relationship that is causing that reaction.

Stiver: We expect that there will be rhythms of connection and disconnection in the therapy relationship. It is the ethical responsibility of the therapist to examine her part in these rhythms and work on them with the client.

Question: I also want to thank you for the risk-taking. I'm concerned, though, about some of the assumptions I heard in Suzanne's paper and also in the beginning of Natalie's—that lesbians bring to therapy great previous knowledge of mutual and intimate relationships. We need to remember that all lesbians are women first. That means that many of our lesbian clients are survivors of abuse, are substance abusers, and have grown up in a violent world. I don't think that we can generalize that they'd have experience with selective boundary-making and with knowing about mutual and intimate relationships. Every client is unique.

Also, can you, Suzanne, discuss how you handled the situation of experiencing sexual tension with your client?

Slater: I really agree with the first part of your comment. I am not attempting to say that lesbians do it best. But because lesbians form relationships with no models whatsoever, because we really have to start from scratch, we come to relationships with more experience of having to work on the process. It does not necessarily mean we've all done a spectacular job or that some lesbians don't bring impediments to that process.

About the clinical example: The presence of sexual tension is one of the most difficult things to handle in therapy. For many people, it comes up infrequently. I certainly don't mean to suggest that this happens all the time between lesbians. In many situations, I would choose not to talk about my sexual feelings, because of the risk of reenacting a frequent situation in female experience, i.e., the imposing of other people's sexual feelings on women. I think you have to be very clear that the revealing of your sexual feelings is in the client's best interests and not a way of coping with your own discomfort. I wouldn't say *never*, but I'd have to have some very clear reasons for it, and if I didn't I'd err on the side of not discussing it openly.

Mencher: I *would* say *never*. I would never reveal to a client that I have sexual feelings for her that come from anything outside of a response to her feelings for me. I think this is because the therapy relationship exists within a culture in which sex is *so* burdened, so laden with baggage, that I think that my saying to a client, "I'm attracted to you" cannot be cleanly therapeutic within that cultural context. The issue of erotic transference and countertransference is extremely complex, and our training is very inadequate. I think that it's often important to bring these questions about particular cases to a consultant or supervisor, while also realizing that our consultants may not feel solidly expert on this issue either. This is clearly a topic that we could explore much further.

Question: I want to raise a dilemma that my colleagues and myself encounter a lot—how to manage participating in a 12-step program, being lesbian-identified, working with lesbian clients, and going to lesbian meetings. I've tried many different ways of dealing with this. I talk to clients about what meetings I go to, and which meetings I'd like them not to attend because I speak there and they are my home meetings. There's quite a lot to that. It pushes against the culture of 12-step programs, that they are open to everyone. It also has implications for anonymity; if I'm at a meeting and I hear a client speak, and I hear something that concerns me, then how do I deal with that piece? It's another issue I'd like us to consider.

Mencher: I think your comment is very important, both within a 12-step context and for therapists as therapy clients as well, e.g., therapists participating in group therapy. You raise the question, how does the therapist communicate and delimit her own authentic needs? At what point do I say to my clients, "I need something from you." "I need you not to go to that meeting." "We need to figure this out." I think it's important that the therapist take the step to say, "We need to figure this out together."

Eldridge: I think that, in your comment, you really delineated your own ethical frame and struggled with how you're going to balance your own needs within that—that's what we need to do more of, proactively and in consultation and collaboration with

our colleagues.

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