ON WEARING MULTIPLE HATS:
A CASE OF PSYCHOLOGICAL INCEST?

When I was seventeen, I went through a difficult time emotionally. At the peak of my distress, I had what might be described as a "nervous breakdown". Though I was still doing well in school and attending my extracurricular activities, I was depressed and despairing. I needed help and did not know where to go. I found myself all alone. My parents had divorced several years earlier. My father was away on a Caribbean vacation. My mother was either unable to see my real anguish or was too frightened by it to be helpful. My boyfriend and I had just broken up. Other friends sensed my loneliness and pain, and like my mother, tried to be helpful but were not able to offer any real support.

My father is a psychiatrist and a sensitive man. When he came back a week later, he recognized my despair and quickly realized that I was in a crisis. In an effort to help me, he gave me the name of a colleague in town and I began to see a psychoanalyst. She was kind, but somewhat distant and politely formal. She did not make much real contact with me and did not help me get hold of myself. After several weeks, as the crisis period subsided, we mutually arrived at the conclusion that our relationship was only intended to be temporary.

She did not encourage me to stay in treatment, and I left. Disappointed that the analyst did not work out, and recognizing that I still needed help, my father suggested that I come, as a patient, to the next few psychotherapy marathons that he was leading. Hoping for relief and trusting my father, I did.

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Though attending these marathons helped me, I felt then and for some time subsequently that doing so also created new problems. I am now a therapist myself, and have the perspective to understand and explain the circumstances clinically. Since I believe that arrangements like this may be more common than is generally discussed, I offer this as a means of shedding light on a "taboo" subject.

Marathons, as used in this practice, are 28 hour long sessions that are a therapeutic adjunct for patients in ongoing treatment. They are not intended as a "quick fix" or as an episodic "growth weekend". Patients in intensive long term psychotherapy come to these sessions an average of once or twice a year, the goal of which is to intensify the work that is normally done in their regular group and individual sessions. There are usually twenty-four patients and at least three or four co-

therapists who lead the sessions. Being together for a prolonged period of time with relatively little sleep lowers the defenses, allows more feelings to surface and more time to work with them, and makes room for more of a person's true character to show.

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I was anxious. Being a patient was new to me, having had only the one brief prior experience with the analyst. When I accepted my father's suggestion, I did not realize how difficult I would find this. My palms were sweating and I did not know what to do with myself. The rules regarding confidentiality and non-acting out had been explained to me, as they were to every patient. I was told that there were no other limitations. I could say anything.

But how could I say anything? Since the marathon was conducted in our house, I was sitting in my own living room with my father functioning as the main therapist. I was confused. I felt ashamed that I was "so sick" that I needed to be there as a patient. I felt like damaged goods. Yet there I was, after all, Dr. B's daughter. As was my way, I believed that I had to put on a good show, seem strong, well put together, for myself and for him. Since he had been the only one whom

I felt had understood the pain and loneliness I was feeling, I did not want to disappoint him. I wanted to do things "right".

As the patients introduced themselves, they spoke about how long they had been in therapy and some of their current struggles. But I was not in therapy. How could I introduce myself? I did not fit in. There seemed to be no way to be just one of the rest. I had a special situation, with special requirements. Besides, how could I talk about myself and still protect my father from having his patients find out about his personal life? As the teenage daughter of a psychiatrist, I conscientiously took it upon myself to abide by the unwritten rule that a therapist never reveals anything about himself to his patients. I started to get angry. As the time passed, I felt more trapped and more angry. How could he do this to me? How could he put me in this room with his patients? What did he expect of me? How could I say anything about myself, even my own name?

So I sat, conspicuously silent, imploding with fear and anger. I fidgeted and wished I could disappear. One of the co-therapists, Mr. G, read my busy but soundless struggle and invited me to speak. I could be contained no longer. I blurted out my name, first and last, (though everyone else used first names only). Then I cried--afraid, hurt, angry, and not knowing how or what

to say next. I expected to be attacked, ridiculed for being emotionally unstable, inspected as Dr. B's daughter, and disdained as an object of envy. Moments passed as I cried and said nothing.

Dr. B gently but firmly encouraged me to speak. My father's voice caught me as it had on numerous occasions when I was growing up. My body tightened and I went on alert. I assumed that I embarrassed and disappointed him, both by crying and by using my last name, thereby revealing our relationship. I should not have said anything. I wanted to run--but sat, without speaking.

Again he addressed me, saying that I could not remain mute. The prod felt like an impossible demand. I snapped back defensively, almost incoherently. Sensing the whir of emotions within me, Mr. G interrupted, advising me to take a breath and not speak for a moment. I felt an urgent need to explain myself, but as I started, Mr. G stopped me again. He told me to take a few breaths before I speak, to depressurize the force that was pushing me to defend myself. With effort, I paused and took several deep breaths. I noticed some relief at the momentary respite.

He then asked me about my relationship with my father. I tensed again in fear. What was he doing? Why was he trying to expose me and this "forbidden territory"? He spoke calmly, looked directly at me and

reminded me to look back at him. His straightforward tone cut through my anxious confusion. I heard him differently than I heard my father. I had known this man for a number of years and liked him. I felt as if he was holding me with his eyes and his voice and became somewhat less frightened as he continued to speak to me.

Feeling him with me, I accepted his opening and hesitatingly began to talk about myself, my father, and how I ended up in this room on this day. He led me out of my confusion, helping me sort out my jumbled and unexpressed feelings. As I drifted from idealizing my father's strength and sensitivity to painting a picture of a harsh and unsatisfiable parent, he helped me step back and compare these images to the real man who addressed me earlier. When I got more anxious and confused again, he slowed me down, my breathing, my speech, my busy gesturing hands. At one point, when my shame and embarrassment again seemed to take over and stopped my words from coming, he suggested that I look around the room. The other patients were quiet, attentive, waiting for me to continue. As I spoke, gradually my fear lessened.

One of the patients addressed me in a bitter whine. I had no business being there. I did not deserve this place. She has been working hard in therapy for years. <u>She</u> had a hard life. She had survived all sorts of

horrors in her family. What was I doing there? How bad could things really be for me, with Dr. B as a father? One of the therapists intervened, addressing the helpless whiny quality in her voice. As he worked with her, the bitterness gave way, exposing powerful displaced anger which he redirected towards himself. He then worked with her as it led to genetic material, which clearly had nothing to do with me.

Another patient got angry at Dr. B for bringing his "messed up kid" into his therapy room and taking up space. His voice cracked somewhat as he spoke and his eyes had the suggestion of a tear. Dr. B commented on these physical signs which stimulated the patient's recurrent sense of never getting enough, of feeling cheated in life. His hurt, which was often masked by anger, surfaced, and became the focus of the work with him.

Different feeling reactions of varying intensity arose in a number of others, which were worked with as each patient's characteristic response based on his or her own personal history. A few patients immediately liked me very much. Several tried to shield me from the anger of others. Some seemed to have little or no reaction to me. As the hours passed, my presence seemed to stimulate fewer reactions as patients became reinvolved with themselves. I was surprised, relieved,

and a little disappointed as I felt their curiosity wane. By the end of the twenty eight hours, most seemed to accept or reject my comments, and me, in the same way as they did with others in the room.

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It is a dictum in psychoanalysis, and a generally accepted concept in all but the most humanistic psychotherapies, that intimate details of a psychotherapist's life remain anonymous. How can this be reconciled with having the therapist's daughter in an extended group session as an active participant revealing personal and family data? Does this not unduly burden the patients with facts, thereby limiting their freedom in a therapeutic relationship, particularly interfering with the transference? Can a daughter be able to see and accept her father as a therapist without excessive confusion? Can a father have enough distance and neutrality to act as a therapist for his own daughter?

I have tried to report, as objectively as possible, some of what happened to me and a few reactions of other patients when I went to these marathons. I am now in a position, having acquired theoretical knowledge and experience in this field, to attempt to fit this

experience into an understandable framework. There are several important preconditions that made the unusual circumstances and reactions not only possible, but useful both to me and to the other patients:

1. A safe therapeutic environment. Two necessary elements are required for a therapeutic setting to be safe. It must be devoid of any actual threats or danger; and it must be experienced by the patient as emotionally secure. A therapeutic framework that includes: a) a no acting-out contract, b) acceptance of the incontrovertability of reality, and c) the expectation of compliance with confidentiality, provides a measure of insurance that no real danger will occur. A by-product of a clearly delineated framework is that it is usually also experienced as reliable and emotionally safe.

The no acting-out contract is an agreement that commits each patient to the goal of separating his feelings from actions and feelings from judgment. This distinction allows the patient to safely feel and express emotions as intense and varied as murderous rage and intimate love, and aim them directly at the therapist, since no spontaneous behavior, i.e. touching of any sort, is permitted. This no-acting out contract, the principles of which hold for the therapists as well,

provides real safety for both patient and therapist in the face of strong feelings.

Equally stressed within the therapeutic framework is the principle that reality comes first; that is, feeling that something is a certain way, even very strongly, does not make it so. Recognition of this simple fact does not come readily or naturally to most people when their own emotions are involved.

Feelings have the tendency to distort most perceptions of life, confuse thought processes, and influence actions. Therefore, from the first moment on, one of the therapist's main tasks is to help the patient separate out his observing ego from the irrational feelings that are memory traces from the past. By reinforcing reality and the here and now of the therapeutic setting, the therapist makes room for the patient to feel emotions that up to now had been experienced as too dangerous. Surviving the full expression of these seemingly dangerous emotions renders a sense of emotional safety.

The concept of confidentiality is also part of the therapeutic contract. Specifically, this means that anything said, heard or seen during a therapeutic session remains limited and confidential to those present. The respect for each patient's privacy outside the therapeutic setting is conveyed by the agreement not to

discuss any other patient or incident in an identifiable way. Guarding for objective danger of repercussions makes room for patients to speak and react more freely, thus providing another element of real safety.

It was explained to me, as it had been to every patient in this therapy, that all feelings and their vocal expression are acceptable and welcome. While I knew that there was no objective danger, and even derived some comfort from the fact that I was in my own house, at those moments when I sat mute and tense in response to my father's voice and presence, the feelings were stronger than my rationality. My immobilizing fear, irrational and exaggerated in regard to the current situation, needed to be lessened before I could speak. It was in this aspect that Mr. G 's manner helped me. Feeling as panicky as a lost young child, I derived a sense of emotional safety from his contact with me. He settled me down much as a good mother might settle a terrified child with a nightmare, by consistently and firmly "holding" me, even as I resisted. Only then did my fear lessen enough so that I was helped to separate my irrational feelings from the reality of the situation and thereby found my voice to speak.

2. The presence of co-therapists. Reality testing improves when there are more sets of eyes for observing,

provided that the vision is not distorted by feelings. This often occurs in the group therapy setting and is part of the explanation for the presence of co-therapists.

I was very frightened about exposing myself and clung to the "specialness" of the situation and my role as "the doctor's daughter" as a resistance. By late morning I was so involved in my feelings that I could not think straight. I was not separating my internalized concept of the man who was my childhood father from the man who sat in that room that day. At the height of my fear, my confusion seemed immobilizing. At that moment, regardless of how Dr. B spoke to me, my immediate, involuntary reaction to his voice resulted in my body tensing and my throat closing. It felt like a Herculean task for me to try to sort out my feelings from reality, especially with only his help. I used the actual uniqueness of the situation to ease my irrational fears. My narcissism found gratification in the apparent absurdity of being angry at one of the therapists who reminds me of my father, and who, in fact, <u>is</u> my father.

By his tone and manner, I felt the co-therapist who worked with me as safe and accepting. At the same time he did not indulge my tears, but helped me step back from my feelings enough so that I could attain an observing perspective during the process. Being thus reminded that

there was no actual danger, despite the intensity of my feelings to the contrary, I was able to begin to sort out and express the emotions that were choking me. I had an ally in the midst of my confusion. He facilitated a situation that would otherwise require unusually competent ego boundaries on both sides in order to be therapeutic.

3. **Ego boundaries.** Although this concept is too great to be explained in detail here, it must be at least touched upon because of its central importance. A fuller explanation can be found elsewhere.(1)

The term, "ego boundaries" refers to the "psychological skin" of a person. It is a concept that describes how far along in the process of separation and individuation a person has gone. The development of strong but flexible ego boundaries means that one knows where one starts and ends, what is internal and what is external to oneself. A few typical examples of common manifestations of poorly formed ego boundaries is seen in people who tend to overidentify with others, or who repeatedly attach themselves to other people or causes, as well as in those who tend to be rigid, i.e. in their appearance or behavior.

Achievement of clearly defined ego boundaries is not common. However, in order to be able to help a patient

in this direction, the therapist must first have relatively intact ego boundaries himself; that is, he has to have a clear sense of himself and is not likely to be confused by changing situations and attitudes of others around him.

When I was first invited to these marathons, I believed that my father's suggestion was a spontaneous gesture. Since writing this article, I learned from one of the co-therapists that prior to broaching the subject with me, my father, together with his colleagues, scrutinized the feasibility of his idea, as well as the risks and benefits to all involved. In their group supervision and staff meetings, they discussed the impact my presence might have on the other patients. They attempted to thoughtfully assess both Dr. B's ability to function as a therapist in this situation, and my ability to derive therapeutic benefit. They examined his motivation and whether he could separate himself from our relationship as father and daughter, at least during this encapsulated period. This is a difficult task, not readily accomplished. It is precisely because of this difficulty that physicians do not generally treat family members, lest their feelings interfere with their good judgment. A sense of personal integrity as well as an accurate assessment of one's abilities in this light is needed.

As I now realize, electing to go to the marathons then was based more on my feeling needy and alone than on a well reasoned decision. On some preconscious level however, I sensed that my father's desire to help me was essentially "clean", that is, not motivated by guilt or overidentification. He seemed confident that he would be able to function as a therapist for me in this situation and I trusted his confidence. Although part of my trust came from my eagerness for relief, I also had years of living with him and knew this man as basically an ethical and honest person.

In clinical terms, I believe that my father's ego boundaries were competent enough that, after examining the situation with colleagues, he was able to ask me to come to these marathons essentially without confusion. My own ego boundaries, like those of the other patients, were not so well defined, which was both expected and worked with as part of the process. Sufficient health was needed on my part however, such that I had the capacity to at least reestablish observing functions and reality testing even at those times when I was feeling very anxious and confused.

4. The pivotal role of the real relationship in therapy. In every therapeutic relationship, indeed in any relationship, there is a varying mixture of

transference and reality. Unlike in psychoanalysis, where the transference predominates in importance, in this model of therapy the real relationship is the basis of the therapeutic work (2). This refers to the human relationship between two people, patient and therapist, based on honest commitment and mutual respect and not limited by their respective roles.

The basis for a trusting relationship is provided by the therapist, who must be consistent and sensitive. He must be aware of his real limitations, yet be unhampered by his own anxieties enough so that he is able to be truly available for the patient. This is often difficult for the therapist, who traditionally does not allow his real strengths or deficiencies to be exposed. In order for the therapist to be able to function in this way as an expert, he must not be confused by his emotions and clearly not act on them. Neither, however, can he deny them, nor try to mask all of his reactions.

For the patient, the solidity of the real relationship is what provides the "grounding", the reality reminder that even in the face of strong feelings, the therapist is still only a caring person with expertise, hired by the patient to help him through a difficult and often painful process.

Although I could see my father as a real person even then, I often distorted him into either an idealized and

perfect caretaker or an unpleasable ogre. The magic needed to be dispelled. Both sides had to be actively demythified for me to be able to see him, as well as other people and situations, as they are, rather than as I unconsciously wished or expected them to be. Defusing the transference towards my father and fanning the embers of a real relationship with this man was the work that I, like most of his patients, had to do.

In light of this, the relatively short-lived stir my presence evoked in many of the other patients is explainable. It was probably assumed, or at least came as no great surprise to most patients, that Dr. B had a family. With the real relationship rather than the positive transference as the core of the therapeutic relationship, it was also conceivable that even their therapist and his family members would have their own pain and problems. Though it may have been difficult for some patients to accept, my presence imposed an undeniable reality that their therapist was also a father, a man, fallible and imperfect. Within the context of the underlying real relationship, even intense transference reactions both to him and to me, were recognized and worked with as expressions of each patient's characteristic responses to challenges to his or her ego boundaries.

Given the persistent emphasis placed on the real

relationship in this model of therapy, my presence may have had little effect on some patients who were in the later phases of therapy. The absence of significant comment by such patients, whose boundaries are more solidly formed, is not indicative of defensive denial or withdrawal. Rather, it likely reflects their greater emotional health. They felt less threatened and therefore experienced less confusion than others. For these patients, the presence of someone who carries the same last name as their therapist is more interesting than ominous, as the therapist is generally experienced more as a real person.

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For some time after these marathons, I often felt embarrassed and confused by my father functioning as my therapist. Even before I was a professional in the field, I knew that it was at least unconventional and did not have the theoretical knowledge to explain it to myself or others. It looked incestuous. Though I knew it was both useful and important, I felt that it was still somehow bad.

I thought it created problems. It did. It forced me as nothing else had until then with as much intensity, to start to give up my idealized images of my father and

see him as a real person. My real and transferential perceptions of him were thickly enmeshed. It was a difficult task to separate my internalized father from the man who sat in the room that day. It required me to activate my health, my observing ego, in the face of very strong feelings. Even the fact that this was a difficult task fed into my transferential feelings that too much was expected of me. Had there not been co-therapists to help me with the separation, and had I not had enough underlying health, the risks may well have outweighed the therapeutic benefits for me. Obviously, if Dr. B was not able to take off his "father hat" and put on his "therapist hat" with me, the situation would have been untenable, indeed, even a forum for abuse.

Looking back, I regret that I was not helped to start ongoing therapy at that time. Much was stirred up in me during these sessions and I did not have a place to sufficiently process my emotions. I often felt raw and vulnerable during that period, and had to rely on my own efforts to integrate the experience. I can easily speculate on the detrimental effects this type of experience would have on someone with less observing capacity.

Even now, seventeen years later and having had my own therapy elsewhere, I was surprised to find how hard it still was to synthesize these old experiences in order

to write this article. The impact of this type of contact must not be minimized. Though it provided an invaluable means of strengthening my ego boundaries, it is obviously not an optimal arrangement and not to be generally recommended. Stringent adherence to the criteria mentioned is necessary, lest the opportunities for confusion and abuse overwhelm the precious, but precarious, benefits.

1. Bar-Levav, R. (1988). **Thinking in the Shadow of Feelings.** pp. 330-336. New York: Simon and Shuster.

2. ibid. pp.223, 229-237