Birth of a Self in Adulthood

THE PATIENT'S RELATIONSHIP TO THE FAMILY

Dorothea S. McArthur, Ph.D.

The Patient's Relationship to the Family

Dorothea S. McArthur, Ph.D.

e-Book 2017 International Psychotherapy Institute

From *The Birth of a Self in Adulthood* by Dorothea S. McArthur

Created in the United States of America

Table of Contents

The Patient's Relationship to the Family

In this chapter we will consider some of the complex ways in which symbiotic families remain as a unit longer than is beneficial for the individual growth of each member. These interactions cause troubling feelings of confusion, guilt, despair, and helplessness for children.

THE PARENTS AS COMPETENT MEMBERS OF THEIR COMMUNITY

Some impinged-upon adults observe their parents as highly valued and admired for competent work within the community. The parents may be intelligent or exceptionally talented and pass their genes on to their creative children. Many parents have managed professional success as another means of healing psychological incompleteness. For example, children may observe the father being elected by the community to serve on prestigious boards or serving as a well-known executive in his field. The mother may be a successful lawyer, a recognized teacher, or a famous entertainer. Parents wield the commands with the same strength with which they make an effective contribution to their profession.

People come to the children and say, “Your mother (father) is such a

wonderful person; she (he) does so many things for other people and never takes any credit for it. She (he) must be a wonderful parent to you." The children, observing all this, wonder why they don't feel the same way the community does about the parent. Something must be wrong or "crazy" since they do not perceive the parent in the home as wonderful, supportive, or full of energy and giving. Instead, the children see the parents as somehow self-centered, fragile, and needy.

Why do these talented parents present themselves within the family as fragile and in need of help? Why do they not gain enough strength and sense of value from their work? They probably do, but for them the feeling of value is temporary. It must be renewed constantly because there is not a complete self to contain the experiences of mastery. The community reaps the benefits of their on-going need to work hard. Despite their accomplishments, these parents still turn to their families for their sense of wholeness (Masterson 1981, Rinsley 1982).

When considering the pathological interactions within families, it is possible for patients and therapists to lose sight of the professional strengths of the parents. Once the patients are able to see both sides of their parents clearly, they may be able to support, nurture, respect, and enjoy this competent professional side. Then the patients will be able to help their parents strengthen their fragile selves rather than consorting with and

rescuing them, which only continues the psychological incompleteness.

PARENTS WHO LANGUISH

Less frequently, the pendulum swings in the opposite direction. Instead of being competent out in the community, parents may present themselves as severely psychologically disturbed. Assuming the role of the totally incompetent member of the family, they lose their job, stay home, complain, and become withdrawn, physically ill, or even immobile. The other parent remains dominant, manages everything, and complains bitterly about the poor health of the spouse. It is interesting to note that the disturbed or ill parents' health varies considerably and seems to worsen suddenly when their children approach or accomplish a growth step (withdrawing object relations unit; see Masterson 1976, Rinsley 1982). The stage is set for one or all of the offspring to come running back, interrupting, or abandoning the new direction of their life. The parents continue to request outside medical or psychiatric help; but, when it is arranged, they find an excuse not to use it. Instead, improvement in health occurs only with attention from the children. The parents get reinforcement for being ill, which sets the stage for another cycle of disturbed behavior. It is indeed a tragic situation when parents decide to sacrifice any kind of meaningful life to maintain enmeshed ties within the family.

At the same time, the martyred spouses play the innocent victim, with little awareness that they perpetuate their marriage partner's incapability. They need the ill spouse to be "in trouble" so that they can call the children home. The marriage becomes "terrible," but neither parent would ever think of a separation. The children are labeled "selfish" and "uncaring" and feel guilty if they stop attempting to rescue their mother and father.

However, patients can learn to understand these manipulations enough to continue with their own growth steps. They start nonverbally reinforcing their parents' capable behavior and set up situations that encourage their parents to manage on their own. As a consequence, the behavior of the parents often improves.

THE PARENTS IN THE PSYCHOTHERAPY HOUR

Sometimes, therapists get a chance to meet their patients' parents. These parents are proper, usually well dressed, and polite. They want the therapist to understand that their child was very much loved and that they have worked hard to provide life's good things for that child. They don't feel that anything has gone wrong; however, if their child feels that something is amiss, they are anxious to help. They have come into the office to fix the child, not to look at themselves. They prefer to believe that most psychological problems have an organic basis, for which nothing can be done. This strongly

held belief is based upon the fact that the child did well during one phase of development; therefore, they have ruled out any environmental influence. They want the therapist to know that their relationship with their child has always been a very "close" one (pseudomutuality; see Wynne et al. 1958). They are concerned that something has happened to that "closeness." They may speak of their offspring's recent disloyalty, if therapy has already begun and the patient is beginning to pull away from the enmeshed family.

On the surface, everything looks fine. The parents seem to know many of the permissions and will swiftly tell the therapist that their child was raised with only healthy messages. They are unaware of any commands or of the psychological need for them. (It is easy for inexperienced therapists to be deceived at this juncture.) Looking more deeply, the therapist will often perceive a brittle and uneasy calm. The parents watch the therapist carefully and may be swayed by his or her reactions. Underneath this niceness comes a communication of a different nature. The patient and the therapist sense unexpressed negative feelings as well as a vague sense of danger.

The patient is obviously tense and looks to the therapist for courage. There is a sense that the conversation could abruptly take an ugly turn. Everyone is careful. It feels as if the parents are not fully there. They continue to maintain that the problem lies with the patient. Everyone is cautious about approaching the hidden or real parents because that might precipitate a

sudden, angry departure. Underneath this facade are fragile parents in need of gentle communication no matter what is presented. Any recommendation to understand the psychological functioning within the family is politely refused by the parents.

After the interview is over, the parents may assure the patient that the therapist is a good one. However, they will find a way to subtly discredit everything that was said in the session. The therapist and the patient will probably never know how the parents really felt about the interaction. Parents of impinged-upon adult patients are generally too accommodated to their own incomplete lives to be interested in the kind of help a therapist has to offer. Instead they will act, in effect, as if the interview never took place.

THE PSYCHOLOGICAL INCOMPLETENESS OF THE PARENTS

As patients begin to understand the degree to which they have been co-opted, they demand to know why and how their parents could behave in such a way toward their own child. They feel angry, despairing, and abused, while at the same time protective of their parents. They want to know if other parents have done the same thing to their children.

In answering these difficult questions, it is helpful to address the fact that the patients' parents must also be impinged-upon adults who have likely failed in achieving their own independence and mastery. The phrase

"psychologically incomplete" seems to capture the essence of the parents' problems. For a time the patients are barely able to hear this; all they feel is anger and hurt. When those feelings have been released, the patients begin to remember what they know about their parents' own history. Sure enough, it is every bit as difficult as their own. They are relieved to find out that their parents are not "crazy," "purposely destructive," or "sociopathic." They may be deceptive, manipulative, hysterical, clinging, or demanding, but these manifestations are in the service of surviving psychologically. The patients were innocent victims until they learned the rules of the game and became unwittingly compliant participants in their parents' pathology.

HOW THE COMMANDS ARE COMMUNICATED

As was suggested in Chapter 2, most of the time the commands are communicated nonverbally. The following analogy sometimes helps patients understand the nature and power of nonverbal communication.

A mother sits in a rocking chair on the porch with her fourteen-month-old baby. The mother is rocking and looks happy and content. The child sees green grass in the front yard and a red and yellow toy truck on the walkway. He wants to go to the truck. He gets down off his mother's lap and begins to edge toward the truck with anticipation. At the same time, he notices that his mother is beginning to look restless and agitated. The farther he moves away

toward the truck, the more agitated his mother becomes. She stops rocking and looks tense. If he turns around and walks back toward her, he notices that she becomes relaxed again. What is this child going to do about getting to the truck?

Impinged-upon adults always confirm immediately their childhood feelings of confusion.

Alex said, “When I go out of town, my mother doesn’t say anything, but she slumps in her chair and looks pathetic. I keep having the feeling that she sits in the same position until I return.”

Dan’s father develops a hearing problem every time his children stray away. One day, he came into my office with Dan and his wife. He dragged a chair all the way across the room to sit right next to me so that he could hear. Interestingly enough, he heard the next patient letting himself quietly into the waiting room. The only things he did not hear during our session were words he did not want to listen to. His hearing problem was apparently a nonverbal communication directing his sons to stay home and mediate his communication with his wife.

Other parents of impinged-upon adults make a strong statement to their children in the form of storytelling. One patient was told the following story over and over again when he was a toddler. “

"You know that you are really not our first-born child. Before you, we had a little girl named Danielle. We took her out on her tricycle one day. We left her alone for a minute while we went into the house to get a warmer coat. There were no brakes on the trike. It rolled down the hill and we never saw her again."

The father laughed each time he told the end of the story. This patient learned to laugh with his father as if it were a joke between them, but secretly he wondered: Could the same thing happen to me? Why didn't Dad go after the tricycle and find his baby? Why was Dad laughing? He felt afraid and learned from this story always "to keep the brakes on" and not to get too far away from the family because they might not come after him.

Some patients report that they are able to discern the initiation of symbiotic behavior: "If you listen carefully, it is possible to hear that Mother sometimes talks in a tone of voice that sounds like a little girl." Some patients refer to this manner of speaking as "baby talk." In addition to the words, with this intonation mothers give out the message that they are in need of being taken care of. Sometimes they will say, in baby talk, that the patients can do something better than they can. The patients feel flattered into helping. The mothers use it only when needed; it is a willful, but not conscious, way of communicating.

Tom came to understand how his mother let him know when he disobeyed a command. He described her as talking to him in a "hint tone of voice"; she would "prattle about inanities" while totally avoiding the real subject of concern. In either case, it was clear that he had "done wrong," should apologize, and should take better care of his mother. It was impossible to get her to ever consider the real issue. There was no talking about it.

Initially, most patients are completely unaware at a conscious level that these kinds of communications are taking place.

PROMISED REWARDS FOR FOLLOWING THE COMMANDS

The commands appear attractive to patients because they are not just rules; they come with their own set of promised rewards, *if* they can be followed perfectly. The reinforcement can be summarized in the following way. The patients will feel

1. Safe and protected from loss or harm because the parents will always be there.

2. Special.

3. In a close and warm relationship with the parents.

4. That failure produces immediate help.

5. Relieved of the responsibility for the mastery of the difficulties of life beyond taking care of the parents.

6. Rewarded with the promise of special gifts of inheritance.

Even though these rewards appear attractive, both the patients and the parents recognize that something is wrong. Quite simply, if a relationship is valid and meaningful, importuning rewards, punishments, or threats are not needed to maintain it.

SIBLINGS' DIFFERING RESPONSES TO COMMANDS

The children within one family will respond differently to the parental commands, depending upon personality and birth order. Some siblings, frequently the eldest, will try to challenge the symbiosis, fighting back without the aid of psychotherapy. The result may be a serious psychological disturbance, such as a psychotic break in adolescence. Other siblings may over-adaptively follow each command to the letter with a superficial "false self," while the "real self" goes into hiding (Winnicott 1965). These siblings are left with the task of reclaiming a real self, but at least they manage to avoid more severe forms of psychotic disturbance. Still other siblings may challenge the system by rebelling passively in a way that is maladaptive to their own growth. For example, they may refuse to attend their chosen Ivy League school because their parents need them to go there. Instead, they

attend the local state college because rebelling is "worth it anyway," until they see what is lost in the process. Then in despair, they seek psychotherapy, feeling "caught" as the over-adaptive sibling, in trying to expose the parental harm.

When siblings take different routes to handling the enmeshed family ties, it is hard for them to be friends with one another because they have so little in common in their approach to life. Rebellious siblings may scorn their over-adaptive siblings for being overly good, whereas over-adaptive siblings may disapprove of their more rebellious siblings' defiance.

THE MYTH OF SELF-SUFFICIENCY

Enmeshed families operate by using several myths and distortions that are critical to holding such families together. The *myth of self-sufficiency* is repeatedly presented by patients. It represents the claim that the family can provide any and every relationship; family members are the only ones to understand each other completely (pseudomutuality; see Wynne et al. 1958).

Marianne was told that no one understood her better than her parents, but she nonetheless felt very much misunderstood. She handled this discrepancy by believing that she must indeed be an unusually strange, complex person.

Believing this myth means that patients do not need to have a boyfriend or a girlfriend because the family will provide Saturday evening activities. Likewise, fathers who have a private business do not need an accountant because their sons can be trained to do the necessary paperwork.

The rule is that each member of the family must maintain projects or goals that they cannot complete without the help of other family members. Fathers are especially good at promising to do elaborate projects with their children. A go-cart or doll's house is started with enthusiasm, but the children soon learn that it is likely that these things will never be completed. Outsiders are not supposed to help. In-laws are considered outsiders.

Children are often puzzled by the fact that their parents complain about receiving an invitation to go out and have a good time at a dinner party. The parents act as if they don't want to go; they tell the children that they would rather stay home with the family. Often they do stay home. The children cannot understand why and try to persuade their parents to feel free to leave home and have a good time. Pleasure outside of the home appears to threaten the existence of the myth of self-sufficiency.

Such parents do not feel a need to plan financially for their retirement because they expect their children to remain at home and to repay them by supporting them in their retirement. Even when a family member dies, the

other family members fill in for the deceased member. An eldest son replaces his father. If this son considers marriage, his mother may attempt to fill the position of the bride. If a son has a successful psychotherapy experience and separates from the family, the next son in the line will quickly fill his symbiotic place. These families thus act like amoebas, rejecting any particle that feels foreign and engulfing any missing part as if it were not absent. Their family's ability to do this quickly is often deeply hurtful to patients who may have taken an independent step but are not yet prepared for the total rejection they face as a consequence of such action. Attempting to become independent forces patients to face the truly enmeshed nature of their family relationships.

In order to maintain the myth of self-sufficiency, family members are not allowed much latitude for progress. One patient had a recurring dream that lasted for years in which she "watched the waves roll over a stone that never changed." Another patient said, "You walk a tight line all the time because you must succeed and fail only as much as you are directed to, and not fail in helping others within the family." Consequently, everyone in the family must reveal any new relationship so that violations of the myth can be monitored with silent disapproval.

Sometimes external circumstances succeed in taking family members away.

Chad was drafted and sent to England for a six-month tour of duty. He described this period of his life as the most memorable and exciting. He had friends and was able to travel. He was puzzled by the fact that, despite his happiness, he had frequent and unpredictable "crying jags" or "sudden blues" in which he needed to share with his family the things he was doing. He wrote lengthy letters home several times a week as a means of dealing with a strong sense of obligation to stay with the family. He both needed and hated to come home.

THE MYTH OF SELF-RIGHTEOUS PERFECTION

The *myth of self-righteous perfection* involves a false sense of perfection in which parents convey the message that they are omniscient, even deified figures with little knowledge of underlying feelings of insecurity that promulgate the commands. There is never any reason to doubt that what the family does is the right thing. The children learn to strive for perfect obedience. They know when they are "doing wrong," and very little needs to be said directly.

On the surface it looks as if the parents are communicating a standard of excellence with this myth, but it is a standard so impossibly high that it becomes another mechanism for subverting growth. The parents will go out of their way to hide from their children anything that they feel represents

trouble so that they can maintain the image of omniscient and omnipotent perfection.

Sometimes these parents flaunt their sense of self-righteousness at the expense of others.

Sally reported that her mother, a seamstress, would come to San Francisco to visit her and buy clothes. Her mother insisted that Sally take her to an expensive store. When they arrived, her mother would criticize the saleswoman's service and the color, quality, or design of the clothes. Sally was forbidden to buy anything for her mother or to pay for her own clothes. Her mother would pay the entire charge. Sally would leave the store wondering how she had managed to pick the wrong store once again and would search harder the next time for a more expensive store. Sally held herself entirely responsible for her mother's unhappiness.

In reality, the parents seemed to be playing out their well-known theme of being perfect, having a lot of money to spend, and viewing the rest of the world as flawed. Actually, the myths of self-sufficiency and self-righteous perfection mandate that Sally in fact allow her seamstress mother to make her clothes.

The myth of self-righteous perfection can be communicated in a variety of different ways. Many patients report being rescued, overindulged, or

spoiled by their parents. More normal and responsible interactions with people outside of the family are evaluated negatively. Therefore, the child is encouraged to return home for special or overindulgent treatment. Patients who have learned this distorted view of normal behavior tend to worry excessively about whether or not they are being treated properly; they obsess about what to do if they face mistreatment. Such worry detracts from having a good time. One patient, Arleen, decided to release herself from this constant worry one day by deciding to "be in a good mood for no good reason." She had taken a major step forward by allowing herself this pleasure.

Striving for perfection can be illusory and attractive bait for keeping children at home. The children are led to believe that if they behave perfectly, they will finally achieve the sought-after loving support for growth and acceptance of their own ideas. Unfortunately, loving is used like the carrot before the mule. The children feel that if they just take one more step it might be attained, though in reality it never can be. Invariably the children find that they make just a little mistake, violating one of the family myths or rules. Such children do not really comprehend that no one can ever be perfect, and that their parents never intend to come through with that love because then the children would have what they need to leave home and go on with life. The children have a vague sense of not being able to trust the parents but nonetheless continue to strive for success and to obtain their love and approval. The children's thinking seems very logical: they failed to get the

love because they were “not good enough.” Other siblings may rebel and give up the game, whereas these children are often the “good” children who try harder than any of the others and believe that they are closer than any of the other siblings to achieving this goal.

Both parents in enmeshed families perpetrate the myth of self-righteous perfection while promising love that they are not capable of giving. Consider the following analogy:

A farmer (parent) with a horse (patient) is in a corral (enmeshed family). The farmer holds out a piece of sugar (love) while walking away from the horse as the horse tries to reach the sugar. They go around and around the corral together, the horse obediently trailing the farmer for the sugar. The horse makes many trips around-surely the next trip will finally yield the sugar? He loses sight of the field outside the corral where the other horses roam freely. He will never get the sugar because if the farmer gave it, the horse would then have the energy and strength to jump the fence.

This analogy helped one patient find and rent an apartment after having lived his adult life with his parents. It is painful for patients to realize that all the trips around the corral have not secured the love but rather have served only to further restrict their growth. It takes perseverance and courage to break through the defense obscuring this knowledge. At times it feels like

defeat to the patients to stop plodding around the corral after the sugar.

Tom explained what his relationship with his mother felt like. He said, "We act like two dogs who meet each other on the street and then circle. We never really meet, just look and pass on down the street, both wanting something different, both unable to compromise or fight. I wish that I had had the kind of parents where I felt like I wanted to just be friendly by wagging my tail."

After years of trying and not getting "love," many patients settle instead for managing their financial lives so poorly that they have to borrow money from their parents. The fathers of many impinged-upon adults have managed to be successful in earning a good income. The parents are happy to give money because that perpetuates the dependency. The children are happy to keep the money, without ever paying it back, because it becomes a substitute for love, for support for growth, and for acceptance. At least it is some compensation for efforts toward perfection. The children are unaware that accepting and keeping the money only serves to further entrap them in this dependent and destructive family system. The children are also unaware of the degree to which they have passed up opportunities in order to maintain a state of neediness, to qualify for funds from the parents. It is tragic to see impinged-upon adults refuse to finish a degree or a training program, fail to take a certification examination, or consider turning down a high-paying job

because they are so hungry for parental support.

One of the by-products of the myth of self-righteous perfection is patients' disappointment when significant others in their lives are not perfect. Girlfriends or boyfriends are frequently rejected after the first or second date because they are not perfect. Therapists make a mistake, such as being late or offering a poorly timed interpretation, explanation, or clarification, and the patients wonder if the psychotherapy will be doomed to failure. The myth of self-righteous perfection not only holds the family together but makes it extremely difficult to find outside relationships that meet the supposed criteria of perfection. One patient, Ron, seemed relieved to hear me say, "Even if you did meet a girlfriend who was perfect, she probably wouldn't be a good match anyway, because it is impossible for *you* to be perfect!"

During the psychotherapy, I sometimes encourage patients to "be bad" and arrive late because a phone conversation or a job interview was more important for their growth than being on time for a psychotherapy hour. Patients are further surprised that I do not expect the psychotherapy hour to be perfect. Even with diligent work, mistakes will be made; they can be discussed and corrected, and the work will be sufficient to accomplish the task. Patients often experience relief in understanding this new concept. It reduces the constant pressure they feel to be exactly on time, watch their behavior, choose their words carefully. They can begin to relax and

spontaneously say what they really feel.

When the myth of self-righteous perfection is realized as an impossible condition, a sense of self-acceptance previously unknown to the patients enters the psychotherapy relationship. However, this myth is very difficult to leave behind; it has been deeply ingrained. One patient said to me, “If it is really true, as you say, that I don’t have to be perfect, it is as if you are presenting me with a fairy tale. I never imagined it could be real.”

The myth of self-righteous perfection can cause trouble in a different way. Because of the parental power they have experienced, patients enter the world trusting too much and with little experience in detecting and handling trouble. If a situation in the real world feels bad to them, they tend to assume instead that others are perfect and that they are wrong. They are not easily able to perceive exploitation from others and may need to be taught that some streets are not safe for walking. They are vulnerable to working too hard for others and feel unable to correct the situation with assertion or a confrontation until it is too late.

The emergence of the myth of self-righteous perfection in the therapeutic relationship enables patients to deal with it. It is hard for patients to realize that they no longer need to strive for this false sense of perfection.

Tanya shared with me a moment in which the good and bad parts of

herself became integrated into a single whole person. She was no longer a slave to the myth of self-righteous perfection. She was sharing a letter that she had received from a friend. Their relationship had been strained for a long time because of some mistakes each of them had made. They had just begun to make contact with each other again. She said, "I always believed that if I did anything wrong with my parents, that they would do something terrible to me. I have done something that was very difficult for this person to handle. Yet, she still seems to accept both the good and bad parts of me. She seems to want to continue the relationship. I feel moved."

It is harder still to realize the parents' imperfections. At first, patients hope that the therapist can make all their parents' imperfections disappear. Then they could justify continuing a closely enmeshed relationship with family and avoid the difficulties of real life.

MISINFORMATION

In addition to the commands and the myths, some parents of impinged-upon adults find it necessary to provide misinformation to their children to keep them from leaving home. It becomes the therapist's job to replace this misinformation with liberating and accurate facts. It is difficult to ascertain the extent to which the parents believe this information themselves, or whether they are conscious of misleading their children. It often serves to put

fear into their children, making them afraid to take the next growth step. Following are some examples:

Dan's mother tells him that he can make a woman pregnant by lying on a beach next to her in a bathing suit. He then becomes afraid to ask a girl for a slow dance because he fears that the bodily contact will make her pregnant.

Judy's mother tells her that something bad will happen to her by the end of the day if she doesn't stop giggling. She makes sure not to laugh on any day that has a special event scheduled for her because she is afraid she will not get to attend.

Alice becomes afraid to go horseback riding because her mother says that the posting on the horse causes her menstrual cramps.

THE TYRANNY OF TIME AND TIME AS INFINITE

Regularly scheduled appointments starting on time allow patients to experience their past feelings regarding their parents' use of time. Many patients report that their parents handled being on time in rigid ways. Their mother or father usually had a strong, unshakable need to arrive either early or late.

Mary's father collected the entire family and insisted that they arrive

anywhere from twenty to thirty minutes early. The family was then expected to stay in the car and listen to a ball game with him. It never occurred to Mary to ask if she could get out and go for a walk.

Alice's father insisted on being twenty to thirty minutes late. That meant that the family assembled together in the living room to wait for him. No one could do anything else during that time.

As the feelings of anger about this abuse of time surface, patients often need to come to the hour either late or early to assert their own sense of independence.

Some parents also communicate a second misconception regarding time. They lead patients to believe that time is infinite and that there is no hurry about applying to college, dating, marrying, or having a family. One patient was very surprised to hear me say, "Perhaps you need to give this matter more attention, because your clock may be running out." The patient responded, "But Mother told me I could marry all the way up to the age of 60." Patients often have aspirations for a certain career- for example, getting into medical school-but no sense that there is any time restriction on attaining it.

THE MYTH OF AN ETERNAL, TROUBLE-FREE WORLD VERSUS REALITY

The myths of self-sufficiency and self-righteous perfection, and the

tyranny of time, combine to make the *myth of an eternal, trouble-free world.* Some patients have a mistaken sense, although they know better, that they will never die as long as their parents are alive and they (the patients) stay close to home. They are shaken out of this notion only when a parent becomes seriously ill. These patients have not learned to consider the finiteness of life. The reflections of one patient fairly define this myth of an eternal, trouble-free world:

I always thought that I would be safe as long as my mother was alive and I was with her. I believed I never needed to worry about anything. I never considered my death or hers. Now my mother is ill. For the first time, I realize that she could die. What will happen to my safe world? Can I survive without her? Then you [the therapist] told me that there was no such thing as a safe world. All of a sudden this week, I have been noticing things that actually could happen. I may never see the person I spoke to yesterday again; my children and I could be involved in a car accident; there could be a bad fire. I feel depressed; I don't like reality. Do other people not like it? It is too late for me to turn back to the way I was before, but I liked it better the old way. Is there nothing I can do about this uncertainty?

This patient was dealing with childhood feelings and the defense of splitting. She had previously seen the world as "all good," and now she saw it as "ail bad" (Grotstein 1981, Masterson 1976, Rinsley 1982). She had yet to

integrate these two views into one reasonable truth.

She could see no benefit in recognizing uncertainty and finiteness as parts of life. I suggested that this new awareness helped her to take good care of herself and her family; to minimize the chance of accident; to maximize the quality of her interactions with others so that her relationships would feel as complete as possible; to take care of problems promptly when they arose; and to formulate a realistic plan for her life based upon her full awareness that the time of her ultimate death is unknown. The tragedy of this myth is that it had eliminated her awareness of the need to take these actions.

THE MYTH OF COMPLIMENTS

The *myth of compliments* refers to the fact that parents of impinged-upon adults give what seem like compliments but are not. These "compliments" are, instead, orders or directives about how to behave within the enmeshed family. This fact becomes clear when patients recoil from any of the therapist's comments that might be construed as complimentary and become wary of the relationship with the therapist.

These patients take any expression of support as an order. If they feel unable to comply with such an order, they feel inadequate, anxious, and afraid of rejection. Therefore, over the years the patients learn to avoid any orders by turning down all compliments. Unfortunately, the patients lose valuable

support from outsiders that should rightfully have gone into building a solid self-concept.

A situation that warrants a compliment for a job well done often receives parental undermining instead. Therefore, patients learn to be wary of and to avoid situations warranting a compliment. One patient experienced this kind of undermining when he was five years old:

Alan's father had been away on a trip and was returning home in the evening with one of his colleagues. The colleague received a phone call. Alan, at age five, answered the phone and memorized the information correctly. When his father came home, Alan proudly ran out to the car to deliver the message, even though it was raining. His father listened and then cut in with "Where are your boots and your raincoat? See how things fall apart here when Daddy is away!" Alan knew that he did not own boots or a raincoat! His father reacted to Alan's mastery with feelings of inadequacy that forced his father to assert his supremacy by scolding. Alan wisely avoided such situations in the future.

A real compliment occurs obliquely in only two ways. The parents will express pride in their children's behavior or in how the children look only to outsiders when the children are not within earshot. If a compliment is given directly to children about their looks, it tends to be said in an oblique way. For

example, a patient who was wearing a new dress was told, “That dress looks nice” rather than, “You look pretty in that new dress.” The compliment goes to the dress. The children never get the compliment directly because the parents sense and fear that their remarks will promote confidence and independence.

Compliments from therapists that support growth may activate the patients’ internalized parental attack. For example, I commented to a patient that he seemed to be a man who knew how to be gentle, especially when he related to women sexually. His intrapsychic parental voice made the compliment negative by telling him, “That means you are probably a homosexual.’’ When I expressed to another patient, Mary, that she seemed to be able to trust me, she confessed that a voice inside her warned, “Look out! You are being gullible.” At first, patients will tend to hear these comments from within and not say anything about them.

PARENTAL PUNISHMENT AND THREATENED ABANDONMENT

Punishment is frequently the vehicle by which parental sabotage is delivered. It is as if, instead of letting a baby bird fly away from the nest when it is ready, the mother bird finds a way to clip its wings. Patients feel punished for something they have done.

Jim was a talented sculptor. During his psychotherapy he brought me some miniature sculptures that he felt “compelled” to create over and over

again. He did not like them; they made him feel “uncomfortable,” but he “had to do them.” The sculptures were a series of people wearing something like life jackets that he called “life supports.” The lifejackets were in the process of being pulled away. The people looked like they were gasping for life and were falling down. He said that was exactly the way he felt. Every time he took a step forward, he risked the punishment of having “the life supports pulled away from his body.”

Martha took a new job and started talking about moving out of her parents’ home, into her own condominium apartment. One day when she came home from work, she discovered her parents obviously waiting for her. Her mother had experienced some difficulty with asthma and had spent a portion of the day at the hospital. As Martha walked into the room, her father angrily held up the hospital identification bracelet that had been placed on her mother’s arm and said, “Look what happened to your mother while you were gone!” His tone of voice implied that if she had not been gone the extra hours at her new job, this would not have happened. Martha felt so guilty because of this accusation that she canceled her appointment with me in order to take her mother to the doctor again. She left a message that said, “Family medical emergency.” By this time, her mother was not in need of further medical attention, but Martha feared she might be the cause of both her mother’s death and her own death (because she was symbiotically dependent upon her mother).

When children are young, parents tend to punish by threatening abandonment. Sometimes this can be carried to a point that is extremely frightening for children. The children then try to avoid such abuse with over-compliant behavior.

Sarah, age six, was not acting according to her parents' wishes. Her parents asked if she liked living at home. She responded honestly, no. They then asked if she wished to leave home. She answered yes. Her parents dressed her and gave her a lunch box containing a few pieces of food. Then they drove her to the bus station and let her out. They waited, hidden in the parking lot. She decided that there was nothing to do but to get on the next bus. She did. Her parents followed and rescued her just before the bus departed. This is a more literal abandonment than many parents dare try with their children (Masterson 1976, Rinsley 1982).

Parental abandonment can also be expressed to adult patients.

Mary got a new and prestigious job. She went out to lunch with her parents to celebrate and tell them about it. Her father responded by saying that he planned to change his trust accounts. He would leave all of his assets to the other three siblings because she would not need the money anymore, now that she had such a good job. Mary became upset, having learned to accept money as the only substitute for family intimacy.

Parental subversion of a growth step may take the form of constant irrelevant criticism, which is then internalized. Therefore, when patients complete an independent growth step, they anticipate a negative attack for doing something wrong. One patient anticipated the pleasure of picking up the bound copies of her doctoral dissertation. However, instead of feeling happy, she felt sad, depressed, and uneasy about what she had done wrong.

Patients have made real progress when they understand that parental sabotage means that the parents recognize that their child has taken a step forward. Sabotage takes on a new meaning as a backward compliment indicating that the child's forward progress is being noticed by the parents. One patient, Martha, spoke clearly to this issue.

"Whenever I wanted something, my parents said, 'You can do without it.' That's one of the key ways they kept me from growing. I now understand that my mother said that because she didn't want me to leave her, and my father said it because he was afraid that I would succeed better than he. But as a kid, the only thing I felt was that I didn't deserve it. Their attack really worked. I felt cut back. Now I understand why I always felt sick to my stomach when I saw a Japanese bonsai tree. I can't stand to see growth stunted."

Sabotage sometimes comes disguised as help, which makes it

exceptionally confusing.

A father, well known for his undermining behavior, helped his son fix the son's dirt bike. Unconsciously, the father tightened one of the parts down so tight that the son couldn't get the bike to run.

Matthew decided to move away from his family on the west coast, to the east coast. The night before he left, he had "the most frightening dream of my whole life." During a portion of the dream, he was being chased by an ambulance with a blind driver. He could not get away. The ambulance was a symbol of the pathologic "rescue from life" his parents insisted on giving him. The blind driver symbolized the reckless pursuit by parents who could not even see who he was, or what they were doing. He was able to escape, an ending which gave him the courage to leave home.

Some patients are born with exceptional talent, making it difficult to fail. They must employ their talents to find ways to subvert their own creativity so that they can continue to live within their families.

Jason was a professional horn player. He created for himself a fear that incorporated Mephistopheles. He imagined that if he played the next note correctly, played a perfect performance, or went away from home to give a concert, he would become possessed by the devil. It was a way of locating the destructive parts of his relationship with his parents outside the family. This

fear became so intense that, for a time, he had to have a member of the family stay with him at all times. He was not aware of his self-defeating behavior. His family stayed home with him rather than insist that he seek psychological help. Even when hypnotic treatment had helped him to overcome the fear of Mephistopheles, he remained fearful that this obsession would return. It was not until he understood his relationship to his family that the fear no longer dominated him.

All forms of abandonment feel real to children. Some of the parents' threats of illness and suicide even seem believable to the therapist. It has become clear, however, through the years with this kind of patient that the abandonment claims are, with rare exceptions, mere threats. The parent does indeed survive after the patient achieves a separation from the family. The threat is not likely to be carried out because parents need their offspring too much to actually abandon them. Patients can do anything reasonable with their lives, and their parents will still be there. In fact, the sabotage generally ceases as soon as the parents realize that the patient is no longer influenced by it. The patients achieve their goals and the parents begin, instead, to get their psychological needs met by feeling like successful parents.

Most impinged-upon adults are understandably hungry for appreciation from others. They want someone to celebrate a success, someone able to say thank you when a job is well done. They seem insatiable in this regard. They

must learn that people in their present lives may not be aware of their past deprivation.

If the parental undermining is extremely severe, patients may decide to use extreme measures to avoid their rage about the demands of enmeshed family ties. Patients have tried (1) homosexuality as a means of keeping away from women like their mother; (2) suicide attempts as a way of saying, "None of this matters. I am already dead." (3) creating a vivid utopian afterlife; (4) collecting large stuffed animals, symbolizing warm cuddly creatures to be close to without fear; and (5) making a vow never to be employed in a job requiring work with people, for example, to work only with computers.

THE FEAR OF ENGULFMENT

The fear of abandonment and rejection is the most common one among impinged-upon adults. This fear manifests itself as anxiety attacks in which patients fear that they will be abandoned by the therapist and by their friends. A less common fear is that of engulfment. This fear results from a disturbed relationship between mothers and infants. Patients react to this kind of violation of boundaries in a completely different way. Patients fear that when they decide to take a step forward with their life, it is really not their step. They feel that the therapist made them do it. Patients feel subtly brainwashed or swallowed up by the therapist rather than fear of

abandonment (Grotstein 1981). One patient, Alan, had a vivid experience that illustrates this fear.

"I was lying in bed, on the edge of sleep. I felt something fluid creeping up behind me. It felt like a nameless form. It was going to envelope me. I realized the form was my mother. I felt intense fear but made the conscious decision for the first time in my life to lie still and see what happened.

"I fell asleep. My fear of being consumed did not occur. I realized, through this experience, that I had felt a need to keep moving to avoid being enveloped. Previously, I felt unable to move slowly and deliberately with life. Instead, I acted impulsively and impatiently, often making decisions that I regretted in the long term. I had felt a need to keep moving to avoid the nameless form."

Alan explained the difference between the fear of abandonment and engulfment by saying, "My fear is not being told to leave, but turning my back. I feel utter loneliness when I feel engulfed. I don't exist by myself. I can't get away or out to anyone else."

Alan wanted "attention in the form of support and guidance." He experienced his mother's engulfing as dangerous as a "duck who headed her brood toward an alligator."

Dan decided to cope with his fear of engulfment by doing nothing with his life. He concluded, “If I have nothing to tell my parents when they call, then they might be forced to leave me alone. I am willing to give up living to keep them off my back.” He had never been given permission to set limits for his parents’ behavior. He described their form of engulfment as follows: “I found a small gift for my parents. I knew that it was something that they would like and I really wanted them to have it. But I was afraid to send it to them because I knew the gift would immediately activate a phone call from them. They would jump back into my life.”

After much working through of these issues, he decided to act for himself and bought a piece of property. He was afraid to tell his parents because, he said, “they will want to jump in and design the house for me and I will lose the property as my own.” He was afraid not to tell them because, when they eventually found out, he knew that they would feel “panicky” about the fact that they had been excluded. Then they would, he said, “bug me even more.”

Dan had a dream in which he was planting a new garden. Every time he made a hole for a new plant, an oversized bullfrog jumped out. They sat around him until there were so many that a friend said, “Look out or you will step on one and hurt it.” He recognized that the planting of the garden represented his new life, and that the frogs were his parents "jumping all

over" him. His understanding helped him design more effective ways to communicate with them. For instance, he decided to buy an answering machine for his telephone and to send a postcard periodically. This way, his parents could feel included, but he had gained control over his contact with them and what he said.

THE VIOLATION OF BOUNDARIES

Enmeshed family relationships involve constant violation of psychological boundaries.

Rachael said that she would prefer to cease any further mention about her parents in her psychotherapy because she felt so compelled to tell her mother everything that was said. It did not occur to her that she could continue her dialogue with me and not inform her mother.

Daniel came into his mother's kitchen. His mother commented, "I feel warm.'' She then walked over to Daniel and began to untuck his shirt, assuming that her son felt the same way.

Ann's parents traveled across the country to visit her for the second time in a three-year period. They came to the door, opened it, and walked in without knocking.

Letters written home by patients are frequently passed on indiscriminately to extended family members. There is no sense that a letter might be private or meant for only one person; the family has only one elastic boundary.

There seems to be a relationship between obesity and the violation of psychological boundaries. Some patients report that they feel anywhere from fifteen to thirty pounds overweight. Try as they might, they have a difficult time losing the extra pounds. Some are still living at home with parents who stock the refrigerator with lots of irresistible high-caloric foods. Several feelings are commonly expressed by these patients:

"If I am fatter, I feel like I have more of a boundary between me and my parents."

"No matter how much I weigh, I feel like a piece of glass. My parents can always see inside."

"Fat is ugly and keeps me from leaving home."

"Food is a tempting substitute for the loving that is missing."

Once they become aware of these misconceptions and understand that the violation of boundaries is psychological rather than physical, they are

often able to embark on a weight-loss program with tangible success.

In what other ways can young children handle the violation of boundaries? Guilty adults tell a lot of stories about the "bad" things they did in childhood. Some of them found something outrageous to do in secret, mainly to prove to themselves that they were something more than an over-compliant extension of their parents. Some children get tremendous pleasure out of hiding from their parents the fact that they steal. If their parents do find out, the children refuse to admit the crime. It is not so much that they fear parental punishment; instead, they want to prove their separateness.

When patients are able to understand their actions in this light, they can view their childhood experiences with a new respect for themselves. Most impinged-upon adults have been good children who are excessively embarrassed about the few transgressions they have committed.

PATIENTS' RELATIONSHIPS WITH SIBLINGS

Impinged-upon adults appear to have a higher than normal incidence of siblings with severe psychological difficulty, often manifesting in a psychotic break during adolescence. These disturbed siblings are often the children who fight back hardest against enmeshed family ties because they accurately perceive the ways in which they are damaging to growth. Patients find these siblings intimidating but watch and learn that in fighting back, more is lost

than is gained. Such siblings may commit suicide, may never leave home, may maintain a marginal existence outside of the home, may live in a state hospital, or their whereabouts may be unknown to the family. It remains unclear to what extent this major disturbance is organic and happens incidental to the environmental problems of enmeshed family ties, is environmentally induced by inadequate parenting, or requires a combination of both factors. This higher ratio of severely disturbed siblings suggests that environment may be a sizable contributing factor.

As patients achieve separateness and mastery over their own lives, it is usually necessary to spend considerable time in the therapy sorting out their feelings about a disturbed sibling. The patients may be afraid to succeed because it will hurt the sibling who is doing poorly with life. The patients feel as if this sibling suffered more than they did and feel obligated not to add to that suffering. They feel this sibling's pain and loss and feel tempted to stay behind and help. It is difficult for these patients to accept the fact that their need to fail will not help their disturbed sibling to function better. Their concern is well founded because the parents have urged the remaining siblings, in subtle ways, not to succeed because it will expose and embarrass the disturbed sibling or make him or her feel left out.

Sometimes the disturbed sibling is creative, talented, and much younger than the patient. If the patient succeeds in leaving home, he or she often has

to work through the guilt and grief resulting from the inability to take this younger sibling along. The patient wants to exercise unrealistic, almost superhuman powers to release this younger child.

Patients have one additional problem in relation to their more disturbed sibling: they have an exceptionally strong fear of expressing emotion because they are afraid that feelings will erupt out of control as they did during the sibling's psychotic break and will again make that sibling "crazy." Therefore, these patients tend to be more guarded in the expression of affect and are in need of more psychological education, encouragement, and support, to enable them to use emotion in a constructive and manageable way. Patients with a disturbed sibling harbor a fear that their offspring will inherit their sibling's problems.

Siblings who are not severely disturbed band together to be supportive of one another. Siblings can validate and help one another to realize that their feelings are legitimate. They may stand in for one another, taking turns being the focus of the problem communications from the parents. They act much as a flight of birds traveling in formation: when the leader gets tired, he or she drops back and another member takes over.

Sometimes one sibling is much older and takes on the job of parenting younger siblings. The younger children may not be aware of this privileged

parenting until the older sibling goes away from home. The younger children do not understand the depth of their loss until they realize years later in psychotherapy that an older sibling provided the best parenting they received.

When patients separate from their family, they may run into difficulty maintaining a relationship with siblings who remain enmeshed with the parents. The siblings who stay with the parents may view the patients as defectors from the family, and the parents may encourage separateness between them. These patients may have to settle for a distant and superficial friendship because there is so little common ground.

CONCLUSION

Enmeshed parents must forego mature interaction with their adult children because they are unable to relinquish the position of power and control that maintains the entanglement. If the parents visit their children, they prefer to buy their own food or go to a restaurant and pay for everyone's meals, instead of eating the food prepared specifically for them by their children. They have an extremely difficult time shopping when their grown children are buying something for them. If the children succeed in paying for the gift, it may well be left unused for some time. These parents prefer to continue to buy gifts for their children.

At an unconscious level patients already have much of the basic information contained in this book. As patients come to understand their difficulty, they can look back on their past creative projects and see glimpses of feelings about past relationships (Mahler 1975). Difficulty with separation emerges as a consistent theme in these patients' stories, poetry, sculpture, and drawings, even at an early age. Sometimes these projects of the past find their way into the therapist's office. The patients' creativity has usually been redirected to defend against or articulate an attempt to resolve the unresolved issues of development, separation, and intimacy.

Melinda gave an address at her high school commencement. The theme of her speech concerned a bird trying to get out of its egg. Someone came along and helped the young bird by cracking the shell; but the shell cracker had inadvertently robbed the bird of the strength it would have acquired fighting its own way out of the egg. The bird was unable to fly properly. Melinda advised her audience not to rescue each other to such an extent that opportunities to conquer the hurdles of living are taken away.

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.

References

Angyal, A. (1965). Neurosis and Treatment: A Holistic Theory. New York: Wiley.

Balint, M. (1968). The Basic Fault: Therapeutic Aspects of Regression. New York: Brunner/Mazel.

Bateson, G., Jackson, D., Haley, J., and Weakland, J. H. (1956). Toward a theory of schizophrenia. *Behavioral Science* l(4):251-264.

Berne, E. (1961). Transactional Analysis in Psychotherapy. New York: Grove.

---- (1974). What Do You Say after You Say Hello? New York: Grove.

Bettelheim, B. (1982). *Freud and Man's Soul.* New York: Alfred A. Knopf.

Bowlby, J. (1969). *Attachment and Loss.* Vol. 1: *Attachment.* New York: Basic Books.

---- (1973). Attachment and Loss. Vol. 2: Separation. New York: Basic Books.

---- (1980). *Attachment and Loss.* Vol. 3: *Loss.* New York: Basic Books.

Boyer, L. B., and Giovacchini, R. (1967). Psychoanalytic Treatment of Schizophrenia, Borderline and Characterological Disorders. New York: Jason Aronson.

Brown, J. R. (1986). *I Only Want What's Best for You.* New York: St. Martin's.

Cardinal, M. (1983). *The Words to Say It.* Cambridge, MA: VanVactor and Goodheart.

Chapman, A. H. (1978). The Treatment Techniques of Harry Stack Sullivan. New York: Brunner/Mazel.

Chatham, P. M. (1985). *Treatment of the Borderline Personality.* Northvale, NJ: Jason Aronson.

Chernin, K. (1985). *The Hungry Self* New York: Harper and Row.

Crawford, C. (1978). *Mommie Dearest.* New York: Berkley Books.

Davanloo, H. (1978). Basic Principles and Techniques in Short-term Dynamic Psychotherapy. New York: Spectrum.

Friday, N. (1977). *My Mother, My Self* New York: Dell.

Gardner, R. A. (1985). Separation Anxiety Disorder: Psychodynamics and Psychotherapy. Cresskill, NJ: Creative Therapeutics.

Giovacchini, P. (1984). *Character Disorders and Adaptive Mechanisms.* New York: Jason Aronson.

---- (1986). *Developmental Disorders.* Northvale, NJ: Jason Aronson.

Gould, R. L. (1978). Transformation: Growth and Change in Adult Life. New York: Simon & Schuster.

Greben, S. E. (1984). Love's Labor: Twenty-Five Years of Experience in the Practice of Psychotherapy. New York: Schocken Books.

Grinker, R. R., and Werble, B. (1977). *The Borderline Patient.* New York: Jason Aronson.

Grotstein, J. S. (1981). *Splitting and Projective Identification.* New York: Jason Aronson.

Gunderson, J. G., and Singer, M. T. (1975). Defining borderline patients: an overview. *American Journal of Psychiatry* 132(1): 1-10.

Halpern, H. M. (1976). Cutting Loose: An Adult Guide to Coming to Terms with Your Parents. New York: Bantam.

---- (1982). How to Break Your Addiction to a Person. New York: Bantam.

Hedges, L. E. (1983). *Listening Perspectives in Psychotherapy.* New York: Jason Aronson.

Johnson, S. M. (1985). Characterological Transformation: The Hard Work Miracle. New York: Norton.

Kaiser, H. (1965). *Effective Psychotherapy.* New York: The Free Press.

Kaplan, L. J. (1978). Oneness and Separateness: From Infant to Individual. New York: Simon & Schuster.

Kernberg, 0. (1972). Early ego integration and object relations. *Annals of the New York Academy of Science* 193:233-247.

---- (1980). Internal World and External Reality. New York: Jason Aronson.

---- (1984). *Severe Personality Disorders.* New Haven: Yale University Press.

Langs, R. (1973). The Technique of Psychoanalytic Psychotherapy. Vol. 1: The Initial Contact: Theoretical Framework: Understanding the Patient's Communications: The Therapist's Interventions. New York: Jason Aronson.

---- (1974). The Technique of Psychoanalytic Psychotherapy. Vol. 2: Responses to Interventions: The Patient-Therapist Relationship: The Phases of Psychotherapy. New York: Jason Aronson.

Lawrence, D. H. (1913). *Sons and Lovers.* London: Duckworth *&* Sons.

Lerner, H. G. (1985). *The Dance of Anger.* New York: Harper & Row.

Lidz, T. (1973). The Origin and Treatment of Schizophrenic Disorders. New York: Basic Books.

Lindner, R. (1955). *The Fifty-Minute Hour.* New York: Jason Aronson, 1982.

MacKinnon, R. A., and Michels, R. (1971). *The Psychiatric Interview: In Clinical Practice.* Philadelphia: W. B. Saunders.

Mahler, M. (1974). Symbiosis and individuation: the psychological birth of the human infant. *The Psychoanalytic Study of the Child* 29:89-106.

---- (1975). The Psychological Birth of the Human Infant. New York: Basic Books.

Mann, J. (1973). *Time-Limited Psychotherapy.* Cambridge, MA: Harvard Press.

Masterson, J. F. (1972). Treatment of the Borderline Adolescent: A Developmental Approach. New York: Wiley.

---- (1976). *Psychotherapy of the Borderline Adult: A Developmental Approach.* New York: Brunner/Mazel.

---- (1981). The Narcissistic and Borderline Disorders: An Integrated Developmental Approach. New York: Brunner/Mazel.

---- (1983). Countertransference and Psychotherapeutic Techniques: Teaching Seminars of the Psychotherapy of the Borderline Adult. New York: Brunner/Mazel.

---- (1985). The Real Self: A Developmental, Self, and Object Relations Approach. New York: Brunner/Mazel.

Masterson, J. F., and Rinsley, D. B. (1975). The borderline syndrome: the role of the mother in the genesis and psychic structure of the borderline personality. *International Journal of Psycho-Analysis* 56(2): 163-177.

Miller, A. (1981). *Prisoners of Childhood: How Narcissistic Parents Form and Deform the Emotional Lives of Their Gifted Children.* New York: Basic Books.

---- (1984). *Thou Shalt Not Be Aware: Society's Betrayal of the Child.* New York: Farrar, Straus & Giroux.

Mitchell, S. A. (1981). The origin of the nature of the "objects" in the theories of Klein and Fairbairn. *Contemporary Psychoanalysis* 17(3):374-398.

Nichols, M. (1984). *Family Therapy.* New York: Gardner.

Norwood, N. (1985). *Women Who Love Too Much.* Los Angeles: Jeremy P. Tarcher.

Ogden, T. H. (1979). On projective identification. *International Journal of Psycho-Analysis* 60:357-373.

Peck, M. S. (1978). *The Road Less Traveled.* New York: Simon & Schuster.

---- (1983). *People of the Lie.* New York: Simon & Schuster.

Reiser, D. E., and Levenson, H. (1984). Abuses of the borderline diagnosis: a clinical problem with teaching opportunities. *American Journal of Psychiatry* 141:12.

Rinsley, D. B. (1981). Borderline psychopathology: the concepts of Masterson and Rinsley and beyond. *Adolescent Psychiatry* 9:259-274.

---- (1982). *Borderline and Other Self Disorders.* New York: Jason Aronson.

---- (1984). A comparison of borderline and narcissistic personality disorders. *Bulletin of the Menninger Clinic* 48(l):l-9.

---- (1985). Notes of the pathogenesis and nosology of borderline and narcissistic personality disorders. *Journal of the American Academy of Psychoanalysis* 13(3):317-318.

Rossner, J. (1983). *August.* New York: Warner.

Sass, L. (1982). The borderline personality. *The New York Times Magazine,* August 22.

Searles, H. F. (1986). *My Work with Borderline Patients.* Northvale, NJ: Jason Aronson.

Sheehy, G. (1976). Passages: Predictable Crises of Adult Life. New York: E. P. Dutton.

---- (1981). *Pathfinders.* New York: Bantam.

Slipp, S. (1984). Object Relations: A Dynamic Bridge between Individual and Family Treatment. New York: Jason Aronson.

Small, L. (1979). *The Briefer Psychotherapy.* New York: Brunner/ Mazel.

Stone, M. (1980). The Borderline Syndromes: Constitution, Personality and Adaptation. New York: McGraw-Hill.

---- (1986). Essential Papers on Borderline Disorders. New York: New York University Press.

Sullivan, H. S. (1956). *Clinical Studies in Psychiatry.* New York: Norton.

Taft, J. (1962). The Dynamics of Therapy in a Controlled Relationship. New York: Dover.

Tyler, A. (1982). *Dinner at the Homesick Restaurant.* New York: Berkley Books.

---- (1964). *If Morning Ever Comes.* New York: Berkley Books.

Vaillant, G. E. (1977). Adaptation to Life: How the Best and the Brightest Came of Age. Boston: Little, Brown.

Waugh, E. (1944). *Brideshead Revisited.* Boston: Little, Brown.

Wells, M., and Glickaul, H. C. (1986). Techniques to develop object constancy with borderline clients. *Psychotherapy* 23:460-468.

Winnicott, D. W. (1958). *Through Pediatrics to Psycho-Analysis.* New York: Basic Books.

---- (1965). The Maturational Processes and the Facilitating Environment. New York: International Universities Press.

Wolberg, L. R. (1980). *Short-Term Psychotherapy.* New York: Thieme-Stratton.

Wynne, L. C., Cromwell, R. L., and Matthysse, S. (1978). *The Nature of Schizophrenia.* New York: Wiley.

Wynne, L. C., Ryckoff, I., Day, J., and Hirsh, S. L. (1958). Pseudomutuality in the family relationships of schizophrenics. *Psychiatry* 21:205-220.

Yalom, I. D., and Elkin G. (1974). *Every Day Gets a Little Closer.* New York: Basic Books.