Work in Progress

Dysfunctional Families and Wounded Relationships – Part II

Irene P. Stiver, Ph.D.

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Dysfunctional Families and Wounded Relationships — Part II

Irene P. Stiver, Ph.D.

About the Author

Irene Pierce Stiver, Ph.D., is Director of the Psychology Department at McLean Hospital, Belmont, Massachusetts; a Principal Associate in Psychiatry at the Harvard Medical School; and a Visiting Scholar at the Stone Center, Wellesley College.

Abstract

This paper will discuss a number of different strategies which people who grew up in dysfunctional families used to stay out of relationships. Alcoholic, incest survivor, and Holocaust families provide contexts to explore some important features of these strategies. They will also illustrate how secrecy, the emotional inaccessibility of parents, and parentification of children often significantly hinder the development of authentic relationships both in and out of the family.

This paper was presented at a Stone Center Colloquium on November 1, 1989.

In a previous paper, "Dysfunctional Families and Wounded Relationships — Part I," I reviewed several characteristics of dysfunctional families, namely secrecy, emotional inaccessibility of parents, and parentification of the children (Stiver, 1990). Three different dysfunctional family contexts — Holocaust survivor, alcoholic, and incest survivor families — illustrated how these characteristics contributed to major disconnections in the children growing up in these families.

Jean Baker Miller's paper on "Connections, Disconnections and Violations" has given us a new vantage point to understand how family dynamics contribute to pathological development of children (1988). Let me summarize briefly the key processes which Miller believes lead to signficant disconnections in dysfunctional families.

Disconnections

When the child's expression of her thoughts and feelings is not heard nor responded to, when she feels that how she is or what she expresses has no impact on the important people in her life, when she experiences a profound sense of powerlessness in her relational interactions, and when her painful feelings cannot be shared with another person, there are profound consequences, in a marked erosion of trust, in the impaired capacity for empathy, and a lack of empowerment.

Most importantly, a child growing up in these nonrelational settings learns to alter her inner sense of herself in the attempt to deal with the images imposed on her by others. She also attempts to adapt her self-image to her understanding of the meanings of the neglect and/or violations she endures from others. More and more of the child's experience is split off or "walled off," leaving her with a constricted and negative image of herself and others.

In these dysfunctional settings, children learn how *to stay out of relationships* while behaving *as if* they are *in* relationships. They do this as the only mode of survival. For these children, exposing their vulnerabilities through being authentic and empathic in interactions with others is dangerous. This danger leads them to develop strategies to hide their vulnerabilities and, thus, to avoid more genuine relational connections. At the same time, a compelling need for some kind of connection to another person often results in destructive and wounded relationships.

Staying out of relationship

In this paper I will explore these strategies of staying out of relationship in the context of the same three dysfunctional families I discussed earlier. There are many ways not to participate authentically and mutually in relationships. For example, there are those who manage through withdrawal and avoidance or over-investment in work to maintain distance from others; or those who become phobic and restrict and constrict their range of functioning and thereby limit their contacts with others; or those who develop somatic symptoms which totally preoccupy them, leaving little energy or available emotion for interpersonal relationships.

However, I will focus on the particular strategies developed by those who make strenuous efforts to make connection with others, but remain unable to engage interpersonally in a genuine and empathic fashion. Although these people are not always aware of the discrepancy between the wish for connection and the nonrelational qualities of their interactions with others, they report that underneath they often feel crazy, isolated, and out of touch with those around them. Some people feel a generalized level of anxiety and unease without knowing why. Others are much more aware of their dissatisfaction with their relationships and are more or less in touch with the source of their distress; many come into therapy as a consequence of this awareness.

One adult child of an alcoholic family reports:

> Our whole life was an illusion. We looked like the all-American family, we had upper middle class income, we had people who came over to the house, they weren't friends but they looked like friends. I was on the swimming team, my sister was a cheerleader, but if anybody had taken the time to look at any of us, none of us had any intimate relationships or ever talked to anybody about how they felt...we were chameleons, put us in a situation, give us five minutes to watch the players and we adapt....we will always feel outside of it but we can present ourselves however we need to present ourselves in order to exist. (V., 1987, p. 39)

Another adult child said, "I was addicted to having a relationship where I was in control; I was addicted to having somebody but not being *in a relationship."* She added, "Those are two different things" (V., 1987, p. 11).

I suspect that gender differences may be significantly associated with the different ways used to stay out of relationship. That is, women from dysfunctional families probably make greater efforts to stay in connection than do men, albeit often through superficial and nonauthentic modes of placating and accommodating others. Men from such families may more often take routes of avoidance, compulsive activity at work or sports or the like, and make fewer efforts to establish connections.

Strategies

I will now describe three broad categories of strategies which I believe are expressed in different ways in the three family contexts I have chosen to examine. They are (1) various forms of emotional disengagement which include the extremes of "psychic closing off" (Lifton, 1968), dissociative states, as well as the use of substances which numb affect; (2) role-playing which refers to assuming a persona, a style of performing which seems adaptive and appropriate, but is not experienced by the person as authentic; and (3) replication of old interactions and family dynamics which are compelling and unrelenting.

These categories obviously do not cover all possibilities, and they overlap to some extent. I think, however, that they help to illustrate how secrecy, the emotional inaccessibility of parents, and the parentification of a child in a family often significantly hinder the development of empathic capacities, self-worth, and a sense of empowerment in relationships. The message explicitly or implicitly given to the child is that she is not allowed to be authentic.

Although the children growing up in these households experience considerable pressure to stay in the family and not to move out into a world labeled as dangerous and hostile, relationships in the family are more illusory than real since there is a lack of mutuality in sharing affects, information, understanding, and caretaking. The resistance to leaving the family is powerful for many reasons. The

parents often have an enormous investment in keeping their children at home to respond to the parents' needs and because they are so fearful of the dangers outside; and the children are afraid that they will be unable to function outside the family because of their profound self-doubts, shame, and need to maintain the family secrets.

Some children try to resolve these issues by leaving home at very young ages, either by running away or getting married very young. However, their emotional investments, worries, and preoccupations often remain with family members, leaving little energy to engage in relationships they attempt to establish with others outside the family. They find ways to hide their vulnerabilities and placate those on whom they depend for any relational connection, in order not to be further assaulted, terrorized, criticized, humiliated, and shamed.

Emotional disengagement

I described the parents in all three families as relatively split off from their own feelings which contributed to how inaccessible they seemed to their children. The children soon learned to limit their own emotional expressiveness out of despair when no one responded and out of terror of the consequences when they did express any feelings. Typically, parents were described as flat, affectless, depressed and depleted, with very low tolerance for affective expression by others.

Particularly distressing to many of the children in these families were the outbursts of rage and episodes of violence, especially since they often occurred out of context, in affectless settings. This has been noted in many Holocaust survivor families, and certainly in alcoholic families when the alcoholic is drinking. In incest survivor families, the intensity of the father's sexuality and sometimes his physical violence, as well, are especially dissonant to the family's style of presentation to the world.

Children growing up in these homes develop little tolerance for their feelings. They learn not to attend to their inner experience, to doubt its validity. With even more serious consequences, they believe emotions are dangerous. Children often do not understand the context in which emotions develop. The possibilities to misundertstand are compounded in families whose emotional life is unpredictable and punctuated by violence and abuse, and further complicated by these families' keeping their chaotic and painful reality a secret from others. In such family contexts, children do not feel safe to show how they feel — not even to themselves — and they are left to bear their feelings in isolation. It is not surprising that their emotions go underground, are numbed, split off, and unacknowledged.

One of the most common consequences of growing up in an alcoholic family, is the use of alcohol to deny pain and numb feelings. Alcoholics often report how much alcohol enabled them to adapt to social situations and to look friendly and happy despite their enormous self-doubts and inability to engage authentically with people. The apparent happy conviviality in many bar rooms or at parties with a high consumption of alcohol belies the underlying feelings of loneliness and isolation among the participants.

The "blackout" phenomenon, in which an alcoholic seems to be participating with others and actively engaging in conversation yet has absolutely no memory of the experience moments later, serves as a kind of metaphor for disconnection; the use of alcohol or drugs can present the illusion of connection, while the person continues to be shut off from authentic feelings, unable to relate to another person.

In the incest survivor family, the young child is overwhelmed by the physical and emotional sensations too intense to be assimilated. This is the beginning of her belief that feelings are dangerous and easily get out of control. We know that one of the major strategies these children develop very early is to split off their feelings and dissociate from their inner experience and what is going on around them. It is the extreme illustration of behaving as if one is present while one is in fact absent, prohibiting any engagement with others.

Some women with a history of incest can identify the moment when they psychologically left the room, the situation, the relationship through focusing on a patch of wallpaper, a pattern in the ceiling. One incest survivor in talking about finding an object in the room to fixate on when she was molested, poignantly describes how she so often felt *out of relationship*. "I have total recall of the most intimate details of different rooms I've been in. I can't remember who I was talking to or what we were talking about, but I sure can tell you exactly what the windows looked like!" (Bass & Davis, 1988, p. 45).

The experience is enormously complicated because the young girl sometimes needs desperately to hold on to the relationship with her father — it may be the only one she has. At the same time, she needs to remove herself emotionally from any engagement with him, which is at once so stimulating and so threatening.

The extreme end of the dissociative continuum is the development of fragmented selves which is called the multiple personality. A person with multiple personalities dramatically demonstrates the ways in which one can behave as if one were in a relationship and yet stay out. Typically, the abused child has split off different facets of her experience (e.g., her anger, sexuality, depression); also the multiple personalities may reflect significant figures in the child's life.

These different personalities can engage momentarily with another individual with more or less enthusiasm and interpersonal responsivity. In the face of any threat of a closer connection and/or the potential of stirring up painful feelings, the more "friendly" personality quickly disappears and a more combative or more withdrawn person appears. At the beginning of therapy, the many personalities usually are cut off from each other, and there is minimal communication which keeps "everyone" isolated and alone despite the profusion of "characters." The major goal in therapy is to help these different personalities begin to connect, to know about and listen to each other.

Incest survivors also use a range of other strategies to stay out of relationship, including substance abuse to numb their experiences. We know compulsive eating is another frequent symptom. The terror of being exploited in relationships and the simultaneous inability to stay away from relationships often result in nonauthentic presentations which are experienced as very dissonant and disingenuous. One woman reported, "My facial expressions didn't match what I said. I was always grinning. I might be down in the dumps, three feet depressed, but I kept smiling no matter what, so the outside world wouldn't know how much pain I was in, couldn't guess my secret. That way they wouldn't fuck me" (Bass & Davis, 1988, p. 197).

Among the children of Holocaust survivors, a very common theme is the need to hide from their parents any sign of their unhappiness and distress; paradoxically, they also experience a deep sense of guilt about not suffering enough. A 40-year-old woman whose parents were both Holocaust survivors recalled that in her adolescent years, when she would come home unhappy and troubled, her mother would look at her face and then abruptly turn away from her; she felt erased at those moments, ashamed of her unhappiness, and very alone. She also developed a very engaging social manner, cheerful and bantering, because she could not believe that any one would want to know or be able to tolerate any expression of her more painful feelings.

Role-playing

This term covers a range of behaviors which reflect efforts to please, control, and gain the attention of significant others. Role-playing may be more or less pathological as a function of how rigidly and how pervasively it is played out — how nonauthentic, how disengaged, and how nonreciprocal the behaviors are.

When children learn that they must hide their own experience and feel powerless to have a genuine impact on the other important people in their lives, they soon disbelieve their inner experience, disregard it, and behave according to what they see are the expectations of others; or they learn how to "manage" or "control" others to gain some response from them. Further, in those families in which denial is a major adaptation, playing a role can serve to sustain the family ideology.

Thus, as they move into adulthood, these children develop a persona which may become so firmly entrenched that it precludes authenticity in relational encounters; an "as-if" quality characterizes much of their interpersonal behaviors. Role-playing can give the illusion of connection and of the presence of a real person when, in fact, the person is basically absent since she is not truly in touch with herself and is so intent on behaving according to others' expectations of her. Role-playing often can become a way of distancing from others. An adult child who is also a therapist writes, "I learned about smiling before I was five...they all would smile back, but they would never see me at all. I could sit behind my smile and watch" (Treadway, 1988, p. 202).

As noted earlier, one of the major roles these children learn is that of taking care of their parents and the family image. This caretaking role often becomes generalized to other relationships as well. When the child is expected to carry burdens beyond her emotional or cognitive capabilities and when the child's efforts are not appreciated, the caretaking is not genuinely felt. Instead of feeling increased self-worth, the child feels worse about herself since she cannot connect good feelings with the caretaking behavior. The way she assumes a parental role involves attending to the other person but not *to the relationship*. The blocking of empathic sensibilities is indicative of the nonrelational aspects of this kind of caretaking.

It is not uncommon to hear from children who grow up in alcoholic, incest, or Holocaust survivor households how dangerous they believe it is to feel for or empathize with their parents or others who demand their care and attention. They fear they will never be free of the burden of caretaking if they allow themselves to truly feel their parents' pain.

Descriptions of alcoholic families emphasize the rigidity of the roles played out and the particular roles which are presumed to be typical in these families. Various writers have identified "the family hero," who is the rescuer, the achiever, the high-level performer — or "the scapegoat," the child who is picked on and communicates that the family is in trouble — or "the mascot," the family clown who creates an illusion of fun to gain attention — or "the lost child," the one who retreats and withdraws (Wegscheider-Cruse, 1981).

Adult children of alcoholics readily identify themselves with one of these roles. I am sure there are many instances in which adult children find themselves shifting among these roles at different times in their lives or in different contexts. What is most relevant is not the particular role, but rather the need to keep oneself in a rather constricted range of functioning in order to deal with the unpredictability in the family.

In maintaining stereotyped behaviors, a person can have the illusion of knowing what to do in any eventuality and avoid any emotional investments. Thus, adult children can feel they are protecting themselves from being caught off guard, terrorized, disappointed, and wounded. At the same time, the role-playing is an attempt to gain attention and some sense of connection with other members of the family.

Incest survivors can also become adept at assuming the caretaking role in their families. Even more than the adult child of alcoholics, the sexually abused child is reported to be excessively compliant and under considerable pressure from many directions in the family to become parentified (Gelinas, 1983; Russell, 1986). Underneath these parentified roles the incest survivor feels inadequate, filled with self-doubt, like an imposter.

In general, children who have been incestuously abused learn through role-playing to present themselves as more sociable, competent, and altruistic than they feel — and especially, to hide the unspeakable secrets of their abuse, the truth about what family members do behind closed doors. Those split-off aspects of themselves that are so ego-alien are often subject to massive amnesia. Their more conventional presentations also represent desperate efforts to placate and please those who have victimized them and continue to intimidate and terrify them. Herman, Russell, and Trocki (1986) state that women with a history of childhood sexual trauma report marked contrasts between high levels of competence and achievement in their working lives and the painfully constricted, isolated, chaotic, and destructive characteristics of their intimate relationships.

Perhaps the most dramatic illustration of role-playing by the incest survivor is the extent to which different selves exist side by side without integration and often without awareness. This is certainly characteristic of the multiple personality, but it also reflects the various degrees of disassociation and altered states of consciousness which are typical coping mechanisms of incest survivors in general. Phenomenologically, the person undergoing these experiences feels a deep sense of unreality. Often she feels as if she exists outside herself as she watches herself go through the motions of interacting and presumably relating to others. The incest survivor feels like a fraud in this process and often does not know who the real person is at all.

One such incest survivor reports that:

> Growing up, I did everything super-right. I was an overachiever. I was an A student all through college. I was a Fulbright scholar in London. I was considered a huge success. I developed a total false personality based on what you were supposed to be, and hid myself. My interpersonal relationships were exchanges of displays nothing more. I got by because of money and status. I knew I was sick. I knew there was something hideously wrong with me. Underneath the false personality was a blankness and underneath the blankness was a tremendous rage. I was sure that if ever I allowed my behavior to manifest any sign of the problems I had inside, everything would crumble entirely and I'd end up in an insane asylum or police lockup. (Bass & Davis, 1988, p. 43)

Children of Holocaust survivors also feel considerable pressure to "perform" for their parents, to hide their true feelings. The most significant finding in a study which researched a sample of this population was the disparity between the inner lives of these adult children and their public presentations of themselves (Kolodner, 1987).

One adult child of Holocaust survivors writes:

> ...to admit to my parents the childish wish to be like everyone else,...to find something positive in the stranger's ways, to doubt and question...those I love who have already lost much too much, required a degree of trust and self-assurance...beyond my reach. The

> superficial smile and nod, "going along to get along" proved to be the easy way of achieving short-term tranquility at the price of long-term discontent and alienation. After a while admitting my own secret thoughts even to myself becomes difficult. (Albeck, 1988)

In one study, many of the respondents described their parents as insensitive or unaware of the demands of their day-to-day life; they saw this as a reflection of the low priority the parents gave to their children's difficulties. One of these respondents said, "There was no empathy or sympathy on the part of parents to what the kids go through in survivor families because compared to what *they* went through, how could you dare to complain?" (Kolodner, 1987, p. 218). It is not surprising that many of these children resisted empathic responses to their parents as well.

Replication

This strategy refers to a compelling and unrelenting need to repeat old traumatic interactions. The notion of replaying past conflicts is hardly new and owes its identification and exploration to Freud's conceptualization of the repetition compulsion (1920/1955). He believed there was a need to recreate traumatic experiences in part to maintain the repression of these experiences and in part as an attempt to master the trauma. He saw the repetitions as essentially self-destructive since they did not lead to gratification or resolution of these conflicts. A more relational understanding of this compulsion would be that these repetitions also operate to keep those who grow up in dysfuntional families locked in the relationships of the past, in their families of origin, and locked out of authentic relationships in their current lives.

The propensity to repeat old behaviors is, of course, not limited to repressed, major early traumata. All of us replay old dramas to some degree; we hold on to patterns of interations that can be traced back in our histories. Much of the work we do in psychotherapy is to link current struggles with these early patterns. However, for children growing up in dysfunctional families, their desperate striving for connection while at the same time defending against authentic interactions with others, contributes to the unrelenting quality of this replication of old issues.

In the alcoholic family, there is the propensity for adult children of alcoholics to become alcoholic themselves and/or to marry another alcoholic. Although the possible genetic etiology of alcoholism may, in part, account for the former, both patterns probably represent replays of the alcoholic family drama (Black, 1981).

A 14-year-old girl came to therapy because of a drinking problem. Both parents and her siblings were alcoholic. She quickly seemed to establish a very positive relationship with her therapist, stopped drinking, and did much better in all areas of her life. The night before a scheduled appointment, she attempted suicide, which took the therapist completely by surprise. Her own explanation was telling. She had become frightened that she did not have a family anymore and didn't belong anywhere. We could speculate that she felt safer returning to old patterns which brought her back into some connection with her family and at the same time protected her from the danger of a new more genuine connection with her therapist (Treadway, 1988). As adult children of alcoholics replicate their early relationships with their alcoholic parents, they can remain in the familiar setting of their families and avoid any intimacy with their spouses who, if alcoholic, are often absent cognitively and emotionally because of the toxic and numbing effects of alcohol.

Worries about the well-being of the alcoholic parent frequently pursue the adult child even after she leaves home and marries. Fear that some calamity will occur if she is not there to prevent it often keeps her out of current relationships with her husband and children. One adult child spoke about her constant preoccupation with her mother's drinking when she was growing up; when she was at school she worried about whether her mother would be on the floor when she came home, whether her careless cigarette smoking would start a fire, and the like. She felt deeply attached to her mother, but in therapy she became aware of how little she ever knew about her, and how distant and unapproachable her mother was. In the same way, she became obsessed with her husband's drinking and her constant terror of what accidents might befall him when he was away from home. She was quite isolated from others; and despite her intense involvement with her husband in her thoughts, she felt very alone and bereft in her life.

The dissociated experiences of incest survivors and people with other post-traumatic stress disorders, are typically re-enactments of the original trauma. Chu (1987) notes that this re-enactment occurs in nightmares, flashbacks in the waking state, and symbolic expressions in day-to-day behavior. When a dissociative episode occurs during a therapy hour, the therapist feels the powerful pull of the actual experience since it is experienced by the patient as a contemporary event. As a result, it is often difficult for

the therapist and client to truly connect as themselves, in the here and now. Chu notes, however, that this process of participating with the client in a replay of the trauma, in a safe relational context, begins the healing process.

The fact that some post-traumatic stress victims represent the second and, sometimes, third generation of violent abuse is evident in their tendency to replay not only their own traumatic past, but the victimizations of parental figures as well. This replay of another generation's painful experiences may allow some incest survivors to experience a degree of connection with a parent, usually the mother. A 35-year-old woman I will call Jane entered a treatment facility for her alcoholism and heroin addiction. She reported that over the past year she had turned to prostitution and put herself in danger in the "combat zone" where she solicited to support her habit. On admission, she talked about her brother abusing her sexually when she was a child and then described a series of violent episodes in her household in which both she and her mother had been battered by her father. Jane was divorced; and as a result of her addictions, her ex-husband was given custody of her daughter whom she rarely saw.

When Jane was 10 years old her mother, who had been a stripper in the combat zone, was thrown out of the house by her father. After that, her father would not allow her mother to come to the house. Jane recalled, however, that on a number of occasions her mother would sneak into the house in the middle of the night, come to her room, and tell her that she loved her. Her mother was tragically murdered by her lover when she was 36 years of age, one year older than Jane was at the time of admission.

Jane expressed her fear that she was "repeating my mother's life." Her life seemed to be consumed with this replication of her mother's victimization, putting herself in danger of being brutalized and murdered, and cutting herself off from any meaningful connection with her own daughter. But she was constantly in touch in some fashion with her mother through this relentless repetition of her perception of her mother's experiences.

Many incest survivors repeat their victimizations, put themselves in dangerous situations, and do not adequately protect themselves from continuous exploitation and violation in their adult lives. If such exploitations and sexual assaults have been their most powerful sources of human connection in the past, it is not so surprising that they would seek similar interactions, even when these put them at risk for repeated traumatizations. And, tragically, these interactions leave these women feeling more disconnected, more wounded, more alone and out of relationship.

Children of Holocaust survivors often attempt to replicate their parents' traumatic experiences. They may have nightmares, often recurrent, in which they are fleeing Nazis and other dangerous, aggressive figures, looking for a place to hide, and feeling helpless about reaching safety. Some of these adult children express puzzlement about the vivid and powerful nature of these nightmares since they do not recall their parents ever speaking of their terrors or experiences.

A therapy experience reported in the literature tells of a woman whose mother was a Holocaust survivor. Her mother had told her that when she first arrived in Auschwitz, she saw truckloads of children dumped into a bonfire and consumed alive; she began to bang her head against a wall in an attempt to kill herself. She wondered, "For what purpose were these children created?" (Auerhahn & Prelinger, 1983).

It was this sense of meaninglessness about the horrors of the Holocaust which haunted the daughter and which she constantly replicated in various forms in her life. For example, she had recurrent dreams of this unspeakable experience which her therapist believed to be her attempt to recreate the emotions that she could not experience *with* her mother. She felt that if she ceased dreaming this, her mother would be left without anyone.

The daughter's dreams represented an attempt to understand, connect with, and help her mother survive. She was not aware of the meanings of her attempts to replicate her mother's history and experienced her mother's alienation, isolation, and depression as her own.

Therapy

Using Jean Baker Miller's model of disconnection and pathological development (1988), I have attempted to explore some of the ways in which dysfunctional families impede healthy growth and development in their children and the strategies these children use to protect themselves from further pain and disconnection. I would now like to consider some of the implications of this model for the therapeutic work we do with children who grew up in these families.

Judith Jordan, Alexandra Kaplan, Jean Baker Miller, Janet Surrey, and I have all been struggling to articulate the ways in which a relational conception of growth and development informs our therapeutic work. We have suggested that mutual empathy and

mutual empowerment are the organizing processes which enable both therapist and client to move in relationship and to grow and change together (Jordan, 1989; Kaplan, 1987; Miller, 1986, 1988; Surrey, 1987; Stiver, 1990).

Jordan has stressed the importance of a change in attitude to guide us in this venture (1989). She notes that as therapists, we need to shift our perspective. Rather than emphasizing issues of control and self-sufficiency, our work should stress relatedness and movement in connection. The attitude therapists bring to the therapeutic encounter is central; it is a point of view, a climate. A relational model of therapy recognizes that both client and therapist will change, that they participate together in the work of therapy.

We all recognize that the therapeutic encounter is not truly equal at several levels. However, empathic mutuality is certainly enhanced when the therapist is ready to expose her vulnerabilities by being responsive and attuned, cognitively and affectively, to what she experiences with her client. This means the therapist is open to change in herself as she acknowledges both to herself and her client that she is intimately engaged in their interaction. The therapist needs to be authentically present, empathically listening; but she also needs to bring her own unique point of view, her own person into the encounter.

In her discussion of the meaning of relationships, Miller noted, "The combination of emotional responsivity and difference allows each of us to add something to the interplay; that's what makes possible the movement, the flow which makes for growth and change" (1986, p. 18). I believe that mutuality in the therapeutic encounter refers to the opportunities for mutual impact on each other, not to the notion of "mutual disclosure."

The client who feels that the therapist is truly listening and trying to understand her experience can begin to move from feeling stuck, hopeless, and isolated. She can change her experience of relationships, at first with the therapist and then with the other people in her life. Surrey believes that it is this experience of mutual empathy which leads to a greater sense of "response-ability" for both people in the relationship (1987). Each person then feels more empowered to act with more energy and courage.

When we consider those features of dysfunctional families which lead to powerful disconnections (namely, secrecy, inaccessiblity of parents, and parentification), we can see how the relational model of therapy provides a new emotional experience. It offers a new context in which the therapist is emotionally present and participates with the client in her experience. It is this accessiblity of the therapist as a real, authentic person who is relatively unashamed and nondefensive about her responsivity and emotionality that offers both a new model and gives the client permission to be more authentic herself.

This accessibility of the therapist is central to empowering a client to dare to speak the unspeakable and, over time, to become less afraid to learn about both her own and her family's secrets. One of the most crucial aspects of a relational model is that it provides the opportunity for the client to have a significant impact on another person. This experience of being listened to, and in that process effecting some change in how the therapist feels and behaves, can help the client feel more empowered in her life. She can become more present herself, more entitled to exist in an increasingly substantial way, and can begin to feel less empty and more alive.

As noted earlier, children growing up in dysfunctional families tend to be parentified so that they are, on one hand, deprived of their own childhood and, on the other, obliged to assume caretaking tasks for which they are not emotionally or cognitively prepared. The therapeutic encounter needs to acknowledge the legitimacy and value of turning to another person for help, support, and care. At the same time, it needs to demonstrate to the client that the therapist is adult and capable and does not require caretaking from the client, at least not in the total and nonreciprocal fashion which prevailed in her family.

This dynamic requires considerable sensitivity in balancing mutual empathy with awareness of some important discrepancies between the roles of client and therapist. I noted earlier that the therapeutic encounter is not equal in all senses and that mutual empathy does not mean mutual disclosure. Just as parent and child can engage in mutual, if not always equal encounters, so too can the therapist and client. It is very important, then, not to burden clients with therapists' personal concerns. For those who grew up in dysfunctional families, therapy may provide their first experience of not having to worry about, to take care of, and to a large extent be responsible for the important people in their lives.

As therapists, we need to be alert to the kinds of conditions which lead to disconnections. We can then help our clients recognize the extent to which family secrets, the inaccessibility of their parents, and their early parentification have contributed to their fear of intimacy and their struggles to stay out of relationship

in a variety of ways.

Equally important, we need to help our clients see that we know how desperately they want to be in connection despite their avoidance of more authentic and growth-promoting interactions. It is very meaningful to clients when they know that their therapists appreciate that at some level they want to feel, to be in relationship, and to move from their isolated, lonely states in life.

The most powerful confirmation of this observation is the enthusiasm, often exhilaration, which people experience when they join others struggling with the same issues in self-help and therapy groups. The growing popularity of these groups speaks to how strong are the yearnings for the validation and support they can offer (Gartner & Reissman, 1984).

We also need to be very aware when we begin to work with people from dysfunctional families that they may appear to be much more engaged with us than they can, in fact, experience. The more we are misled in this way, the more isolated and disconnected will our clients continue to feel. Often they are quite unaware of the source of their disquiet and continue to feel misunderstood. Many such clients leave therapy, confirmed in their belief that no one can help them and that it is their fault. In pursuing these themes in my own work, both my clients and I are sometimes surprised at how long and how profoundly isolated they continued to feel in the face of apparently productive therapeutic work.

Earlier I referred to the value of self-help groups and their role in validating the basic need for connection. These groups can offer a powerful adjunct to individual psychotherapy. Over the past 10-12 years there has been an explosion of these groups. Many are modelled after the oldest and enormously successful self-help group of Alcoholics Anonymous. Begun in 1935 with a handful of participants, the organization now consists of well over a million members.

As one reviews the basic tenets of AA, it is apparent that they describe a highly relational model which recognizes the importance of asking for and giving help to others and the power of talking to others who can understand and validate one's experience. It is no small matter that alcoholics for many years found much more help from AA than from the more traditional therapists who often have been strongly resistant to appreciating the importance and value of AA.

For each of the types of dysfunctional families discussed here, self-help groups have offered a very important therapeutic contribution. The combination of individual psychotherapy and self-help and other therapy groups can increase the benefits of each. Historically, self-help groups have developed at the grass roots level, bringing to the forefront psychological issues that the professional community has not acknowledged and often minimized and misunderstood.

The emphasis in traditional theories on intrapsychic processes with a minimization of the recognition of the power of real life trauma, is evident in the negative therapy experiences reported by many adult children of alcoholics, Holocaust survivors, and incest survivors. The mental health profession has consistently resisted and, even worse, often disbelieved both the reality and importance of reports by the victims, themselves. Those writers, professionals, and survivors with great vision and courage who began writing about extreme trauma were largely ignored in traditional mental health settings (e. g., Armstrong, 1978; Black, 1979; Brown, 1974; Butler, 1978; Cork, 1969; Epstein, 1977; Herman & Hirschman, 1977; Krell, 1979).

The women's consciousness-raising groups which evolved in the 60s and 70s empowered many women to resist and challenge the prevailing social and political climate. This climate operated like a major dysfunctional family hindering women's growth and development. It has been out of these experiences that women, and men who have been victimized as well, have formed self-help groups and written about their experiences. Their stories forced our attention to the ways in which they have been deeply wounded by their families, society, and the mental health profession. Certainly, this is most striking for those women who have been sexually abused. Over the past 10 to 15 years, personal accounts of such abuse have reached wider audiences. Professionals, sometimes with their own histories of sexual abuse, have reframed individual, group, and family treatments.

Adult children of alcoholics have also been ignored, despite the pioneering work of professionals such as Black and Brown who as early as 1979 were emphasizing the significance of this population (Shah & Reese, 1979). They identified the need to form special therapy groups for adult children which would address the specific problems they faced. At the grass roots level, there were 14 registered adult children groups in Al-Anon in 1982; by December of 1983 the number had risen to 194 (Cermak, 1984); and by 1987 over 900 groups had formed (Krovitz, 1987). Only in the last few years has the mental health profession begun to attend to this population — after enormous

resistance and skepticism.

Children of Holocaust survivors tell the same story. The power of growing up with parents who had been through such unspeakable horrors went unacknowledged by the mental health community until recently. Self-help groups for children of Holocaust survivors formed primarily through their own efforts. However, there were some professionals, themselves children of Holocaust survivors, who formed some therapy groups or facilitated self-awareness groups in order to establish a setting of community, understanding, and an opportunity for mutual help.

In 1977 a journalist and a child of a survivor, Epstein began a quest for her own growth by interviewing other adult children of Holocaust survivors. The communications in this process proved continuously exhilarating to both Epstein and her interviewees. When the *New York Times Magazine* published an account of these interviews in 1977, Epstein was astounded at the response. Hundreds of letters poured in from others who were moved and felt less alone as a consequence of reading her stories. Only then did the professionals begin to take some notice.

Family therapy is considered by some professionals as the therapy of choice with dysfunctional families. I feel less qualified to speak about this since I am not a family therapist. Yet I have certainly learned from those family therapists who have been open and creative in their work with alcoholic, incest survivor, and other families in which violence is a central theme. Innovative approaches such as intervention in alcoholic families (Johnson, 1980) and disclosure techniques in incest families (Schatzow & Herman, 1988) have broadened the horizon further. Recently, feminist perspectives on family therapy have raised our consciousness about the degree of gender bias still existing in all therapeutic approaches (Luepenitz, 1988; Goodrich et al., 1988).

Certainly, family therapy has not been exempt from blaming the victim. There are still those family therapists who believe that the mother acts in collusion with the father's incestuous relationship with the daughter, and that the daughter needs to take responsibility for her seductiveness. Many therapists who work with alcoholic families continue to resort to pejorative labeling of the nonalcoholic members as enablers and controllers, which misses the point of how much they hold on to some form of connection, sometimes at great cost to their own integrity and personhood.

There is less written specifically about family work with Holocaust survivors; but here one also sees two predominant therapy models. Some family therapists see their task as helping the parents to become less protective, and the children to "separate / individuate." Other therapists recognize how important it is for family members to see each other in context — appreciating the meanings in these families of those "overprotective" mothers, for example, and the children who have trouble leaving home. As one child of a Holocaust survivor said, "When my mother separated from her mother at Auschwitz, her mother went to the left to the gas chamber, and my mother went to the right (and was saved)...how could I possibly do anything like that?" (Danieli, 1985).

Whatever therapeutic interventions are used, the task usually takes time, patience, and tolerance of unbearable affects. In preparing this paper, I read many accounts of victimization and violation and reviewed my own clinical experiences of similar accounts. It was extraordinarily painful. I could not always sustain my concentration. I would stop in the middle of a passage and have to get up and walk around. Sometimes in a therapy hour I found myself holding my breath, overwhelmed and overpowered by the pain. Hard as these experiences were, however, and despite my need to flee from them episodically, I knew that each time I had moved a little further in my sense of community with others. I felt more enlarged inside and paradoxically more hopeful that movement and change could continue to occur between me and my clients and my comrades.

Finally, I believe that the particular mode of therapeutic intervention is less the issue than the need to rely on more than one therapeutic resource. A relational model would indicate that both client and therapist need to find larger opportunities and settings for connection, support, validation, and empowerment. The therapist needs to connect with her colleagues, to talk about the work she is doing, or to speak with another therapist who is working with the same client in another modality, or perhaps to form a self-help group for therapists working with dysfunctional families. Some of this is already going on in small ways and making large differences.

Therapists need to join together and resist holding on to points of view or practices which do not feel congenial to our experience; we need to try to move into new arenas and consider less popular positions. This means, of course, listening carefully to our clients and the stories they tell and write about their own experiences. We can do this as long as we

come together in conferences like this, where it is safe to explore and raise our consciousness together and thus become more empowered to expand our experience, skills, and ways of connecting with our clients and each other.

Discussion summary

A discussion is held after each colloquium presentation. Selected portions of the discussion are summarized here. At this session Drs. Judith Jordan and Jean Baker Miller joined Irene Stiver in leading the discussion.

Question: How can we help a person titrate her experience and emotions? This could be difficult since there is a kind of contradiction when a person cannot tolerate too much closeness in a relationship, and yet what we're offering in therapy is a close relationship.

Stiver: It is paradoxical in a sense since it reflects the client's struggle between fear of connection and wish for connection. The therapist has to be very sensitive to the client's terror of connection *and* her yearning to be in connection. I think that it is important for the therapist to voice and respect that dilemma. When the therapist can be moved openly by what is going on, something begins to happen because it is so different from the experiences many of our clients had before. However, even when it looks as if they have begun to feel much safer, some clients continue to feel isolated. This startles me sometimes. Yet although the feeling of isolation continues for a very long time, it is not as overwhelming as before. Little by little, the person allows herself to grow more connected. You have to think of it as a process, and the therapist needs to acknowledge both sides of the client's dilemma. It is scary for people who grew up in a dysfunctional family to move into a connection; at the same time, it is what they want so much.

Question: Many adult children fall into a chameleon-like role and adapt to all situations and other people's expectations even after years of therapy. How do you know when you're being authentic, and when not? Even now I wonder is that who I really am, am I really being authentic?

Stiver: If you feel that for many years you have been behaving according to someone else's agenda, and you haven't the habit of paying attention to your own inner experience, then you are not sure what you "really" feel. But when clients begin to feel safe to attend to their experience in a new way, then things begin to change. We all know those wonderful moments in therapy when our clients feel something that is real. It is very hard to define, but those moments occur when these genuine feelings are acknowledged by another person who says, in effect, "Yes, of course! 'No wonder you feel that way!" and, "Isn't it great that you can finally feel that?" It's an amazing process. That's why groups are so useful. You can't do it by yourself. It needs to happen with another person, a therapist or other members of a group who recognize that something has emerged out of your heart.

Miller: It isn't that anyone is or is not authentic. It's a process. We hope to move more to that, and we can only do that in connection with other people.

Jordan: One place that you really can develop authenticity is in the kind of empathic resonance you develop with someone else with whom you can identify. I think the twelve-step programs are so powerful because in them you can develop this empathic resonance with others and in that process develop something like self-empathy, that is, the capacity to bring empathy to bear on yourself, to get to know your own experience.

Question: Many people who grew up in dysfunctional families are constantly judging and criticizing both themselves and their therapists. Do you have any recommendations on how to work with these adult children, who are so judgmental of themselves and so critical of their own voice as well as the therapist's voice? It so gets in the way of moving in therapy.

Stiver: I think you begin by trying to understand how they got to this critical, judging place and look together at where that came from. What emerges is that it is such a replication of old issues. It keeps them in the old family system. Adult children can begin to get gradually unstuck from this critical stance when they see how it reflects, at least in part, their efforts to stay connected with their families and with what is familiar. It also protects them from building a connection with the therapist in a positive way because this connection is frightening and may feel like a betrayal of their families.

The important piece is not to fall into the trap of becoming critical and judging of the client. I think in alcoholic families, there is little opportunity to see behaviors and experience in context. There is much denial, little understanding of their meaning, and little recognition of the sequence of events. Therapy can acknowledge how the traumata of growing up in these families are significant factors shaping the clients' development and their critical, judgmental voices.

Question: How does one deal with timing and interventions with people from dysfunctional families who, because they are so afraid of connection, have various ways, if you will, of entertaining us, talking about the weather, etc.? How do we intervene in those

cases?

Stiver: In a way, by not doing what we think we should do. We worry that our clients won't be getting their money's worth unless there is an interpretation all the time. In fact, however, the relational context is what is central to any movement in the therapy. If people need to talk about things that don't seem so relevant to the significant issues in their lives, maybe that's the only way they know to make some kind of connection. And in those instances, we might try to participate in people's lives just at that level. It may be very meaningful to people if we are truly interested in what they have to say, not obliged to follow our own agenda. It's true, of course, that at times these represent attempts by clients to avoid talking about things they also want and need to talk about. These are judgments therapists are always making: when to go along with the clients' agendas and respect them, and when to begin gently to wonder about how much the people need to keep distance and not look at certain things. It's important that therapists not feel a lot of "shoulds" here which only make both therapists and clients feel guilty.

Question: Since many people from these kinds of families enter into the profession, how does that produce complications for them?

Stiver: I think therapists need to get therapy for themselves as a way of working on these issues. In many ways, people can be much more attuned to a lot of these experiences if they've been there themselves, but I also think they need perspective by having another place to talk through their own experiences and understanding them. That's true for all people who do therapy.

Miller: There is a dilemma for therapists who want to go to some of the self-help programs such as ACOA meetings and are afraid of meeting their clients there. I think we all really need to talk about this together and think about what it may mean for therapists and clients.

Stiver: I think that therapists in general are very lonely people in many ways because of all the demands on us for how we're supposed to be. This often has little to do with how we are. There are very few opportunities for us to have a place to go, to have someone to talk to, where we feel it's safe and confidential. It's especially difficult because of our training. Our participation in mutual-help meetings where our clients may be, can be very hard for the clients. As each client tries to titrate how close to be with the therapist, having the therapist show up at a meeting, may be very problematic.

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