

RESPONSE TO
COMMENTARIES ON
"CENTRALITY OF
RELATIONSHIP"

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I want to thank Dr. Richard Kluft, Editor-in-Chief of *DISSOCIATION*, for the opportunity to present my views on the importance of relationship issues in the therapy of severe abuse survivors. I also want to thank the discussants chosen by Dr. Kluft to respond to the paper. It is difficult enough to find time to do one's own writing in the midst of a hectic professional life. To respond to the work of another is above and beyond the call, and I thank each of you for your thoughtful commentary.

In the limited time and space allotted for response I can not discuss in detail all the interesting points made by the respondents, but will try to reply to the major themes they raise. The respondents seem to make five major points.

1. Responses to the idea that therapy of severe abuse survivors is different and special.

Several respondents—Drs. Fine, Sachs, Young, and Ms. Olson—questioned whether considering this work as special is an error. In general, these commentators question whether viewing these relationships as special invites patients longings for rescue, opens therapists to doing more work than clients, and misses the fact that abusers use "specialness" as one way of exploiting children. Furthermore, Comstock raises the question of whether I overvalue the therapy relationship, which she perceives more as backdrop than as foreground.

Certain of these comments appear to me to be thoughtful cautions, what I would call "friendly amendments" if we were sitting in a committee meeting. Ms. Olson contributes several additional questions to my list which are important enough so that I wish I had written them myself. Other commentators raise the issue of rescue fantasies. Patients *do* have rescue fantasies, and hope we will be everything to them their parents were not. Here I believe that our task is to listen respectfully to these wishes, set limits on them, and help patients grieve the loss of what is not possible.

And, as several respondents suggest, male therapists *must* be careful of appearing seductive to female patients. But they can also teach about safe closeness. Rage and destructive feelings *will* emerge, as Ms. Comstock so eloquently raises. But the enormous vitality and creativity of so many survivors will also naturally emerge as part of the process.

These issues will occur in the therapy of survivors whether or not we consider the work as special or different. We must

work them regardless of how we choose to look at the therapy. And even if we work them successfully, we may not get to the heart of the matter. *When we work with severe abuse survivors, we work at the level of the safety and trustworthiness of life and people*, at the level of basic frames of reference. At the level of trust, we must be taken in as good internal objects, to become counterweights to terrible experiences. And affecting people at this level requires a different kind of relationship.

Several commentators, among them Dr. Torem and Dr. Fine, mentioned that I failed to connect my ideas to important sources in the literature. In preparing a manuscript attempting to explore and describe an emerging therapeutic outlook, you have to make choices about what you can include. Each point I made could stand elaboration and greater specificity. However, let me accept the invitation to connect this major point about difference and specialness to sources in the literature which support the idea that a special kind of responsiveness is needed to reach patients at the level of their deepest wounds.

Harry Guntrip, an English analyst, entered therapy with both Fairbairn and Winnicott, in part for help with life issues, but also for help in recovering dissociated memories connected with the traumatic death of his brother. His paper on these analyses (Guntrip, 1975) makes clear that he was only able to recover and resolve his deepest issues, relating to his mother's profound depression and abandonment of him, as a result of an extremely close and warm connection with Winnicott, which Fairbairn was unable to provide because of his more formal and distant style. Guntrip resolved these issues "finally by Winnicott entering into the emptiness left by my non-relating mother, so that I could experience the security of being myself" (p. 155). Guntrip goes on to say that, "Winnicott, a totally different type of personality, understood and filled the emptiness mother left in the first three and a half years" (p. 155).

Stern emphasizes the crucial role of early attunement to the infant in preventing psychopathology (Stern, 1985). Kohut suggests that one of two major parental functions is to admire the child's possibilities, and that it is this admiration which helps maintain self-esteem and hopefulness in the face of life's inevitable defeats (Kohut & Wolf, 1978). Barach suggests that a particularly useful way to think about certain transference problems in MPD patients is to think of them as reflective of "adaptive attachment behavior" (Barach, 1992). And Mordecai makes clear that psychic structure is built through a process of inevitable empathic failure and optimal responsiveness to that failure (Mordecai, 1991).

I am simply suggesting that to help repair damage to

basic attunements and attachments, to help recreate the sense of having possibilities in the world, requires a particularly connected therapist. And that such a therapist often goes beyond traditionally taught notions of boundaries. Why has Dr. Sachs taken so many phone calls at home over the years that her grown children would cringe (Sachs, 1991)? Why do we see patients two and sometimes more times a week (Kluft, 1987)? Why make such careful coverage arrangement for emergencies, conference attendance, or vacations? Or create and monitor careful contracts which persecutor alters hopefully cannot circumvent (Putnam, 1989)? I think it is because we are aware that we are trying to respond on a deeper level, and that these patients need it. As Dr. Kluft states, "Virtually every aspect of treatment depends on the strength of the therapeutic alliance, which must be cultivated globally and with each personality" (Kluft, 1987, p. 371). This leads naturally to the second point raised by the discussants.

2. *Responses to the idea of affirming a patient's worth.*

If I make the point about responding on the level of basic attunement and attachment successfully, then it is follows that sometimes helping to reassure a patient of his or her basic goodness is helpful. Certainly when patients ask why they are listened to, affirming their worth is not the only answer. Still, an affirming response, however anyone is comfortable delivering it, can be experienced by patients as supportive, as being believed in and cared about.

3. *Responses that I am ignorant of important literature which already resolves these issues.*

Dr. Fine, in particular, feels that my paper is the response of a beginning conference attendee who is not familiar with important work in this area, particularly that of Dr. Kluft. To this I must respond that I submitted this paper to Dr. Kluft, who felt that it raised issues important enough for the community of people who treat dissociative disorders that it should be used as the centerpiece for this discussion. Dr. Kluft proposed using the paper for this purpose, chose the discussants, and edited the paper as it appears here. While this certainly does not constitute an endorsement, it does appear to show that the issues I raise are far from resolved. Indeed, as Dr. Kluft says elsewhere, "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. . . . Our knowledge is imperfect and our comprehension incomplete." (Kluft, 1991, p. 178)

And further along, in a list of currently unresolved questions about dissociative disorders: "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." (Kluft, 1991, p. 178)

I offered the thoughts contained in this paper in the

spirit of this discussion. And I have certainly read much of Dr. Kluft's important and voluminous output, and attended at least a half-dozen presentations by Dr. Kluft in several cities. To the charge of ignorance, and of traumatic countertransference, I must simply respond "Not guilty." I have treated abuse survivors for 20 years, my first multiple ten years ago, a person now stably integrated and functioning in a high professional capacity. My personal bibliographic database on these issues numbers in the hundreds. I hardly see how I can be faulted for using many of the same references about incest and abuse which Dr. Kluft does in his recent book (Kluft, 1990). And some of those square wheeled patients are out there rolling around pretty good!

4. *The reaction that while I may write well, I say nothing new.*

Dr. Torem graciously praises the writing, and then suggests that my point about working at the level of trust is well known. I think he implies that it is agreed upon by others in the field. I do not think I would be getting the reactions which this paper has provoked if this were an agreed upon point in treatment of severe abuse survivors. My purpose in writing the paper was not to suppose that I had invented something entirely new, but to clarify my ways of working, which do appear somewhat different and controversial, and to engage in a conversation about, or stimulate consideration of, certain issues. Many painters have set out to paint an apple. Perhaps someone occasionally shows it from a particularly interesting angle or in a manner which makes us look at it differently, if even momentarily, once again.

5. *The reaction that distancing and underinvolvement is not a problem in the treatment of dissociative disorders or severe abuse survivors.*

This point is raised primarily by Ms. Olson. And, if this had been my personal experience, I never would have attempted the paper we are discussing. Perhaps my experiences are idiosyncratic and do not represent a trend or a concern in the field. Then again, perhaps this is a real issue. So, let me just sidle out a little further on this branch on which I appear so precariously perched. . .

In various settings, I have heard patients referred to, disparagingly, as "MPD wannabees," or as "real bad multiples." I have seen, again in various settings, childlike and regressed alters treated punishingly for their wishes for nurturance, treated with applications of power where compassion and connection would have worked just as well. I was around when the term *borderline* personality disorder first came into the literature. I believe and feel that I have seen this term move from an explanatory concept applied to persons with a certain kind of attachment and transference behavior, to a regularly used pejorative applied to difficult and demanding patients.

Now perhaps this is just shop-talk, just people blowing off steam, ventilating as we all need to do when confronted with cruelty on a daily basis. But there is a developing literature on the effects on therapists of dealing with horror, most especially McCann and Pearlman's paper on vicarious

traumatization (McCann & Pearlman, 1990) in which Danieli is reported to have found "empirical validation for some of the following themes; guilt, rage dread and horror, grief and mourning, shame, inability to contain intense emotions, and utilization of defenses such as numbing, denial, or avoidance *in therapists working with Holocaust survivors.*" (p. 135) (my italics).

I was afraid that I was seeing some of this in the dissociative disorders field, and wrote the paper in part to try to stimulate thought about it. The paper was written about a year ago, and whenever one goes back, one sees ways one could have improved things. I wish I had taken a less morally superior and outraged tone about these matters, and had the courage to just raise them directly. I do think they are real concerns for anyone working with victims, and hope to engage in a continuing dialogue about how to support each other in not becoming traumatized, and either too distant, or without boundaries, in this work that we all care about so deeply. ■

REFERENCES

- Barach, P. (1992, June). *Multiple personality disorder as an attachment disorder*. Paper presented at Eastern Regional Conference on Abuse and Multiple Personality Disorder, Alexandria, VA.
- Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott (How complete a result does psycho-analytic therapy achieve?) *International Review of Psycho-Analysis*, 2, 145-156.
- Kluft, R. (1990). *Incest-related syndromes of adult psychopathology*. Washington, DC: American Psychiatric Press, Inc.
- Kluft, R. (1991). Editorial: Living with uncertainty. *DISSOCIATION*, IV (4, December), 178-179.
- Kluft, R. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry*, 39 (4, April), 363-373.
- Kohut, H. & Wolf, E.S. (1978). The disorders of the self and their treatment: An outline. *International Journal of Psycho-Analysis*, 59, 413-425.
- McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, (1), 131-149.
- Mordecai, E.M. (1991). A classification of empathic failures for psychotherapists and supervisors. *Psychoanalytic Psychology*, 8 (3), 251-262.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: The Guilford Press.
- Sachs, R.G. (1991, November). Opening remarks: Ritual abuse workshop. Paper presented at the Eighth International Conference, International Society for the Study of Multiple Personality Disorder and Dissociation, Chicago, IL.
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.