PATHWAY CLINICAL GROUP · SAN DIEGO, CALIFORNIA

RELATIONSHIPS AND BOUNDARIES

People-Pleasing

From self-abandonment to speaking plainly

An educational resource for patients.

This is not a diagnostic tool and not a substitute for care from a clinician who knows you.

IF YOU NEED HELP RIGHT NOW

If you are in immediate danger, call 911.

If you are thinking about harming yourself, call or text 988 (Suicide & Crisis Lifeline) — free, confidential, 24/7.

If someone is threatening, controlling or hurting you, the National Domestic Violence Hotline is free and confidential, 24/7: call 1-800-799-7233, text START to 88788, or chat at thehotline.org.

WHAT THIS GUIDE IS, AND WHAT IT IS NOT

"People-pleasing" and "self-abandonment" are everyday descriptions, not medical or psychological diagnoses. Nothing in this guide produces a score, and nothing here can tell you what is happening for you. It is written to help you notice patterns, try small experiments, and decide whether to bring something to a clinician.

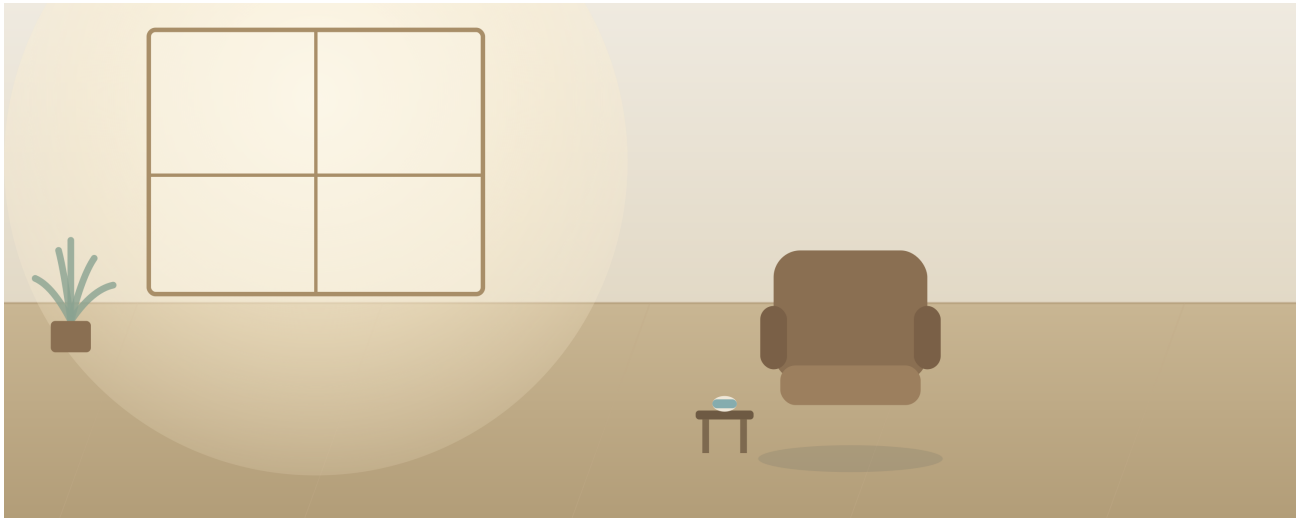
Your own read on your own life outranks anything in this document. Skip whatever does not fit. If something here conflicts with guidance from a clinician who knows you, follow theirs.

A clear place to begin

There is a particular experience this guide is about. Someone asks you for something, and the yes is already out of your mouth — not because you decided, but because the answer got there first. Later, sometimes hours later, you notice you did not want to, and by then it feels too late and too small to raise.

That is not a character flaw, and it is not the same thing as being kind. Kindness is something you choose. What this guide describes tends to happen faster than choosing, often because at some point it was the response that worked.

You can read this in one sitting or take one section at a time.



SOME CONTEXT ON HOW COMMON THIS IS

There is no prevalence figure for people-pleasing, because it is a description rather than a diagnosis and nobody counts it. We do have figures for one condition it is often confused with: national survey data estimate that about 12 in 100 U.S. adults experience social anxiety disorder at some point in their lives, and about 7 in 100 in a given year.

Those numbers are included for perspective only. They are not a statement about you, and people-pleasing is not the same thing as social anxiety disorder. Source: National Institute of Mental Health (survey data collected 2001–2003).

The reason to mention it at all: people who assume they are unusual often wait years before asking anyone, and the waiting tends to be the expensive part.

THREE THINGS TO CARRY WITH YOU

- It probably came from somewhere. Patterns like this often develop in response to what a person was living with at the time. Nobody can say with certainty why a particular pattern formed in a particular person, and it is not a defect you were born with.
- It likely served a purpose. Whatever it costs now, it usually offered something at the time — safety, calm, approval. That is often why it persisted.
- It can change. Slowly, unevenly, and with practice and support. Skills like these are learned, and learned patterns can be changed.

Two things to clear up first

This is not an argument for caring less

It would be easy to read what follows as a case for being less generous. That is not the case being made. Generosity you chose and can afford is one of the better things about a person, and there is no version of this work that ends with you keeping score.

The distinction throughout is between generosity and compliance. They can look identical from outside and feel quite different from inside — one tends to leave you steady afterwards, the other flat, resentful, or rehearsing. Many people find that difference in the aftermath more useful than any rule about when to say no.

This is not about assigning blame

Understanding where something was learned is a different act from deciding who is at fault. Most of the people in these stories — parents, teachers, earlier partners — were managing their own constraints with what they had, and many of them loved you. You can hold both: that circumstances shaped you, and that no one necessarily set out to do it.

A note on culture and obligation

Much popular writing on boundaries assumes a particular set of norms: that adults are separate units, that duty to family is negotiable, and that saying no to a parent is a sign of health. In many households, and in much of the world, that is not how it works. Duty to family is a value people hold deliberately, not a symptom to be treated.

So the question here is not whether you are too available to your family. It is narrower: is this something you are choosing, and do you have any say in the terms? A person can carry real obligation and still be consulted about how. If a section reads as an instruction to become less loyal, disregard it.

When this guide is the wrong tool

Everything that follows assumes one thing: that if you say no, the worst likely outcome is that someone is disappointed. For some readers that assumption does not hold — and then the advice to be more direct can be the wrong advice, because being more direct may not be safe.

If saying no is not safe

Some relationships punish refusal. That can look like threats, but often it looks quieter: days of silence, money withheld, contact with family or friends made harder, your version of events steadily rewritten until you are unsure of it.

If any of that is familiar, please do not start practicing boundaries inside that relationship on your own. Talk with someone experienced in domestic abuse first. Where abuse is ongoing, couples or joint therapy is generally not recommended, because it can increase risk to the person being harmed and its benefit is uncertain.

Sources: American Psychological Association — couples therapy and intimate partner violence; review of recognizing and responding to intimate partner violence.

CONFIDENTIAL SUPPORT

National Domestic Violence Hotline — free and confidential, 24/7. Call 1-800-799-7233, text START to 88788, or chat at thehotline.org.

Advocates focus on your safety and your options rather than pushing a particular decision. You do not have to be ready to leave, or to label what is happening, in order to call.

Please talk to a clinician rather than continuing to read if any of the following apply:

- Refusing anything at all has become impossible rather than merely hard — including with people who have never given you reason to fear them.
- You are losing time: hours gone, conversations you cannot reconstruct, or a sense of watching yourself from slightly outside.
- Your mood, sleep, appetite or interest in things has dropped away for weeks at a stretch, not just after a hard conversation.
- You are managing the feeling with more alcohol, more of something else, or by not eating.
- You are having thoughts of harming yourself, or a sense that people around you would have an easier time without you. If this applies, call or text 988 now.

SECTION 1 OF 6

The moment before the yes

Most people describe the request and the agreement as a single event: they asked, I said yes. It is usually not one event. There is a brief gap between them, and that gap is where much of this guide happens.

The gap is short, and it often contains something physical before it contains a thought — a lift in the chest, a slight lean forward, a quickening that reads as eagerness and is closer to pressure. Then the yes, which arrives feeling like a decision because it came out of your mouth. (No research gives a reliable figure for how long that moment lasts, so we have not put a number on it.)

WHAT THIS CAN LOOK LIKE

- Agreeing to something and only working out on the drive home whether you wanted it.
- Answering a message within seconds when nothing about it was urgent.
- Saying "no problem at all" in a tone slightly brighter than your actual mood.
- Volunteering before you have checked what is already in the week.
- Feeling a small drop after you agree — before anything has even happened.

THREE THINGS TO TRY

NOTICE

For one week, note the moment before, not the decision. Just: they asked, and here is what happened in my chest.

UNDERSTAND

Look back at your notes. Which people, and which kinds of request, close the gap fastest? That pattern is the useful information.

CHOOSE

Pick the easiest one. Next time, let the gap run one breath longer before you answer. That is the whole task.

A NOTE FROM PRACTICE •

The hard part in session is almost never the no. It is that people are certain the request and their answer are a single motion. Once someone can feel the gap, what follows is ordinary skills practice — and that is a much easier problem than the one they thought they had.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

SECTION 2 OF 6

Self-abandonment, plainly

"Self-abandonment" can sound like an accusation. It is not meant as one. It names something quite ordinary: not knowing your own answer until you have checked someone else's face for it.

It is not that your preferences are gone. It is more that they may not have been asked about often enough to stay loud. If you have ever been asked where you want to eat and felt a genuine blank — not politeness, an actual absence of data — that is the thing this section is about.

WHAT THIS CAN LOOK LIKE

- Being able to describe exactly what everyone else in a situation wanted, and going blank on your own.
- Deciding how you feel about a film, a plan or a person after you hear what someone else thought.
- Finding your preferences arrive only as complaints, weeks later, about something already agreed.
- Answering "what do you want" with "whatever works" so consistently that people stopped asking.
- Discovering you have opinions mainly when someone gets something wrong on your behalf.

THREE THINGS TO TRY

NOTICE
Catch one low-stakes blank this week — food, film, weekend plans. Do not solve it. Just note that it happened.

UNDERSTAND
Ask what would have to be true for the answer to feel safe to have. Often it is smaller than you expect.

CHOOSE
Answer one such question with a real preference, on something where being wrong costs nothing.

A NOTE FROM PRACTICE •

I watch for a specific moment: someone gives me a detailed account of what every other person in a situation needed, then stops cold when I ask what they wanted. Not evasive — blank. In my experience that signal does come back, but faintly and out of order, often as irritation before it arrives as preference. Irritation is not a setback.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

SECTION 3 OF 6

Direct is not the same as harsh

A common fear is that the only alternative to going along with things is becoming someone who steamrolls people. That fear keeps many people where they are, because the alternative looks worse than the problem.

The distinction is not volume. It is whether both answers count. Overriding means, yours counts and theirs does not, enforced with pressure or guilt. Direct means you state yours plainly and leave the other person genuinely free to say no back.

Early attempts often overshoot in one direction or the other before they settle. That is usually what learning looks like, not evidence that you have got it wrong.

WHAT THIS CAN LOOK LIKE

- "I can't take that on this month." — direct, and it does not require them to agree with your reasoning.
- "I want to, and I don't have the time. Both are true." — a no that does not withdraw the warmth.
- "That doesn't work for me. What did you have in mind for the rest?" — a limit and an open door.

THREE THINGS TO TRY

NOTICE
After a direct sentence, note what you feared you had been — and what you can see, on reflection, you actually were.

UNDERSTAND
Ask the test question: were they still free to say no back? If yes, it was direct, whatever it felt like.

CHOOSE
Say one plain sentence with no softening clause attached. Let it sit there unqualified.

A NOTE FROM PRACTICE •

Nearly everyone I work with overshoots once. They hold a limit, it feels awful, and they conclude they were cruel. When we go back over what was actually said, it is usually an unremarkable sentence delivered in a shaky voice. The discomfort is real; it is not evidence.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

SECTION 4 OF 6

Build a pause you can use

If the yes arrives before you do, the most useful change is often not a better no. It is a delay — something you use by default, so that an old habit does not get to answer on your behalf.

The point of a pause is not to buy time to construct a justification. It is to let you find out what your answer is. Use it even when the answer will obviously be yes, because a pause you only use for refusals quickly becomes a signal that a refusal is coming.

WHAT THIS CAN LOOK LIKE

- One default sentence, used everywhere: "Let me check and come back to you."
- A standing rule that nothing involving your calendar gets answered in the same conversation.
- Checking four things before answering: time, energy, what you already promised, and whether you want to.
- Answering messages at set points in the day rather than as they arrive.
- Giving the answer without the essay. "I can't make that work" is a finished sentence.

THREE THINGS TO TRY

NOTICE
Count how many times this week you answered instantly. No judgement attached — just the number.

UNDERSTAND
What do you expect will happen if you pause? Name it. Then watch whether it actually happens.

CHOOSE
Use one default sentence three times this week — twice on things you fully intend to say yes to.

A NOTE FROM PRACTICE •

"Let me get back to you" is the sentence people push back on hardest, because it feels like cowardice. I would call it a rate limiter, and rate limiters are what you install when a system answers faster than it can think. You also do not have to earn it with a good reason.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

SECTION 5 OF 6

The hours after you hold a limit

Many people prepare for the conversation and are unprepared for what comes next. You say the direct thing, it goes fine, and then two hours later you are replaying it, certain you were cold, drafting a message that walks it back.

This is the window in which limits quietly get returned — not during the hard conversation, but afterwards and alone. Feeling an urge to soften it is common and is not proof that you did something wrong. If it turns out an apology is genuinely needed, it will still be available tomorrow, when it is easier to tell the difference between repair and retreat.

WHAT THIS CAN LOOK LIKE

- Rereading a message you sent, looking for the sentence that was too much.
- Adding a softening follow-up an hour later that undoes the original.
- Offering something you did not intend to offer, to settle the feeling.
- Reading a slow reply as proof of damage, when nothing about it says that.
- Feeling relief and dread at once, and trusting only the dread.

THREE THINGS TO TRY

NOTICE

Name the window when it starts: "this is the two hours after." Naming it takes some of its authority away.

UNDERSTAND

Ask what you are afraid the silence means. Then ask what else it could mean. Often: they are busy.

CHOOSE

Try not to send anything for two hours. If it still needs saying then, say it deliberately.

A NOTE FROM PRACTICE •

It helps to decide in advance what you are doing in the two hours afterwards — a walk, a call to someone who knows what you are attempting, anything other than sitting alone with a phone.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

SECTION 6 OF 6

When relationships change

Changing this can change the people around you, because they have been in a particular arrangement with you and the arrangement is what shifts. Much of the reaction is small and passes.

It is worth being honest about the range. Some relationships become noticeably easier — often the ones where the other person had no idea you were straining and would have preferred to know. Some cool off. A few end. There is no reliable way to predict which, so treat this as something clinicians commonly observe rather than as a forecast for your own life.

WHAT THIS CAN LOOK LIKE

- A friend saying you have changed, in a tone that makes clear it is not a compliment.
- Someone testing the limit two or three times to see whether it is real.
- A relationship that turns out to have been running on your availability alone.
- Someone visibly relieved, because they had been guessing at what you wanted for years.

THREE THINGS TO TRY

NOTICE

Notice who gets easier as you get clearer. That group is often larger than people expect.

UNDERSTAND

Distinguish someone adjusting to a change from someone punishing you for it. Over weeks, these tend to look different.

CHOOSE

Line up one person who knows what you are working on before you need them, not after.

A NOTE FROM PRACTICE •

I am not going to tell you that everyone worth keeping will stay. What I would add is that, in my experience, the relationships that end rarely end because of the boundary. They end because the boundary made visible something that was already true about the arrangement.

This is clinical perspective, offered as one clinician's experience rather than as research evidence.

Three patterns that can look alike

From outside these can be hard to tell apart — all three can produce someone agreeable who is quietly struggling. From inside they feel different, and they may call for different kinds of help. Only a qualified clinician can work out which, if any, applies to you.

PATTERN	WHAT TENDS TO DISTINGUISH IT	WHAT USUALLY HELPS
A learned relational habit	Tied to closeness and obligation. You can often be plain with a stranger or a barista, but not with people whose opinion of you matters.	Practicing plain sentences, building in a pause, and support from a therapist, a group, or a structured program.
Social anxiety disorder	Runs across situations, including ones with nothing much at stake, and centers on being judged rather than on someone being let down.	CBT designed specifically for social anxiety is the recommended first treatment for adults. Medication (usually an SSRI) is a further option to discuss with a clinician.
Appeasement linked to past trauma	Speed and automaticity, often with a history of danger behind it. You may go pleasant and blank at once, and come back to yourself later with details missing.	Treatment that addresses the trauma, alongside skills practice. Practice on its own is often not enough here.

On treatment for social anxiety: national guidance recommends offering adults individual CBT developed specifically for social anxiety disorder as the first treatment, with medication usually a second-line option (NICE guideline CG159). In the largest review to date — 101 trials and 13,164 participants — individual CBT showed the strongest effect compared with a waiting list (Mayo-Wilson et al., Lancet Psychiatry, 2014).

The same habit, read two ways

A common mistake in working on this is deciding the pattern was always a flaw. Each item in the left-hand column below probably bought something real, and treating the whole thing as pure damage tends to make people fight themselves rather than change anything. Gratitude for what a habit did is compatible with no longer wanting to pay for it.

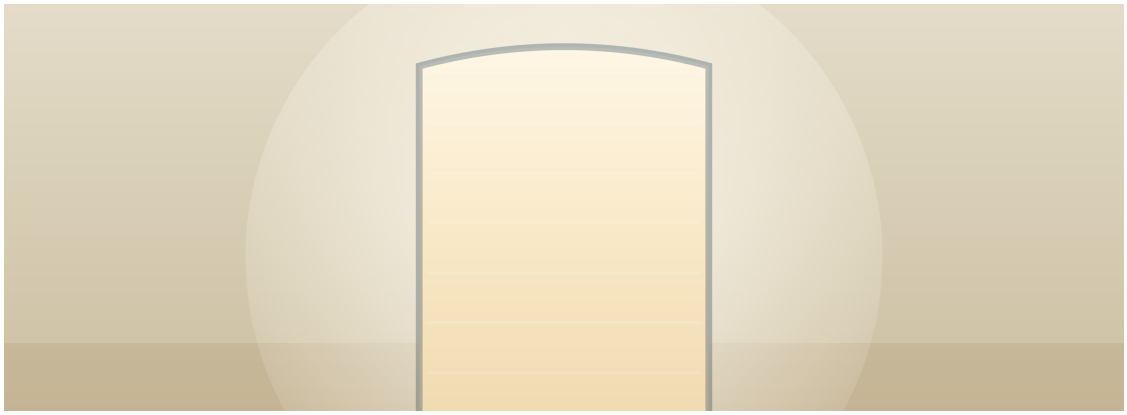
WHAT IT GAVE YOU	WHAT IT COSTS NOW
Quick, accurate reading of other people's moods.	Attention pointed outward so consistently that your own signals get faint.
Fewer conflicts, smoother rooms, less friction.	Agreements you did not want, and resentment that arrives late.
Being seen as reliable and easy to work with.	A workload set by other people's requests rather than your capacity.
A sense of safety when approval felt necessary.	Difficulty knowing what you want when nobody is asking.

What the evidence does and does not show

Assertiveness training has been tested directly. A meta-analysis of 12 randomized trials (503 participants) found a medium-sized reduction in social anxiety (g = 0.62, 95% CI 0.32–0.92). In plain terms: on average it helped, the benefit was moderate rather than dramatic, and the evidence base is still small. A medium-average effect also means that some people in those studies improved a great deal, while others improved little. If a first approach does not work for you, that is information about fit — not a verdict on you.

There is also observational evidence that chronic self-silencing may not be only an emotional cost. In the Framingham Offspring Study (3,682 adults followed about 10 years), women who described "self-silencing" during conflict with a spouse had roughly four times the risk of dying during follow-up (hazard ratio 4.01, 95% CI 1.75–9.20). Please read that carefully: this is a single observational study, the number of deaths was small, and the range around the estimate is wide. It shows an association, not a cause. It is included because the opposite error — treating this as purely a matter of comfort — is the more common one, not because staying quiet in an argument has been shown to shorten anyone's life.

Talking to a clinician



You do not need the whole story to ask

People often delay because they feel they should be able to explain the problem properly first, or because it does not seem serious enough to take up someone’s time. Neither is a requirement. "I agree to things I do not want to do, and it is costing me" is enough to open with. Working out what it is made of is the job of the person you are talking to.

What a first appointment is usually like

A first session is mostly the clinician asking questions: what brought you in, what it is affecting, what you have tried. It is entirely normal to say "I am not sure how to describe it." Nothing has to be decided that day.

You are also allowed to ask them questions: have you worked with this before, how do you approach it, and how will we know whether it is working? A clinician who is a good fit will not mind being asked. If it is not a fit after two or three sessions, saying so is not rude — and it is, in its own way, the exact skill this guide is about.

A rhythm, not a program

None of this is a course you complete. It is a small loop you return to: notice, understand, choose. It works best on ordinary requests rather than on the conversation you have been dreading for a month. Running it imperfectly on something small beats running it perfectly on something large.

Use the worksheet below on one real situation — ideally an unremarkable one from the last week. The last two boxes are the pair that matters: what you were afraid would happen, set next to what actually did. Over a few of these, the gap between those two boxes may be the most persuasive thing you read on the subject, because it is about you rather than about people in general.

What was asked

Who, and what — as plainly as you can put it.

What happened first

In your body, before any thought arrived.

What you actually wanted

Even if you only worked it out later.

What you said

The words, not the summary.

What you feared would happen

Name it specifically.

What did happen

Compare it with the box to the left.

Deciding what this week calls for

This is not a screening instrument and it does not produce a score. It is a way of thinking about whether what you are dealing with is something to watch, something to raise with a clinician, or something that should not wait. Read down the column that fits rather than across all three. If two apply, act on the one further to the right.

REASONABLE TO WATCH

- You recognise the pattern and it is uncomfortable rather than disabling.
- You can be plain with some people, some of the time.
- It costs you time and energy but is not affecting your sleep, mood or health.

WORTH RAISING WITH A CLINICIAN

- You have read a lot about this already and nothing has shifted.
- Refusing feels impossible with most people, most of the time.
- Your mood, sleep, appetite or interest in things has been low for weeks.
- You are drinking more, using more of something, or eating less to manage the feeling.

PLEASE DO NOT WAIT

- You are having thoughts of harming yourself, or feel that others would be better off without you — call or text 988.
- Someone is threatening, controlling or hurting you — call 1-800-799-7233 or, if you are in immediate danger, 911.
- You are losing time, or cannot reconstruct conversations.

If you land in the first column, working through a section or two and giving it a month is a reasonable plan. If you land in the second, a conversation with a clinician will probably get you further than more reading. If anything in the third column applies, that is not a matter of degree — and you do not need a tidy account of why in order to ask for help.

IMPORTANT

This guide is general education. It is not medical or psychological advice, it is not a diagnostic instrument, and reading it does not create a clinician–patient relationship with any clinician at Pathway Clinical Group. It cannot account for your history, health, relationships, culture or current safety, and it is not a substitute for individual assessment. If something here conflicts with guidance from a clinician who knows you, follow theirs.

Where to turn

Keep this page. It is the part worth having to hand when you will not feel like going to look for it.

SERVICE	HOW TO REACH IT
988 Suicide & Crisis Lifeline	Call or text 988, any time — free and confidential. Chat at 988lifeline.org. Spanish: call 988 and press 2, or text 988 and reply "Ayuda". American Sign Language: use the 988 ASL videophone option via the Deaf/Hard of Hearing link at 988lifeline.org. TTY: dial 711 then 988. Interpretation available in more than 240 additional languages.
911	For a medical emergency, or when someone is in immediate danger.
211	Free, confidential local referral line for community mental health services, reduced-fee care and basic needs. Available 24/7 in most of the U.S.; search by ZIP code at 211.org.
National Domestic Violence Hotline	Call 1-800-799-7233, text START to 88788, or chat at thehotline.org. Free, confidential, 24/7.

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- American Psychological Association. Couples therapy and intimate partner violence: considerations for assessment and treatment. apa.org
- Centers for Medicare & Medicaid Services. Emergency Medical Treatment & Labor Act (EMTALA). cms.gov
- NHS. Antidepressants — side effects and stopping. nhs.uk/medicines/antidepressants
- 988 Suicide & Crisis Lifeline — access options and language services. 988lifeline.org/faq
- The National Domestic Violence Hotline. thehotline.org
- 211 — local community services referral. 211.org