
Relational Complexities and Case Presentation Construction: Co-Creating Opportunities for Mutual Healing

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Case presentations fill our texts and professional scholarship and indeed serve as invaluable teaching and discussion tools. Issues related to informed consent, client anonymity, and means for disguising identifying information are a primary concern for therapists pursuing the publication or presentation of such material. Ethical concerns have historically focused, and continue to focus, on client privacy so as to “lessen the probability of litigation against the authors, their employers, and their publishers” (Clift, 1986). It is important to note that issues related to privacy are but one facet of the client’s experience with regards to these endeavors.

Clients who agree to have their “stories told” are at risk for psychological distress resulting from having their lives analyzed or criticized by real and imagined audiences, and by their therapists in ways they had not imagined. This article explores ways in which Relational-Cultural theory (RCT) can guide therapists' management of their clients' vulnerabilities and ultimately their therapeutic relationships during case presentation construction and publication through the experience of mutual empathy.

In contrast to traditional models of psychotherapy and human development

that are grounded in the notion of the separate self, the core tenets of RCT include the ideas that:

- people grow through and toward relationship throughout the lifespan
- movement toward mutuality rather than movement toward separation characterizes mature functioning
- relationship differentiation and elaboration characterize growth
- mutual empathy and mutual empowerment are at the core of growth-fostering relationships
- in growth-fostering relationships, all people contribute and grow or benefit; development is not a one-way street
- mutual empathy is the vehicle for change in therapy
- real engagement and therapeutic authenticity are necessary for the development of mutual empathy (Jordan, 2000, p. 1007)

Based on these premises, RCT proposes that case presentations can be approached as “co-creations” between client and therapist undertaken with the idea or intention of *mutual* growth and relational transformation for the client, the therapist and their relationship. Specifically, co-created case presentations can become a means for the therapist to authentically demonstrate how they have been moved and impacted by the client and for the client to be empathic with the therapist’s experience of them. This

dynamic is referred to as “mutual empathy,” which is the essence of healing in Relational-Cultural therapy.

Traditional case presentations published in texts and those used as training tools in other formats are almost exclusively written *about the client from the therapist’s perspective* and with very few exceptions, the client’s own voice is absent as is the therapists experience of the client or of their relationship. In addition, very little is written about the impact case presentations have on the client upon reading them, the therapeutic relationship or the actual process of case presentation construction with respect to either of these two factors.

By their very nature, case presentations expose the most vulnerable, perplexing side of human beings in the spirit of educating others on the specifics of how particular diagnoses unfold, how theory guides case conceptualization or how creative methodologies are employed by skilled and knowledgeable therapists. Generally, such examples project an image of a competent, sometimes idealized therapist, a fact, which is documented in the literature (Kantrowitz, 2005).

As mentioned above, very little is written about the effects of case presentations on the client, and what is published is nearly exclusively

within the psychoanalytic literature. According to the latest research in this area, Kantrowitz (2005), reports that clients generally have negative feelings in response to what they read about themselves including condemnation, anger and disappointment. In some case examples, it is clear that clients are objectified, pathologized and stripped of the sociopolitical context of their lives. Within such a conceptualization, the therapeutic relationship can become hurtful, evoking a destructive power-divide. As a result, the client and therapist can experience a relational rupture (or “impasse” in traditional terms), which in a worst-case scenario, is blamed on some intrapsychic character flaw in the client (one-way thinking) versus a relational dynamic (two-way thinking).

Kantrowitz (2005) also notes that in some cases there is an idealization of the therapist by the client. We’d like to suggest this is another type of response that leads to disconnection and is one that is inconsistent with a sense of mutuality in the relationship. Therapy, as described in this context, is a one-sided process where, in the face of a disconnection or impasse (one which may or may not have been evoked by what the client has read about themselves), the therapist has the privilege to focus on some deficit in the client. This model is in contrast to the RCT perspective that considers the

therapist's role in complex relational dynamics.

An alternative to the traditional case study presentation is the “co-created” case study, first introduced in *How Connections Heal: Stories from Relational Cultural Therapy* (2004), the first RCT casebook in which I, Dana, was a contributor. In the foreword, Jean Baker Miller, the founder of RCT, explains that:

Trying to talk about therapy is elusive because it means trying to talk about a process in motion, not a fixed, static entity. It means talking about ‘movement in relationship.’ Therapy involves a flow between two or more people in which each (or all) tries to represent her or his experience as it is occurring-and as it is modified in the moment by the very experience each is having, because of what the other person(s) is saying, doing, feeling. This interplay is the essence of connection in therapy, as in life. Unfortunately, our culture does not provide us with a good language to describe it. (p. x)

Miller goes on to add that the contributors to the casebook do not necessarily create this language in the text, but rather they try to meet this need, in part, by addressing their role in the relationship and work to avoid

speaking “objectively” about their clients as is the case in some traditional case presentations. Miller poignantly describes this effort as speaking to “the space between: not one person or the other, but the dynamic interchange between them that is the heart of therapy” (p. x).

To illuminate the process of a co-created case presentation I, Dana, will highlight some of the efforts that went into preparing my contribution to the casebook, an essay entitled “Reflections on Life, Loss and Resilience.” The heart of this particular case centered around my relationship with a client whom I called “Carin.” Carin had entered therapy after her two-month old son had died after suffering a catastrophic seizure. Then, just three months after his death, she became pregnant again. Our work centered around her unrelenting grief, her immobilizing shame and the fact that she blamed herself for her son’s death insisting he suffocated while seizing by becoming entrapped in a blanket she had used to cover the stiff mesh lining of the bassinet in which he was sleeping one night.

Most of my effort went into trying to talk Carin out of believing she killed her son and most of her effort went into trying to convince me otherwise. Her self-blame was unrelenting, exhausting and irrational, particularly in light of the autopsy report, which clearly delineated the cause of her son’s

death. We spent a lot of time going in circles and it was no secret that we both felt disconnected and despairing most of the time. On top of all of this, we struggled with many of the milestones in her subsequent pregnancy. Yet in spite of our respective relational challenges, she gave birth to a healthy 10.6-pound baby boy.

This particular relationship, and case presentation, was complex for me in that I, too, had suffered a loss, which was something I shared, but did not detail, early in our relationship. As is the case in preparing any type of case presentation, this one began with the “permission request.” Carin, like any other client, was curious as to the process, who the potential audience would be and where it would be published. From a relational perspective, these concerns were code for: “What will *you* be doing with *my* life?”

Guided by RCT, a process was outlined whereby we would set aside time for us to “process” aspects of our relationship, which was different than our normal therapy style in that our focus was on the “we.” I explained that she would be given the opportunity to edit and approve the final draft, which she did, and that she could change her mind at *any* time. With very little reservation Carin agreed adding it might be helpful to others for her to share her story. As I wanted Carin’s voice represented in the piece (and she

happened to be a gifted writer), I suggested she journal aspects of her experience related to her loss. Her words, particularly those describing the night her son died, were riveting and were incorporated into the essay. What emerged for us was a unique therapeutic space that was characterized by mutual risk-taking and supported vulnerability.

For us to take on this task signified a mutual level of trust in our relationship that seemed to serve as an exclamation point to the work we had persevered. In requesting her participation in this project I also considered developmental factors related to her current level of adjustment and to the felt sense of resilience in our relationship. At the time Carin and I began co-creating her case presentation we were nearly 15 months into our work together. Her new baby was healthy and doing well and she had recently disclosed she had needed to believe she had killed her son because feeling like it had been something beyond her control would have made the vulnerabilities in her subsequent pregnancy simply intolerable.

In our processing time, Carin and I revisited aspects of our relationship and explored what alternative approaches to her therapy might have felt like. Simply put, most of our time was spent sharing how we had been impacted by each other and developing a deep appreciation for each other and our

relationship which was prompted, in part, by the drafts I shared with her to proof. Through this process she learned how ineffective I had felt as her therapist and I, paradoxically, learned how supported she had felt. She also shared how crazy she felt and in the case presentation I offered my official diagnosis: “Carin suffered from a complicated mix of grief, loss, PTSD, a garden variety of depression (major and postpartum, several times over), betrayal, isolation, yearning, sensitivity, hormones, normal pregnancy neurosis, shame, sleep deprivation, secrets, paranoia, imagination, a mother’s love, and a broken heart” (Comstock, 2004, p. 101). Informed by RCT, CO-creating case presentations can lead to a deeper connection and a unique therapeutic space that can provide opportunities for mutual healing through mutual risk-taking and supported vulnerability.

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