

THE CENTRALITY OF RELATIONSHIP: WHAT'S NOT BEING SAID

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ABSTRACT

This paper presents the author's theoretical attempt to balance two important needs in the therapy of adult survivors of severe abuse: the need for clear structure and boundaries, and the need for deep therapeutic engagement. The author believes that it is the combination of safety with engagement which is crucial in modifying survivors' lack of trust in themselves and others. The author believes we are conducting "special relationships" in our work with severe abuse survivors, with goals different from those of traditional therapies. Therefore, we require a different way to understand how to conduct this work. Some productive questions for thinking about boundaries and structure are offered, as well as an outline of the characteristics of this type of therapy relationship.

INTRODUCTION

I returned from the eighth Annual Meeting of the International Society for the Study of Multiple Personality and Dissociation (ISSMPD) in a state of confusion and doubt. As in many clinical hours, my mind juggled what was said, how it was said, and, sometimes most importantly, what was not said. I heard a great deal about limits, but saw that a lot was unsaid about the crucial place real engagement with our patients plays in this work.

I heard Dr. Roberta Sachs state that we all learned via the "brick wall theory." Until we ran into the brick wall of doing too much, we were bound to work harder than our patients and not help them. And I resonated with pain and recognition when she told of her grown children cringing when the phone rang (Sachs, 1991). Yet I saw a videotape where Dr. Sachs was extremely connected to her patient, providing physical comfort and containment, prevention of self-harm, and making statements such as "I'm not going to let you do that to yourself."

I heard Dr. Jim Chu and Dr. Kathleen Adams insist that an internal part of patients must come forward and take responsibility for treatment progress—even heard Dr. Adams say that she requires a two-month trial before she believes clients are demonstrating that they are really ready to work

with her (Chu & Adams, 1991). Yet I saw Drs. Chu and Adams engage in an extended role-play that displayed exactly the kind of sensitive contact with the inner world of the client which would make it likely that some part which wants to grow would actually come forward.

I felt that what I was hearing sometimes did not match what I was seeing—or at least what stood out of the background for me was not the same as what was standing out for others. I thought I saw continual evidence for the central place extremely engaged relationships play in the work, but I felt this part of the message was not being said.

In fact, I left the meeting confused, doubting whether this was even important, whether maybe I was just one of those "mushy-gushy" over-involved types. I felt that others perhaps had a "protocol" they applied to patients, and if the patients did not fit, they were therefore not "ready to work." I wondered why I find this work so difficult, tenuous, and experimental, why I am challenged every day in my assumptions about what it means to be a good therapist. I left provoked to self-examine, to think through, and, finally, to write down how and where I think extremely engaged relationships are central in this work. I owe the title of the result of this process to the pioneering Roland Summit, M.D.

A PERSONAL VIEWPOINT

My sense of the work with severe abuse survivors, people whose lives have necessarily involved the use of dissociation and distrust to survive, has always centered on the primary role of the relationship with the therapist. It is in relationships that abuse has harmed our clients, and, I believe, it is in restorative relationships that they recover.

THE "LESSONS" OF SEVERE ABUSE

Severe and profound abuse affects and permeates the entire meaning of life for its victims. Recent research into the natural history of abuse suggests that:

- Multiple abuse is very common in our patients' lives. Approximately one-third of psychiatric patients were childhood victims of a variety of types of abuse, including many incidents of abuse over long time periods (Bryer, Nelson, Miller, & Krol, 1987; Carmen [Hilberman], Rieker, & Mills, 1984; Herman, Perry, & Van der Kolk, 1989; Herman & Van der Kolk, 1987;

Jacobson, 1989; Jacobson & Richardson, 1987; Perry, Herman, Van der Kolk, & Hoke, 1990; Rieker & Carmen [Hilberman], 1986).

- Pervasive abuse leads to pervasive effects in adult life. The more types and incidences of abuse a person has suffered and the earlier the abuse begins, the greater the impact (Bryer, et al., 1987; Burgess, Hartman, & McCormack, 1987; Carmen [Hilberman], et al., 1984; Chu & Dill, 1990; Coons, Bowman, Pellow, & Schneider, 1989; Donovan, 1990; Fish-Murray, Koby, & Van der Kolk, 1987; McCann & Pearlman, 1990; Rieker & Carmen [Hilberman], 1986; Waterbury, 1991; Wilson, Smith, & Johnson, 1985).

Children often live in remarkably abusive situations. For example: Donovan (1990) studied the abuse histories of rural mothers in a parenting program. She studied sexual abuse, physical abuse, domestic violence, and parental alcoholism. Almost three-quarters (74.1%) of her population experienced at least one of these types of abuse; 46.3% of the mothers had experienced multiple abuse. Of the abused women, 73.5% reported more than one type of abuse. *The most frequent finding was that the women had endured all four types of abuse.* What conclusions are children to draw from this kind of experience? What assumptions can they make about life?

I believe that this kind of abuse history destroys what Erickson called the sense of Basic Trust (Erikson, 1963)—the belief in the possibility of a good world and a good self. It makes it impossible to establish a meaningful "frame of reference" for life (McCann & Pearlman, 1990)—a way to make sense of life, and to have hope and dreams (Bowlby, 1980; Browne, 1990; Carmen [Hilberman], et al., 1984; Courtois, 1988; Figley, 1985; Fish-Murray, et al., 1987; Frankl, 1959; Janoff-Bulman, 1985; McCann & Pearlman, 1990; Miller, 1990; Putnam, 1989; Rieker & Carmen [Hilberman], 1986; Rivera, 1991; Summit, 1983; Summit, 1991; Terr, 1991; Van der Kolk, 1987).

Hope requires being able to look into the future and see safety and pleasure. Foresight requires believing that it matters what you do and how you do it. Dreaming requires some way to believe that your dreams might come true.

Severe abuse teaches damaging lessons on many fronts:

- Lessons about the entire meaning of life—about whether, in the words of many patients, "it's even worth it."
- Lessons about other people—most often that they are dangerous and inconsistent and unpredictable.
- Lessons about the self or selves—in particular that one's self or selves are hateful, shameful, and deserving of terrible treatment.
- Lessons about relationships—most frequently,

that they are fraught with pain, exploitation, violence, and every conceivable form of violation.

THE LESSONS OF RELATIONSHIP

A good therapy relationship for the severe abuse survivor creates an environment which *through its very nature and quality* counteracts these lessons, and teaches other, more hopeful ones.

- Through not violating boundaries, and teaching our patients ways to sooth themselves, we teach the possibility of personal safety and comfort.
- Through availability, real caring, and deep engagement, without *either* inappropriate limits or under-involvement, we teach that it may be possible to trust some of the people some of the time. This helps create hope.
- By our caring, we help teach our patients their worth as real, lovable human beings. I cannot tell the number of times I have been asked by patients why I care and listen when others have not, and have answered "Because you're worth it."
- By acknowledging our failings and errors as therapists we teach that it is OK to be both good and bad inside *one* person. We teach the possibility of "realistic love"—that interpersonal error is *not* the same as violation, and that all interpersonal errors do not require dissociation and splitting. I have found myself saying to patients, as we try to work out some relationship clumsiness on one or both of our parts, "Love is worked out in the mistakes."

Carefully acknowledging and working fallibility and error teaches an ability to stay there, in the field, without having to dissociate or run, nor to idealize or disparage others.

The ability to care for yourself with both good and bad parts is the essence of the ability to love yourself—and, possibly, even to be *one self*. The ability to accept others, with their good parts and their faults, is the essence of the ability to love.

- By modeling boundaries which are both firm enough to protect ourselves and our families, and flexible enough to recognize and respond to our patients' real pain and need, we show that it is possible to remain both personally intact *and* in deep and meaningful contact with others.

WHAT OUR PATIENTS TELL US

When severely abused patients are asked about what has been most meaningful in their therapy relationships, they are nearly unanimous in speaking of trust and deep engagement. This comes through exquisitely in the book edited by Barry Cohen, Ester Giller, and Lynn W., *Multiple Personality Disorder From the Inside Out* (Cohen, Giller, & W., 1991). A few examples:

"Therapists should know how very integral consistency is to the successful building of trust. Trust is the *most vital* issue in treatment." (Carol T., p. 99)

"We have an enormous need both to be loved and to love, because we were so totally deprived of that in our childhood. It took our therapist a long and painful time to accept a careful expansion of the boundaries of the therapy relationship to meet those needs. She has added some mothering-type stuff and some friendship-type stuff, when the primary needs of therapy allow them, and we have thrived on it." (Jessica T., p. 101)

"I had one part that was determined to rid myself of other parts, and went through some very suicidal phases of therapy as a result. Fortunately, my therapist was fully aware of the situation. He allowed unlimited phone calls during that time, and for several months we talked daily (including weekends and vacations). I am now past that point, thankfully. But, I believe, that I survived (literally) — and stayed out of the hospital — because of the unyielding support I received when I needed it. I have read that some therapists limit phone calls. Perhaps this works for some clients under other circumstances. But I *know* I would not have made it under those conditions." (Lori B., p. 103).

IT'S NOT "JUST GOOD THERAPY"

I do not believe, therefore, as others have asserted, that our work with severe abuse survivors is "just good therapy" with additional use of specialized contracting and hypnotic techniques (Chu & Adams, 1991; Van der Kolk, 1990). I believe that the goals of this work are considerably different from the goals of the more typical therapies I conduct on an outpatient basis. I am not trying to establish basic safety and hopefulness in the lives of obsessional neurotic clients, nor in those who present with marital difficulties or parent-child problems. The goals of therapy with the severe abuse survivor are different, and *this therapy requires a different degree of engagement and availability* than does a traditional therapy. Virtually every therapist I know who does this kind of work reaches out far further in this work than he/she does in any other. The patients simply require it if we are to really do our jobs. This does not mean that we can or should ever plan on gratifying the enormous oral neediness of clients deprived of loving and decent relationships with their par-

ents — we all know this is impossible. However, I am concerned that by not acknowledging the depth of the changes we are trying to bring about, we are potentially re-enacting destructive family dynamics.

Therapists doing this work sometimes extend themselves beyond their traditional boundaries because they sense that this is required in a particular case — but then they feel guilty, withdraw, and reproduce the family pattern of inconsistent and vacillating relationship. The therapy comes to resemble a wildly swinging pendulum rocketing from over-involvement to a rigid application of "the importance of limits" (Barrows, personal communication, August, 1991).

I submit that if we acknowledge the central place that helping to establish trust occupies in this work, we will be better able to ask productive *questions* of ourselves in doing the work, and will be better able to maintain a consistent stance of deep engagement *with* safe boundaries.

SOME PRODUCTIVE QUESTIONS

Here are a few questions I try to use in deciding whether particular ways of being with a client are properly in balance between being engaged in doing trust work and doing too much:

1. Will this action really help the person feel safer and believe the world is a more dependable place?
2. Am I doing something for the patient that he/she *could* do for himself/herself, and so making them less capable rather than more?
3. Is my saying "No" just to protect myself or is it really not a good idea? If it is to protect myself, can I have the courage to say so and to model personal boundaries?
4. Can I think of two colleagues with whom I could discuss this, who would support whatever action I am contemplating in a particular case? If not, it is undoubtedly going too far.
5. Will I feel guilty and cowardly for saying "No," when I think at a deep level that it might be really helpful?

SPECIAL RELATIONSHIPS

I believe we are conducting "special relationships" in our severe abuse survivor work. A model for such a relationship includes:

1. Extensive and dependable contact. The typical therapy contract is 2-3 times per week.
2. Availability to the patient after "normal" hours, within reasonable limits. I have not found it necessary, in general, to limit phone calls in frequency or duration, but I do have to make it clear that

my own time is precious and that I expect my family to be respected.

3. Allowing extremely strong attachments to form towards the therapist.

- a. Acting as the "ego" for the patient in a variety of circumstances until the patient is able to do this on his/her own.

4. Lack of retaliation or punishment for the demandingness of the patient.

5. Careful and flexible attention to which demands to meet and which to set limits on. This requires extensive and respectful use of peer consultation and support.

6. Quick acknowledgement and encouragement of growth as the natural course of events in such a therapy — attending a great deal to the patient's strengths.

7. Dealing constructively with the patient's inevitable disappointment in the helper.

8. Knowing how to let go even when it is "not all done." Our patients do as much as they are capable of during any one period of therapy, and all therapies do not end with all the work done. We have to be ready to let go but to remain available for further work.

If, in my mind, I am aware that I am conducting a "special relationship" which is going to follow this outline, I can be more consistent and clear about what I am doing with my patients.

CONCLUSION

Psychology as a profession has recently affirmed that the ability to form meaningful and engaged relationships is central in the training and evaluation of professional psychologists (Edwards, 1992; Peterson et al., 1991; Polite & Bourg, 1991). Feminist theorists have been reminding us for some time of the central place empathy and connection play in human growth and in human healing (Jordan, 1991; Miller, 1990; Stiver, 1991). I have tried to show that the ability to form a deep and trustworthy relationship is central to our work with severe abuse survivors, and to suggest some ways to stay in good balance between the two central needs human beings seem to share for positive growth—deep caring and effective structure.

I share these ideas in a spirit of self-examination, of provoking thought, of trying to clarify my own ways of working. They are not meant to offend or criticize, but to offer my perspective on why it is as necessary at our conferences, and in our papers, to discuss the need for therapeutic engagement, as the need for distance and boundaries.

I sit on the Psychology Board in our state. I am certain-

ly aware of the enormous harm done to patients by over-involved therapists or through poorly thought-out boundary violations. But, I have yet to see a case in which anyone was charged with being too cold, uncaring, inflexible, and distant—and sometimes I think that this is too bad. ■

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