

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

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In this article, Dr. Kinsler discusses his beliefs regarding the centrality of the therapeutic relationship in the treatment of adult survivors of severe abuse. His basic premise is that the therapeutic relationship with this patient population is "special" in nature. He further purports that the goals of treatment with this patient group are different from treatment goals for other psychiatric populations. He discusses the need for deep therapeutic engagement balanced with appropriate structure and boundaries within the therapy frame. Based on these beliefs, he offers a model for conducting these "special relationships."

Dr. Kinsler raises some important and provocative questions in his article. We do need to examine how we work with these challenging patients, including how our relationship with the patient impacts their recovery process. There is still much to learn about the work and the efficacy of certain methods and techniques. As Kluft recently reminded us, "Our knowledge is imperfect and our comprehension incomplete" (1991, p. 178). There are many areas of uncertainty.

Unfortunately, Dr. Kinsler's article generated more concerns for me than it resolved. I disagree with some of his statements and approaches. Several of my concerns and areas of disagreement are outlined below.

1. In his abstract, Dr. Kinsler states that this is his "theoretical attempt to balance two important needs in the therapy of adult survivors of severe abuse..." I failed to find clear theoretical grounding in the article. He mentions the well-known effects of severe abuse on the patient's ability to trust, and cited anecdotal accounts of what some patients perceived to be helpful in their therapy relationship. Throughout the article, he referred to "real caring" and "deep engagement." These concepts were not defined at either theoretical or operational levels. Nor did he describe what he considers to be "appropriate boundaries." Individual therapists' understanding and application of these terms may vary significantly depending on their theoretical orientation and personal style.

2. Much of the material seemed superficial and vague. He repeatedly spoke of the need for balancing appropriate boundaries and limits with "deep therapeutic engagement," but did not ever elucidate how this is to be accomplished. For example, he stated that we can't/shouldn't plan to gratify

"the enormous oral neediness of clients..." but he does not state which needs he believes are appropriate to gratify within the context of the therapeutic relationship. Later, he described how he does not limit telephone contact, but he does "have to make it clear that my own time is precious and that I expect my family to be respected." This is very ambiguous. Another element missing throughout the discussion was the functional level of the patient.

3. I agree with Dr. Kinsler's statement that abuse destroys the individual's "sense of Basic Trust" and ability to "establish a meaningful 'frame of reference' for life." I also agree that the therapeutic relationship creates a context for the healing process. However, it takes more than "availability, real caring, and deep engagement without either inappropriate limits or under-involvement" to develop trust and promote healing. As several authors (Fine, 1989; Greaves, 1988; Kluft, 1988; Putnam, 1989) have pointed out, the critical elements in an effective therapeutic relationship include structure, consistency, clear boundaries, and an explicit therapeutic contract. Dr. Kinsler tends to minimize these crucial aspects in the service of "caring." He mentioned therapists who "extend themselves beyond their traditional boundaries *because they sense that it is required* [*italics mine*] ...but then they feel guilty..." He does not indicate how (or how far) these therapists extended themselves.

I am also concerned by stepping outside of usual boundaries because one senses it is necessary. This implies a rationale that is based on intuition without cognitive/analytic reasoning. The danger in this is that the therapist may be responding to a situation in the moment without considering potential future ramifications of an action. In a similar vein, I think that Dr. Kinsler's list of "productive questions" is incomplete and rather subjective. Two important questions omitted from his list are: "What are the potential consequences of this action?" and "What alternative actions might serve to meet the patient's need?"

4. I disagree with Dr. Kinsler's statements that therapy with this population has "considerably different" goals and is more than "just good therapy." While the level of intensity of the work and some of the specific techniques may be different, the majority of the tenets of good psychotherapy remain intact.

5. I have a great deal of difficulty with some of the semantics presented in this article. I am particularly uncomfortable with his use of "love" in the context of the therapeutic relationship ("Love is worked out in the mistakes"). "Love" carries an intense emotional valence for many

patients, particularly when perpetrators used (so-called) love as a justification for abuse. I am also concerned at the implication that the therapy relationship is one of love. While I can accept this on a philosophical level, most of my patients are very concrete and would probably have significant misconceptions about the meaning of love in our relationship.

Dr. Kinsler also referred to being "both good and bad inside" and "the ability to take care of yourself with both good and bad parts..." I spend a great deal of time challenging dichotomous "all or none" thinking with my patients, and presenting this good/bad split is counterproductive.

Finally, I cringed at the use of "special relationships." Again, many patients were told that the abuse occurred because they were "special" in some way. I have also worked with many patients who believed that they should have a "special relationship" with me because of their abuse. This sense of entitlement has caused difficulties at times, both in outpatient treatment and especially on the inpatient milieu. In a few situations, being "special" has provided a secondary gain which patients found most difficult to relinquish. In a caseload predominated by survivors of severe abuse, how special is "special"?

In conclusion, I found Dr. Kinsler's article far from convincing. I have found no evidence, in either the literature or my experience, for his contention that under-involvement by the therapist is a significant problem in the treatment of this population. ■

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