Birth of a Self in Adulthood

THERAPEUTIC ISSUES AND THE THERAPEUTIC PROCESS

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e-Book 2017 International Psychotherapy Institute

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Therapeutic Issues and the Therapeutic Process

Patients and therapists discuss many issues over the course of therapy. They consider present relationships and problems, the presence of commands or myths, past memories of significant others, and the relationship occurring between them. The following therapeutic issues, questions, and processes seem to appear consistently in the psychotherapy of impinged-upon adults.

DEFINING THE DIFFERENCE BETWEEN FAILURE AND IMPINGEMENT

When patients want to take a step forward but hesitate, the question that should be asked is *why.* The consistent response is, “I am afraid that I am going to fail.” Conceptually, patients are afraid to succeed and at the same time experience fear of failure. This feeling is accurate because the myth of self-righteous perfection dictates that they never did anything quite right. The lack of positive recognition from their parents for growth steps means failure to patients. Impinged-upon adults experience a lack of success when they have actually done well.

Impinged-upon adults tend to view their lives in terms of degree of

failure. They have not gotten where they wanted to go; it does not occur to them to look at the situation as anything other than their fault. They do not see themselves as potentially successful people who have tried to keep moving ahead. Therapists can help them to define the difference between failure and impingement with the following analogy.

A runner runs a race. If he did not bother to practice and cannot make it around the track in good time, one could say he failed. However, if he practices a lot and runs as fast as he can but loses the race because someone mistakenly puts several wooden hurdles in his lane only, it is reasonable to use the word *impingement* He has been impinged upon by an external source; it is not his own inability or lack of motivation to perform. He must clear the obstacles away. Even if impinged-upon adults manage to scale the barriers, they feel as if they failed because the accomplishment causes so much psychological distress.

Nancy said, “I am a failure in getting to psychotherapy on time.” In reality, before I could see her, she had patiently waited several weeks without losing her motivation. She managed to get the necessary referral for insurance purposes from an unsympathetic physician. Then on her way to my office she circumvented traffic that had ground to a halt because of an accident. Despite these obstacles, she arrived at her session only ten minutes late and did some good work. I pointed out that Nancy had been successful in

getting around several obstacles, but she seemed to feel like a failure merely because the obstacles were there.

Tim came to the psychotherapy hour feeling triumphant because he had been able to find a way around several "snags" in his graduate school electronics assignment. He explained that he had erroneously learned from his parents that a problem is a "signal to stop working." He had never been told that problems are a normal part of the challenge of living, merely something to surmount. He lived in "dread of snags" because they seemed like unfair obstacles outside of his control.

THE FIGHT FOR SUPREMACY BETWEEN THE SABOTAGING SELF AND THE SUCCEEDING SELF

Success in life makes impinged-upon adults anxious and therefore only marginally happy. First, they are afraid of abandonment. Then they are surprised at how much hard work living is, and miss being "rescued" by their parents. As patients progress, periodically there are some therapy hours in which it is obvious that they are doing extremely well while trying hard to convince the therapist of their failure. The patients keep regression in the picture to protect their relationship with their parents and, transferentially, with their therapist.

Patients get angry with their therapist for not buying into the

sabotaging self and frustrated when the therapist does not rescue them from their hard work by giving special help.

Andrea was attending a course that provided important preparation for an entrance examination. During the first class meeting her sabotaging self reigned completely. She worked slowly, answered sample questions incorrectly, and came home feeling “like a dummy.” After her hour of psychotherapy, she went back to the second class. She had stomach pain all the way to the class and feared that she might vomit. She went into the ladies’ room and looked at her reflection in the mirror. She said, “You will take this class no matter how many times you have to throw up. You will sit near that door so you can leave to vomit if you have to. You will come back into class.” Her nausea went away, and she started to work. She did well for the remainder of the course and achieved a high score on the entrance examination.

This is an excellent example of a patient’s ability to let the succeeding part of her self triumph over the self-defeating part. She was proud of her understanding and her ability to do something constructive about it.

ENTITLEMENT AND HAPPINESS VERSUS THE FEAR OF DEATH

The feeling that one is *entitled* to reasonable help goes hand-in-hand with a positive and supportive relationship. Impinged-upon adults have little

sense of the meaning of reasonable help. They are more skilled at failing for the purpose of eliciting unnecessary help and “taking care” of the therapist than they are at taking care of themselves. For example, they tend to clock-watch for therapists, making sure that they get only their allotted time. They are anxious if therapists choose to extend the hour by a few minutes. They do not believe that if they want something reasonable, they can simply ask for it because the person they ask might be uncomfortable saying no.

The issue of *entitlement* comes up in relation to telephone calls to therapists between hours. Although some discomfort is a normal part of psychotherapy, there are times when a legitimate need arises for telephone contact with therapists. During the initial stages of therapy, many patients are unable to act on this need, even if therapists offer their availability when the situation warrants. In the next hour, their therapist may hear about painful meetings with their family or sleepless nights of working through alone. A five-minute phone contact might have helped. Sometimes therapists can encourage them to take advantage of this phone privilege by saying, “I would rather talk with you for just a few minutes in a way that would be helpful than to hear later that you had such a long, sleepless night.” Such patients spend hours wondering whether or not they have the right to make the call.

It is only fair to say that the issue of telephone calls tends to be complex for this kind of patient anyway. The pathologically symbiotic part of

impinged-upon adults wants therapists to magically intuit when they are upset and call them, as the impinged-upon adults have to do with their parents. A vast majority of enmeshing parents have manipulated their children into calling daily or at least several times a week. Patients often report an expense of up to hundreds of dollars a month for calls to their families. They are expected to call their parents, while their parents rarely call them. If patients do not call, there is silence from their parents for a time, and then an irate or tearful guilt-provoking telephone call to say "How could you do this to me?" The patients are resentful of being required to telephone, especially when they come to understand just how much these contacts are solely for maintaining their parents.

Opposing the feeling of entitlement is a fear of death. Most patients are better acquainted with this fear than any sense of entitlement. In fact, they fear and expect death daily, especially when they have just completed a new step forward. This fear is the result of having been repeatedly threatened with abandonment. When the patients were children, abandonment meant death (Masterson 1976). The fear of dying is the logical consequence of stepping away from taking care of their parent in adulthood.

Arleen finished writing a book with a co-author with whom she had been enmeshed. It was due to be published shortly. She said, "My co-author would like it if I fell off a cliff now that I have finished the hard work so that

she can have the glory." During that week, she feared death by a car accident but did not connect her fear with her statement about her co-author.

Jackie worked the hardest she had ever worked to find a job for herself. During that same week she had a dream in which someone came up to her and said, "Now you are going to die." She was led into another room and directed to die. She did, but discovered that she felt no different after she had died. The dream reassured her that the threat of death was not real.

Many patients fear death by a serious illness, especially cancer. A scratch that runs into a mole becomes a major concern about a cancerous melanoma. These patients need to be able to talk about the various ways in which they fear death; they need advice as to whether they really need to act on their fear by consulting a physician. Such patients tend to live life fiercely because they expect it to be snuffed out at any moment. To die is the logical extension of the fear of being "caught," "left," "hated," and "rejected." It is a difficult way to live. Therapists' reassurance and interpretations can be tremendously helpful.

There is an additional reason for patients to raise the issue of death. Some patients temporarily consider taking their own lives. Most will be quick to acknowledge that they are not truly suicidal in the sense of feeling the deep despair that makes one want to bring an end to one's life. Instead, they think

about death because the truth revealed in their psychotherapy is painful and suicide is the only way they can think of to make it go away. They consider death as a substitute for the pain of psychological incompleteness and abandonment by their parents (intrapsychic or real). In addition, the issue of death may come up because they want to go back to the most basic entitlement: deciding for themselves whether or not to live. Then they must decide if they will live for themselves or exist only as extensions of others.

Along with the fear of death comes avoidance of pleasure. Happiness is hard-won, and when it first comes it feels frightening. Many patients say quietly “I feel happy” while fear crosses their faces. If something good happens, patients are likely to be very quiet and offhanded about it. In fact, it is the absence of joy that is one of the hallmarks of the lives of impinged-upon adults. As one patient’s mother said, “The good times are just a respite from the bad times.”

Impinged-upon adults need time to realize that they have not been happy. They tend to confuse happiness with being special to their parents and are led to believe that being special “feels good.” But to be special to their parents, they have to avoid loving others and mastering life experiences, richer sources of true happiness. There comes a point in the psychotherapy when patients have to choose between symbiotic specialness and being happy as an independent, productive person. In the process of sorting this

out, patients may attempt to become a therapist's special patient. There is a sharp distinction between a therapist's liking the independent person that a patient is becoming and feeling that a particular patient is "special." Patients are surprised when told that they are in trouble if they become their therapist's special patient because that probably means that the therapist needs them to fill some incomplete part of himself or herself.

PATIENTS' DIFFICULTY WITH TAKING VACATIONS

It is difficult for impinged-upon adults to spend money on a vacation to get away from everything to relax and be happy without a lot of attendant anxiety.

Alan came to his psychotherapy hour just before leaving for a vacation with a friend. He claimed to have "nothing to talk about today" and recognized that he felt "shut down." Even though he had carefully scheduled his time away so that he would not miss a therapy hour, we figured out that he was anxious that I would disapprove of his plans to relax. If he was already "shut down," he felt that he could better protect himself from my abandoning of him. Part of him wanted me to object to his vacation and request that he stay home because such an action on my part would make him feel important to me. In addition, he recognized that he felt guilty about not being at home for his parents' weekly phone call and was afraid of the intimate thoughts that

he had about the girlfriend going with him. Finally, two neighbors had offered to take care of his bird. He was afraid of rejecting one neighbor's offer. These thoughts culminated in a nightmare about not getting to the train station on time and being prevented from getting on the train by the conductor. He awoke arguing vehemently with the train conductor. He could catch only glimpses of fantasies of relaxing and being happy on the upcoming vacation.

Once we had analyzed the dream, Alan was pleased to discover his emerging ability to fight back with the conductor (his parents) for some time to relax and to be happy.

THE FIGHT BETWEEN THE FALSE AND REAL SELVES

Ann talked about her fight between her false self and her real self by saying, "I submerged myself so deeply to cope with my parents that I don't know who I am inside."

As has previously been pointed out, impinged-upon adults have developed a false self that carefully watches and attends to the needs and commands of others for the purpose of avoiding abandonment. This false self operates automatically, hiding what there is of the real person underneath, and is a frustrating obstacle to what patients otherwise should be feeling (Balint 1968, Masterson 1983, Winnicott 1958, 1965).

In addition, the false self often demonstrates proficiency, appears self-sufficient, and provides little interaction with the therapist. When the false self reigns, patients usually feel safe and protected during the hour but realize soon after leaving that none of their questions were answered and little contact was made. This ability of the false self to hide real concerns can make a session very frustrating for both patients and therapists.

Patients also have to fight the myth of self-righteous perfection (see Chapter 4) along with the false self. Impinged-upon adults believe that they must "do it right" to be able to maintain the therapeutic relationship. This self-imposed demand obscures the patients' own feelings. It is especially frustrating for patients when therapists do not tell them what they (the therapists) "need." As the patients try to guess, anxiety mounts, with an ensuing loss of a sense of themselves. The therapeutic relationship, which the patients value, then comes to a standstill.

Sometimes patients try to protect themselves from this frustrating circumstance by pretending that they do not value the therapeutic relationship. Then they can thus feel somewhat more relaxed, which allows the relationship to progress more easily. The issue of entitlement is at the core of this problem, too, because the patients feel that their affection for their therapist can only be expressed by meeting the therapist's needs. At this point, the therapist can help by reflecting the process just described. This is

often successful, enhancing the patients' understanding and allowing them to regain a sense of their real self.

The false self implies something negative to be gotten rid of, while the real self is good, to be fully exposed. Sometimes patients strive to come up with the real self in an over-adaptive, false-self way.

It seems more productive for patients to think of the false self as having had a critical adaptive and protective function in the past. It is a valuable part of the self, to be retained in numerous work and social situations. The false self of some patients is impressive, allowing them to be proficient at teaching a class or handling an administrative assignment. If the false self is not rejected by therapists as simply a defense, the real self can begin to emerge from behind it.

As patients begin to differentiate between the false self and the real self, they encounter many frustrating moments of trying to make the shift from one to the other. The false self tends to serve a protective function within the therapy. It reasserts itself after a vacation or other interruptions in therapy, a confrontation or an argument with the therapist, a major insight, or an important step forward. Recognizing and respecting its presence as a protection can often lead to a profitable discussion about what needs to be protected. As the therapy proceeds, there tends to be less false self, more real

self, and a progressive integration of these two parts of an emerging whole person.

Actually, patients often know their own feelings, but they become confused because they have been taught by a symbiotic family that it is only possible to have "one feeling at a time." That feeling is supposed to be positive toward the family. Therefore, feeling both happy to see family again and sad because of the obvious limitations in interaction makes patients feel "crazy," disloyal, and bad.

OBJECT CONSTANCY

Patients develop positive feelings of affection and trust for therapists, causing a low-level anxiety for the patients. Basic to entitlement and a supportive relationship is the issue of object constancy, whether or not patients have a visual memory or picture of their therapist when not in the therapist's presence. If patients feel like mere extensions of other people, they tend not to focus in on and recognize other persons as separate wholes. Therefore, some patients cannot visualize their therapist in between hours. When patients are asked about this, they frequently say something like "I don't have a picture of you, but I do have a sense of your presence." That "sense" may be something like a feeling for the colors in the therapist's office. One patient said, "When I try to call on a picture of you in my head, I come up

with a huge picture of my father instead. I am beginning to get a picture of you, but you are very small compared to him, and very vague. I really have to work on what you look like and push him aside." This comment suggests that this patient feels conditioned by her parents not to truly notice anyone outside the family.

Patients who have achieved some degree of object constancy within other relationships occasionally and temporarily lose this ability in their relationship with their therapist. Since this developmental skill has been achieved in other relationships, it may be that the lack of complete object constancy within the therapeutic relationship is an issue of entitlement rather than a developmental failure.

At first, Jessica realized with surprise that she could not clearly remember what I looked like. Next, she acquired a black-and-white inner image of my head, excluding my eyes and mouth. Then she reported an image of a stem-looking mug shot in a black turtleneck. She saw me as a convict, a reflection of her ambivalence about whether I was a person to be trusted or an enemy of her as yet much-needed family enmeshment. Next she reported a full color picture of me but only from the back. One day she was surprised by a very clear picture of me which stayed with her for about a day. She did not have the control to make it go away. Finally, she acquired a full front view of me in color. She was able to maintain this picture, unless there was a vacation

or a disturbance in the therapeutic relationship. Over time, she acquired full control of the object constancy.

A person who has gained or regained object constancy feels an inner sense of companionship and calm. As one patient said, “I am not alone in here (pointing to heart area) anymore now that I can see you anytime I want in my head.”

Another effect of impinged-upon adults’ lack of object constancy is that they do not expect therapists to remember the details of their psychotherapy in between sessions. Many patients will automatically offer to fill therapists in on details already explained or will pause to ask, “Do you remember?” It is very important for therapists to keep a written record of each psychotherapy hour to review before the next therapy session so that they can remember those relevant names and details accurately.

There are some ways in which patients can facilitate the acquisition of object constancy. They have figured out ways to acquire a few simple items that can be used as transitional objects between psychotherapy hours. A common one is a tissue used during the hour (Winnicott 1958, 1965). Instead of throwing it away, they take it with them. Sometimes that one tissue can be carried for a long time in a pocket or in the car. It is simply a reminder that the office, the hour, and the therapist are still there. Other patients help

themselves to a business card, sometimes taking away one each hour. One patient reported tacking them up on her bulletin board, which gave her a concrete record of her growing commitment to the relationship. One therapist, when requested to by patients, would write the most important message from the hour in a single sentence on a piece of paper and give it to them. Another patient asked for a small picture of his therapist to help maintain a visual awareness of the therapist outside of the hour. His request made the therapist think that perhaps more impinged-upon adults might benefit from a small professional photograph of their therapist on a business card. Finally, therapists can directly encourage their patients to look at them carefully, giving their patients permission to concentrate and visually memorize the therapists' physical appearance.

THE PROCESS OF GAINING SEPARATENESS

Patients' parents have offered them a false sense of security in a pathological way by advising the patients to stay away from "change." Patients therefore tend to define change as "giving up something" instead of "adding something new."

One patient, Nancy, evinced especially severe pain over her separation from her family in her initial evaluation.

Nancy had decided to move across country to take a new, high-paying

job. She was able to say good-bye to her family and friends and to pack her belongings. However, when she arrived, she began to feel an anxiety that reached panic proportions. It kept her up at night, unable to sleep or even lie down, and made her unable to take any steps to find new living quarters. She felt a tremendous restlessness, mitigated only mildly by a constant pacing, an "out of control" feeling as though she were having a "nervous breakdown." The only thing that calmed her briefly was a phone call to her parents. We discussed the separation issues likely making her anxious, but it was impossible for her to consider a psychotherapy with me because my office was so far from her home. First she had to reduce her anxiety. She decided to return home immediately and seek psychological help where she was more comfortable.

Another patient tackled the same problem from a different vantage point.

Michele spent some time talking about an unusual scene in the middle of New York City. While walking down the street, she saw a young man join a painting crew working on a new building. He picked up an empty paint can and a clean paint brush. He began "to paint" the trim of a window with the same expert motion as the other painters. Quite a crowd had collected to watch his performance with invisible paint. Michele watched for a long time, amused and envious of how easily this "fake" painter violated the

expectations of everyone around him. He did exactly what he wanted. Michele recognized that this man might be a little crazy. But she recognized something she could not do herself: she was unable to “fool” people; instead, she could only conform to their expectations.

During the period of gaining separateness, patients usually have many dreams expressing their feelings of fear, doubt, guilt, and impending punishment. These dreams reflect the sudden and irrational sabotaging turns that parents have taken to prevent their children from separating.

One patient, Janet, reported the following dream after a step forward in her professional life.

Three policemen came to my house because two numbers on my credit card were reversed. In addition, I was about to be accused of a crime I didn’t commit. There was no way to present my point of view.

Janet realized that the three policemen were her parents and the one sister who was still symbiotically attached to the family. The crime and the reversed numbers represented her family’s attack.

Randy had a difficult time finishing his doctoral dissertation because of a dream in which he dropped dead while the academic hood was being placed over his head. On several occasions, his mother had said to him, “I'll be dead

before you finish that!"

Guilt is passed from parents to patients when they decide to do something independent. The parents say in words, gesture, or tone of voice, "So, you don't want to take care of me anymore?" This guilt haunts patients with each independent move, in relation to taking care of their parents and other people.

There is a second part to this guilt-inducing parental message. It is a retaliation that frequently has a childlike quality. The parents say, "If you don't want to take care of me, I won't take care of you either!"

Dawn, a nurse, had invited her parents to visit and was supposed to meet them at the train station. She was delayed due to a medical emergency. Her parents did not wait, but instead took a taxi to her home. The next three times she flew home to spend a holiday with her family her parents failed to meet her at the airport because they were "too busy."

Patients have fairly reliable ways of responding to this parental accusation. They try to proceed with their plans and take care of others at the same time. This response is automatic.

Tracy was about to sign the papers that would enable her to buy a house. She postponed her meeting with the real estate agent. Instead, she

stayed home to brood anxiously about whether to give parties for various members of her family.

Each patient has a different way of becoming separate. One patient, Lucille, chose to share with me a series of fantasies in which she returned to being a young child starting over again with a trusting relationship. She called it her “TV screen.” Some of the images occurred spontaneously within her therapy hour, while others emerged between sessions and were reported during the following hour. Each fantasy represented progressive steps away from home into a new and trusting relationship with her therapist.

I am a grown woman in an astronaut’s suit with many strings attached. I cut the strings and climb out of the suit. There are so many strings that the suit stands by itself! I feel very thin and nude and embarrassed. There is no place to hide. Someone hands me a pink bunting. I can’t move much in it but it keeps me warm. [This fantasy expresses Lucille’s fear of, and her sense of the aloneness in, stepping away from the commands into her own world. It also expresses her feeling that she has to start over again from the beginning like a baby.]

I am a young girl in outer space. It is black. I am standing on a huge metal disk with sharp, ragged edges. The rest of my family is cowering close together in the middle of the disc. I am standing on the edge. After much fear

and deliberation, I jump off the disc. I don't know where I will land.

I float through black space and land in the middle of a patch of plants called baby tears. There is an African violet in the middle. There is also a small pair of ladies' shoes. I look up to see a woman [whom she identifies as her therapist] wearing a suit. She is very tall and I feel very small. I can't see her head.

A woman is lying on the grass reading a newspaper. I am still a little girl, and I crawl in between her and the newspaper. We do not talk. I feel safe and happy.

The woman is very ill. She is in bed. I am about age ten now. I bring her a present and leave it on her bedside table. She does not wake up.

When I am a teenager the woman helps me to write something. She stands behind me pointing out necessary corrections. She encourages me to keep on writing. [This fantasy articulates Lucille's emerging ability to differentiate between supportive criticism and sabotage.]

For our psychotherapy hour I am in a rowboat in the middle of a small lake. You [the therapist] are on the dock. I stay out on the water. You wait for me to return. You don't leave the dock. You don't seem to mind. [This fantasy appears to represent for Lucille her emerging ability to be herself without

wondering what other people would think. She is beginning to accept that she will not be abandoned.]

The woman in Lucille's fantasies was the symbol for her therapist. For Lucille, the fantasies represented working through. These fantasies were intermixed with other images representing the negative experiences in Lucille's childhood. She had to compare the two kinds of fantasies with each other and decide which one was really true of her relationship with me. My acceptance of the images allowed her to believe that she could have a positive relationship with me. She felt assured that her fantasies represented realistic wishes and needs.

GUIDING PATIENTS TOWARD INDEPENDENCE

When the therapy is successful, patients manage to find the courage to head out on their own. There is some practical information that therapists can give that will help the process along.

First, the myth of self-righteous perfection makes patients afraid to make mistakes. Instead of understanding errors as a necessary part of learning and living, they believe that mistakes signal an inability to manage; they are embarrassing and should be hidden or instantly corrected. To counter this misconception patients might be instructed to "be sure to make at least four mistakes between now and your next appointment."

Some patients naturally tend to cling to their relationship with their therapist. They discount their successes in life, hang onto problems, and demand special rescuing. These patients have come to believe that their self-esteem comes only from their parents, by being “special” or through receiving help. Such patients need the information that they can best build their selfesteem by mastering the problems of life, becoming independent, taking a risk, solving a problem for themselves, and feeling the pride that can come with success.

Impinged-upon adults do not view the anxiety that normally accompanies any new task as normal or as a universal experience. They have been taught that the feeling means “You can’t do it; therefore, you should stop trying.” These patients are surprised to learn that anxiety is simply a warning meaning “You are in new territory, so go slowly and be careful until you learn your way.” They are pleased to learn that the anxiety will dissipate as the work of learning proceeds.

Therapists can encourage and model a sense of humor, which is another element almost always missing within an enmeshed family. Usually humor emerges as patients test their plans and strengthen their resistance to parental sabotage. Its emergence signals the appearance of an observing ego and the development of a whole self.

Andy paused a moment in his hour, reflected, and then started to say something that he felt was completely spontaneous and humorous. But he was uncomfortable and said, “Spontaneity means that I am not following the parental prescription. I am being myself. I am being bad.”

This new sense of humor should not be confused with the defensive humor intended to sidetrack the therapist. An emerging sense of humor makes therapists laugh enjoyably, while a defensive sense of humor makes the therapist uncomfortable about consorting with the laughter.

In the course of psychotherapy, it often helps patients to clarify the difference between getting constructive help with a life project and running back home for help within an enmeshed relationship to foster dependency. This difference was explained to one patient by using the following analogy.

Suppose that you are a Cub Scout about 7 years old. You seek appropriate help by going to the scout master and asking him how to tie a complex new knot. He shows you and you are now able to do it. Then you feel a strong urge to run home to Mother. She gives you one of those looks that says, “My, you have been gone a long time.” You find yourself inviting her to help you to tie your shoe even though you learned to do that simple knot years ago. Your anxiety about your mother’s discomfort with your progress in Scouts makes you act like you don’t know how to tie your shoe.

Once patients begin to feel joy, they are often reluctant to "bother" therapists with their excitement. Joy means loss. Many patients say, "If I feel great, then you will respond by telling me to wind up the psychotherapy. If I feel ecstatic about what our relationship has been able to accomplish, then it will go away." There is a lot of work to do on this issue.

When patients are able to be joyful, it seems critical for the therapist to feel joy too. The patients are brave to share this new feeling openly. A therapeutic stance of neutrality can be devastating to this kind of patient since it is perceived by them as rejection or disinterest. The therapist needs to model excitement, curiosity, pleasure, relief, and humor, but in a manner that also maintains a proper degree of professional objectivity within the psychotherapeutic relationship.

Masterson (1976, 1981) speaks of the necessity of "communicative matching," or sharing in the details of the plans relating to a step forward. This form of help is a departure from a more traditional psychoanalytic approach. It seems a critical part of the work with impinged-upon adults.

When patients feel excessive pain, they may backtrack into the family symbiosis. They give their parents another chance to respond in a manner different from the way they always have before. The patients are usually disappointed.

At times the process seems like a Catch-22. Impinged-upon adults have to stop investing in the symbiotic relationship to be able to receive caring from other sources and build a separate person; it takes a whole, strong ego to handle all this, yet their ego is still in the building stages. Therapists need to keep in mind how far patients have come, the distance left to travel, and the goal.

DIFFICULT MOMENTS FOR THE PATIENT

The therapeutic relationship becomes important to patients. Patients want to believe that it is also an important relationship for the therapist.

Although patients do get to know therapists personally, they have to come to terms with the fact that the therapists may choose to present only the part of themselves necessary to effectively accomplish the therapeutic task. The patients are also able to present only a limited version of themselves through most of the psychotherapy because they do not yet feel like whole persons; usually that version is one of pseudo-compliance or rebellion, developed as a style of functioning. One patient, Alice, wrote about this issue in her diary soon after a therapy hour.

My therapist has been what I need her to be, from a blank screen where I could discover my own thoughts, to lending me her ego when I had no idea what to do, to clarifying the misconceptions that have constrained my life. I've

just come to realize that I don't really know who she is the way her friends do. She said that she felt privileged to do this work with me; but she has not allowed the relationship to become too important so that she can acknowledge my need to come and go. She told me something about her relationship with her students today. As I left the hour, my frustration mounted. I wanted to have the kind of relationship they had with her. I suddenly realized that I was not a whole person. I never had intimate connections within my own family. I was just a piece of a larger need. Now I find that, to become a whole person, I have many hours with someone who must limit what is presented with me. I lose the intimacy once more. Again I feel excluded. The only thing I can do is to face what I am not, so I can see what it is that I need to become. I must keep going because I know that there will be more for me.

Even harder is coming to terms with letting the real self emerge through movement toward an appropriate relationship, now possible, with the therapist. It is a frighteningly new relationship. Patients have to face the possibility that they will be totally rejected by their families, becoming psychologically orphaned. They can turn to friends, but friends are not the same as family, especially during holiday times. In addition, patients usually discover that many of the friendships that they thought important are also symbiotic. They have to be changed or relinquished. Patients must endure periods of feeling alone and avoid turning back to old pathological

relationships for rescue.

One patient, Kendall, described the feelings that accompany this stage when reporting a dream.

She was leaving a concentration camp. She had found a way out, but realized that there was no way to go back in. Outside of the camp lay miles and miles of fields. She felt alone.

The existential separateness, after being taught that it does not exist, feels isolating. On the same day that Kendall reported this dream, she risked giving me a gift; the gift declared her commitment to, and appreciation for, her new therapeutic relationship.

After patients work through these feelings, a longing occurs for the missed events, relationships, and material things that would otherwise have been acquired. One patient felt it when she was walking down a street filled with beautiful homes. At middle age, she was single, living in a studio apartment. For the first time in her life, she wanted a home and family. The strength of this longing was uncomfortable. Another patient, who felt ambivalent about having a baby, visited a friend in the hospital who had just given birth. She reported the strong longing to have a baby of her own as different from the pain of not being a whole person. She saw the longing as a more positive kind of pain and was glad to feel it. It meant that she was on her

way to getting a baby because her need was now clearly felt.

EXCITING MOMENTS FOR THE PATIENT

There are exciting realizations for patients. Some are subtle experiences, taken for granted or not noticed by others. Impinged-upon adults get excited every time they take a new risk, disobey a command, and thereby find out that nothing terrible happens to them.

Arnold, after having set some limits with a friend, said, “The most gratifying thing in the world is to face a situation in which you have to say no, face the threatened abandonment, and find out that the rejection doesn’t happen.”

Patients feel surprised and delighted when they discover that someone *wants* to be with them, instead of abnormally *needing* them. They feel pleased to discover that relationships can be “straightforward and uncomplicated” rather than enmeshed with the commands. Patients derive a real sense of accomplishment when the therapist is unavoidably late for an appointment and they do not feel diminished by this event.

When their spouse leaves on a business trip, patients can feel exhilaration from the sense that they still exist as a whole person while the spouse is away. They are not just a piece of the marriage, fading away if their

spouse is absent.

Achieving object constancy (discussed earlier) also brings a feeling of triumph and security. One patient, Cheryl, reported acquiring object constancy rather suddenly:

The detail was incredible. You had a soft look on your face, and you were wearing the same clothes you had on the last time I saw you. The image stayed with me all day. It was mine and I felt a triumph. I wanted to call and tell you about it. It was hard to go to sleep that night because of my excitement. It arrived just in time because you are going on vacation. Now I will have company while you are gone, and I can believe more fully that you will come back.

Patients feel a sense of mastery when psychosomatic symptoms (see Chapter 7) diminish. Even though these symptoms can be uncomfortable, patients may also feel a mild sense of loss because the physical symptoms act as intrapsychic parents stepping in to thwart the patients. Therefore, when the symptoms diminish, patients feel farther away from both real and intrapsychic parents. Since the patients are still searching for a new set of relationships, this sense of physical mastery is often accompanied by a feeling of loneliness.

Patients discover that feeling like a whole person is only one of a series

of steps in the process of having meaningful relationships. As one patient, Ann, said,

First I find myself. Then I want to see who I am! Once I begin to know that, then I want to see who I've married. Next, there are changes to make in the relationship. I want to assert more than I did before. It really makes me anxious to do all that. Again, I am still afraid of being left, of losing everything, to step out of my quiet security and complacency. It feels so good when I do, though. Now I can accept change as part of the relationship. ... I am fascinated with the differences between me and other people, not the sameness. I enjoy it as much as a color blind person might who sees color for the first time.

Each patient is proud of the courage that it took to face anxiety, go on, trust someone else, and let that person be different and significant. It is a relief to want to be alone without agitation, restlessness, and feeling incomplete. There is now the option to cancel work to take care of a sick child, go home for an evening and read a book, or not go out on Saturday night just because other people do.

PATIENTS RISK A RELATIONSHIP WITH THE THERAPIST

When impinged-upon adults have dealt with their intrapsychic parents, they feel some power and control and are less afraid to deal with their real parents. When patients feel like a separate person, they feel secure within

their own boundaries and are more able to set limits and also to trust.

The stage is now set for the patients to focus on the relationship with the therapist. It is scary because expressing personal, intimate, or affectionate thoughts may seem to the patients that they are giving up those newly formed boundaries that make up a whole self.

Tim asked, "If I let you know that I like you, does that mean that you can come in and do anything you want to me?" His therapist explained that valuing him precluded her doing anything that would not support his growth. Tim responded, "Are people really like that?"

Toward the end of therapy, patients may wish to define and discuss the nature of the therapeutic relationship. Each relationship is unique. Patients who have worked very hard and shared pain and personal feelings may ask, "Can I love you?" "Do you love me?" They experience the relationship as a loving one.

Therapists will choose to answer this question in different ways. Some therapists feel that loving has no place in the therapeutic setting (Miller 1984). It would certainly not help patients for the therapist to attempt to replace the love missed in childhood or to substitute love for the working through of therapeutic issues. However, Freud said in a letter to Jung, "Psychoanalysis is in essence a cure through love" (Bettelheim 1982, p. iii). In

the unique relationship of psychotherapy, therapists and patients may achieve aspects of the definition of love as defined in this book. They become two whole, separate persons who respect each other deeply. They share the development and expression of the patient's real self. However, the limits provided by the therapeutic relationship ensure that the relationship does not go beyond its stated therapeutic purpose.

WHAT IS LOVING SOMEONE ELSE?

Dan said to me, "My new girlfriend said that she was in love with me." He felt confused as to how to respond. He brought his dilemma into the therapy hour by saying, "What is love, anyway? Is it something that is supposed to come along and hit me between the eyes? I have experienced that. It feels like a head-on collision with someone else that is out of my control. Soon it runs into trouble. If that is what it is, I don't need it. I don't feel that with my girlfriend. I told her that I felt warm and happy when I was with her, and that I loved to talk with her, but I refuse to say I love her until I understand what that means. At least, I can be honest."

Lucinda thought love was "being totally open and honest, telling everything as if my life were an open book." Then she asked, "If my boyfriend refused to do that, does that mean that he doesn't love me?"

Both patients were referring to past experiences with symbiosis and

current unresolved relationships. They felt a strong pull to be together, to be completely open (as if there were no separate boundaries), and to meet the other person's needs. The expected result is eventual unhappiness. Real loving is instead a commitment that builds much more slowly from a friendship, with much quality time and frequent, consistent interaction together.

OEDIPAL ISSUES

In many cases, the identification, analysis, and working through of maternal and paternal commands will be sufficient. However, there are a few cases in which an additional issue needs to be addressed. Patients may ultimately achieve some measure of autonomy, but something still stands in the way. The issue that blocks their exit from psychotherapy is often an oedipal one.

In the literature, therapists have argued that oedipal issues cannot exist until there is a sense of a separate self and the achievement of object constancy. If this is true, impinged-upon adults may have achieved just enough wholeness to deal with, and be affected by, both separation-individuation issues and oedipal issues concurrently.

Some parents are seductive and flirtatious as well as undermining. Their offspring are tantalized with the nonverbal invitation from the parent of

the opposite sex to a sexual relationship that is never consummated unless there has been overt sexual abuse. These patients thus have an additional reason to stay home and strive for perfection: to win illusive forbidden sexual rewards and replace the parent of the same sex. These patients get stuck at the oedipal level trying to achieve the love in a sexual way they feel they never got as a younger child because of the enmeshment.

This issue comes up for both male and female patients. Some of them have stayed home for years, aborted college plans, or passed up dates to win a romantic relationship with the parent of the opposite sex. If they do manage to marry, they usually find a way to spoil it so that they can return home and remain romantically faithful to their parent.

Oedipal issues and enmeshment issues complement each other. A mother and a son have a relatively easy time setting up such a relationship when the father is in the background commanding that the son take psychological care of the mother. Maternal commands 2 and 3 serve to validate the oedipal issue.

If these romantic feelings are transferred to the therapist, the psychotherapy will be unduly prolonged unless this particular issue is confronted and worked through. Even when properly addressed, it often takes a long time to free patients to turn their romantic attention to a more

available partner. Patients, who do not understand their romantic attachment to their therapist, have learned to wait tenaciously and indefinitely for their reward. The parents of such patients have done nothing to help the patients resolve this issue appropriately because the patients' romantic faithfulness is in the service of the enmeshed relationship. The patients are caught without being able to fulfill their needs for a loving and sexual partnership in life.

When patients do resolve the oedipal issue enough to have their own sexual partner, they tend to have nightmares about "killing" their opposite-sex parent and feel extremely guilty about abandonment. Thus, in the final analysis the patients return to the separation-individuation issue.

The following dialogue is an example of separation and oedipal issues occurring within the same therapy hour.

Dan, an older banker, began his therapy hour by saying that his mother had telephoned to inform him that she would be coming to see his new house. He had not given any response because he hadn't known what to say. In the first part of the hour, he addressed separation issues:

"I resented not being asked. I resented that she did not even consider that I might not want her to come. She has never seen where I live, and I don't want her to see it because she will be critical and sabotaging of the life that I have built for myself.... I feel like I would be taking care of her, and I don't

want to do that for more than a long weekend."

Next he turned to oedipal feelings:

"But in a way, I do want her to come. I am afraid that she will like everything I have done and then I will feel strangely disappointed and angry with her for doing that. I would want to pick a fight with her. If she liked everything about my life, I would take that to mean that she didn't really want me to come back home and be the center of her life. ... I feel really confused. I guess there is no right way for Mother to be with me. Maybe I do want her to visit. At least that will give me fresh information to figure this out."

The enmeshment issue must be dealt with first, followed by the emergence of the oedipal issues. For a time, the issues intermingle because parents will often use the myth of self-righteous perfection to lure patients into a romantic relationship that can never be really satisfying. These patients are encouraged to think of themselves as special, as somebody perfect-as long as they stay home with the parent of the opposite sex. The implicit message is that if perfection is achieved, the reward will be sexual union. The patients strive for the perfection but never obtain the sexual union. This leaves patients extremely confused about who they really are.

Laurie was considering a new dating relationship instead of continuing to battle the oedipal issues with her father. She described her new boyfriend

as handsome and “the kindest person” she had ever known. Yet she doubted the value of any relationship because “no one was perfect.”

I presented the following analogy to Laurie: “It is as if you had been climbing a mountain all of your life. It is so high that the top has always been in the clouds, but you are determined to get there [oedipal union with her father]. You come to me [the therapist], and I challenge your climb and invite you to consider staying in one of the beautiful valleys [boyfriend]. You like the valley but it is not perfect. You keep looking over your shoulder at the top of the mountain. You’ve even considered climbing the neighboring peak (transferential relationship with me). You are reluctant to give up that climb.”

Laurie strongly confirmed my analogy and added, after a pause, “It would be so nice to think that I didn’t have to make it to the top. It has taken so much time and energy. Yet, I’ve gone this far; it is hard to give up.” I inquired, “What is getting to the top?” Laurie replied, “I can’t see it clearly; as you say, it is in the clouds, but I think it means being crowned the most special, like a queen, getting to live a romantic perfect life where I am taken care of.”

After considerable working through of this issue, and after she had been dating a man she was very fond of, Laurie reported the following dream: “I was climbing up a vine on the outside of my father’s house to his bedroom on

the third floor [oedipal conquest]. My boyfriend was climbing with me. When I got to the window, my father refused to let me in [abandonment]. I was faced with climbing down again. I was very scared."

Laurie was on her way to facing abandonment from her father and resolving both her separation-individuation conflict and her oedipal conflict.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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