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Ready or Not, Here I Come: Surrender, Recognition, and Mutuality in Psychotherapy

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Randall Lehman Sorenson practiced what he preached as a scholar, teacher, and clinical psychoanalyst. In my experiences with him in personal and professional contexts, he encouraged relationships characterized by mutuality, respect, curiosity, and genuine personal involvement. These key values and processes distinguish relational psychoanalytic psychology. This article will explore the clinical outworking of two interrelated concepts; namely, mutual recognition and self-assertion in the psychotherapy relationship. These together are foundational to the creation of what Benjamin (1995) calls intersubjectivity. I will develop a particular focus on how to move out of moments of relational impasse and into a new experience of freedom and possibility for growth. An in-depth case presentation with a particular focus on therapeutic interaction will illustrate the struggle toward mutuality and recognition, and the powerful positive effects for both persons in the relationship.

Hanging on the wall between the two overstuffed chairs in my psychotherapy office is a print of a painting by Mary Cassatt, an American woman that was invited into the inner circle of the French Impressionist painters at the end of the 19th century. *A Child's Bath* depicts a fully dressed woman bathing a child wrapped in a towel on her lap. There is a basin of water on the floor at their feet. "The woman's gestures–one firm hand securing the child in her lap, the other gently caressing its small foot–are both natural and emblematic, communicating her tender concern for the child's well-being. The two figures gaze in the same direction, looking together at their paired reflection in the basin of water" (Art Institute of Chicago, 2006). This painting has become, for me, a beautiful and instructive metaphorical picture of psychotherapy: themes of holding, vulnerability, closeness, attachment, peace, and, most especially, recognition come to mind. And these relational themes emerge in the context of a purposeful relationship–both people engaged in a goal-oriented task aimed at promoting the well being of the child.

The most fascinating aspect of this particular painting for me is the focus of the attention of the mother and child: they are both looking down into the basin that the mother is using to bathe the child's feet. Their gaze at their paired reflection is a symbol for one of the most significant aspects of the psychotherapy relationship; namely, that it provides a way of seeing self and other–it represents symbolically a reflective space in which both persons can see and be seen together, where both mutual recognition and self-expression become a possibility (Pizer & Pizer, 2006; Benjamin, 1995). In that reflection, both see themselves individually and see themselves as a dyad. Both see a reflection of self and other that is in some proportion based on what is arriving from the outside (i.e., the incoming sensory data from the reflection), and in some proportion based on what is emerging from within that colors their perception (i.e., the projected wishes, fears, expectations). Moments when both therapist and patient together can create and sustain the conditions for this kind of gazing are powerfully therapeutic. This article will explore the clinical outworking of this concept of mutual recognition and self-assertion in the psychotherapy relationship, with a particular focus on how to move out of moments of impasse and into a new experience of freedom and possibility for growth.

Introduction

Randy Sorenson was an exceptional person. He possessed a remarkable mind. The scope of his

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knowledge about psychoanalysis, psychological and social science research methods, Christian theology and history, philosophy, and the integration of faith and psychology astonished many of us that knew him. But I think that the thing that made the most lasting impression on me about Randy was his openness to people and ideas that were divergent from his own. He practiced what he preached: he encouraged relationships characterized by mutuality, respect, curiosity, and genuine personal involvement. He engaged with ideas and people with different horizons than his own orthodox Christian worldview. And not only did he engage—he formed real relationships characterized by humor, genuine interest, and honesty. He was generous and 'big-hearted' —he gave and received in our relationship. I consider myself deeply blessed to have been one of those people that got to know Randy a bit as a person.

My own approach as a psychotherapist finds its greatest resonance with the contemporary relational psychoanalysis that Randy both practiced and taught (Mitchell, 1988; Sorenson, 2004). This perspective is characterized by its social constructivist commitments, focus on interpersonal and intrapersonal domains of experience, and view of mind as '… transactional patterns and internal structures derived from an interactive, interpersonal field' (Mitchell, 1988, p.17). In brief, the contemporary relational perspective can be contrasted with more classical (i.e., drive theory) psychoanalytic ideas. So, for example, the relational perspective developed and revised assumptions of the classical model:

- From drive for gratification to drive for relationship as the basic motivational construct
- From asymmetrical relatedness to relative mutuality in the therapeutic relationship
- From objective knowing (via interpretation of 'data') to subjective understanding (via empathy) as the primary epistemic method
- From viewing the change process as making the unconscious conscious so that people are more free to choose to uncovering and loosening attachments to familiar maladaptive relational patterns in order to broaden relational options

Clinically, this approach emphasizes and makes use of the relative symmetry, mutuality, and shared power in the therapeutic relationship. In contrast with most *modern* psychotherapeutic models, including classical Freudian psychoanalysis, this approach does not privilege the psychotherapist with a 'view from above' or outside of the therapeutic interaction. Instead, it understands that the therapeutic relationship is a special type of 'interactive, interpersonal field' within which the therapist is necessarily and actively *both* participant and observer. As such, the therapist anticipates bringing the whole of her subjectivity into her psychotherapy relationships: she allows herself to be affected by her participation in a real relationship and she is aware that she affects her patient in ways that transcend her professional behavior (e.g., her psychotherapeutic technique).

What I would like to highlight in this brief clinical article is the value and, I would argue, the necessity for the therapist to look at his own contributions as a *participant* in the therapeutic relationship to 'stuck points'—times when little or no progress is being made in psychotherapy because both patient and therapist are resisting in some way. I use the word resistance very carefully and deliberately here: the psychoanalytic tradition reflects much on both patient and therapist's attempts to defend themselves against what they anticipate to be frightening and/or painful interpersonally-mediated moments.

When the patient utilizes psychological defenses in the context of the therapeutic interaction, they are said to be *resisting* the process of therapy, whether that process involves becoming aware of disturbing thoughts or feelings, or acting in the therapeutic relationship in ways that resonate with their typical relational expectations and behavioral patterns (i.e., their transference). When the therapist uses his own psychological defenses to accomplish the same self-protective goal, he is said to be *counterresisting* the process of therapy (Schoenwolf, 1993). I am particularly interested in clinical situations in which the pattern of resistance and counterresistance interact and sometimes interlock. In the contemporary psychoanalytic literature, these interlocking patterns of behavior have been called enactments (of both parties' maladaptive relational patterns) (Mitchell, 1988; Aron, 1996; Stark, 1999) or relational (k)nots (Pizer, 2003). These moments (or sometimes hours) are difficult for both persons and are sometimes characterized by feeling stuck, confused, or inert. There is often a sense of impasse that may lead to a sense of frustration, stagnation, or feelings of anger or even panic.

At such times, most therapists struggle to shift from participant to observer—to be able to step back and reflect on what is happening between herself and her patient that has led to a self-protective impasse or enactment of familiar maladaptive relational patterns. I have found it useful at such times to

ask myself variations on one main question: What are these two people (myself and my patient) trying to make happen *or* trying to avoid from happening? What do we both want that we are trying to make come true *and* what is it that we fear happening between us? As such, we are looking at the intersection and interaction of two bodies, minds, and spirits. At this level, we are trying to understand the interpersonal dance that human dyads engage in—the intricate mix of interpersonal wishes and fears, desires, and dreads. Clinically, as a way to shift from participant to observer mode, it is occasionally useful to me to try to fill in the blanks of this sentence: 'It looks like two people trying to ________ (or not to ________).' This level of reflection on what is going on in the therapeutic relationship sometimes yields a key piece of understanding critical to breaking out of the impasse.

But there is, of course, a price to be paid for this valuable type of understanding. For the therapist to reflect on his own contribution to the relational impasse (and it is the *therapist's* responsibility to do so both ethically and morally, I would argue), he needs to be willing to surrender some aspects of his own defenses—to make himself a bit vulnerable personally and emotionally. It may even be necessary for him to make his vulnerability and surrender to the therapeutic process explicit to his patient. This is, of course, exactly what we expect our patients to do in relation to us—to surrender their resistances (interpersonally) and defenses (internally), to tolerate the feelings of exposure and vulnerability, and to allow us to 'move closer' to them.

This gets to a distinctive of the contemporary relational approach: namely, that, at the right moments in psychotherapy, what is most therapeutic is a real relationship between two people characterized by mutuality, reciprocity, and intersubjectivity (Stark, 1999). In other words, there are moments in good psychotherapy when both people mutually surrender some aspects of their psychological defenses to each other—come out of the bushes like Adam and Eve naked and exposed (and legitimately ashamed), metaphorically speaking. And, in those moments of vulnerability, that which has been avoided by both therapist and patient can finally be acknowledged, named, and worked through. Fears of genuine closeness, wishes to be special, sexual feelings, fears about being 'too much' or 'not enough' for each other, a sense of being family to each other, wishes to save or rescue, fears of feeling hatred or aggression and accompanying fears of rejection or abandonment—all examples of the very human stuff that inhabits the unspoken space within and between therapist and patient—come out into the open when both people engage in healthy mutual surrender.

One of the potential positive outcomes of this type of mutual surrender is what Benjamin (1995) calls intersubjectivity. By this, she means "… that mental state within which a person is able to sustain a paradoxical tension between recognition and self-assertion, between acknowledging the other and negating the other … [r]ecognition entails receptiveness to perceiving the other as existing outside one's own omnipotence and possessing a separate subjectivity—a separate internal world of memories, desires, needs, wishes, assumptions" (Pizer & Pizer, 2006, p. 77). It is this state of intersubjectivity that allows for real seeing—for mutual recognition and discovery. And it is precisely maintaining this state that promotes psychological growth and reparation of damage from the past.

The complexity (and brokenness) of human relatedness, of course, is that this state of intersubjectivity is fragile and prone to break down. Recognition of the other begins to collapse when the pressure of self-assertion (sources operating from the *inside* out, like wishes, fears, expectations, repetition of past relational patterns, etc.) unbalances the relational space. At these times, the stage is set for the power relations between the dyad to shift.

Healthy therapeutic surrender can be contrasted with a type of sadistic domination and masochistic submission that is profoundly destructive and hurtful to both persons (Ghent, 1990). This experience typically is a reenactment of a relational pattern for both persons in which one person assumes the position of 'sadist' (master, victimizer, aggressor) and the other 'masochist' (slave, victim, aggressed). The patient and therapist power 'teeter-totter' tips: rather than being balanced (i.e., achieving intersubjectivity), one person goes up and the other down—one is over and the other under. Both persons assume familiar roles and exert pressure on the other to 'read from their script.' This often leads to a deepening of the impasse and lack of movement in the therapy—but both people feel mired in something vaguely familiar in this way of relating. The hallmark of these moments is a sense that neither person is really free to choose anything other than their familiar role. In addition, the capacity for self-reflection and meta-

communication typically collapses (Pizer & Pizer, 2006). Both feel trapped and confused.

By way of contrast, mutual surrender opens up new possibility and the opportunity to become self-reflective and more capable of recognition of the other as they are. Mutual surrender (of resistances and counteresistences) creates space necessary for reflection—we can actually talk about the bondage of our mode of relating without falling right back into it. My work with Rebecca illustrates, I believe, this type of impasse and our work together to become free to form and maintain the intersubjective, reflective space between us.

Patient's Relevant History

Rebecca sought out psychotherapy to help with the emotional, relational, and psychological aspects of substantial weight loss. A significant precipitating event was a consultation with her physician who told her that her blood pressure levels were high enough that she would soon need medication to lower them. This was clearly related to her overweight, diagnosed by her physician as severe obesity. She reported numerous cycles of dramatic weight gain and loss throughout her adulthood, and, on the front end of another course of weight loss, she wanted psychotherapy to help her to address the emotional issues that she believed contributed to gaining back the weight in the past.

Rebecca is a Caucasian woman in her mid forties. She holds an executive position in publishing, an industry that she has worked in for the vast majority of her professional career. She holds two master's degrees, one in business and another in theological studies. She is a practicing Christian that grew up in a conservative, Protestant denomination. She is single and has never been married and she has no children.

Rebecca grew up in an intact family with one sibling. Her memories of her childhood often focus on her body image: her perceived overweight in a family of athletic, 'fit', image-conscious parents; her excruciatingly painful memories of feeling her father's disapproval of her physical appearance; her embarrassment at limited clothing options; her feelings of intense dissatisfaction, shame, and self-loathing with her body. She once summarized her childhood as "… not feeling comfortable in my skin." Rebecca regularly anticipated that others—especially men—would feel disgust in relation to her body. But just as significant a theme in her family was her feeling of being unrecognized, unseen, and somehow 'other' than them—isolated and alone. She reported that one of her earliest memories (age 4) was of falling asleep and waking in the clothes hamper in a bedroom closet "… with the dirty clothes." At age 13, she discovered that she was conceived before her parents were married, which signified to her (in her Christian cultural context) that she was essentially unwanted by both her parents *and* by God (since she was conceived outside of His ideal plan of sex within marriage). This discovery broke her heart and left her with little hope that she would ever be a candidate for God's best 'plan' for her life—particularly in the area of love and relationship.

From early on in our therapy work together, I felt a sense of excitement and dread working with Rebecca. I had a daydream during a session early on in our work that we were two children playing hide-and-seek: both of us taking turns hiding from the other while the other looked. Both of us waiting in the dark (in the hamper?) for the other to find us. Both of us increasingly excited when the other gets closer—both of us dreading at the same time the moment of being discovered. Two people with somewhat similar histories of both wanting and dreading being seen and recognized.

My own motivations for becoming a psychotherapist are relevant here. It is clear to me now that, while I want to offer my patients good gifts of recognition (of their personhood), interest, and help, I also want to receive gifts of recognition, genuine interest, and help. This is, for me, a remnant of my own wish to give good gifts of my attention and care to my parents hoping, in turn, that they would eventually be able to offer those relational and developmental necessities to me in return. And so, from the standpoint of patterns of transference and countertransference, I have noted over the years my sensitivity on my part to this relational dynamic: am I giving enough? Are they offering enough in return?

From the very first session, I noted what seemed to be a recursive interpersonal pattern for Rebecca related to her fearful expectations that others—especially men—will fail to notice her loss of weight and feel disgusted with her weight gain and, more generally, her body, thus reenacting the early pattern in her family of wishing to be seen and fearing that being seen will be traumatic (i.e., the other will recoil in disgust).

Over time, she shared her sense of self-protective isolation. She once said that she created a life for herself in which no one knows her—the real Rebecca

would, in her view, shock or dismay or disappoint. She once shared an excerpt from her personal journal, "… [I've] gotten so private I'm invisible. I keep myself to myself … and now I'm a façade in my own life."

While it was fairly easy for us both to identify the extent of Rebecca's isolation and desires for connection and recognition, actually making progress in that direction was considerably more difficult. We both settled into our roles as therapist and patient: she initiated our sessions, decided what she wanted to work on, tried to pay attention to her thoughts, feelings, and behavior; I listened carefully, offered empathic reflections, careful interpretations, and occasional prescriptions. Both of us were working hard at being good and dedicated in our respective roles. At the same time, I had the sense that we were like two opponents warily circling each other, carefully studying, scanning, and measuring each other up. I told her early on that I would not engage her in a power struggle over a 'treatment plan,' because I discerned that she would resist and defeat my efforts to help soundly. She responded by stating that she had difficulty knowing how to use therapy without a clear plan and goals to work toward, the implication being that I should be more directive.

Things began to shift when we focused in our sessions on our difficulty being vulnerable with each other—i.e., stepping outside of our 'flat,' prescribed therapist-patient modes of interaction. I consider it a piece of my professional growth and, ultimately, my spiritual formation that God has brought a few patients like Rebecca into my life that have challenged me to come out from behind my self-protective 'scheme' by pointing out my counterresistances. She has consistently, patiently, and gently pointed out manifestations of my avoidance of a real relationship in therapy. This is most clearly evident in moments of interaction during which her emotional attunement to me and her willingness to point out her observations after 'scanning' me lead to a kind of analysis of my defenses. (Who's the therapist here?!) As intuitive a therapist as I believe that I am most of the time, Rebecca often picks up on the emotional tone between us at any given moment before I do. This is an unsettling experience as a therapist when her observations strike at the heart of what part I'm playing in our therapeutic impasse.

Her intuitive, psychologically minded, and thoughtful observations have centered around three types of 'moments' in our therapy relationship. First, she is remarkably skilled at picking up on my emotional state when I greet her at the doorway of my waiting room. By the time we reach my office (about 10 yards down a hallway), she will often comment on what her scan has revealed about my current phenomenological state (e.g., are you feeling exhausted today? Or, you look really sad—is that how you're feeling? Did something happen today—you look upset? Are you preoccupied with something?). Most of the time, she is dead-on in her assessment of me. Second, there have been other moments when I become markedly sleepy and have a hard time staying focused on the conversation and even keeping my eyes open. This is pretty obvious behavior for any relatively sensitive patient to observe and Rebecca regularly stops what she is saying to comment on my somatic reaction. These moments are obvious cues to me that I am having a strong countertransference/ counterresistance reaction to her. Third, there are moments when I react with more genuineness or spontaneity—typically by a non-verbal gesture or an obvious emotional reaction that she can see. Of the three mentioned, this last moment is the one that breathes life into our conversations—to help us to move into an intersubjective, reflective space that leads to moments of recognition of each other as persons *and* of self-assertion that lacks the 'power-over-the-other' dynamic.

Rather than present a 'broad and shallow' perspective on our work together, I will instead offer a 'narrow and deep' view into our therapeutic relationship. This particular interaction stands out, in my mind, as a significant step toward more realness and authenticity in our therapeutic relationship. It felt, in retrospect, like a beginning of coming out of hiding —in this case, it was necessary for me to take the first step in order to help us to move forward productively and therapeutically.

Therapeutic Interaction

About one year into our once-per-week psychotherapy relationship, Rebecca began the session by asking this question: "When did you know that you wanted to do this for your job?" I answered her directly (i.e., what came to mind at that moment), and then I asked her to tell me what prompted her question. She said that she had been reviewing the past 6-7 months of our work together and wondered what motivated me to "… do what I do." She then reported that a significant moment during our last

session was my spontaneous, non-verbal reaction to her story of her interview with another health-care provider. She stated that she knew she was being 'resistant' during that interview, at which point I rolled my eyes—a genuine, spontaneous reaction reflecting my feelings of frustration and anxiety about working with Rebecca. She said she thought it was funny in retrospect and felt a sense of relief and comfort. She commented, "I just thought about it that night and laughed out loud."

Rebecca also said that she felt that she had, "... made a withdrawal from (her) trust account" with me because it made her wonder what else I was feeling that I had not revealed to her. I commented that safety in relationships is related to knowing what the other person was 'holding' and their willingness to expose it. She replied that she felt like our relationship was set up with 'ground rules' that made her always have to assume the role of the 'actor' and that my role was always the 'reactor.'

She then commented that she was surprised when I spontaneously said 'good' when she told me she was direct with the health-care provider during the interview—as if I thought that that must have been hard for her to be direct and assertive. She then asked me if being direct was hard for *me*. I felt a little anxious, but then disclosed that I could be very direct if I was able to 'read the signs' that the other person could handle/receive it. I said I was not likely to be the 'bull in the china shop.'

She then said that she has wanted someone (me) to be direct with her and give her honest feedback because there is no one in her life today that does that. She said that it has been hard for her in our relationship when she has suspected that there might be a 'dead elephant in the living room' and I don't comment on it or bring it up in the next session unless *she* does. She asked me why this was so. I told her that I was surprised to hear that my reaction last session (rolling my eyes in relation to her story of being resistant) felt like the first time I had given her direct feedback and I recalled in the first or second session that I told her that I wasn't willing to get into a power struggle with her over the 'treatment plan' because I knew that she would become very resistant and would undoubtedly win by thwarting my attempts to 'help' (*I'm getting defensive*).

She then said that she perceived that the ground rules of therapy were that it was therefore her responsibility to always be the actor and for me to be the reactor: in other words, that if she wanted anything from me, *she* would have to initiate it. I told her that my only ground rules were that I expected her to take responsibility to begin our sessions—to decide what was important to talk about, and that my responsibility was to listen and then participate. (*This comment, is, of course, only partly true since it reflects only the professional side of the ground rules—not the personal side*). I commented that her sense of the ground rules was different than mine and I wondered why. I suggested that maybe a relational pattern was being played out like a script—that she was playing her part and I was playing mine.

She said that she has a problem with being too direct—being the proverbial 'bull in the china shop'—and has had to learn how to read the signs about how to be direct at the right times. I suggested that maybe part of the pattern had to do with a person who is too direct (her) trying to communicate with a person who is too careful about directness (me). I asked her if this type of relationship pattern was at all familiar. She stated that some people at work gave her feedback that she can be intimidating because she is demanding and perfectionistic.

I told her that I didn't experience her as intimidating, but rather that my intuition led me to believe that being direct with her would lead to her rejecting and thwarting what I was offering. (*Feeling dread at having my 'gifts' rejected is that old countertransference dynamic of mine that comes up regularly across most domains of my life, as I mentioned earlier*.) She stated that she has always wanted people to tell her the truth and recounted (now with angry feelings) an interaction with her father about ten or so years ago in which she had to ask very specific and detailed questions of him in order to get him to be direct with her. He responded with a flood of emotional reactions toward her that shocked and angered her—mainly because he felt this way for so long and didn't communicate it to her. She wasn't shocked that he felt what he was feeling—she had already deduced and intuited it. She also related this to her sense that her father felt 'disgust' toward her physically since she was overweight as a child/teenager, and that it would have been much easier to deal with if he had been direct.

I responded that it must have been difficult to feel so different from her family—she being typically more direct and the rest of them typically indirect. I commented that something like this pattern happened between us: that she has been hoping for

direct reactions and feedback from me all along, but, like her family I have been playing the part of the indirect other. She has felt stuck because she thought the ground rules were similar to those of her family: that *she* has to be the actor and me the reactor. I told her that I took up the role of the indirect other—in my caution about getting into a power struggle I would surely lose (and painfully have my gifts rejected—my maladaptive relational pattern), I never engaged in a real relationship with the 'resistant' part of her until last session when I reacted (acted) honestly and spontaneously to that part of her. She commented that what I was trying to not play into (i.e., providing an agenda to be resisted) actually has happened in that the driven, perfectionistic side of her has been working hard within the perceived ground rules. We ended with a mutual sense of authenticity and accomplishment. And, in retrospect, this was a pivotal session that helped us to move toward more genuine relatedness.

Discussion of Clinical Material

This session reveals something of our struggle to create together the conditions for mutuality and intersubjectivity: first, by mutual surrender of our resistances; second, by collaborative reflection that leads to authentic engagement. I will highlight several themes that emerged for me from reflection on this important sequence of interactions with Rebecca.

Ground rules for therapy. This excerpt highlights ways in which the unspoken 'ground rules for therapy' are often more significant than the manifest content of our conversations with patients. Operating under the radar of our awareness, Rebecca and I were enacting an interpersonal dance that reflected aspects of *both* of our maladaptive relational patterns. As I made the shift from participant caught up in an enactment to observer of the interaction, I silently attempted to fill in the blanks of the sentence: 'It looks like two people trying to ________ (or not to ________).' My internal response to this reflective exercise was this: it looks like a person who is too direct (her) trying to communicate meaningfully with a person who is too careful about directness (me) for reasons embedded in our respective relational histories.

Rebecca perceived that the ground rules of our relationship were that she had to be the 'actor' and me the 'reactor.' Her perceptions were, on a number of levels, valid. She clearly understood the *professional* 'frame' of psychotherapy that I explicitly set up at the beginning, as well as the *personal* ground rules of relationship that our interlocking maladaptive relational patterns revealed. Revelatory moments like this are both humbling and gratifying for me as a therapist: humbling because they display my humanness and brokenness, gratifying because they hold out the promise and hope of getting unstuck.

Mutual surrender. I would now like to explore several aspects of the ways in which my readiness to come out of hiding and respond to her observations and questions can be understood as a kind of surrender on my part—and invited surrender on her part. When Rebecca, in her insightful, attuned way, called me out into the open (into more realness of relationship), I was faced with what might be called Adam and Eve's choice. Her voice was like God's in the Garden of Eden: "Where are you? Why are you hiding?" (Genesis 3) This is both an exciting and frightening question. It is one that we have posed to each other at regular intervals throughout our therapy relationship—especially since this important session. Being seen vulnerable and exposed—naked, so to speak—evokes feelings of legitimate shame. My willingness to come out of the bushes first and to be a participant helped us, in this instance and over time, to move from pressuring each other to read from familiar scripts (transference-countertransference enactment) to reflection and mutual recognition. We are better able to look at our reflection together in the basin.

Since this important session, we have reworked and reformed the ground rules framing our psychotherapy relationship. This process of coming out into the open helped us over time to create more space to talk about, explore, feel, and connect in new and very meaningful ways. The fear of being found is slowly giving way to being found—being recognized. The fear of self-assertion is slowly giving way to being spontaneous and genuine. Our fears of being either the bull (sadistic) or the china (masochistic) are fading.

Rebecca has made major gains since the beginning of our work. Examples include significant weight loss and lifestyle change maintained over time, allowing herself to hope for a love relationship with a man, spiritual growth and a desire for increased intimacy with God, and decreased cynicism and self-protective despair. Over time, the focus of our conversations moved gradually in the direction of sexuality, love, desirability, spiritual formation, and self-acceptance—sometimes focused on these types of

feelings between the two of us. These conversations, when both of us are vulnerable and genuine, have been the most powerful and helpful for Rebecca and, in a secondary way, helpful to me as well.

Particularly valuable in recent months have been our conversations about sexuality and intimacy. The themes of being seen, known, recognized, and desired stand out prominently in these sessions. In addition, what might be considered the Oedipal theme—wanting to be loved, cherished, aroused, touched, and held by someone that belongs to another—also emerged. One manifestation of this familial drama involves the way that fathers serve as 'midwives' of their pre- and young-teen daughter's sexuality. A girl's first boyfriend is, ideally, her father (Mangis, 2006). Rebecca has no memories of these types of experiences with her own father. She once told me of a business meeting in the home of a male colleague with a teenage daughter. When the girl entered the room, Rebecca noticed the atmospheric change. The men in the room (all of them fathers of daughters) softened and warmed. She noted the healthy, palpable love between this father and daughter—that her colleague seemed a bit flustered and intoxicated by his daughter's presence. His adoration stirred something deep within her.

This has been a powerful dynamic between us. I have felt her longing to be longed for, to be seen in *more* than a spiritual or intellectual sense, to be held close, to be recognized as a desirable woman. And this desire triggered anxiety in me: the oldest kind from early in my life. If I am supposed to 'give' something to someone (e.g., in this case, my mother) who wants something from me, will I be able to give enough? Will I do it right? Or will I be deemed 'not enough'? This describes my ongoing counterresistance dilemma: my interpersonal *wish* is to give and to be enough for the other person—my *fear* is that I will be found incapable or lacking and the other will turn away from me. So, self protectively, I offer to' help' and stir up the hope of the other person, but then when they want something from me or just want me, my fear of not being enough is triggered and I begin to withdraw. I believe that this is a significant piece of my interpersonal enactment dance with Rebecca.

What a perfect vocation being a psychotherapist is for someone with this relational dynamic: I get to offer a relationship where I have more authority and power, set up the ground rules and frame, stir up hope by offering my help, and deciding what I can and can't give to my patient because of my professional 'role'. *And*, I get paid for doing it! The temptation to hide behind my professional façade is strong, but my relationship with Rebecca and a few other people like her have shone a bright light into this dark corner of my motives for being a psychotherapist. And I am a better psychotherapist and person for it.

When Rebecca and I broach this tender subject now, the level of anxiety is much lessened. She is less fearful of being or wanting too much and I am less fearful of being or offering too little. The end result has been productive, genuine conversations about sexuality, desirability, intimacy, and love. And the atmosphere between us, rather than filled with anxiety, is appropriately warm and tender.

Trinitarian intersubjectivity. Our capacity to maintain this intersubjective relational space is the psychotherapy ingredient that I believe is most helpful to Rebecca, but I would be dishonest not to also acknowledge that it has been helpful to me. This interaction highlighted a significant moment followed by many moments like it since then, in which we have struggled toward mutuality, intersubjectivity, and authentic engagement. We are two people trying to both hide from and find each other: two people trying to offer recognition of the other's subjectivity and to preserve our individual self-expression—the essence of true relationship. There is something that reflects, I believe, the image of God in this struggle—something distinctive to the Trinity: relationship without the motive of power-over the other; relationship without resistance or compulsive repetition of past painful patterns; freedom within the bonds of love. In this space the members of the Trinity "… live and move and have [Their] being" (Acts 17:28; English Standard Version). We are created for nothing less.

Conclusion

Stephen Mitchell (1988) wrote the following about the therapist's need to engage deeply in the therapeutic relationship:

> Unless the analyst affectively enters the patient's relational matrix, or, rather, discovers himself within it—unless the analyst is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses—the treatment is never fully engaged, and a certain depth within the analytic experience is lost. (p. 293)

My work from a relational perspective bears out Mitchell's point in recent years. Certainly this is the case with Rebecca and me.

In a recent session, Rebecca was describing her relationships between friends and family—some are held together by ribbons (look pretty, but are not functional); some by silk scarves (pretty but not strong); some by iron bars (not pretty but extremely strong). She said that she was thinking about our relationship and that it occurred to her that it feels 'arterial'—flowing, life-sustaining, nutrient-bringing. I commented that veins take blood away, and arteries deliver the 'good stuff'.

It reminded both of us of a water color that she painted about a year into our work together that was inspired by the previous session, during which she said she felt a kind of emotional surrounding and holding by me: she commented at the time, "… it felt containing." What reminded her of that painting was that the outer ring (representing what I bring to the relationship) was 'arterial'—it looks like there are blood vessels and living tissue. The next layer is in cool colors with sharp defensive spikes that surround a soft core painted in warm yellows, oranges, and reds. These layers represented her inner life—formidable defenses protecting a living, passionate core. We are working our way together toward the center.

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