PARTINGS AND IMPARTINGS: TOWARD A NONMEDICAL APPROACH TO INTERRUPTIONS AND TERMINATIONS

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ABSTRACT: It is the thesis of this paper that therapy offers a sequence of opportunities for the patient to experience a comfortable oscillation between togetherness and parting: the *petit* partings within each hour, those moments of silence or withdrawal, partings at the end of hours, vacations, spontaneous interruptions (when allowed), and, ultimately, termination. A nonauthoritarian method particularly respecting and fostering the patient's self-determination is proposed.

Most of our patients would probably subscribe to the old French proverb, "to part is to die a little," for they often experience separation or impending aloneness as threatening psychic extinction, if not as stirring up actual suicidal impulses. These are frequently persons who have had too early and too often to face the trauma both of miserable relationships and of unchosen breakings up. Most tend to react by a desperate search for new ties, and their very urgency makes for a tendency to repeat past patterns. Others resolve, "Never again" and rigidly avoid commitments. Neither is left with a sense of free choice.

This article is concerned with the reverse of that old proverb, maintaining that to part is also to live a little, or even a lot, depending on the preconditions. It posits that the whole course of life may be seen as a series of felt oscillations between connectedness and apartness, the quality of each phase of relating being determined by the individual's measure of the quality of separateness that preceded it, and the quality of each phase of separateness being affected by the experience of the relationship out of which it emerged. Thus all change, both regress and progress, evolves from the dynamic interweaving of these two aspects, in the pattern of a dialectic spiral, with separating as essential as uniting. Since each person develops his or her unique timing and rhythm no two patterns will be identical.

Freud (1937) called our attention to Empedocles, who in nearly 500 B.C. recognized that two principles governed the life of the mind: one,

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striving to agglomerate primal particles into a unity and the other seeking to undo fusions, to disconnect elements. The first principle was called love, the second strife. We have become considerably more sophisticated since Empedocles, and would no longer subscribe to such a simplistic explanation of the motives for union and for separation. Instead we see as existing certain basic energies which may flow in either direction, out of both positive and negative feelings.

On the positive side, when one feels an inner abundance there is an urge to overflow, to give to others; when one can function productively and creatively, there is pleasure in participating with others; and both make for the wish to develop exchange in communication. On the negative side, felt emptiness can lead to a desperate attempt to seek supplies from another; inability and constraint in functioning can compel one to seek others for structure, direction, safety; both predispose to "part-object" relationships rather than to equal exchange.

There are also qualities experienced in togetherness that can move a person toward self-withdrawal. On the positive side the feeling that one is receiving plenty of emotional or intellectual nourishment of the right kind can make for an inner comfort which permits some pulling away to assimilate and to create; when there is a safe milieu for exploration there is freedom to leave in the knowledge that one can return to the provider at will; and when there is an open flow of communication, it can lead to rich inner dialogue. On the negative side, when one feels denied of that which one needs and seeks, there can be a disappointed retreat to inner resources; when there are impositions and restraints on functioning, fears of being caught and trapped can make for withdrawal, actual or emotional; and when there is difficulty either expressing oneself or understanding the other, sometimes the very attempt to relate to others can be suspended.

All of the negative motivations decrease the sense of choice either for relationships or for self preoccupation. It follows then that therapy ideally directs itself toward maximizing the patient's feeling that he may elect his own options according to his inner promptings.

It is the thesis of this article that therapy offers a sequence of opportunities for the patient to experience a comfortable oscillation between togetherness and parting: the *petit* partings within each hour, those moments of silence or withdrawal, partings at the end of hours, vacations, spontaneous interruptions (when allowed), and, ultimately, termination.

To actualize the healing potential requires that the therapist respect patients' right to their own inner measures about timing, duration, and content of each phase. This means permitting them to determine the schedule of appointments, as to frequency and duration, possibly even as to length of session when that is feasible. It means within each session

keeping alert to those subtle signals which indicate the patient's shifting predilections, actively enabling him or her to be more continuously in touch with them, thus minimizing the likelihood of impulsive acting out. Perhaps most of all it means no longer interpreting every pulling away as resistance. For instead of being part of "the trend of forces within the patient which oppose the process of ameliorative change" (Menninger, 1958) such withdrawals may be aspects of a benign regression essential to self repair. To see them in this latter way we may have to correct a possible bias of psychotherapists—perhaps especially of *social* work therapists—a bias toward object relatedness.

Many of our patients have had special difficulty reconciling their inner needs and wishes with the demands of the social world, and especially of intimate relationships. Despairing of the possibility, they are ready either to relinquish "selfishness" and adapt to others, or to abandon the search for permanent ties and resign themselves to loneliness or to superficial contacts.

Nevertheless, a hope is never quite quenched that somewhere they might find someone with whom there could be an identity of wishes and interests. The persistence of this hope can be seen as rooted in the universal experience of every infant with its mother—dreamlike moments of primary illusion in which no boundaries are felt to exist, in which there is harmony between inside and outside. We see the quest for reexperiencing that lost paradise as a powerful motive both for self repair and for improving of intimate relationships (Shor & Sanville, 1978).

In the regressions which occur in intensive therapy we can discern evidences of this basic quest in the patient's wanting to be both joined with and separated from the therapist. Instead of interpreting these phenomena as symptoms of an infantile wish, ergo bad and pathological, to be gotten rid of as expeditiously as possible, we point out and hence heighten the reparative intent so that patients may become increasingly capable of mobilizing their own resources toward achieving their new version of that primary harmony. (See example below.)

I am calling such comments "impartings" to differentiate them from classical "transference interpretations," which deal with phases of the patient's withdrawal from the treatment relationship as attempts to escape or perhaps to destroy the therapist. Such interpretations may even be, in part, "correct." They may impress patients as clever and apt, and they will probably bring them back into alert inner-relatedness. But they will not have been enabled to recognize and be fueled by an experience of the therapist as part of what Michael Balint calls "the friendly expanses," "which need no longer be defied or watched with suspicion" (Balint, 1959). If, on the other hand, the therapist's impartings stay close to reflecting what the patient brings, to what Winnicott calls the "mirror role," "the patient will find his or her own self. . . and have a self into

which to retreat for relaxation" (Winnicott, 1971). When that becomes true, the only impartings necessary will be those simply to signify the therapist's presence and availability.

An example may serve to illustrate both the clinical outlook and the clinical approach which I am suggesting. I will refrain from giving the full case material but only offer excerpts from selected interviews to illustrate a way of dealing with phenomena which in the past have usually been seen as resistances but which we might increasingly regard as the inevitable workings of the dialectic of togetherness—apartness.

Betsy, 20, had been coming in for several months, by her own arrangement twice a week. Because of the distance she had to travel she arranged with me that, when she wanted, she might request a double session. This was possible for me as she came either weekends or evenings. Her presenting problems were her difficulties in achieving either a comfortable togetherness with or separation from her parents and her boyfriend.

One evening, in a mood in which Betsy was aware of some reluctance about being here, she expressed distress that her mind "goes in and out" in contact with me. This would happen when, after presenting some dilemma, she would look at me for comment, but when I would begin to speak she would be unable to hear what I had said. She had noted this happening frequently in conversations with other people, although for the most part she was able to conceal it. What distressed her about tuning out was that she did not will it. She likened it to an LSD trip when she was frightened at loss of control. After reporting that this symptom was somewhat more frequent when she did not like someone, she became flustered and assured me that did not apply to me. I responded that there could be some aspects of seeing me that felt unpleasant to her, facing things that are painful, and noticed that tonight her "goings-out" were in the context of not particularly feeling like coming to her appointment. But, I continued, on some level she might be motivated also by a need and wish to attend to more pressing things within herself, that these might simply at the time be of more central concern to her than what I or anyone else might be saying. I suggested that, as an alternative to being so distressed about it, she might simply say to me, "Jean, I'm not hearing you just now, but this is what I am thinking." Betsy expressed noticeable relief. The next time she found herself "going out" she informed me that what she was thiking was that she had not let me know whether she wanted a single or a double hour this evening, but she had decided in favor of the single hour, thus experiencing for then her power to limit her own connectedness, without my minding at all.

Betsy, as the daughter of a therapist, had an inordinate desire to be a good patient, who, she thought, would unceasingly bring in fascinating material to keep me interested. Here, as in all her relationships, she wanted so to be liked that she was ready to pay the price of self abnegation. But it already meant some greater easiness with me that she could admit to tuning me out, in favor of thoughts of separation from me earlier than her possible double session would have required. In previous sessions she had been sensitive lest I would feel hurt and rejected if she did not utilize all the time available.

In the middle of a subsequent hour, Betsy went into one of her silences, looked to me with that half smile, as though pleading wordlessly. I commented that there was something that she seemed to want of me, perhaps that I should somehow reach out to her. With tears in her eyes, she reported her feeling that

mother never does this. When Betsy was away at school, mother wrote to her only once. She was always the one to reach out to mother, and then there was often only an unsatisfactory gesture of response.

She reported a dream: she sees mother who has just received a letter that Betsy has written. Betsy told me that she had in reality sent a letter to mother explaining why she had not come home for some while, that she needed to be apart just now but that mother should not take it to mean she did not care. In the dream mother suggests that they talk, but Betsy tells her that she prefers to communicate via letter. I commented on her wanting mother or me to reach out for her, to be closer, but at the same time wanting flexible distancing which only she could define. I wondered whether in those moments of silence Betsy might fear that her connection with me is disrupted. She confirmed this tearfully, and confessed that sometimes when she is quiet she imagines that my mind must wander, that I "go away from her." I suggested that she wanted the comfort of a felt connection whether or not we are actively talking together at the moment. She might like to simply be able to take the relationship for granted, sure that I would be there and available. She brought out some further material indicating the tenuousness of connectedness with mother, which made it not safe to go off, lest mother might not be there upon return. She thought that was some part of why she had not been able to stay away at school, but had returned to be near her home. Yet now that she is near home, she finds it difficult to be with her mother, toward whom she is forever feeling guilty.

It would have been easy to respond to Betsy's imploring glance by taking the conversational initiative or by an interpretation, for she was still tending to experience silences as arid and frightening. Had I done that, she would dutifully have followed whatever topic or problem area my comments had suggested, resulting in a constriction on her freedom of self exploration. Had I interpreted her silence as evidence of some form of resistance, this would have reinforced Betsy's notion that what a therapist expects is that the patient keep connected, keep talking. Instead, my impartings here were further attempts to help her to convert silence into that sort of tranquil, quiet and peaceful state reminiscent of that of the infant before the complications of "object relationships." This could permit her to explore "an area of the mind in which exists a possibility of creating something out of self" (Balint, 1968).

Betsy's discomfort with both beginnings and endings she saw as true of her life everywhere. She was hesitant to drop in on her closest friends, always needing to ask anxiously whether her visit was convenient. She got depressed when her stepfather greeted her effusively. She spoke of her fear of being "swallowed up" by her boyfriend's family, as they seemed to have some vested interest in her relatedness with him. She was most comfortable with her father and his wife who were more casual, invited her to their social events, but accepted it when she declined. She suffered an uncomfortable self-consciousness about leaving as about arriving, a worry both over staying too long and over departing so prematurely that her host might take offense. Some of the same awkwardness pertained when guests came and left her, an excessive deference to the feelings of others. yet when I took off for several weeks, she was able to experience even some pleasure contemplating the interlude.

In the final hours before my vacation Betsy reviewed some of what she felt to be gains made in the months of therapy, as though to own them for herself. She noted how often she makes a nervous little giggle when she has said something, and how frequently just after that she is blocked in further talk. She was always looking for feedback as a guide to her next statement. She noted an overseriousness about herself, observed that she even listened hard, and that her very

anxiety made her sometimes deaf to my comments. She was reading Carlos Casteneda and noted that his Brujo was helping him to integrate that which he experienced as his "separate reality" with the rest of his life. She felt that she was beginning to be able to do that, whereas everything used to be compartmentalized. As the hour ended, Betsy found herself thinking about a film that she had seen about an 80-year-old woman, who, faced with death, kicked over the traces, and "did whatever she damn pleased." Laughingly, I noted that this might be something of what Betsy was wishing to do herself while I was away, losing all that self-consciousness, that need to tune in to what someone else thinks, and just finding a playfulness within herself.

Betsy was thus able at least to sample that "potential space" of which Winnicott speaks—an area of playing, which is different both from the world of shared or external reality and from the inner world of private reality. It is his thesis that when infant (or patient) has sufficient sense of the trustworthiness and reliability of the mother (or therapist) this safe space is made possible, and then "separation is avoided by the filling in of the space with creative playing" (Winnicott, 1971).

But the potential space was not yet hers to safely keep. After my vacation, Betsy's first hour began with her helpless look at me, tears welling, saying she had been depressed. She felt she didn't want to talk, and even noted a sensation that her throat was closing up, but said, "I know I have to."

"You have to? Maybe it could be more useful just to understand your reluctance," I responded. She said she did not understand anything that had happened to her in my absence. "It was as if you had no framework to fit it in?" I asked.

She thought that was perhaps part of the poor memory of which she often complained. She then observed in herself an opposite impulse, "I now feel that I'd like to tell you all and let you tell me the meanings, but you don't do that."

I said lightly that she was a little bit mad at me for going away and hence forcing her to sort of "begin again" when I know full well how hard beginning relationships are for her. But I noted that in her not speaking was a hope that I would understand anyway, and that in her "dumping it all" on me was a hope that we could make sense of whatever showed.

She wound up the hour saying, "It was hard having you gone and I didn't think it would be."

The following session she, for the first time, got into the morass of "have to's" which have dominated her life, the urgent perfectionism geared to make her as unlike a "sick sister" as possible. Yet underneath was always the dread that something was profoundly wrong. Her fantasy was that perhaps she had some fatal disease of which her parents would not tell her. Thus, in response to a lack of external compulsion, she revealed her internal ones and her most profound "irrational" fears. She asked for a double hour, her felt resistances clarified and spontaneously put aside.

Not long after that Betsy began to manifest both a greater comfort with apartness and a greater ease with togetherness. In a movement therapy group with which a dance therapist and I had been experimenting, Betsy was relatively free of some of the transference responses characterizing other patients. For example, the dance therapist, one evening, suggested in a totally nonjudgmental tone, that each participant find out inside herself whether she felt like contracting, pulling in, or whether like expanding, reaching out. Several of the group subsequently admitted that although they felt like contracting they had pushed themselves to move expansively, assuming this was the more desirable behavior. Betsy, however, stayed with her own feelings, permitted herself to stop huddled over, arms around her knees, head down.

Around the same period, she began to spend time at her mother's home and even found some bases for identification and communication with the stepfather who had for years been anathema to her. But—most moving of all—she urged her mother into a talk about the latter's having abused Betsy in her infancy. Mother was most reluctant, declared Betsy's father should not have told her; it was better forgotten. Betsy assured her mother she had no interest in blaming; it was just that she was trying to understand in her therapy some special complications of beginnings for her, and that her experiences as a baby might be part of those. Mother wept, said she has carried guilts for years over the memories that both she and father struck Betsy in her crib when she would not cease crying. She recounted numerous bad scenes, such as in a theatre when Betsy was barely 2 and had to go to the toilet in the middle of the picture; mother had taken her but screamed and scolded until the little girl was in terrified tears. (One of the "symptoms" Betsy had presented initially was an enigmatic fear in social situations that she might feel a need to go to the bathroom; the tension about the possible body need had prevented relaxation in group situations.) Mother and Betsy talked and wept for hours and mourned the past together. Their mutual grieving seems to have enabled this patient to make a new beginning.

I will not attempt to illustrate here what I think to be the value of spontaneous interruptions which are often chosen by the patient during the course of therapy. I never see a patient as "leaving against advice" because I never offer advice to stay if the patient wants to leave. In general, I simply tune in to the anxieties and to the apprehensions as well as to the hopefulness about any interruption, that is, I try to keep my impartings close to the patient's own measures.

Sometimes, of course, the "interruption" is termination, but we may not know for some years. I believe in an open door policy. I do not think it is my right to set up criteria for discontinuance. *I* could not measure, as Melanie Klein suggests we do, whether the patient has worked through paranoid and depressive positions. As for Wilhelm Reich's emphasis that there should be strong orgastic potency, I believe we could make a case for the value of the exact opposite, particularly in those men who have previously emphasized machismo. Karl Menninger (1958) set up an elaborate list of criteria, many of which we might reverse if we are responsive to individual patients today. For example, he declared that there is usually an elevation of goals as gauged by our cultural standards, but we see many patients who measure their own gains by whether they can feel comfort with a phase of lower goals. He mentioned that the patient will have "no need to find satisfaction for childish wishes," which we could see as the old tendency to put down regressive phenomena. Quite the contrary, a patient, who feels he or she has progressed enough may delight in more episodes of benign regression (Balint, 1959). The very ability to experience *love* demands what the Kleinians seem to hold as impossible—namely the idealization of another *without* loss of self-esteem. Menninger speaks of a likelihood that there will be a greater

interest in those weaker or needier than the patient, but in many patients the opposite is the case, as for example the man who has always chosen weak women, and who now shows himself able to relate to someone on a more equal basis. Among the unmarried, Menninger declares, there will be "a trend toward a marriage set," while today the capacity to enjoy single existence is often a felt achievement. Menninger believes there will be improved work patterns, while I would suggest that play attitudes would tend to permeate even the arena of work. He speaks of the possibility that there will be sublimation in competitive play and constructive work, while I would note that many patients, particularly males, want to become less competitive, less driven in work.

Let me end with a few worrisome comments about the present state of affairs in which clinical social workers are rushing to be a part of medical science, to be vendors under insurance programs which, of course, must be concerned with shortening treatment. I am reminded that Freud, in "Analysis Terminable and Interminable" noted that, from the first, attempts had been made to shorten the duration of treatment. He saw in those attempts some trace of the "impatient contempt" with which neuroses were regarded by "medical science of an earlier day," as "uncalled for consequences of inevitable injuries" (Freud, 1937). Today too we see the resurgence of an attitude that if such consequences must be attended to, then it should be done as quickly as possible. Freud wrote of his own resorting at one time to the "heroic measures" of fixing time limits, but found that while part of the material will become accessible under pressure of threat, another part will be kept back. . . "and lost to our therapeutic efforts." The work of Otto Rank, which affirmed that if we could analyze the primal trauma of birth we would eliminate neurosis, influenced a whole school of social work, the so-called Pennsylvania School. They affirm that where there is not an inherent ending, it should be established in the beginning "based on the time usually required." Currently we are finding ourselves pressed to do just that and we are observing that those who claim to do it quickly may be preferred by those who are footing the bill. The burning question may be, "Can we be in the world of medicine and not of it, or can we presume to change things in keeping with our own belief?" I am hoping that we can avoid taking on the heritage of the physician to be the authority, to be the judge of what the patient needs, how and how much, and to make prognostications.

Ruth Smalley, with whom I disagreed in many ways when she was my teacher of Rankian philosophy, yet writes the following about endings so beautifully: "In developing the capacity and the courage to enter on something, use it, and let it go, he [the patient] develops confidence and capacity in living with all things temporal, and in small degree with the fact of life itself, with its inevitable physical ending" (Smalley, 1967).

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