

RESPONSE TO THE CENTRALITY OF RELATIONSHIP: WHAT'S NOT BEING SAID

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Dr. Kinsler points out the extremely complicated nature of the relationship present at the center of most psychotherapies. The therapeutic involvement is a deep relationship, although, it has limits. It would be easier to grapple with Dr. Kinsler's observations if he had clarified exactly what he was using as a working definition for the concept of "real caring" and "deep engagement" without either "inappropriate limits or underinvolvement." His terms and comments fail to describe what appropriate and caring and limit setting might be, and fall short of defining what kinds of behaviors constitute caring.

Clearly, his understanding of trust, projection, and dissociation have long been recognized as cornerstones in the working through of dissociative conditions. To what extent, however, must a therapist abdicate traditional therapeutic postures to gain trust? This has not been clearly delineated, with the exception of some instances where he seems to offer unlimited availability to patients by telephone and an unlimited feeling of caring about patients "because you're worth it." Presumably, this continues even in situations when many therapists feel overwhelmed, fatigued, angry, and may wonder whether the patient is "worth it" due to excessively demanding behaviors or destructive and homicidal threats toward their therapist. It may be hard to indicate "you're worth it" to a patient who is trying to play out underserving behaviors. Honesty may create more trust than "unlimited anything." We can aspire to the former, and can never guarantee to provide the latter. What we can do, however, is to have dignity, respect, a non-judgmental attitude and an understanding of the patient's needs. We can try to help them to work in therapy to the best of their ability at any moment in time.

I have seen "deep caring" become deep countertransference. I have known therapists to advise patients to remain at home to avoid danger, and at times, to allow patients to virtually move in with them for periods because of their own fears for the patients. Others have driven patients out of state and involved themselves in what might be considered both real caring and a deep personal centrality of relationship when, in fact, these behaviors may reflect these therapists' confusion about what really might help in terms of encouraging a patient's personal growth and sense of mastery through encouraging independent behaviors in other

instances. We may mistake gratification for a mode of therapy instead of a countertransference enactment when we, as therapists, feel overwhelmed, accept a patient's burden in treatment as our own, and feel impotent to help in more clearly defined ways that might also lead to our patient's healing and trust. What a patient needs and what a patient wants are often different things, a fact that is not always recognized by patients, and may not be appreciated by naive therapists.

When patients confront agreed upon limits that do not gratify them and that may require them to tolerate frustration, it opens a whole new arena of transferences around experiences of neglect, abandonment, and abuse. This important therapeutic opportunity can be missed if a therapist adopts an over-gratifying position of caring and engagement. The patient's capacity to experience and work through the negative side of their feelings toward important persons in their past may be overlooked for a long time when these transferences are not appreciated and addressed.

Lastly, in regard to some of the patient issues, one has to recognize that some of this caring and deep engagement is dependent upon the patient's fulfilling other obligations such as the financial commitments and rules within therapy. Therapy is not made available on the basis of someone's deciding or decreeing that a patient is "worth it." Furthermore, patients are not purchasing relationships. They are purchasing therapeutic expertise, and hopefully, their therapist will provide empathy, sensitivity, and understanding within those relationships. Granted, patients will often say what it is that they needed in the course of their treatment and that they would not have made it without them. These may be retrospective judgments and oftentimes, self-fulfilling prophecies.

Whether we define such therapy situations as a special relationship, or as the recognition of special technical problems in MPD may be of some concern. It makes patients feel different and special in the way that we are trying eventually to discourage, so that the peak points of their lives and their primary identifications are not around their specialness through illness, crisis, or their specialness to a therapist who, in the long run, will be weaning himself, or herself, from them.

Most of us have gone through a variety of shifts in therapeutic rationalizations searching to find more humanistic ways to help. In my experience, many return to more traditional treatments and constraints, for a variety of reasons, including that a patient can know the person he begins with will remain a constant as transferences emerge. Further, we

must remain committed to a model of the world that the patient must accept. Doing good psychotherapy in some way automatically affords special "deepness" that should be emphatically present for all patients. ■