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A light in the dark: the history and ethics of a therapeutic relationship

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Abstract. The therapeutic relationship is like a tailor-made dress: specific for the individual patient. Its objective is the well-being of the patient and the overcoming of his difficulties; in some cases the goal is to teach the patient to take care of himself. The therapeutic relationship can also have a positive value for the therapist, in the context of a reciprocity, which learns from the patient some teachings that he gives himself to the patient. In the therapeutic relationship there can be some issues linked to new and unexpected difficulties and which can be overcome with a careful examination of one's defense mechanisms.

Key words: patient doctor relationship, therapeutic relationship

After years of good health, a patient of mine, a blind lady, contacted me to tell me that she had been diagnosed with breast cancer. This was painful news. My first reaction was one of anger: this woman had already been unlucky in life, she had been born blind and now she had to face a cancer; I felt this new turn of events was utterly unfair, as she had already been given her share of suffering. However, there was something else in my being upset that I could not put a finger on, I felt a certain discomfort. It was a thought that stuck in my mind.

I thought back on the past therapy with her. She had come to me at a very low time in her life, as she was searching for personal autonomy despite her disability. We had embarked on a path together. We had succeeded in overcoming her fears, the ghosts of the past that stumbled around in the darkness of her life and blocked her more than the non-perception of light. I had managed to convince her to take classes to learn to walk unaided, manage household chores, use gestures in conversations.

Then we progressed even further. Together we had steadily raised the bar of her goals: learning to travel alone, going to concerts, visiting museums, listening to books. The therapy for her 'low' times was personalised (1), I started with the question 'what would please you when you feel sad?' at which she would reply for example: 'I'd like to feel something soft because life is rough.' So, the therapy would be to feel and stroke a silk or cashmere fabric, or wear perfume to bed, listen to soothing music before going to bed, listen to a good book.

She cast off the grey smock she had worn over her many years in a boarding school and a residential institution, and began to choose clothes, shoes, accessories, displaying a keen and surprising good taste and, most importantly, feeling happy. She learnt to listen to her needs and to strive to achieve her wishes, she learnt to trust herself and others, while standing up for herself.

Over time, we smiled at many things together, with the help of her self-irony, and she would say to me: 'Professor, we must admit I'm blind and it's a constant struggle ... but I'm happy to fight for myself, in order to feel well'. She realised that her therapy was to take care of herself. So we progressed from the search for autonomy to working on achieving a good quality of life, while maintaining awareness of diversity and managing her disability.

Over time I realised that there was a lot of reciprocity in her therapy. Her therapy was good for me, too. I encouraged her, explained to her the dynamics underlying her limits and together we found the strategies to overcome them; she responded with courage, enthusiasm, determination, and in so doing she also stimulated and encouraged me, in my personal and professional life. I remember that in those days I often dreamt that I was swimming against the current, and yet I did not feel tired, I wanted to continue. The outcome of her therapy was successful... for both of us. We found light in the dark.

And now what? Would we go back to square one? Not really. We would not have to redo what we had already done; we would have to do something different, walk a new path: I would have to stand by her in her suffering, in her pain, and accompany her to the end of her days. No more perfumes, silk, cashmere, music, books, but pain, nausea, vomiting, hair falling out, the body changing as it slowly fades away. I finally understood that the unclear thought in my head was a strong temptation to avoid this new commitment: the confrontation with the suffering and death of a patient, which confronts me with the limits of our existence. I wondered for a while whether I would be up to this task or I should entrust it to the dedicated cancer care team. But then I realised that mine was a rationalisation to avoid getting fully involved and facing with her the crucial challenge, that of life in a new, different, disturbing darkness.

And so here we are, together, dealing with a wobbly healthcare system, as I help her to book tests, chase the surgeon, choose the type of surgery and then .... we'll take things as they come. As Hoffman (2) wrote, I will listen to the sound of her silence, because silence is also comforting and therapeutic. And perhaps we will once again see the light together in the dark.

References

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