"Being There" in the Psychotherapeutic Relationship: Introduction

Students of psychotherapy have long debated which element of the treatment is the critical one—interpretation and insight or the relationship between patient and therapist, often conceptualized as a corrective emotional experience with a new object or the therapist as container or holder of the patient's emotions. The two brief descriptions of psychotherapy in this month's "Introspections," with two very difficult although very different patients, point to a crucial element in the relationship—being there, being committed to the patient, and making clear that that commitment is unconditional. One therapist made clear that she would not abandon her patient as the patient feared progressive deafness. The other therapist was flexibly willing to accept the patient's needs and adapt himself to them—whether as an object of scorn, an audience for grandiose display, a partner in a trial relationship, or a friend as the patient embarked upon a new life. Initially, both patients expected very little, and both therapists had little optimism, but, critically, both persisted. Certainly they felt doubt, and probably were themselves surprised by their success, but success they achieved. Their persistence in being there for their patients, for trying in spite of doubt and uncertainty, was a powerful healing force.

ROBERT MICHELS, M.D.

Psychotherapy With Pen and Ink

During her intake interview, I discovered that the new patient I was seeing in clinic that day was in the process of a neurological evaluation for unusual seizures. She was seeking relief from shaking episodes that had persisted despite several medication trials, hospitalizations, and previous neurologic consultations. "They seem to happen when I am around strange men," she told me.

I offered to start seeing her for psychotherapy, and she agreed to give it a try. Initially our sessions involved discussions of her feelings of shame about the fact that a recent video EEG report indicated that the episodes were not "real" seizures. She spoke in an emotionally flat tone, staring off into the distance. She was also dysarthric as part of a congenital hearing impairment.

Eventually, she stopped taking antiepileptic drugs. She stopped seeing neurologists. She continued to have shaking episodes—but only in my office. Each session would start with disengaged small talk. Then she would stare far away and begin to shake as she recounted her secret stories of sexual abuse beginning when she was 4 years old. She was singled out, she said, because she was hearing impaired.

She could hear well enough for us to interact. She heard when I called her name to bring her back to the present. She nodded her head in response when I explained that talking about these things would ease the pain and stop the nightmares.

These sessions would cause me to shake too—secretly, on the inside. Although her episodes were nonepileptic on an EEG tracing, they looked convincingly epileptic in person. It was initially difficult to sit calmly when I felt like I should be administering a dose of lorazepam. It was worse when she would fix her eyes on me and ask again if I was sure that it was necessary to bring up all this buried emotional pain. "I don't like it,"