

EDITORIAL:

LIVING WITH UNCERTAINTY

Richard P. Kluff, M.D.

One of the most vexing and demoralizing difficulties encountered by those who treat or suffer chronic complex dissociative disorders is the virtual omnipresence of uncertainty. Although a great deal is known about the treatment of such conditions, each individual therapist and every particular patient confronts a welter of confusing dilemmas session after session, often without palpable prospects of bringing them to resolution. Our knowledge is imperfect and our comprehension incomplete.

However, our patient's pain is here and now; they cannot perform some alchemy that puts their problems and hurts in storage, hoping to wait out the advancement of the field until they can be treated by better informed and better equipped mental health professionals who possess a level of knowledge and expertise unprecedented and unanticipated by contemporary clinicians. The consequences of this state of affairs are appreciated every day in thousands of offices, clinics, and consulting rooms, as earnest clinicians attempt to alleviate the suffering of concerned patients, doing the best they can with what they have to offer.

The healing arts are imperfect, and uncertainty is ubiquitous, us to try to achieve unrealistic certainties, urge us to be more definitive than we have reason to be, and all too often insist that only the resolution of particular uncertainties will allow them to recover. The therapist experiences an enormous pressure to provide an illusion of certainty in order to create the conditions that the patient feels will facilitate healing.

I would like to review some of the uncertainties that I am called upon to resolve as a clinician, scientific investigator, and educator in the dissociative disorders field. By listing them and offering a few comments, I do not intend to resolve them. My goal is rather to emphasize that within the medical tradition, the healer's education is what the sociologist Renee Fox has described as "training for uncertainty," to do the best one can in the absence of definitive knowledge. This is true for every known medical condition and psychopathology. When we forget this, we are vulnerable to entering an unacknowledged cycle of projective identification and introjective identification with our patients, taking their urgency into ourselves, and paralleling this process in our interactions with the patient and with others. We become unwitting extensions of our patients' urgent quest for premature certainty, and dissociate our awareness that the literature demonstrates that for all their imperfections, our knowledge base and our skills are sufficient to provide a reasonable quality of care for patients with chronic complex dissociation disorders. We can perceive ourselves unneces-

sarily as depotentiated and deskilled. Our patients introject that, and the vicious cycle deepens.

The very stuff of the therapy is fraught with uncertainties. Traumatized persons must come to terms with their pasts. However, their pasts are encoded in memory. Trauma distorts the memory process. Were past perceptions encoded accurately? How can we reconcile different alters' mutually contradictory accounts? Were the memories retained without contamination or alteration, or have they become adulterated? Has their retrieval been optimal, or has it occurred under circumstances that may possibly influence what is "retrieved"? To what extent should we regard the possibility of contamination as a probability in the absence of data that points one way or the other?

Furthermore, what are we to make of much of what is retrieved? How can we understand allegations of ritual abuse, or rather, how can we choose among the rival unproven hypotheses? How does the conscientious clinician treat an apparently credible person who professes such experiences, or who is tormented about whether such apparent memories are accurate, and threatens to kill herself on the basis of them?

How should abreactions be managed? How should they be dosed? How can the clinicians determine whether it is safe or appropriate to go forward? How much processing and working through should occur before still more abreactive work is done? Are the newer techniques designed to slow and control abreactions necessary? Desirable? Preferable? Equally effective as more traditional methods?

With regard to treatment in general, is there a "best way" or a "right way," or are there myriad ways? What are the best or most reasonable goals of therapy? How can prognosis be determined early enough in one's contact with a patient to ensure appropriate treatment planning and prevent misadventures? What is the importance of work in the transference (some authors its importance, while others see it as central)? How are we to understand and best intervene with our patients' misperceptions of us in view of their pasts? What are the characteristic interactions of dissociation with other defenses, and how can we best approach their different combinations? As we struggle to maintain boundaries in the treatment of dissociative disorder patients, how can we relate to the newer writings on countertransference, which, as they reflect a process of conceptual evolution, often appear to be giving us mixed messages about what limits are appropriate to preserve?

What is the best way to understand the myriad symptoms that accompany complex chronic dissociative disorder?

ders? Should we see them as epiphenomena, as reflections of comorbidity, or as puzzling manifestations to be understood differently in every case? If there are apparent comorbid pathologies, which should be treated first? What is the interplay of character pathology and dissociative pathology? Is there a significant difference between multiple personality disorder and closely allied forms of dissociative disorder not otherwise specified?

Several issues emerge with regard to the emerging "MPD subculture." What are the trade-offs when such patients seek out one another, press to enter peer-led support groups, immerse themselves in the literature of the field, and acculturate themselves to a more open MPD lifestyle with MPD peers? Are the benefits of group membership and feeling less alone with their pathology more substantial than the risks of becoming ensnared in one another's difficulties and building relationships built on shared problems? Do such experiences have the potential to become crash-courses in dysfunction? Are the treatments of patients in support groups prolonged by their need to use therapy time to address the vicissitudes of such experiences and relationships? Should such patients be encouraged or discouraged with respect to reading about their problems? Is it possible that deviation is being amplified rather than reduced by such exposures?

This listing is by no means comprehensive. These are only a few of the uncertainties that the clinician who treats dissociative disorder patients must contend with and address on a daily basis. It is important to bear in mind that a similar list could be generated for any other group of mental disorders. One of the few comforts available in the face of the confusion and uncertainty that prevails in this type of work is to appreciate their universality and scrutinize the process by which they achieve such a forceful and compelling presence in the treatment of chronic complex dissociative disorder patients.

It is equally important to accept uncertainty and to attempt to dispel it. The impact of uncertainty is an important topic for the personal reflection, exploration in consultations, and discussion in study groups. Giving careful thought to the observations of the most hostile critics of the field can be helpful and illuminating. *DISSOCIATION* will welcome correspondence on the subject of uncertainty and its management.

Appreciating the need for extensive scholarly exploration of the above issues (among many others), with a keen awareness of the difficulty of obtaining funding for research on any aspect of the dissociative disorders, *DISSOCIATION* will initiate a modest contribution to this process. Beginning in 1992, with issue 1 of Volume V, *DISSOCIATION* will publish researchers' descriptions of their proposed projects and their requests for collaborators and subjects. Hopefully this will facilitate networking and communication. Interested scientific investigators should communicate in writing with the Editor-In-Chief. Such proposals will be reviewed in the same manner as articles, and will not be published before the Editors have ascertained the scientific merit of the proposals, and their compliance with appropriate ethical guidelines.

Richard P. Kluft, M.D.