WELLESLEY CENTERS FOR WOMEN
Center for Research on Women
Stone Center

Work In Progress

Dysfunctional Families and Wounded Relationships-- Part I

Irene P. Stiver, Ph.D.

Jean Baker Miller Training Institute
at the Wellesley Centers for Women

(1990) Paper No. 41

Work in Progress

Work in Progress is a publication series based on the work of the Jean Baker Miller Training Institute at the Wellesley Centers for Women. Work in Progress reflects the Institute's commitment to sharing information with others who are interested in fostering psychological well-being, preventing emotional problems, and providing appropriate services to persons who suffer from psychological distress. These publications also reflect the belief that it is important to exchange ideas while they are being developed. Many of the papers are intended to stimulate discussion and dialogue, while others are finished research reports.

Jean Baker Miller Training Institute

Founded in 1995, the Jean Baker Miller Training Institute bases its work on the Relational-Cultural Model of psychological development, which grew out of a collaborative theory-building process led by Jean Baker Miller and her colleagues. The Institute offers workshops, courses, professional trainings, publications, and ongoing projects which explore applications of the relational-cultural approach. At the heart of this work is the belief that the Relational-Cultural model offers new and better ways of understanding the diversity and complexities of human experience. For more information, please visit: www.jbmti.org.

The Wellesley Centers for Women

The Wellesley Centers for Women (WCW) conducts scholarly research and develops sound training and evaluation programs that place women's experiences at the center of its work. WCW focuses on three major areas:

- The status of women and girls and the advancement of their human rights both in the United States and around the globe;
- The education, care, and development of children and youth; and
- The emotional well-being of families and individuals.

Issues of diversity and equity are central across all the work as are the experiences and perspectives of women from a variety of backgrounds and cultures. Since 1974, WCW has influenced public policy and programs by ensuring that its work reaches policy makers, practitioners, educators, and other agents of change.

The Wellesley Centers for Women is the single organization formed in 1995 by combining the Center for Research on Women (founded 1974) and the Stone Center for Developmental Studies (founded 1981) at Wellesley College. For more information, please visit: www.wcwonline.org.

Ordering Information

Work in Progress papers and other publications of the Wellesley Centers for Women (WCW) are available for purchase through the WCW Publications Office. For a complete list of current publications, visit our online catalog at: www.wcwonline.org/publications.

Publications Office - Wellesley Centers for Women
Wellesley College, 106 Central Street, Wellesley, MA 02481
Phone: 781-283-2510 Fax: 781-283-2504

Dysfunctional Families and Wounded Relationships — Part I

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 offers a relational model to explore dynamics in dysfunctional families. Some of the salient characteristics of these families are identified, i.e., secrecy, emotional inaccessibility of parents, and parentification of children. Holocaust survivor, alcoholic, and incest survivor families are used to illustrate different contexts in which these characteristics contribute to major disconnections in the children who live in them.

This paper was presented at a Stone Center Colloquium on May 3, 1989.

In this paper I would like to explore the application of a new conceptualization of psychopathology to an understanding of dysfunctional families. This new conceptualization is based on a relational model of growth and development and is articulated in the paper by Jean Baker Miller entitled, "Connections, Disconnections, and Violations" (1988). The model began with an attempt to understand women's development within our cultural context, an attempt which contrasts with the propensity to pathologize women's experience and behavior in most traditional theories.

The optimal conditions for healthy development arise in those families which create a high degree of mutuality between parents and between parents and children. This mutuality encourages growing children to be expressive of their feelings and needs, so that they can feel heard and can become more and more authentic in their interactions with others.

In the process, the child can then develop more clarity of thought and desire, and can feel free and unafraid of expressing curiosity and interest in the people around her. Empathic skills can grow and develop in such a family context. The child then will feel encouraged to move, participate, and actively engage with others in the world. Of central significance here is the empowering effect on the child when she recognizes that her experiences and behaviors truly have an impact on the important people in her life, who then modify their experiences and behaviors accordingly. The underlying processes in these growth-enhancing family contexts have been conceptualized as mutual empathy and mutual empowerment. These ideas have been developed and elaborated in a series of the Stone Center Working Papers by Judith Jordan (1986, 1987), Alexandra Kaplan (1987), Jean Baker Miller (1984, 1986, 1988), Janet Surrey (1985, 1987), and me (1984).

Disconnections

Dysfunctional families, on the other hand, impede rather than foster growth-enhancing experiences in their children. Instead of developing toward a greater sense of connection with others, the children feel more and more disconnected and isolated. Miller, in exploring the circumstances which lead to significant disconnections, has identified and elaborated a number of key processes.

When a child's expression of her thoughts and feelings is neither 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.

More importantly, a child growing up in these nonrelational settings learns to alter her inner sense of herself to fit with the images imposed on her by others. She also attempts to adapt her self-image to her understanding of the meaning of the neglect and/or violations she endures from others. More and more of the child's experience becomes split off or "walled off," leaving her with a very constricted and highly negative image of herself and of others. In this description of some of the key aspects of a child's development in dysfunctional families, I particularly would like to stress the disempowering effects on the child as she learns that she cannot reach the other person, as she feels powerless to effect or in any way change — that is, have an impact on — the meaningful people in her life.

Miller recognizes a significant paradox in these circumstances. Because the child feels more and more isolated, she tries to establish ways of connecting in the only relationships available but can do this only by *staying out of relationships.* That is, because of the constrictions on self-expression, she cannot fully engage with others in ways which lead to growth and change. Instead, the connections are apt to be static, rigidly programmed, and fixed in place, with little chance of change in all the people involved.

More traditional characterizations of dysfunctional families have used rather static terms, labelling parental *roles*, e.g., the overprotective, the engulfing, the narcissistic, the depressed, or the rejecting mother; the distant and peripherally involved father; or labelling the *type* of dysfunctional family, e.g., the alcoholic family, the incest survivor family, the schizophrenic family, and the like. The major indications of the dysfunctionality of these families have been that the children become "triangulated," have trouble "differentiating," and cannot effectively "separate/individuate" (Luepnitz, 1988).

I would like to use Jean Baker Miller's model of disconnection and pathological development to reframe our understanding of the "dysfunctional family." This formulation involves attending to the particular ways in which relational interactions lead to disconnections in a sustained and relatively chronic fashion. Also, we need to try to identify the variety of ways in which people growing up in dysfunctional environments express these disconnections. Finally, I believe this model of psychopathology will help us to reexamine and clarify our therapeutic interventions so that we can become more effective and more empowering in our clinical work in individual, family, and group psychotherapy.

I will present this material in two parts. Tonight I will focus on a number of themes which characterize those family dynamics which do not foster growth and development in either children or adults. The major thrust of this paper is that growing up in dysfunctional families, 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. The strategies continue into adulthood. The second part, which will be presented at a later date, will focus on those strategies which give the illusion of relational behavior but which are in the service of disconnection and disengagement from others.

Three vignettes

Let me begin with three clinical vignettes which illustrate three different kinds of dysfunctional family contexts, the Holocaust survivor family, the incest survivor family, and the alcoholic family.

Arthur, a 42-year-old, unmarried, and highly successful businessman who appears very warm, charming, and witty, describes a visit "home" over a weekend. Parenthetically, it should be noted that he considered himself and was considered by others to be a very kind and dutiful son who came home frequently on weekends and holidays. In one of these visits he is sitting in the living room watching television, reading a book, and eating peanuts. Opposite him sits his mother, knitting, and talking

nonstop about the meals she made during the week and what she is planning to cook for him that evening. He is barely aware of the content of her conversation — he is "not listening."

He tells me in a therapy session that until recently he was never aware of this dynamic. He had originally entered therapy because he had been in what he believed was a very destructive relationship with a woman, and he could not leave it. What felt most destructive to him was her expectation that he take care of her on the one hand, which was in fact appealing to him, and her distance, aloofness, and unavailability on the other. He was also aware that he had had a series of such relationships and wanted to understand this pattern.

As our work evolved, one of the most significant aspects of his history was that both parents were Holocaust survivors. His mother was the only one in her family who survived; his father, who had succeeded in rescuing two of his siblings, lost everyone else. Arthur was born in Europe, moved to Israel and finally to this country where the family lived in an isolated setting, a non-Jewish community. Neither parent ever spoke of that unmentionable six-year period of the Holocaust, although they did at times talk of their childhoods with highly idealized family images.

Although his mother wept often, it was typically in reaction to her husband's criticism of her or his threats of divorce. His father, on the other hand, rarely showed emotion except for rages when his children were not immediately available to him, and especially when Arthur went out with women who were not Jewish. The latter was consistently the case. The only time Arthur had seen his father "emotional" was when his father's only brother was dying; this image of his father looking so overwhelmed, in such pain, and unable to enter the hospital room, has remained an enormously vivid memory for him. Arthur did extricate himself from the relationship which brought him to therapy, and he was eventually able to become involved with an expressive, warm, and engaging woman. When he brought her home, she was "stunned" to see how no one seemed to relate to anyone else; rather, there was constant bickering or withdrawal by various family members. Her perspective, together with his work in therapy, helped him see and then recount to me that scene in the living room.

He talked then about how he, his parents, and his sister had each avoided close relationships all their lives because it was too dangerous to try to feel for the other person; it felt like unbearable pain. He saw how much he had been isolated in his life, focusing all his attention on taking care of his parents and managing family matters, or stewing about how to get out of a particularly frustrating relationship with the woman he happened to be involved with at the time. He had some male friends but did not discuss personal matters with them. His one area of intense interaction was on basketball courts where he was unusually aggressive and intensely involved at the moment, but he never saw the other members of the team except at the weekly games.

He began to understand more fully his parents' behaviors and his reactions to them; that is, how their behaviors precluded engaging in relationship with them and how his behaviors were reactions to that disconnection. His mother's constant talk about trivialities reflected her struggle to not talk of anything really important for fear it might open up such old and painful wounds; his irritation and intolerance of her "chatter" reflected his deep frustration in trying to connect with her on the one hand and his terror about hearing her true story on the other. His father's rages when Arthur brought home non-Jewish women reflected his deep sense of betrayal by his son, who seemed to him to be joining the outside hostile forces. He was also clearly terrified that he would lose another family member and be left without his son. Arthur's anger and resistance to his father, in turn, reflected his attempts to end the burden of his painful Jewish heritage and to be free to move on in his own life. Understanding this, Arthur realized that his parents really did not want him to get married and "go out of the family" and "leave them"; he also recognized that for years he had believed that he would destroy his parents if he ever left home, went out into the world, and established a family of his own.

Mary, a 30-year-old woman, who had been a very competent office manager, came to see me about terminating her therapy with someone she had been seeing for two years. She felt he was no longer helpful to her. She was discharged recently from a psychiatric hospital, having been admitted for depression and suicidality; in the course of the hospitalization she was diagnosed as a multiple personality.

She had sustained unspeakable sexual abuse from her father, stepfather, grandfather, and others, and had experienced other great personal tragedies which included her daughter's death in a fire. Her grandfather had sexually abused her daughter also. Her appearance completely belied this history. She was very attractively dressed, articulate, and apparently very sure of herself as she outlined all the

logical reasons to fire her therapist. Lively and funny — albeit in a rather ironic and sardonic fashion — she provocatively challenged me to convince her to stay with her therapist. I knew of some events in her current life that were quite sad, and I asked her whether her sadness about these events had anything to do with her decision.

After some convulsive movements, I realized that another personality had emerged. It is extremely difficult to translate into words the power of my emotional reactions to what I saw. I don't think I have ever seen a sadder face. She introduced herself by another name and told me that "she" had never "come out" before; "the others" had kept a tight lid on her lest she upset the "host personality" who would surely kill herself if confronted with the new personality's story.

The story was almost unbearable to hear because it was this personality's profound belief that she had deliberately set the stage for the daughter's death and, in the end, did not respond to her cries for help. It became clear that the wish to terminate therapy rested on her terror that this awful memory was threatening to break through. This had to be avoided at all costs. After I negotiated with her to help her not to carry this burden alone and in such isolation, the host personality returned, still inaccessible in any authentic way, slightly irritable, and anxious to terminate our interview.

This woman had stayed *in* her family in several ways, but clearly in ways that were not in relationship with the family members. Until her hospitalization, she had never disclosed the secrets of the incest history and, even then, did so only through one of the multiple personalities. The host personality had begun only recently to realize some of the horrible realities of her past. Probably she had split off, dissociated herself from her inner experience — her terrors and rage — for some time, beginning at age four when the incest began. Thus, I might speculate that her anguished belief that she had deliberately caused her daughter to be burned to death reflected, at the very least, her murderous rage directed to herself and her child on whom she projected her self-hate. Simultaneously, her experience of overwhelming bodily excitement in response to the family members' molestations was probably split off into the imagery associated with the fatal fire.

Mary had no friends; she was well liked by her colleagues at work, but she had only the most superficial contacts with them. Returning to her family home regularly, almost every weekend, she continued to suffer verbal abuse. Still, she felt obligated to take over major household responsibilities and to take care of various sick family members. But she also stayed "at home" within herself; her "community" was self-contained in all the personalities inside of her. The host personality remained aloof and disconnected from her inner experience while the many other personalities, some of whom represented significant family members, manipulated and contrived various situations which kept her in the dark about her feelings and perceptions and without a sense of agency in making decisions in her life. She had dissociated, split off crucial aspects of herself, and despite her social demeanor, she remained alone, isolated, in despair, and chronically suicidal.

Lucy, a 40-year-old nurse, came to see me because of intense anxiety, increasing difficulty concentrating at work, and fear that she was becoming addicted to some of the drugs she was self-administering; she was also worried about an increase in her alcohol consumption. Feeling that she was highly regarded in her profession, she worked longer hours than necessary and demonstrated great care and concern for her patients. However, she was aware that she was able to stop thinking about them as soon as she left work and did not feel really connected with them.

Recently, feeling more and more burdened in her work, she thought about a career change but felt she was "not fit for anything else." Both her parents had been alcoholic, and both died in an automobile accident when she was 15. Her grandmother had lived with the family. She recalled the many nights she and her grandmother would stay up until they heard the parents arrive home and knew they were safe. While these nighttime vigils were terrifying, because her grandmother would be pacing the floor and sometimes wringing her hands, her grandmother never spoke her fears out loud. Lucy felt it was her job to help her grandmother feel better. Her parents' alcoholism was never mentioned.

As she told of her current life, it was clear that she was replicating this scene over and over again. She had a lover, Joan, who was alcoholic (which she said was an old pattern and that she was always drawn to women who were addicted to drugs and/or alcohol). Joan would spend the evenings going to various bars. Often Lucy came home late at night after working the evening shift to find that Joan was not there. Lucy would roam the streets, driving around to the bars, trying to identify Joan's car in order to make sure she did not drive home drunk. Their relationship was alternately very stormy and intensely close; the closeness occurred during those times when the lover

was remorseful about her drinking and felt sick and frightened. Lucy would then take care of her, would try to persuade her not to drink again, and would feel hopeful for a very brief time that things would improve.

Trying through drugs and alcohol to numb herself from the pain of feeling disconnected, isolated, and unable to have any impact on her lover, Lucy was terrified of another major loss. This numbing of herself also kept her out of any danger of getting into a relationship. Through caretaking of others in general, and Joan in particular, she stayed out of real engagement, but she felt less alone. Through pursuing Joan at night, Lucy attempted to control a situation from the past which had been out of her control; all the pacing, staying up at night, and hand-wringing had not saved her parents from, in effect, killing themselves. She tried over and over to replay the old script and protect her lover from a similar fate.

As a consequence, she also "stayed in her family" through repeating an old family drama which kept her connected, in a sense, with her grandmother who was with her as she roamed the streets, and with her parents as she continued to worry about someone in the same way she had worried about them. Thus, she remained stuck in an old dynamic, unable to see how sad, angry, and alone she truly felt. Through our work, she became more aware of the replication of the past, and she was able to understand better the source of her anxiety attacks. She was then able to *move*, to become empowered in her life; she joined both AA and Adult Children of Alcoholics (ACOA) groups in which, for the first time, she began to feel truly connected with both her inner experience and with other people.

Commonalities

As noted, these three vignettes represent three different dysfunctional family contexts: They are all contexts in which growing children cannot have mutually empathic relationships, but in which children behave as if they are related. These families were organized to maintain silence and secrecy and to deny reality, i.e., the actual events of the Holocaust, the incest, the problems with alcohol; in all three, the children were placed prematurely in positions of parenting and responsibility that were not effectively reciprocated. Unable to share their experiences and their inner worlds with their children, the parents were too preoccupied, too split off, too depleted, or too much compelled by their own needs to be responsive to their children — and to the children's need to know their parents. In all three instances, the message to the children was that they were expected to stay at home, remain in the family, take care of their parents, and not go out into the world. They all felt that their wish to make connections outside of their families was a betrayal and an abandonment of the people they most wanted to love them.

The degree of dysfunctionality in these and other families clearly will vary along a continuum, and some of the children will emerge as adults with more resilience than others. Interestingly, recent research strongly suggests that "relational variables" are the major factors contributing to resiliency in children growing up in families characterized by poverty, marital discord, desertion, divorce, parental alcoholism, and mental illness (Werner, 1989).

In addition to temperamental differences among children, evidence of a close bond with at least one caregiver and few prolonged separations from the primary caregiver during the first year of life operated as strong predictors of resiliency in the children even 30 years later. Interestingly, even the "temperamental variables" are "relational" in nature. That is, the "resilient" children very early elicited positive attention from family members; these girls were described as "affectionate" and "cuddly," and the boys were described as "good natured" and the like (p. 73). Thus, it is very important not to pathologize all such families. Probably the best index of the degree of dysfunctionality is the extent to which family members develop and hold on tenaciously to those strategies which will continue to keep them "out of relationships."

I will now describe some of the significant commonalities among the families I have chosen to examine here. They can be identified as (1) secrecy in the family — sometimes referred to as "a conspiracy of silence"; (2) inaccessibility of the parents — children have neither permission nor the opportunity to learn and know about them, that is, to be with their parents in inner, affective experiences as well as to gain information about past life and family history; (3) parentification of children — their caretaking of parents and family members is minimally reciprocated. All of these features contribute to significant power imbalances in the family and preclude the development of mutuality in family relationships.

Secrecy

Every family has its share of secrets. However, the pathological effects of secrecy become most apparent in those families that are energetically organized to maintain secrecy about those issues of

crucial importance to family members. The climate of secrecy produces enormous ramifications for how one develops a sense of reality, how one understands and trusts one's own experience, and how one establishes connections with parents and siblings. As we shall see, all of these rest on the potential for establishing authentic relationships.

In the alcoholic family, the secrecy is largely in the service of the family denial of the alcoholism. As one member in an ACOA group said, "There were two rules in my family: the first was 'there is no alcoholism,' and the second 'don't talk about it'" (Brown, 1988, p. 34). The alcoholic needs to deny in order to keep drinking; the spouse and the children need to deny partly to maintain the connection with the alcoholic and partly out of shame. Often the family members' silence about the alcoholic's behavior represents an attempt to protect the alcoholic from others' judgments and criticisms. For the child growing up in these circumstances, there can be significant consequences.

A 50-year-old child of an alcoholic recalls that every evening after supper his father would sit down in front of the TV and begin drinking until he was comatose; no one ever mentioned it or alluded to his father at all in this setting. He learned not to notice, not to "see" a significant reality in his household. Only years later in therapy did he make a connection between that and his inability to "see the whole picture" in a variety of jobs. This inability significantly limited his capacity to solve problems and to succeed. He also became aware of how much he held himself back from close relationships and believed that his feelings and his point of view were too insignificant to be noted or communicated to the other person.

In the incest survivor family, the conspiracy of silence is essential to the continuation of the incestuous relationship. If the father is the perpetrator, he threatens, terrorizes, cajoles, and victimizes the child. As in the alcoholic family, other family members maintain the secrecy and denial in order to have some connection with each other. Characteristically, the father exercises extreme control over all family members so that contacts with people outside the family are minimal, and dependency on each other is intensified (Herman, 1988). Research data (Goodwin et al., 1981) indicate that at least 3l% of the mothers of incest survivors have suffered sexual abuse themselves; their denial of their own fearful pasts leads to their inability to break through the secrecy to acknowledge their daughters' incestuous experience.

Secrecy serves to bond the father and daughter together through terror and compliance, thereby isolating the child further from other relational possibilities (Lister, 1982). The horror of exposure and the enormous guilt and shame contribute to the child's silence and isolation from peers and other adults outside the family. Many incest survivors continue throughout life to have difficulty speaking about anything personal or speaking "the truth"; one woman, entering an incest group with much trepidation, said, "I have the sensation that just as I am ready to talk, a clamp comes over my mouth." Another said, "If I speak about it, I'll betray my family" (Hays, 1987, p. 148).

In the Holocaust survivor family the conspiracy of silence has a very different meaning, but the consequences are as powerful (Danieli, 1980, 1988). The parents have an enormous investment in not remembering and not speaking about the years of the Holocaust. It confronts them with the unbearable pain of traumatic experiences and family losses for which there was never an adequate opportunity to "bury the dead," to mourn and grieve (Krystal, 1968). Learning early in their reentry into life that others could not bear to hear their stories entrenched their conspiracy of silence.

Their children collude in the silence, in part to protect themselves from hearing about their parents' suffering, in part to protect their parents from being confronted again with their pain. A woman in a Holocaust survivor group said, "When I was born, my parents decided never to mention the Holocaust...I would never ask, that was taboo...I didn't want to suffer more either, it was a matter of saving them the agony" (Steinitz & Szonyi, 1975, p. 36).

Of course, despite the secrecy, the silence, and the denial, the children know what had occurred and are left to fill in the gaps of history in their imaginations. But the injunction against "knowing" is so strong they have trouble seeing and hearing. One man spoke of his parents having some remnants of Auschwitz on a shelf: Nazi arm bands, photos, and the like. He said, "I could have gotten them if I wanted to but I knew I wasn't supposed to know, so I pretended I didn't" (Epstein, 1979, p. 168). Another woman felt sometimes that her eyes "would fall out," and she would be unable to see; sometimes when her mother spoke, she was confused about whether she had heard her correctly or whether she had said something other than what she meant (Auerhahn & Prelinger, 1983).

Despite the different dynamics around the secrecy which organizes each of these types of dysfunctional families, the consequences are similar. In particular, they interfere with the development of

authenticity and relational capabilities. Parents cannot "see" or acknowledge fully what they are aware of at some level, and they become blind to communications which may threaten to lead them to emotions associated with the secrets.

Secrecy also affects deeply the development of self-esteem. As we know, when there are secrets and when the child is aware of some discrepancy between her perceptions and what she is told, she typically will blame herself for not seeing it "right" and, more significantly, will feel that she did something really bad to make the secret so necessary. Thus, in alcoholic families, children grow up thinking they caused the parent to drink; in incest survivor families, the children think their sexual feelings caused them to be abused; in Holocaust survivor families, the children carry enormous guilt about having an easier life and feel responsible for their parents' suffering.

Finally, secrecy isolates children from the world and disempowers them from moving out of the family for support. Even in the family, relationships are so conditional on maintaining a myth that authentic interactions are impossible. Thus, the *key* result of secrecy is denial of reality and of inner experience — the conspiracy of silence requires all family members to collude to maintain some semblance of connection, but in the process, all members are kept out of relationship.

Inaccessibility of parents

Secrecy certainly interferes with parents' accessibility to their children. Other factors also contribute to parents' inaccessibility. This inaccessibility conveys the powerful message to the children that they, too, cannot present who they truly are and are not free to tell the truth about their experiences in life. Although the parents in each of the families examined here differ in the reasons for their inaccessibility and also in the ways in which this is experienced by children, they all share some significant factors. Many of the parents, themselves, suffer from some degree of post-traumatic stress syndrome (PTSD).

Certainly, that is true of Holocaust survivor families. What has been called the survivor syndrome has many of the classic signs of what we now call PTSD. The parents in these families have been described often as demonstrating psychic numbing, chronic depression, mistrust and fear of the outside world, withdrawal, amnesia, confusion of past and present, catastrophic overreactions to every day changes, and somatization (Danieli, 1985; Krystal & Niederland, 1968).

As noted earlier, at least 31% of mothers of sexually abused children themselves suffered sexual abuse, and we certainly can assume this is an underreported statistic. Thus, many mothers of incest survivors also show symptoms typical of PTSD with various degrees of dissociation, flashbacks, nightmares, anxiety, feelings of detachment, and depersonalization (Herman, 1981; Gelinas, 1983; Herman et al., 1986).

Cermak (1984) and others (Krystal, 1968) present a strong case for classifying the "codependents" in alcoholic families as suffering from PTSD as well. Cermak argues that members of alcoholic families suffer from chronic trauma because for years they have been deeply wounded by the alcoholic's unpredictable, inconsistent, and often frightening behaviors (1984). In particular, he notes that many adult children of alcoholics demonstrate psychic numbing, anxiety and hypervigilance, depression, survivor guilt, and "intensification of symptoms by exposure to events that resemble the original trauma" (e.g., withdrawal by others, explosive outbursts, and the like).

Thus, many of the parents in these families are to significant degrees apt to be inaccessible emotionally because they are split off from their feelings and are substantially limited in what feelings they can experience and express. Intense emotions may break through in nightmares, in dissociative states, and in alcoholic states; also, outbursts of rage or weeping may occur, apparently out of context.

These indications of numbing and restricted emotional experience seriously limit the parents' capacity to be empathic and responsive to their children. In Holocaust survivor families in particular, the children talk about how much they felt they needed to look cheerful and not express any sadness or distress lest they upset their parents. The language they use to describe their parents consistently focuses on how unemotional they seemed. One woman said, "My mother was stunned by solitude," another, "My father was silent, he never talked or showed emotion," another, "My mother was a shadow, my father kept busy," and another, "My mother seemed to be behind a pane of glass" (Epstein, p. 39). One man said, "You know I don't know my parents. I'm 30 years old, and I don't know my parents. They're like strangers to me" (Epstein, p. 209).

In incest survivor families, whatever emotions the abuser does express are apt to be disbelieved or to create terror in the child. Driven by their impulses more than their feelings, the abusers are unable to be either genuinely expressive of feelings or emotionally

sensitive to their child's experience. One incest survivor said, "My feelings don't matter...that goes back to my grandfather saying how good it felt when it didn't...when I was bleeding" (Hays, 1987). Often the mothers in these families — because of their own propensity to dissociate, their desperate need to maintain the family myths lest they be left alone and abandoned, and/or because they are often too depleted to respond inwardly or outwardly — will be unable to express their terror and outrage or to "see" and respond to such feelings in their children (Gelinas, 1983).

In a recent documentary about one woman's struggle to heal after the trauma of incest, we see her return home to talk to her mother after a successful therapeutic experience. She attempts to confront her mother, to ask her why she didn't protect her, why she allowed her to visit with her father when she "must have known" what was happening. I still see the image of the mother in that film, looking completely depleted, without any affect, yet attempting to be responsive somehow to her daughter's pleas. All she could answer was, "I don't know," without emotional expression as if she were barely alive.

I think many of the mothers of incest survivors are very much like that mother: depressed, feeling empty and powerless and completely out of touch with the happenings around them. Herman and Hirschman (1981) and others (Goodwin et al., 1981) report that mothers of incest survivors are significantly more likely than mothers in a control group to be ill and disabled; to suffer from alcoholism, psychosis, and depression; and to have been battered and/or sexually abused themselves.

In the alcoholic family, the alcoholic parent is, of course, most inaccessible when drunk. Children growing up in these families talk about the confusion and anxiety aroused by the apparent presence of their alcoholic parent when he or she was not present at all. Even in the best of circumstances, that is, when the alcoholic is neither violent nor unpleasant, he or she will often not recall what transpired, will make promises that will be denied later, and will be incapable of genuine and consistent affective expression.

One adult child states, "I never know who it is I am responding to. There are so many different personalities: the sober father, the drunk father, the father who is so tense when he's trying to stay off the booze." Another woman says, "I was perplexed by my father's personality changes and wondered how he could always act like nothing out of the ordinary happened the morning after" (Cork, 1974, p. 32). How difficult it is to get any sense of "knowing about" a parent who changes personality style so dramatically and in such an unpredictable fashion.

The alcoholic parent drinks, in part, to become emotionally numb, in order not to feel. This drinking typically results in either a person who is barely present at all, comatose, nonreactive or one who is explosive and rageful, whose feelings are dissociated and later blacked out, forgotten. As in Holocaust survivors, these explosive reactions seem to occur out of context, contributing to fear and confusion in other family members and adding to the experience of the parent as unfathomable.

In addition to their lack of emotional availability and constricted range of emotional tolerance, many of the parents in dysfunctional families are often strikingly uncommunicative about their histories, the important people, and events in their pasts. As a consequence, the children experience considerable difficulty in seeing their parents in context and in empathizing with them and engaging with them. This, of course leaves all members of the family isolated from each other while at the same time deeply entrenched in "nonrelational" interactions.

Auerhahn and Prelinger (1983), reporting a detailed analysis of the treatment of a woman whose mother was a Holocaust survivor, stress how knowing about the history helps give some meaning to both the lives of the living and those who died. This woman recalls how hard she tried, as a child, to preserve her relationship with her inaccessible mother by trying to understand her; she hoped that her mother could be more responsive to her if only she could be less preoccupied with the dead about whom she rarely spoke. The authors note that no matter how devastating the communications about the past might be, they begin to close the gap between parent and child. The healing began in the treatment when the mother's behavior became more comprehensible to the daughter.

The abuser in incest survivor families is particularly difficult to know. The discrepancy between how he presents himself to the outside world and how he appears to the child behind closed doors must be extraordinarily confusing. Abusive fathers often look like model citizens, and the roles they play in the family may be as fluctuating as those of the alcoholic — nurturant one moment, violent and destructive the next (Ganzarain & Buchele, 1988). But in addition to the confusion and cognitive dissonance in attempting to understand these fathers, incest survivors need to defend against knowing more about someone who has stirred up such terror in them.

In both incest survivor and alcoholic families, the past is often idealized largely as a function of the picture the family attempts to present to the community. The children learn not to ask about a past that they know at some level is very different from what it is supposed to be.

Surrey suggests that the need to understand is as powerful as the need to be understood (1985). In all of these dysfunctional families, we see how hard it is for the children to have a sense of their parents and how much this loss contributes to the children's lack of a sense of their own truths and the validity of their own feelings. When parents are unaware of their own emotional experience or have split off essential memories of their pasts or are too preoccupied with just surviving, their children are left with a deep sense of shame about their own feelings. Consequently, they do not feel entitled to their own experience and negate their yearnings to know more about who their parents really are.

Because these parents have so little tolerance for their own experience, they often cannot effectively allow children to convey their experience in general; and, in particular, they cannot take in the children's responses to what they see and feel *in them*. The children are left with feelings of helplessness because they do not believe they can have an impact on their parents; they cannot participate in a mutually evolving interaction. In this context the development of the capacity for empathy can become significantly blocked or impaired. Empathy is a state of "knowing" the other person. As long as the other person is not fully present in all the ways noted above, it is not possible to see or hear him/her in a full, authentic way. And as long as any child does not feel that the reactions from others are responsive to her true experiences, she will learn to wall off aspects of herself; these parts of herself become more and more unavailable to her and unseen by others (Jordan, 1987; Miller, 1988). Thus, inaccessibility makes mutually empathic and mutually empowering relationships impossible; the lack of these relationships leads the child to become removed from large parts of her own experience.

Parentification

In all three of these dysfunctional families, the children tend to assume a parenting role quite prematurely, at least in certain significant areas of family functioning. Parentification offers a striking method by which children can remain out of true engagement with others but appear to be in relationship. Cotroneo defines parentification as "age and context inappropriate expectation for care and devotion from children" (1986, p. 422). Most importantly, she notes that the burden of responsibility which the children assume for the well-being of the parent overrides the children's own entitlement to care and devotion.

Cotroneo appropriately observes that parentified behavior is not in itself pathological because a certain amount of caretaking of others is part of the relationships necessary in a well-functioning family. In learning how to listen and to be responsive to their parents' needs, children develop the capacity to empathize and to engage with others. However, when the caretaking of parents begins long before the child is cognitively and emotionally capable of handling the burdens imposed on her, then parentification becomes destructive. Thus, nonmutual parentification may lead the children growing up in these families to learn very early to split off their own needs and to have little expectation that others will want to know what they are. Despite their yearnings for connections, these children grow into adulthood regarding relationships in general as burdensome and nongratifying. Their interactions with others are, therefore, often characterized by caretaking behaviors but with little access to their own feeling for the other person.

In alcoholic families, one of the "roles" considered characteristic of at least one of the children is that of the "family hero" (Wegsheider-Cruse, 1981), sometimes also called, "the super responsible child" (Black, 1981). This role is often assumed by the eldest child who learns to feel responsible for the family pain and works hard at making things better. Making things better usually involves achieving and performing at a very high level at home, at school, and in extracurricular activities, thus assuring the family that everything is fine.

Outwardly these children look highly successful, responsible, and self-confident, but underneath they feel very frightened, inadequate, and like frauds. One of these adult children described herself as a child as "12 going on 50." Her mother was the alcoholic, and she began at a very young age to make breakfast for the family every morning and to get her younger siblings off to school. She felt she could not hang around after school because she needed to go home and check on her mother.

When the father is the alcoholic, the mother may increasingly turn to her children, often to her daughter, to help manage the household. Some of these mothers become so depressed that they gradually relinquish almost all household responsibilities to their children (Grishham & Estes, 1986).

For incest survivors, the beginning of the sexual

abuse marks the end of their childhood. The child assumes a pseudoadult sexual life and often is encouraged by the father to act as a partner (Ganzarain & Buchele, 1988). As noted earlier, the fathers are very controlling of all family members and often undermine the daughter's relationship with her mother as well as with her peers and others (Herman, 1988; Schatzow & Herman, 1988). The child becomes more and more isolated from connections outside of the family, feels very much alone with her burdens and uncertain about how to understand these responsibilities. Typically, she grows up thinking that these are normal expectations, and there must be something wrong with her to feel overwhelmed by them.

Gelinas notes that in incest survivor families, the abused child often does the cooking, laundry, child care, and the like; but she notes that the role is not of "helper," but one of assuming total responsibility for these tasks (1983). This is partly a function of how much the father has organized the family around his need to maintain the incestuous relationship with his daughter, and partly due to the frequency with which such mothers are absent because of illness, depression, and feelings of their own inadequacy and powerlessness. These children often try to cover up their guilt and shame by preserving the family picture of conventionality; they also feel the need to reassure and protect their parents, who are all they have.

In Holocaust survivor families, children also assume parental roles prematurely, but different dynamics prevail. On the one hand, highly overprotective of their children, these parents try to maintain them in their role as children well into adulthood; on the other hand, they turn to their children to assume many parenting roles. As adults these children feel extremely guilty about moving out of the family and into other relationships. The feel they are abandoning their parents who have sustained so many losses already and have so few people to turn to; often they also see them as incompetent to manage their lives.

Although these parents may take care of their children, the children tend to experience the care as an attempt to influence and control them rather than as responsive to their feelings and needs. Like the family hero in alcoholic families, the children of Holocaust survivors often feel very pressured to succeed. In this instance, it is a way of making up to their parents for all the deprivations. One major area in which these children performed parenting functions was through helping their parents negotiate social situations because as immigrants the parents often felt frightened and appeared incompetent. These children did not so much take on responsibility for household chores as they felt burdened by the need to be supersensitive to their parents' feelings and to protect them from the dangers of the outside world.

These various modes of parentifying behaviors in children growing up in dysfunctional families are destructive insofar as they preclude true mutuality of caretaking among family members. In addition, these behaviors may lead to precociously developed ego skills at the expense of a true sense of mastery through age-appropriate, problem-solving behaviors; the result is that these children have low self-esteem and feel a great dissonance between how they are perceived by others and how they experience themselves. These children, who look so competent and who are so responsible, may experience considerable confusion and disorientation, particularly when faced with a crisis.

One adult child, who was his family hero, reports that when his parents were out drinking, he was expected to take care of household chores and his younger siblings. He recalls an incident one evening when he was around 12 years old. He was cleaning up after feeding the younger children when his brother had a bad accident, banged his head, and was bleeding badly. This family hero panicked because he could not decide which to do first: load the dishwasher or get help for his brother. He felt terrified of being yelled at by his parents for not completing the cleaning up.

Cotroneo observes that in such families the parents often fail to acknowledge the care and devotion that the child gives; rather, they criticize the child for not meeting the family's expectations which are, of course, often inappropriate and impossible to meet (1986). As a result, these children believe that they are unworthy of trust and feel they don't deserve a legitimate place in the family. They all continue to try to please, to achieve, to take care of others, without any sense of their own needs, their validity, or self-worth. The capacity to establish authentic relationships with others under these circumstances must become seriously diminished, and, again, the appearance of connection belies the degree to which children growing up in these families continue to stay "out of connection."

Conclusions

The commonalities in these three types of dysfunctional families — secrecy, inaccessibility of parents, and parentification of children — serve to keep children stuck in the family, with little

permission or opportunity to seek help and connection with others outside the family, that is, with peers or other adults. Secrets demand family loyalty, and the children in these families feel responsible to protect their parents from any exposure of these secrets; the shame that these secrets stir up in the children requires further insulation from the world outside. The inaccessibility of parents through their own restricted emotional experience and expression impacts powerfully on the children. They learn early to restrict their own expressiveness which is either unrecognized or actively discouraged by the parents; and they learn to hide their vulnerabilities from others.

Finally, parentification of children is a major way parents keep children "at home." These children have trouble leaving their parents without feeling guilty. They also are quite fearful that outside the family they will be exposed as incompetent and bad. Yet it is crucial to emphasize that despite how entrenched these families often appear, and how much the parents in these families attempt to keep their children at home, and despite how much they discourage and undermine connections outside the home, the relational connections within the family are based largely on denial, distancing, and role-playing, rather than on authentic, mutual interactions.

The ways in which these family dynamics lead the children to develop strategies of behaving as if they are in relationship while staying out of relationship will be explored further in Part II of this paper.

These three types of dysfunctional families — the alcoholic, incest survivor, and Holocaust survivor families — have been used as illustrations to point to some significant factors which contribute to powerful disconnections in families. We know that these factors exist in other families, too, with various degrees of pathological consequences for the children. I chose these particular types of families because all three factors seem so central to their organization.

Clearly, each of these families varies considerably in degree of constructive and destructive relational possibilities. Research data suggest that some of these families offer a range of typologies with considerable heterogeneity (Danieli, 1985; Kolodner, 1987; Vannicelli, 1989). We know there are those who emerge from these families with great resilience and strength of character. Despite all the obstacles to empathic development, many become highly sensitive, caring people who, in fact, end up in the helping professions.

I think these families offer a structure in which we can reframe the ways we understand family relationships. The three families help us focus on the relational contexts in which children are relatively helped or hindered in their development of authenticity, in their sense of being able to have an impact on others, and in their capacity to be relatively unafraid to receive the reactions of others.

For it is in those contexts which foster authentic relational opportunities that mutual empathy and mutual empowerment can enable growth and enhance the development of all family members. In such families, there is no need to separate/individuate. Instead the children can be empowered by the parents to move out of the family while still remaining connected with family members. When parents are interested in and able to make connections with others within and outside the family, it gives the children permission and freedom to do so too.

In healthy families, children then are encouraged to expand their personal development through their engagement with peers, teachers, and relatives; and they will continue to grow and develop through all the relationships in their lives. For many of the clients who come from dysfunctional settings, our major task is to provide another "family context" which will offer new models of connection in which secrets see the light of day, in which the expression of feelings and needs is encouraged and explored through the mutuality of the therapeutic encounter, and in which therapist and client share the responsibilities for healing.

Discussion Summary

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

Question: You stressed that in incest survivor families, the mother is often depleted and depressed, but you did not say too much about the mother's anger and the effect it has on the child.

Stiver: Well, I think the mother often cannot afford to be angry in these families because she is often a victim, too, in one way or another. She very often is battered, for example, or victimized in other ways. Research data suggest that she may have been victimized in her own family of origin; so she learned very early the dangers of being in touch with her anger and other feelings as well. The message to the child is that it must be dangerous to be angry at the abuser, that her anger is forbidden and can neither be acknowledged nor expressed. In such a setting, to take any position of strength and to move out of danger is absolutely not considered a possibility by

those victimized in the family. I think it's so much easier for the child and others to blame the mother for not being angry enough or supportive enough. It is easier to be angry at the mother than the father who is the abuser because he is a much more dangerous person.

Question: Can you say something more about how to encourage young people to share what is going on in spite of the secrecy in the sexual abuse and alcohol abuse families? How might young people have an avenue to tell what is going on?

Stiver: I think it's really a terrible dilemma for the child who is caught between her loyalty to the family member, who may be all she has, and her desperate need to be able to tell someone what is going on. We know that often where there is the opportunity for disclosure, good things begin to happen; there is a chance to change family dynamics, and very often it may empower the mother to help herself and her child move out of the dangerous situation. At other times, however, disaster may follow the disclosure or confrontation. The child is sometimes seen as the one who's the "trouble maker," and she is accused and may be forced to recant. We have to be extraordinarily sensitive to the dilemma this presents for the child when we are evaluating ways of intervening and helping the child tell her story.

Miller: I just want to say another word about that. It is difficult in the face of these powerful dynamics to find ways to help the child break through the family secrecy. However, the Stone Center is, as you know, dedicated to prevention. We keep trying to seek other ways to make relational contexts in the world that will fortify those children and adults who are victimized in their environments. There's a recent paper by Joan Featherman, who has studied women who have been sexually abused as children. She found that, for some children, having a teacher to have a relationship with outside the family was of tremendous help, even if the children were never able to disclose their terrible secrets. That there was someone else in the world with whom they could be in a relationship made all the difference.

Question: What percent of families are dysfunctional?

Miller: All families are to varying degrees, I would say. The reason is, in a word, patriarchy. What I mean is that our families are not grounded in mutuality. Once you have a power imbalance, where one person can determine what is allowed to occur in the relationship to a very large extent and also has material power, value, and prestige in the world, then you have a set-up for nonmutuality. I think this is central to all we have been talking about. We all struggle in such settings in various ways. In addition, there is the inherent power imbalance between parents and children. That will always be with us. But I think if adults had the possibility to engage in mutual fashion around the key and important issues in their lives, then we would be in a much better position to engage with our children in a more mutual fashion. To the extent that we, as adults, do not yet have sufficient possibilities to participate equally with the other adults in our lives, we will be impaired in engaging with our children.

Surrey: I just wanted to add to that. I think that the absence of a growth-enhancing relational context is abusive in itself. As Carter Heyward has said, the abusiveness that we all experience is not just abusiveness as a result of physical or sexual trauma, but the trauma of not having a relational context of mutuality. We all live in that state of trauma and abuse.

Question: When can a child be taught to respond to her parents' pain? At what point can a young mother let her child know that she is also important and is to be valued?

Surrey: There is never a reason totally to hide one's feelings. I remember a mother who had lost her husband and was very grief stricken. She was trying to hide her feelings from her four-year-old daughter, and it was causing great problems. Finally, the mother was able to let her daughter know about her sadness and cried with her child. She also let her daughter know that she could take care of herself and her daughter. Thus, she was able to share who she was in an authentic way. We keep making the mistake that to be ourselves is to impose on others.

Jordan: Research has been done on the development of empathy which indicates that infants, one-to-two days of age, respond with cries of distress to other infants in distress. They have also found that there are sex differences, and you can guess which babies responded more with distress cries — the girls. So I think part of what Jan is saying is that it may be more destructive and more painful for the child to have what really seems to be a built-in responsiveness to another cut off or clouded by the obscuring and hiding which parents so often do in the service of not overburdening their kids.

Miller: I think, again, the point is that it's very valuable to acknowledge feelings between people. The big concern is that the child should not end up

feeling she has to take care of the difficulty all alone, solve the problems herself.

Stiver: The problems in these families where there is parentification and nonmutuality is that there is *not* much direct expression of feelings by the parent. Rather the child often has the additional burden of trying to interpret what is going on as well as taking care of everyone's feelings. The other point about those families where children take on too much responsibility is that they are not appreciated for their responsiveness and help and, consequently, don't even feel good about what they are doing.

Aside from the families with parentification, it is worth noting that life is tough, and the kids cannot be spared from suffering. I think that's what parents often struggle with, since they feel they have to protect their children; but that leaves children feeling mystified and alone and without a sense of participating in their relationships with their parents. Obviously, parents need to be attentive to what children can take in, cognitively and affectively, in terms of their maturational level of development.

References

Auerhahn, N. & Prelinger, E. (1983). Repetition in the concentration camp survivor and her child. *International Review of Psychoanalysis, 10*, 31-46.

Black, C. (1981). *It will never happen to me*. Denver: MAC Publications.

Brown, S. (1988). *Treating adult children of alcoholics*. New York: J. Wiley & Sons, Inc.

Cermak, T. (1984). Children of alcoholics and the case for a new diagnostic category of codependency. *Alcohol, Health and Research World, 8*, 38-42

Cork, M. (1969). *The forgotten children*. Toronto: Paperjacks, Addiction Research Foundation.

Cotroneo, M. (1986). Families and abuse: A contextual approach. In M. A. Karpel & W. R. Beavers (Eds.), *Family resources: The hidden partner in family therapy* (pp. 413-437). New York: Guilford Press.

Danieli, Y. (1980). Countertransference in the treatment and study of Nazi Holocaust survivors and their children. *Victimology: An International Journal, 5*, 355-367.

Danieli, Y. (1985). The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors and their children. In C. R. Figley (Ed.), *Trauma and its wake* (pp. 295-313). New York: Bruner / Mazel.

Danieli, Y. (1988). Treating survivors and children of the survivors of the Nazi Holocaust. In F. M. Ochbert (Ed.), *Post traumatic therapy and victims of violence* (pp. 278-294). New York: Brunner / Mazel.

Epstein, H. (1979). *Children of the Holocaust*. New York: G. P. Putnam & Sons.

Ganzarain, R. C. & Buchele, B. J. (1988). *Fugitives of incest: A perspective from psychoanalysis and groups*. Madison, CT: International Universities Press.

Gelinas, D. (1983). The persisting negative effects of incest. *Psychiatry, 146*, 312-332.

Goodwin, J., McCarthy, T. & DiVasto, P. (1981). Prior incest in mothers of abused children. *Child Abuse and Neglect, 5*, 87-95.

Grisham, K. J. & Estes, N. J. (1986). Dynamics of alcoholic families. In N. Estes & M. E. Hienemann (Eds.), *Alcoholism, development, consequences, and interventions*, (pp. 303-313). St. Louis: C. V. Mosley Co.

Hays, K. F. (1987). The conspiracy of silence revisited: Group therapy with adult survivors of incest. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 39:4*, 143-156.

Herman, J. (1981). *Father-daughter incest*. Cambridge: Harvard University Press.

Herman, J. (1988). Father-daughter incest. In F. M. Ochberg (Ed.), *Post traumatic therapy and victims of violence* (pp. 175-195). New York: Brunner / Mazel.

Herman, J. & Hirschman, L. (1981). Families at risk for father-daughter incest. *American Journal of Psychiatry, 138*, 967-970.

Herman, J. L., Russell, D. E. & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry, 143*, 1293-1296.

Jordan, J. (1986). The meaning of mutuality. *Work in Progress, No. 23*. Wellesley, MA: Stone Center Working Paper Series.

Jordan, J. (1987). Clarity in connection: Empathic knowing, desire and sexuality. *Work in Progress, No. 29*. Wellesley, MA: Stone Center Working Paper Series.

Kaplan, A. (1988). Dichotomous thought and relational

processes in psychotherapy. *Work in Progress, No 35.* Wellesley, MA: Stone Center Working Paper Series.

Kolodner, A. (1987). *The socialization of children of concentration camp survivors*. Ph.D. dissertation, Boston University Graduate School, p. 320.

Krystal, H. (Ed.). (1968). *Massive psychic trauma.* New York: International Universities Press.

Krystal, H. & Niederland, W. G. (1968). Clinical observations on the survival syndrome. In H. Krystal (Ed.), *Massive Psychic Trauma* (pp. 327-348). New York: International Universities Press.

Lister, E. D. (1982). Forced silence: A neglected dimension of trauma. *American Journal of Psychiatry*, *139*, 872-876.

Luepenitz. D. A. (1988). *The family interpreted.* New York: Basic Books.

Miller, J. B. (1984). The development of women's sense of self. *Work in Progress, No. 12.* Wellesley, MA: Stone Center Working Paper Series.

Miller, J. B. (1986). What do we mean by relationships? *Work in Progress, No. 22.* Wellesley, MA: Stone Center Working Paper Series.

Miller, J. B. (1988). Connections, disconnections and violations. *Work in Progress, No. 33*. Wellesley, MA: Stone Center Working Paper Series.

Steinitz, L. Y. & Szonyi, D. (Eds.), (1976). *Living after the Holocaust: Reflections by the postwar generation in America* (pp. 33-53). New York: Block Publishing Co.

Stiver, I. (1984). The meanings of "dependency" in female-male relationships. *Work in Progress, No. 11.* Wellesley, MA: Stone Center Working Paper Series.

Surrey, J. (1984). The "self-in-relation": A theory of women's development. *Work in Progress, No. 13.* Wellesley, MA: Stone Center Working Paper Series.

Surrey, J. (1987). Relationship and empowerment. *Work in Progress, No. 30.* Wellesley, MA: Stone Center Working Paper Series.

Vannicelli, M. (1989). *Group psychotherapy with adult children of alcoholics: Treatment techniques and countertransference considerations***.** New York: Guilford Press.

Wegscheider-Cruse, S. (1981). *Another chance: Hope and health for the alcoholic family*. Palo Alto: Science and Behavior Books.

Wermer, E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry*, *59*, 72-81.