Birth of a Self in Adulthood

THE PATIENT'S RELATIONSHIP WITH THE THERAPIST

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The Patient's Relationship with the Therapist

Psychotherapy has evolved to help patients with many important psychological issues. Traditionally, effective therapy has helped patients to modify defenses that block out important feelings, to clarify misconceptions, to resolve unresolved relationship conflicts, to discover the source of feelings of inadequacy, to build self-esteem, and to widen the range of possibilities for coping with life. Psychotherapy has helped patients to restore a good balance between loving, working, and playing. There is another way in which psychotherapy helps impinged-upon adults. In addition to the working alliance and transferential relationship, impinged-upon adults must be allowed a real relationship with their therapist that encourages and guides the birth of a whole individuated self, separate from family.

BEGINNING THE THERAPEUTIC RELATIONSHIP

During the first hour with a new patient, therapists might ask themselves three critical questions basic to doing good psychotherapy for impinged-upon adults. If one or more of the answers is negative, another therapist may be better suited to conduct this psychotherapy. The first question is, Do I like this patient? If therapists do not like the patient, they will

not be able to do the difficult work that lies ahead without reacting aggressively at a time when they need to clarify, confront, or interpret constructively. The second question is, Do I understand the central problem well enough to be able to treat this patient? If the central problem remains confusing, the patient should be referred to someone who can see it more clearly. The third question is important for all patients but is essential in the case of impinged-upon adults: Will I be able to separate from this patient when it is time for him or her to terminate? If therapists get too fond of, or dependent upon, a patient because of their own countertransference, they may provide a replica of what happened with the patient's parents instead of providing a healing, growth-producing environment where separation is the ultimate goal.

It may seem deceptively easy to form a relationship with impinged-upon adults during the initial phases of psychotherapy. This is sometimes referred to as the "honeymoon stage" or the stage of "transference cure." Patients are often extremely relieved to find a person who appears to understand and be supportive. Some patients respond with an immediate attachment that involves instant caring for the therapist. Most impinged-upon adults arrive on time and are eager to come for their hour. Overt resistance is minimal.

Most patients transfer a strong need to comply into the therapeutic

setting and are skilled at intuiting exactly what they think the therapist is suggesting that they do. It is necessary to be wary of this phenomenon because patients may do something that is not in their best interest just because they perceive the therapist as suggesting or needing it. If the therapist appears troubled, this kind of patient will assume that they are responsible and will try to help.

In the early hours, patients may feel a need to prematurely resolve a presenting problem just to maintain the relationship with the therapist. Short-term therapy can sometimes successfully capitalize on this initial stage to help patients take a major step forward. Dining this time therapists may be misled about their effectiveness, feeling flattered or powerful. However, the patients' improvement precedes the full working alliance and real relationship necessary for growth. Both take longer to develop. The patients are more likely relating transferentially in the only way they know how.

In contrast to this over-compliance are patients who have learned to handle the pathological relationships within their families by being rebellious. In this case, the rebellion surfaces in the first hour and persists, presenting therapists with an entirely different kind of relationship.

Impinged-upon adults come into therapy with little trust unless they have had significantly healthy long-term relationships with persons outside

the enmeshed family. Therefore, most patients must slowly build a sense of trust in the positive and supportive therapeutic alliance. At first, patients may feel as alone and unsure of this new kind of relationship as they would entering a different culture. They will feel mistrustful, while at the same time hoping that this new relationship will be helpful.

THE FIRST SENTENCE IN EACH HOUR

After a greeting in the waiting room, it is generally best to leave it to patients to begin the hour unless they are experiencing obvious difficulty. Therapists can suggest that the patients are the most qualified to open the hour because they best know their feelings, experiences, and events that have taken place since the last meeting. A patient's opening sentence is significant because it usually provides a reliable clue regarding the nature of the hour ahead. For instance, if the patient begins the hour with "I have thought about what we said last hour and have a lot more to tell you today," it is an indication that the patient is already at work without resistance or defense. On the other hand, if the patient begins the hour with a yawn and "I don't have anything particular to talk about today, and I can't remember the last hour," it signals a more defensive hour that requires a more active, confrontational stance from the therapist. Should the patient begin the hour with "I have something I've been meaning to tell you for a long time, but I haven't because I feel so embarrassed," the therapist may need to provide

support for this difficult communication. When a patient sits down with an angry series of gestures or glares at the therapist silently, the therapist is called upon to help the patient figure out the disturbance in the therapeutic relationship by exploring how much the negative feelings are rightfully attributable to something inappropriate the therapist may have done and how much they may be transferred from a significant other in the patients' past.

THE THERAPISTS' USE OF THE COMMANDS

Much of the work with impinged-upon adults can be accomplished by listening carefully, not interfering when the patients are working well, refusing to rescue patients with a solution they can come to on their own, and confronting the patients' failure to proceed with the work (Masterson 1983). However, sometimes patients appear to run into a dead end. They either stop progressing or start to repeat information already given, for lack of knowing what else to say. This is where a knowledge of the commands is invaluable in terms of keeping the work moving forward. Such knowledge helps me to comment on, and to encourage patients with the work. If patients strongly confirm my statement and move forward with the work, I know that the information I have given them is accurate and that the patients are ready for this next step. However, discussing the commands directly with patients would rob them of the opportunity of discovering significant information

themselves.

My use of the commands can also help me to take a statement made by patients and reframe or state it in a new form so that it can be seen from a different perspective. The following is a brief example.

> *Patient* : I feel bad about not having had time to call my mother before I came here today. I feel as if I should ask you if I can use your telephone now.
>
> *Therapist* The word "bad" seems vague. Can you explain your feeling more?
>
> *Patient:* It is not that *I* want to talk to *her.* It's that I feel worried.
>
> *Therapist:* Worried for whom?
>
> *Patient:* Not me, that's for sure! I must be worried that she is missing hearing from me. Oh yes, I'm worried that she will be mad at me for not doing the same thing each day at the same time. That's it! [maternal command 3]

Sometimes patients are unable to achieve this new outlook by themselves because the commands forbid it. The therapist, who is outside the enmeshed system, can encourage this new information.

> *Patient I:* Mother spoiled me rotten and gave me everything I wanted.
>
> *Therapist:* I think your mother gave you too much so you never learned how to experience the challenge of getting it yourself.
>
> *Patient II:* It feels like no one in my family likes me.
>
> *Therapist:* No one seems to be able to enjoy or support your steps forward.

Patient II: I don't care about anything for me anymore.

Therapist: I wonder if you mean you have strong feelings that you should fail obediently.

Patient IV: I feel like I was bad.

Therapist: I think you may not understand that the unnecessary criticism you have received is sabotage.

It is difficult to prescribe techniques for impinged-upon adults because any formalized interaction detracts from the *genuine* kind of relationship that these patients need. The commands serve as a general source of knowledge that therapists can draw on to understand their interaction from moment-to-moment with their patients.

THE LANGUAGE OF THERAPY

Many therapists are trained to avoid using any theoretical or technical language that will distance them from their patients. Instead, they speak in the language that patients introduce, facilitating the patients' ability to express personal feelings (Masterson 1976). This position generally seems valid, but a few terms can be helpful in bringing a new perspective to patients' experience. Two such terms are *impingement* and *entitlement.*

As patients try to express feelings more openly, it becomes evident that important concepts such as symbiosis and enmeshment are difficult for the

patients to formulate themselves because the commands forbid such understanding. As patients attempt to clarify symbiotic enmeshment, it can be helpful to use the term *impingement.* Patients frequently confirm that this term expresses just what they are attempting to say. Their parents impinged" upon them as children, and continue in adulthood to obliterate psychological and sometimes physical separation, without asking the patients. The patients thereby lose their "entitlement," or rights given at birth, to decide what to do and what to share or withhold.

THERAPISTS' STANCES WITH PATIENTS

Many therapists have received training in being a "blank screen" or a mirror for patients' feelings. This has traditionally called for therapists to hold back information about their own life so that patients could then freely project onto the therapists any transferred feelings from past relationships. Impinged-upon adults need to transfer feelings, but they also need the therapist to be more of a real person. Attempting to be a blank screen can be devastating for this kind of patient because it reminds them of the false self of their parents hiding the fragile real self. These patients feel as if they never really knew their parents, and they have a hard time if they feel similarly distanced from their therapist. The result is that the patients shut down.

Therefore, therapists need to be more spontaneous, real, and active

without crossing the line into a social relationship or burdening patients unnecessarily with the therapists' own life situations (Angyal 1965, Greben 1984, Kaiser 1965, Lidz 1973, Masterson 1985, Taft 1962, Wells and Glickau 1986, and Winnicott 1965).

Such active therapists ought to be very versatile. Traditionally their work calls for

- silence when patients are working well.
- process comments, or comments and questions about what is happening with feelings and actions between patients and therapists.
- transference interpretations, or comments that clarify the feelings about past relationships that are brought forward into the therapeutic relationship.
- comments that encourage memories from the patients' past life experiences.

In addition, impinged-upon adults benefit from

- confrontation regarding unnecessary dependency.
- explicit support for growth.
- caring about patients as different and unique individuals.

· teaching, advising, and sharing information regarding a present problem. This may include selective sharing of the therapists' life experiences only if directly relevant to the problem under consideration.

· teasing patients as an alternative to confrontation.

· openly sharing and expressing with patients pain, sadness, and joy.

Therapists need to be whole, real persons. Then patients become able to try out a mature, intimate relationship.

If therapists had something negative happen in their own life which mildly intrudes on the therapy, the patients will detect it and may assume responsibility for the problem. Patients will avoid areas of concern to protect therapists. Therefore, it is appropriate for therapists to acknowledge the patients' sensitive, overprotective response and then address, directly but briefly, the issue that may be compromising the therapists' response to the patients. This response assures patients that the problem is the therapists' and clears the way for both of them to continue work.

Patients need a role model that is different from their parents. They can benefit from seeing that the therapists have problems that can be handled with integrity, perseverance, and independence. Such demonstrations need to be concise and should be presented only when directly relevant to the patients' material.

The advent of a failed adoption required an abrupt change in my vacation schedule. Each patient was concisely informed about the loss of the infant and my changed working schedule. One patient, Margo, came to her next hour and watched me closely for a while.

Therapist: What are you thinking?

Margo (after a long pause, in which she seemed to weigh whether she could talk with me so personally): I have thought a lot about you and your life the last few days. You must be very sad. Are you all right? I really want to know. How can you go on working? Are you going to try to adopt again? Do you have the strength to start over again?

Therapist: Yes, I am going to try again. The pain my husband and I have felt tells us we would be missing too much if we gave up now.

Margo: Will my troubles seem small to you in comparison? (another pause) I thought about all the things I have lost too, for other reasons. We've both lost. And my losses are important too. If you can try again, and find another baby, then it stands to reason that I can quit bitching about my past and get on with what I want, too. You can have another baby and I can have a husband.

Therapists need to be flexible in another way. As has been noted, patients come into treatment with an incomplete psychological self. The development of a whole self tends to be uneven. Therapists must therefore be willing to move flexibly with patients from issues of basic trust to creativity to neurotic and oedipal issues until their incomplete self is filled in.

A therapist can actively support a patient's not taking on something that

someone else wants him or her to do unless there is something in it for the patient. Patients are initially surprised by this stance and regard it as "the highest form of heresy." It is entirely out of their character but gradually they learn that it is a valuable guide. They realize that they are not just being "selfish" and that the best giving to others can occur when their own needs are also being considered and met.

It is possible to shorten the average treatment time by not always waiting for patients to talk about an issue that needs to be discussed. If patients present therapists with new material that indicates a new issue, the therapists can articulate that insight as soon as they understand it and feel that the patients are ready to hear it, instead of waiting for the patients to get to it on their own. It can be assumed that the patients are ready for a new step or the material would not have surfaced. If the patients are not ready to hear the issue, they can tell the therapists, who can then make a judgment as to whether to let it go or confront the unwillingness to proceed further. Patients seem to appreciate these insights that move the work along more quickly. Impinged-upon adults have already lost so much time, it seems undesirable to waste any more.

IMPINGED-UPON ADULTS' DECEPTIVE FRAGILITY

Many impinged-upon adults look fragile because they have been taught

to do so and their lives have not been going well. Therapists may treat these patients as fragile, “going very slowly” and avoiding confrontation because the patients “aren’t yet strong enough to handle it.” Therapy can take years-with therapists acting like the patients’ parents by treating them in a manner that prolongs psychotherapy.

It is a mistake to treat these patients as if they were fragile. Therapists may get into the position of feeling sorry for patients, thereby relieving the patients of their responsibilities within the therapeutic relationship. For instance, if patients undermine themselves in such a way that they lose a job, it may seem kind to let them postpone paying the bill for the psychotherapy. This is almost always a clinical error for several reasons. First, the therapists’ leniency sends a not-so-subtle message that the patients can’t really manage. Secondly, the therapists end up acting just like the patients’ parents by picking up the tab. Resentment builds on both sides. The patients resent being viewed as incapable of paying, and the therapists resent late payment. Therefore, the working alliance is damaged. Therapists need to set limits, rather than encouraging or reinforcing failure in managing life, even if that means postponing the continuation of psychotherapy for a few sessions until the financial problem is worked out.

Experience shows that impinged-upon adults are not fragile; they have already survived a great deal of abuse. They can handle, and even appreciate,

a confrontation that will enhance their own growth. Those patients who have assumed a passive-aggressive stance, using failure and rebellion as a way of punishing their parents, are in need of consistent, strong confrontation, some of the hardest work that therapists have to do. In contrast, those patients who have become over-adaptive and compliant as a way of surviving need little confrontation, since this intervention only increases their over-adaptivity. Compliant patients need to be encouraged to be less tuned in to others' needs, and more attentive to their own lives. They need to know that the primary goal is to get out of psychotherapy and on with living as soon as possible.

Masterson's view is that borderline patients should always be treated as if they could function in a normal manner (Masterson 1976, 1981, 1983). When and if they don't, the issue needs to be confronted until they fulfill their end of the contract. The therapists' expectation and respect for the patients' functioning becomes one of the most powerful tools in supporting the patients' growth. This is sometimes a difficult stance to maintain, because impinged-upon adults skillfully ask therapists to make things easier or to give the kind of gift that inhibits growth.

Therapists often fear that borderline patients have so many complex problems, it is useless to try to accomplish anything besides just listening, unless the patients can guarantee to spend a long time in therapy. However, my experience has shown that much can be accomplished with a knowledge

of the unresolved issues and appropriate confrontation within a limited time, even if it is only three to six months. This may be necessary because some patients manage a growth step that moves them to another geographical location, putting a time limit on the therapeutic relationship.

RESPONSIBILITY

Patients frequently raise questions regarding the important issue of responsibility.

The following discussion has occurred many times with impinged-upon adults:

> *Arnold:* How can you manage to see more than one or two patients during the same week?
>
> *Therapist:* I am here to help, but the responsibility for the outcome of your life remains with each one of you.
>
> *Arnold* (after a stunned silence): That is very interesting. This is going to be an issue between us, making the relationship difficult because my whole life has been spent taking responsibility for others.

Arnold and the therapist continued on to consider Arnold's additional assumptions and questions:

> I have been expecting you to take care of me the way I took care of others.
>
> Why haven't you solved my problems yet? Isn't that your job after all?

> If you really take responsibility for me the way I took responsibility for my parents, won't you be too exhausted to see anyone else but me?

Therapists' clarity in presenting the issue of responsibility, both verbally and behaviorally, is critical for the successful treatment of impinged-upon adults (Kaiser 1965, Masterson 1983). Impinged-upon adults are accustomed to having their parents take unnecessary responsibility, in the form of rescuing the patients. In turn, deeply ingrained in patients is the need to take responsibility for the parents' defective sense of self. Therefore, it follows logically that impinged-upon adults expect therapists to take responsibility for their patients' lives.

This need for someone else to take responsibility is especially evident among patients who choose retaliation in response to poor parental caretaking. These adults keep returning home with a problem that worries their parents no matter how much it compromises their own growth and development. They convey to therapists their intention of trying to force their parents into finally taking the natural caretaking responsibility that would have been appropriate in the past. Unfortunately, the parents consort with this pattern of subversion.

Patients want therapists to fix a problem for them so that they do not have to risk working through painful feelings or to change their ways of relating to others. They not only expect it, but feel that they deserve it.

Patients and therapists have to confront the difference between “rescuing” and “giving constructive help.”

Therapists rescue when they do or say something that their patients could do for themselves. Therapists therefore need to decline invitations to rescue and should instead confront these manipulations. Therapists can effectively help only when patients have already done everything possible to advance the work and are taking responsibility for the quality of their own therapeutic work. This is the point at which therapists can provide some insight, explanation, or clarification.

Not taking unnecessary responsibility is a difficult task for therapists because the patients have modeled their parents’ skill in asking to be rescued. If therapists truly decline invitations to help unnecessarily, impinged-upon adults go through a period of feeling angry, rejected, and unloved. If therapists fall into the trap of rescuing patients, as they do from time to time, the therapists are responsible for confronting this therapeutic failure so that the psychotherapeutic work can get back on course. The therapists’ admission of error helps to further dispel the myth of perfection and usually launches patients back into the transferential working through.

However, therapists have to be careful not to overdo withholding help because patients may perceive this as sabotage. The issue of responsibility

has to be combined with properly timed supportive discussion of new alternatives. Fortunately, declining to do something for patients that they can do for themselves automatically conveys one of the highest forms of respect and support. Therapists' clarity about the issue of responsibility helps patients with their confusion over this issue.

THE TWO PARTS OF PATIENTS

In a given psychotherapy hour, it is possible to see two different versions of the same patient. The first version usually presents itself in the first and second hours. This person is extremely perceptive and articulate about the problems at hand, has obvious capabilities, and is remarkably honest in expression of feelings. As soon as the psychotherapy gets more fully underway, the second version of this same patient emerges. This is the person the patient learned to be. This version of the patient works against therapists with such techniques as playing helpless, whining, complaining, being condescending or sarcastic, clinging, asking for more time, or manipulating for a rescue, and proclaims that failure is the only possibility. If therapists are not prepared for this version of the patient, they may feel let down and frustrated. This is the aspect of the patient that often baffles psychotherapists because such behavior appears to oppose therapeutic help. This second version has to be confronted and challenged. Once therapists have perceived it, it is not difficult to identify because there is usually a repetitive

characteristic phrase or behavior that is a reliable clue that the failing version of the patient is in charge. As the psychotherapy proceeds, the patient will alternate between these two versions of the self, testing one against the other until one of them finally triumphs.

It is helpful to define these two differing aspects of the self for patients. The first is the capable part of the self. The second is the helpless or failure-prone part of the self created to survive within the family enmeshment. Initially, patients may feel embarrassed when therapists address these different versions, but gradually they learn to recognize when each part of the self is in operation, both during and outside of the hour. For example, with one patient, Rob, the therapist addressed the capable version of his self as "your own Rob" and the failure-prone version as "your parents' Rob." Patients can gain control over which self they present to the world.

PHYSICAL CONTACT BETWEEN PATIENTS AND THERAPISTS

Therapists are traditionally taught that any physical contact is inadvisable with patients (Langs 1973,1974). Most patients have enough to handle just dealing with the verbal and emotional intimacy within the psychotherapeutic process. It is a comfort to patients to know that the therapist will not be physically intruding. However, there seem to be some exceptions in the case of impinged-upon adult patients. A therapist's hand on

a patient's shoulder or elbow at the end of a difficult hour is a genuine way to provide support for the painful individuation process that is taking place. Bettelheim (1982) tells us that Freud shook hands with his patients at the beginning and ending of each hour.

On rare occasions patients may ask for a hug. It always appears to be a difficult request for them to make. Again the issue of entitlement is a strong one. They are not "supposed" to want it, and they must face their fear of engulfment. If they ask for it once as a way of expressing intimacy, as a way of accepting therapists' support, or as a way of saying good-bye at the end of the therapeutic relationship, it does not seem to disturb or retard the therapeutic relationship. On the other hand, the therapy becomes disrupted when hugs are repeatedly demanded out of clinging dependency, the need for reassurance, sexual need, or unresolved oedipal issues. Therapists must accurately intuit the difference often without much time to think about it.

PATIENTS' AWARENESS THAT THEIR FEELINGS ARE FELT BY OTHERS

Patients sometimes harbor the illusions that their therapist's relationship with them is the only relationship the therapist has. Therapists often have separate exit doors so that one patient does not have to run into the next patient. Therapists have been trained never to make references to other patients. However, it sometimes proves helpful to break this rule for

impinged-upon adults. There are two reasons. First, they need to know that they have the same feelings as other impinged-upon adults because they have believed their feelings to be so out of place within their own families. Second, the illusion that their therapist has no other patients is a variety of the family myth of self-sufficiency. Impinged-upon adults need to have occasional reference to the fact that the therapist has a larger world than the therapist's relationship with them. That world is meaningful to the therapist, and in turn contributes to the therapist's relationship with them. This reality gives permission for patients to have their own larger world that does not include the therapist and enhances the therapeutic relationship.

SEPARATIONS FROM THE THERAPIST

With many kinds of psychotherapy, it seems wise to have a consistent pattern of regularly scheduled hours over an extended period of time. Impinged-upon adults are used to "closeness" without separations within their families. Therefore, separations that do come about because of vacations or therapists' occasional need to reschedule an hour may assume a temporary but necessary and important part of the total psychotherapeutic work. Therapists who take a national holiday but reschedule patients' hour into a later part of the week may be depriving patients of the opportunity to explore feelings about the separation. If the rescheduling is because therapists want a vacation but don't want to lose the income, they are behaving like the

patients' parents, by considering only their own business needs and discounting the patients' valuable experience with separation.

Initially, separation evokes several predictable feelings from impinged-upon adults: feelings of being cut off, disapproval, and punishment. They fear that the therapist will forget about them completely and may never come back again. If patients have difficulty with object constancy, separation feels like the total loss of the therapeutic relationship. (The patients learned in childhood-command 11 from mothers-that separation meant death.) In adulthood, these feelings symbolize a psychological death because the patients' feeling of "being" has always come through being an extension of someone else. The patients may feel, at times, like a limb cut off from a body; the limb cannot feel pain, strength, or freedom to move without the blood supply from the rest of the body. As one patient said, "Not coming here is like being dropped off into a nothingness."

The following dialogue from a therapy hour illustrates both the feelings about separation and patients' relief after brief mention of the experience of other patients.

After a separation during the holidays, the patient, Leah, came to her appointment forty minutes early. She sat curled up in the comer of the waiting room couch looking unhappy. She started crying as soon as she sat

down in the office.

Leah: I've had a horrible vacation, and I have been on the edge of tears all day. I'm so embarrassed that I can't get them to come out or go away.

Therapist: Well, now in the privacy of this office, perhaps you can let yourself cry and find out what you are feeling.

Leah explained that her mother reacted negatively toward her, first attacking and then rejecting her, because Leah had begun the painful process of becoming independent from her mother.

Therapist: Now go back to your tears and tell me how all this makes you feel.

Leah (sobbing): I feel alone ... very small... betrayed, rejected, and as if I should probably kill myself.

Therapist (quietly): Why would you want to do that?

Leah: Life just doesn't feel worth living when I feel so alone and incapable. But it was just a feeling; I don't think about it seriously. When I drove away from my mother's house, I was crying so hard that I decided that it was dangerous to drive, so I pulled into a parking lot until I could calm myself. Then I drove very slowly and carefully the rest of the way home. There is no point in a car accident, because I might injure someone else. I just need to get used to being all by myself without running to my mother for the wrong kind of help.

Therapist: I am glad to hear that you are so sensible in taking care of yourself and other people. I wonder if part of your feeling of being alone and rejected is because of your separation from me during the holidays.

Leah (sobbing subsided): It must be because I felt so relieved when you came into the waiting room to get me. I needed to see that you are still here.

Leah and the therapist then worked on the dynamics between Leah and her mother and considered the degree of psychological pain that her mother must also be feeling.

> *Therapist:* I think it's impossible for you to become a separate person in your own right without feeling this kind of pain. It is like the birth of a baby; it can't be done without labor. You seem to be feeling the way many of my patients do at this point in their separation from their parents. It is not unusual for you to feel momentarily suicidal as you have just reported. Your mother's response sounds pretty predictable too, in response to your changes. Remember that your mother doesn't consult with anyone about the changes that are going on the way you do. She sounds confused and scared.
>
> *Leah* (relieved and more relaxed): My mother kept saying that I was crazy. I thought the way I was feeling, maybe she was right. Maybe it is more accurate to say that I just feel pain. I'm exhausted, sweaty, and sick to my stomach, but I'll be OK.

Patients cannot become whole, separate persons without going through feelings about separation. The experience comes during vacations in which the canceled hours are not rescheduled. During the initial separations, patients do not miss the therapist as much as they fear the separation. During these periods, patients visualize and practice their separateness and begin to feel it in a new way.

Tammy knew that her therapist frequently traveled out of town. She would visualize the car moving away from her until she could no longer see it. She feared that her therapist might have an accident and never return. During

each successive trip, however, she became more comfortable as she increasingly realized that the therapist did return. The break in the therapeutic work was for a rest, not a reflection of her inadequacy. Even if the therapist did not think about her, Tammy could still exist as an independent and valuable person while they were apart. Gradually Tammy came to enjoy the separations as a time for her to be on her own. During a longer vacation, she was able to feel like a "satellite" in her "own orbit." She had enjoyed her time alone and came to the following hour both pleased to see the therapist and resentful that "the space ship was picking up the satellite again" when she was "^just beginning to have a little bit of fun."

After a therapist's vacation, patients may come into the next psychotherapy hour confused about the differences between "missing," deeding," "clinging to," and "depending upon" the therapist. Sometimes patients will look sad or depressed but will say nothing about missing the therapist. Instead, they listlessly begin to cite failures, inadequacies, or worries that occurred while the therapist was on vacation. The therapist may well feel disconnected from the relationship during this monologue, while the patients are frustrated or angry about feeling "dependent" upon the therapeutic relationship. A closer look at the patients' activities during the therapist's absence may show that the patients actually coped well.

In fact, the patients missed the therapist but act as if they needed help

and had failed. This is the only way they have been taught to express feelings after a separation. Frustrating feelings of dependency replace a natural sadness about separation. When this was pointed out to one patient, he said, "But I've always been led to believe that depression and sadness were bad feelings to have. How could you want to encourage those feelings from me now?" If patients can turn the feelings of dependency into appropriate sadness at the temporary loss of the therapeutic relationship, then they are on the way to healthily dealing with separations.

Patients' feelings about separations from the therapist change during the course of psychotherapy. Therapists have been trained to expect and elicit negative comments from patients about their reaction to a vacation. This training may be counterproductive during the latter part of the psychotherapy with impinged-upon adults if it forces therapists into interpreting something negatively that may not really be there. Impinged-upon adults reach a point when they anticipate a separation from therapists with positive feelings. They want it and enjoy it as a break from hard work. There is nothing unhappy to talk about; in fact, their pleasure about a vacation is something to celebrate. Any indication from therapists that a vacation should be upsetting is seen as parental dependency and sabotage. Therefore, it seems better for therapists to announce most vacations clearly and without questioning feelings, while simply watching to see how the patients react.

There are times when therapists must legitimately reschedule a regular appointment because their child is ill or there is a conference to attend or a lecture to give. If this happens infrequently and for a good reason, impinged-upon adults may appreciate the chance to help with the therapists' life problems or obligations by not coming in or by being willing to reschedule an hour. They appreciate it because they have rarely been able to aid their parents in a non-enmeshed way. Their parents tend to decline help because it makes them feel imperfect, and to see aid from their children as a disturbing statement of their children's mastery and independence.

THE THERAPIST'S RELATIONSHIP WITH THE PATIENT'S SPOUSE OR LONG-TERM MATE

In the medical model, it takes three persons to help someone with a physical problem: there must be a willing patient, a physician to do the medical procedure, and a nurse or caretaker to provide the steady psychological and physical before-and-after care. The treatment may deteriorate if any one of these three persons does not fulfill his or her responsibility. It is also helpful to have a triad in the psychotherapy process.

Ideally, there is a willing patient, a psychotherapist, and a third party to handle the support role. This third party is frequently a spouse, a mate, or a good friend, with whom patients have a healthy relationship. Patients may not have someone initially, but the process of psychotherapy will help such a

relationship to evolve. Patients need someone to "be" with when there is psychological pain, between psychotherapy hours. This person listens nonjudgmentally, is able to leave patients alone when they are in a bad mood, and confronts patients when they are behaving inappropriately.

These significant others are in an inherently difficult position because therapists are an invisible third party in the relationship between patients and their significant others. The patients bring feelings to their therapists previously shared only with their significant other or not shared at all. The therapists will be talking about the significant other and making changes that will affect that person. The significant others may need to have some information about what is going on in the psychotherapy. Sometimes, it becomes advisable for therapists to meet patients' significant other at least once, of course with the patients' consent. It may be a brief contact in the waiting room, or third parties may join a psychotherapy session. The latter may be beneficial for at least two reasons: significant others get a chance to see who the therapist is, to ask questions, and to develop their own perspective on what is going on; this helps to establish trust that the process will ultimately result in constructive changes both within the patients and within the relationships between the patients and the significant others. Again, it may provide understanding about the underlying issues and how best to respond to the patients in difficult circumstances.

Significant others should be kept in mind as the psychotherapy progresses because these third parties can be deeply affected. From time to time, therapists may want to send messages to third parties that consider their feelings, clarify what is going on, and respect their rights in the relationship. This temporarily offers support to third parties in staying within the helping role and seeing the psychotherapy through to its end. Patients carry these messages voluntarily and do not seem to regard them as any violation of confidentiality.

This policy is much debated among psychotherapists because it involves a sharing of a relationship that is designed to be private. However, the advantages generally outweigh the disadvantages. Significant others are able to ask appropriate questions, give patients and therapists valuable information, and be very supportive of patients' work. Patients are often proud to briefly share aspects of the psychotherapy relationship with their significant other and their loved-one. Meetings with these third parties will be few, and can be requested by any one of the three concerned parties, but only for a reason that promotes forward progress. The basic privacy of the therapeutic relationship is maintained.

Significant others who do not meet the therapist are in an inherently difficult position because they must change with the patients, but without any help because they have no one to consult. They may be afraid the patients will

discover through psychotherapy a desire to leave the relationship with the significant other. If it is a solid relationship created for healthy reasons rather than unresolved dependencies, it will likely survive and deepen.

What happens to present relationships that are enmeshed or based upon past unresolved conflicts? These are the relationships in which the third parties may try to undermine the psychotherapy rather than to help. As patients understand and resolve their conflicts, there is sometimes a need to confront, modify, or leave the relationship if their partner is unable to make constructive changes with the patients. These are the relationships that give psychotherapy the unfortunate reputation of "breaking people apart."

Similar support can be offered to patients' parents. Unfortunately, most of the time, they choose to go without it. Their level of deception does not allow them to consider the enormity of the pathological enmeshment for which they need help.

LENGTH OF TREATMENT

Knowledge of the commands and experience gained through case material make it possible for therapists to shorten psychotherapy. Impinged-upon adults can often afford to come only once a week. Together they and their therapist can do a satisfactory job involving a deep understanding of the problem and a working through of the feelings in a period of from 50 to 150

hours (1 to 3 years), the average being somewhere around 120 hours (2 years). This amount of time makes patients feel that they are taking on a reasonable financial and emotional investment that might well achieve a desired goal.

Sometimes patients come to therapists with an externally imposed time limit that only allows for a very short contract of 10 to 20 sessions. Even in that limited time period, it is still possible to meaningfully address the overall issue of enmeshment in a way that allows patients to see themselves and their relationships to others differently (Davanloo 1978, Mann 1973, Small 1979, Wolberg 1980).

DIFFICULT ASPECTS OF TREATMENT

Even with understanding, there are several aspects of the psychotherapy that seem exhausting in treating impinged-upon adults. One is these patients' pervasive underlying drive against the psychotherapy growth process and toward failure and regression as the main means of preserving a relationship. A second is therapists' feeling that patients may summarily dismiss the therapists if the patients are displeased with them, much as the patients' parents threatened to abandon the patients. A third difficult aspect is surviving and cutting through patients' defenses that have been created to fend off their parents but also work to hold back the therapeutic relationship.

To survive these constant threats, therapists must understand the process fully enough so that their feelings are not continually hurt or frustrated. Therapists must instead hold a steady and consistent course that allows for forward progress without hesitation or undue discouragement.

THE TERMINATION, OR GRADUATION, PROCESS

I used to think that a good psychotherapy resulted in one final termination. If patients needed to return or contact their therapist, it meant that the previous work was deficient in some way. If patients had to leave before the work was fully completed because of external life circumstances, that meant that the patients were resisting. In contrast, it is possible to adopt a much more flexible attitude toward the termination process. It is, perhaps, better viewed as a graduation. There are many different graduations incorporated in the educational process, with resting periods in between these steps. The same should be true of psychotherapy. Therapists should be available to their patients, much as their family physicians, to help with a particular problem when, and if, it arises.

Patients appear to know best when it is time to stop. This usually occurs when the presenting problem or symptoms have diminished to the patients' satisfaction (Gardner 1985). It is possible for therapists to anticipate patients' initial request to consider a graduation simply by noting the therapist's

enjoyment regarding the obvious growth that has taken place.

Psychotherapy does not take the difficulty out of life. Instead it enriches and expands people's horizons, perhaps leading them beyond into greater complexity. People will always be confronted with problems. Patients leave when they are ready to take on life alone. Many patients will do a sizable piece of work to solve one problem, go off alone, and return several years later for additional help with a new challenge. They return because the previous therapy was useful. Some patients need to leave prematurely as a way of working through the separation issues (as described in the vignette that follows). If this is the case, they will return to finish the work.

Exceptions to this rule are patients who may want to "abort" because the pain is too great. I try to halt this kind of termination with consistent support and understanding regarding the pain. Occasionally, patients will leave because they want to hold on to their pathology and they realize that I will not accept that. Sometimes patients leave the therapeutic relationship to test the therapists' ability to allow separation.

Margaret was faced with the issue of a premature termination in the middle of her work because her husband's insurance terminated when he moved to a new job. This crisis allowed her to transfer onto me everything that she had been taught by her parents about leaving relationships. In the

five hours remaining, she raised the following critical issues, demonstrating her awareness of seven of the commands. My responses demonstrate the use of some of the permissions.

First, because of her transferential feelings, she was terrified to tell me that she wished to stop therapy. She was convinced that I would react as her mother did: I would become angry with her (maternal command 7); I would feel that Margaret was rejecting me because I was not competent (maternal command 3); I would tell Margaret that she hadn't tried hard enough to get additional funds, and that she was allowing her husband to run her life while forgetting the importance of the patient-therapist relationship (maternal command 2). If that tactic failed, I might convince her to stay by saying that she was not well enough to leave (maternal command 5).

Margaret and I worked together with these transferred feelings.

> *Therapist:* I support your wish to stop therapy when the insurance no longer covers it, especially if you thought you were coming to see me to support *my* self-esteem [maternal permission 1]! Is there any other reason *you* have been coming to see me? Have you accomplished what *you* want [maternal permission 3]?
>
> *Margaret:* I really have had no clear agenda for myself. I stole moments of the hour for me [maternal command 1]. [crying] I have never thought about leaving [maternal command 3].

She discovered that the issue of her departure was up to her and that I

would let her leave. She then displaced her feelings of sadness about leaving me onto absent family members.

Margaret: I have nothing for us to talk about today [maternal command 8]. Because I am going to leave, I expect you to be petulant and uninterested anyway, so why should I bother. I know that there is more work to do, but I have already managed to bury those issues, so they are now forgotten.

As long as the insurance paid for a large portion of each hour, Margaret didn't really have to deal with the issue of whose hour this was.

Margaret: Is this hour yours because you are supposed to cure me, or is it my husband's because he sent me to deal with my bad behavior?

Therapist: If it is indeed your hour, have you finished [maternal permission 6]? Perhaps you want to leave to find out how I will react [maternal permission 8].

Margaret: What would happen if I stopped for a while and then called you again? [She hypothesized the rejection that she was accustomed to from her family.] I'll bet you'd be angry. You will retaliate by saying that you don't have time to see me or that I must come in at a time inconvenient for me. Or you might only give me part of your attention [maternal command 7]. Perhaps you will manipulate me to come back by rescuing me with a gift of a very low fee [maternal command 4].

Therapist: I only want you to do what you want to do [maternal permission 9].

Margaret: I still do not know what I think about relinquishing this hour. It would feel like a gift if I could come back because I have gotten so much out of the work we have done together. I fear that the only way I could return would be to arrange a crisis. Then my husband would send me back and you would have to take me in [maternal command 5]. Or, maybe a a gift of money would drop out of the sky [magical thinking].

Therefore, when she wants something for herself, the only two ways she can get it are to fail or to hope for magic. She cannot be assertive.

She could not tell her husband how much the psychotherapy had meant to her because she feared he would feel threatened that she had felt intimacy with me [maternal command 2]. She was surprised to consider that her husband might appreciate and benefit from the intimacy that she had allowed herself with me [maternal permission 9].

> *Therapist:* You are entitled to evaluate our relationship in terms of what it means to you-both its negative and positive aspects [maternal permission 7]. You have never thought to do this. It has not occurred to you to consult with me or your husband about your psychotherapy because you assumed we would control you.

She was learning through her exploration of this issue that intimacy includes letting a person come and go as they have the need (maternal permission 3).

By the end of the final hour she had decided to leave with the considerable gains that she had made. It seemed that she left because she had to test, rather than talk about, my response to her needs to separate both physically and psychologically. Most important, she had made the decision by herself and for herself. She promised herself to return when she felt ready. Six months later, she sent a card expressing appreciation for my help and suggesting that she would be calling me again soon. Then she returned to

finish her work.

Therapeutically, the graduation phase can be difficult to manage. It takes time because the patients have never really experienced an acceptable "good-bye" with a significant other. Patients find it hard to believe that leave-taking would be sanctioned and supported by the therapist.

Patients may be in a hurry to leave as soon as they acquire a sense of separate self and can freely disobey the family commands. They want independence and are acutely aware of what they have lost. At this point impinged-upon adults can leave home psychologically, as well as physically, and are able to express ideas and affection with greater freedom and trust that others will honor their needs.

Before their departure, it is optimal for patients to practice this newly found trust and affection with the therapist. They now feel lovable, have love to give to others, and feel indebted to the therapist for providing the therapeutic relationship.

However, natural affection and the ability to love, practiced within the therapeutic relationship, must then be withdrawn and turned to others who are able to return it more fully than therapists within the structured fifty-minute working hour of psychotherapy. The relationship has served its purpose by ultimately freeing patients to invest their love more fully

elsewhere. This realization presents patients with another painful moment. They may be impatient about wanting to "make up for lost time" and to put their affection in a place where it can be more fully reciprocated. It is difficult for therapists to balance supporting the graduation process of a newly individuated self and, at the same time, suggesting a proper and affectionate good-bye.

If patients leave too early, the pain of loss will continue longer. The therapist has been of help with only a few hundred hours of support for growth. It is hard-won and financially expensive support that patients were entitled to have earlier in life without charge.

Most patients have parents still living, some close by. The patients need to continue to deal with them in a reasonable manner that preserves the relationship but is minimally importuning to themselves. The irony for patients is that they must leave the nurturing relationship with the therapist and continue with the psychopathological one with the parents.

Some patients choose to keep in contact on occasion with a card, a call, or stopping by the office to share news of their next achievement. These contacts are infrequent and generally mean that the patients are touching base again with an important person.

There is pain for the therapists too. This job requires psychotherapists

who are willing to grow and able to handle and support multiple separations. Impinged-upon adults enter the office for the first time confused by the fact that life has gone wrong. The therapists must watch, listen, and intervene to recapture each patient's potential. Patients begin to handle life with an understanding they didn't have before, accomplish what they need to do and leave, just as they should. Many, in the process, become people that would make good friends, had they and the therapists met under different circumstances. They leave, and the therapists may grieve the loss.

Patients make a long journey by the time they are ready for graduation. They have pulled away from a family environment believed to be perfect, warm, and close. They understand the destructive nature of that relationship to growth. They have given up the temptation to be taken care of in a regressive way and have refused the offer of an allegedly "easy life" if they serve their parents. They are alone and separate, finding out that life is as difficult for them as it is for other people.

Alice expressed her feelings about graduation by saying, "I think I can get ready to go now because I know that I am not a part of my mother. Instead, it is now only my mother still trying to be a part of me.

During the graduation process, one patient summed up what her psychotherapy had meant to her. She had only worked with me for one year

because of a professional opportunity that she had accepted across the country. Before she left she said, “What my mother taught me is that I need to fail, to get attention. I construed that as love. What I’ve learned here is that I have to do the very best I can with my life. That will be quite sufficient and people will respond, more than likely, with love and caring.”

Ben said in his graduation hour, “I used to feel inadequate and less than anyone else because of my problem background and consequent difficulties. I don’t feel that way any more. In fact, if anything, I feel stronger than the average person because I have looked at my own personal horror. I know what it is like to be on both sides of the fence now, and I feel the wiser for it. I am like a person who has received a small-pox shot: I have some of the pox in me and it will always be there, but I also have the antibodies. I will be able to share what I have learned with others, especially my children. I have been successful with you and I feel good.”

The unconscious mind gives patients and therapists information that the patients are ready for graduation. The patients’ dreams are generally clear and therefore easy for the patients to interpret. One patient reported the following two dreams with his own interpretation during his next-to-last therapy hour.

I dreamt that I was in a forest camping out, and two characters came

along that were obviously up to no good. Suddenly I became Paul Bunyan and went over and picked one up in each of my huge hands. I restrained them from doing any harm. The two men were my parents, and now I know that I am in control of what they can do with me. I didn't kill them.

My fiancee and I went down into a subway and looked at the map only to discover that this subway was just a spur and only went to a dead end. We turned around and got our money back and left. This dream reminds me that I can tell when a relationship is not good for me and I have the capability to get out of it.

CONCLUSION

As my experience doing psychotherapy has increased, I have found myself moving more and more in the direction of providing a relationship for patients that is relatively open, as human as possible, and explicit in its caring and honesty. Sometimes I have to fight a feeling of guilt that I am bending, if not breaking, some of the traditional rules of therapy.

As I have wrestled with these issues, I have wondered if some of our language and our manner with patients is more to protect our need as therapists for omnipotence and distance from intimacy than it is to provide an uncontaminated and optimal environment for patients' feelings. My patients wonder with me why we call people "objects" and talk about

"termination" rather than "graduation" or "celebration." As one patient said, "The word *termination* implies that you never want to see me again!" Why do we use such cumbersome phrases as "libidinal unavailability" and write about people in a style of jargon that makes them sound like something less than human? Feelings are best expressed in an atmosphere of openness and caring. To provide this, therapists must be willing to risk ethical intimacy with every patient contact.

Glossary

Clarification: those dialogues between patients and therapists that bring the psychological phenomenon being examined into sharp focus. The significant details are highlighted and carefully separated from the extraneous material.

Entitlement: rights given at birth to decide what to do and what to share or withhold.

False self: the patient's facade of compliance and accommodation created in response to an environment that ignores the patient's needs and feelings. The patient withholds a secret real self that is unrelated to external reality (Hedges 1983).

Impingement: the obliteration of psychological and sometimes physical separation between individuals without obtaining permission.

Insight: the ability to perceive and understand a new aspect of mental functioning or behavior.

Interpretation: the therapist's verbalizing to patients in a meaningful, insightful way material previously unconscious to them (Langs 1973).

Introjection: the taking into oneself, in whole or in part, attributes from another person (Chatham 1985).

Object: a psychoanalytic term used to represent another person, animal, or important inanimate object (Chatham 1985).

Object constancy: the ability to evoke a stable, consistent memory of another person when that person is not present, irrespective of frustration or satisfaction (Masterson 1976).

Object relations theory: a theory that focuses on the earliest stages of life when children become aware of the difference between the self and the external world. This theory describes accompanying developmental tasks and also explains the difficulties that result if these tasks are incompletely accomplished.

Observing ego: the ability to stand outside oneself and look at one's own behavior.

Oedipal: a stage of childhood development that begins at about 3 years of age. After a stable differentiation of self, mother, and father has been achieved, children engage in a triangular relationship with their parents that includes love and rivalry.

Preoedipal: the period of early childhood development, ages 0 to 2, which occurs before the oedipal period. The developmental issues are the formation of constant internal memory of others and a separate sense of self.

Projective identification: fantasies of unwanted aspects of the self are deposited into another person, and then recovered in a modified version (Ogden 1979).

Reframing: the therapist's description, from a different perspective, of an event in the patient's life, providing new insight.

Separation-individuation: separation includes disengagement from mother and the creation of separate boundaries, with recognition of differences between mother and self. Individuation is ongoing achievement of a coherent and meaningful sense of self created through development of psychological, intellectual, social, and adaptive coping (Chatham 1985, Rinsley 1985).

Splitting: the holding apart of two opposite, unintegrated views of the self or another person, resulting in a view that is either all good and nurturing or all bad and frustrating. There is no integration of good and bad (Johnson 1985).

Symbiosis: an interdependent relationship between self and another in which the

energies of both partners are required for the survival of self and other (Masterson 1976).

Transference: the inappropriate transfer of problems and feelings from past relationships to present relationships (Chatham 1985).

Transitional object: a soft or cuddly object an infant holds close as a substitute for contact with mother when she is not present. A transitional object aids in the process of holding on and letting go and provides soothing qualities. It represents simultaneously an extension of self and mother (Chatham 1985).

Working through: the second phase of therapy involving the investigation of origins of anger and depression through transference, dreams, fantasies, and free association. Patients satisfactorily relate elements of past and present relationships. As a result, patients risk giving up old behaviors no longer needed in order to adopt new behaviors.

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