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A ROLE-REVERSAL IN THE MOTHER-DAUGHTER RELATIONSHIP

Roberta Kabat, Ph.D.

ABSTRACT: Psychoanalytic theorists have noted a particular dynamic in the mother-infant relationship in which the emotional needs of the mother predominate. When this situation occurs, the emotional needs of the infant may go unmet, resulting in impaired self-development. Through an integration of the ideas of mainstream psychoanalytic theorists and feminist psychoanalytic thinkers, this paper proposes the idea that, because of the intensity of the mother-daughter relationship, this dynamic may be more prevalent between mothers and daughters than between mothers and sons. A mother-daughter relationship is described in which the mother comes to depend on her daughter for emotional attunement and response, and the mother's selfobject needs predominate. As a consequence, the daughter is unable to develop a cohesive sense of self and experiences difficulty in achieving separation. Two clinical reports are presented to illustrate the way in which this mother-daughter dynamic manifests itself in the patient's life and in the therapeutic relationship. A negative transference dynamic is described resulting from these patients' fear of duplicating their relationship with their mothers in the therapeutic relationship by having to meet the selfobject needs of the therapist.

KEY WORDS: mother-daughter relationship; role-reversal; separation-individuation; negative transference.

This paper will focus on a particular mother-daughter dynamic, which came to my attention through the treatment of certain female patients in whom a distinctive kind of negative transference developed. The transference manifestation seemed to be a reflection of the fact that in these mother-daughter pairs, a role-reversal had occurred in which the patients had been utilized by their mothers as selfobjects, while their own needs for emotional responsiveness had gone unmet. The neg-

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ative transference appeared to be a consequence of fear on the part of the patient of a duplication in the therapeutic relationship in which she would be called upon to provide these same functions for the therapist.

Barth (1988) has pointed out that there are legitimate non-pathological selfobject needs which patients provide for the analyst, and I believe that these needs are either consciously or unconsciously sensed by our patients. For patients who have experienced adequate emotional responsiveness from parental figures in childhood, the therapist's needs contribute, in the positive maternal transference, to a re-enactment of the mutual enhancement that is the result of a healthy mother-child bond. In the optimal mother-child interaction, the child's self develops through the selfobject responsiveness of the parent, while the parent's self-esteem is enhanced by the emotional response of the child. It seemed important, therefore, to explore further those cases in which the less than optimal mother-child experience of some patients, had led to a particular sensitivity to the needs of the therapist, to a fear of those needs, and to a subsequent acting-out in the transference.

While the phenomenon of the parental narcissistic needs predominating in the parent-child relationship has been discussed in the literature by many prominent psychoanalytic thinkers (Winnicott, 1971; Kohut, 1971, 1977, 1984; Stolorow, Brandchaft & Atwood, 1987; Miller, 1981), what has not been noted is the possibility that this, what I call a role-reversal, is more likely to occur between mothers and daughters than between mothers and sons because of the particular intensity of the mother-daughter bond.

Freud (1931, 1933), though focusing on the centrality of oedipal dynamics, acknowledged the prolonged and on-going preoedipal tie between mother and daughter, and Melanie Klein (1945) offered a theoretical explanation for her observation of a particular hostility and subsequent ambivalence on the part of the daughter toward her mother. Mahler (Mahler & La Perriere, 1965; Mahler, Pine & Bergman, 1970; Mahler, Pine & Bergman, 1975; Mahler, 1981) attributed the difficulties experienced by daughters in their separation process to their having to separate from, while selectively identifying with, their mothers. Bergman (1982, 1987) described the parallel difficulties experienced by mothers in allowing their daughters to separate. She notes that for the mother, giving birth to a girl can give rise to the fantasy of creating a new and better self, and can provide a sense of closeness and narcissistic fulfillment. The loss of union with a daughter seems to come as a particular disappointment to the mother, one different in intensity from her feelings regarding separation from her son.

Though they acknowledge differences in mother-daughter and mother-son dynamics, mainstream psychoanalysts have primarily of-

fered a general psychology of development. In contrast, feminist thinkers (Chodorow, 1978, 1989; Miller, 1976, 1991; Jordan, 1991a, 1991b, 1991c; Surrey, 1991a, 1991b; Benjamin, 1984, 1986, 1988; Dinnerstein, 1976), placing the mother-daughter relationship in a socio-cultural context, have focused their attention on the differences between the mother-daughter and mother-son relationship and the effect of these differences on female development. I believe that their ideas provide a theoretical basis for believing that the close relational bond between mothers and daughters lends itself to a reversal in roles in which the daughter plays a mothering role, sacrificing her own emotional needs in order to maintain an emotional connection to her mother. Through an integration of the thinking of those mainstream psychoanalysts who have explored the consequences for the child's development of parental narcissistic needs predominating in the mother-child relationship and the ideas of the feminist thinkers, I hope to show that not only does a dynamic exist in which children provide the emotional attunement for their parents, but that it is more likely to occur between mothers and daughters. I will then present two cases which illustrate the consequences of this mother-daughter role-reversal and its implications for treatment.

In psychoanalytic theory a dynamic has been described by some theorists in which the narcissistic needs of the parent overshadow the needs of the child. Winnicott (1971), for example, noted the mirror function of the mother, cautioned against taking it for granted, and pointed out the possibility that in some instances the mother may be unable to provide adequate mirroring for the infant. He wrote that,

> Some babies, tantalized by this type of relative maternal failure, study the variable maternal visage in an attempt to predict the mother's mood, just exactly as we all study the weather. The baby quickly learns to make a forecast: "Just now it is safe to forget the mother's mood and to be spontaneous, but any minute the mother's face will become fixed or her mood will dominate, and my own personal needs must then be withdrawn otherwise my central self may suffer insult" (p. 113).

Winnicott clearly was not describing the mutual attunement that occurs in healthy mother-infant pairs which provides emotional satisfaction and growth for both parties (Beebe, 1986; Beebe & Lachmann, 1988; Stern, 1983, 1989), but rather a situation in which the mother's needs predominate. In this sort of interaction the central self of the infant goes unmirrored and unrecognized, and the infant is forced to gauge the mother's moods and behave accordingly, while his own inner subjective states remain unresponded to.

Narcissistic pathology in the child has been attributed by Kohut (1971, 1977, 1984) to the mother's own narcissistic fixations, leading her to provide either faulty or inadequate empathy for her infant. Stolorow, Brandchaft and Atwood (1987) point out that, "If parents cannot adapt themselves to the changing needs of their developing child, then the child will adapt himself to what is available in order to maintain the required ties . . ." (pp. 90–91). They suggest that the requirement for maintaining these ties may involve the child's need to serve significant selfobject functions for his or her parents. Again, while there are healthy selfobject needs which children serve for their parents, I believe that what Stolorow, et. al. are describing is the same situation which Winnicott identified, where the subjective states and selfobject needs of the child are subordinated, to an inordinate degree, to the needs of the parents.

The childhood narcissistic deprivation of the parent and the way in which the parent utilizes the child to make up for these early deficits is eloquently described by Alice Miller (1981), who believes that in response to the parental need the child develops "An amazing ability to perceive and respond intuitively, that is, unconsciously, to this need of the mother, or of both parents, for him to take on the role that had unconsciously been assigned to him" (p. 8). Later these children become ". . . (the confidantes, comforters, advisors, supporters) of their own mothers, . . . (pp. 8–9).

All of these theorists point to a similar dynamic, one in which the self-development of the infant is impaired by the narcissistic demands of parental figures. The feminist psychoanalytic thinkers, however, provide additional insights which I believe suggest that this dynamic may have a different quality between mothers and daughters than the dynamic as it manifests itself between mothers and sons. Chodorow (1978, 1989), for example, stresses the centrality of the mother-child pre-oedipal relationship and the unconscious effects of early involvement with a female for children of both sexes. For the boy, the development of a gender identity requires a turning away from the mother. However, for the girl, since the development of gender identity does not require a rejection of her early identification with the mother, her later identifications are embedded in, and influenced by, her ongoing primary identification and pre-oedipal attachment.

Chodorow goes on to suggest that a Western middle-class woman has limited opportunity for interaction with family and other women in her daily activities. Since she is primarily isolated with her children, the mother looks to her children for self-affirmation. She believes that for daughters, in particular, because of their continued bond to the mother, the breaking of dependence and the maintenance of a consistently individuated sense of self is a difficult task. She observes that a kind of guilt

exists for daughters in their desire for individuation, which reflects a lack of adequate self/other distinctions.

The ability of the girl to be attuned to the feelings of others is emphasized by Jean Baker Miller (1976, 1991), who believes that this capacity is forged in the special reciprocity experienced between mothers and daughters, which she sees as growth-enhancing for both parties. She maintains that because of the emphasis on the development of autonomy for boys, this sort of relationship does not exist between mothers and sons. Her colleagues Judith Jordan (1991a, 1991b, 1991c) and Janet Surrey (1991a, 1991b), both point out the close relationship between mother and daughter. Jordan notes that the mother tends to identify more with her daughter than with her son and feels more comfortable about encouraging a daughter to feel more connected with her on an affective level. She describes a mirroring role played by the daughter, and says that, ". . . the daughter may be experienced by the mother as providing a closer reflection of the mother than does the son . . ." (Jordan, 1991a, p. 33). Surrey goes even farther in saying that the daughter is actually encouraged to take a mothering role with her mother and discusses what she calls the "oscillating mother-daughter introject," in which the daughter may either take the role of the mother or the daughter, depending on the situation at any given time (Surrey, 1991b, p. 58). The relational capacity of girls and its development through the mother-daughter relationship is also noted by Gilligan (Gilligan, 1982; Gilligan, Lyons & Hanmer, 1990; Brown & Gilligan, 1992).

The child's difficulty in seeing the mother as a separate person, a situation resulting from the early infant fantasy of the mother as an all-powerful presence, is noted by Dinnerstein (1976). She believes that while mother is experienced as providing perfect protection, she is also seen as opposing the child's development of an autonomous sense of self. Dinnerstein states that the boy is able to utilize his identification with the father to separate from the mother, while the father does not encourage his daughter's identification. The father's discouragement of his daughter's desire to identify with him, results in the daughter perceiving her relationship with her mother as a greater threat to her own sense of selfhood.

Benjamin (1984, 1986, 1988) notes a similar dynamic to that pointed out by Dinnerstein and describes the difficulty daughters have in separating from their mothers, due to their inability to combat the omnipotent maternal imago, because of their lack of a penis and their inability to identify with their fathers, as sons do. Benjamin believes, as does Dinnerstein, that in early childhood the power of the mother is seen as both comforting and a threat to the ability to develop autonomy. The son's "otherness," symbolized by the penis, makes it easier for him to perceive himself as separate from the mother. The girl's "sameness"

requires that she identify with and separate from the same person, a problem noted by more mainstream theorists as well.

The feminist analytic thinkers point to an intensity in the mother-daughter relationship which they attribute to the predominantly female care of children and to the mothers' lack of intimate relationships with their husbands or with other women—a situation partially determined by the isolation of the nuclear family and cultural norms for men, encouraging autonomy and discouraging intimacy (Chodorow, 1978, 1989; Miller, 1976, 1991).

I believe that the particular bond between mothers and daughters noted by the feminist psychoanalytic thinkers lends itself to the development of a relationship in which the needs of the mother may predominate, particularly if the mother has suffered narcissistic deprivation in her own childhood. While sons may be utilized to provide caretaking functions for their mothers, functions more appropriately provided by a spouse, I believe that a son's ability to separate, aided by gender difference and an identification with "maleness," allows him greater freedom to achieve differentiation and pursue an interest in the outside world. It is, of course, true that mothers may utilize their sons as selfobjects, but this seems more likely to take the form of desiring and having their self-esteem enhanced by the reflected glory of their son's achievements in the outside world. In contrast, mothers seem to look more readily to their daughters for empathic attunement and emotional connection.

A role-reversal between mother and daughter was a prominent dynamic in the young women patients I will describe and the one which seemed to have the greatest impact on their subsequent development. It appeared that, as a result of their mother's narcissistic vulnerability, these patients had been called upon to provide emotional responsiveness and empathic attunement for their mothers. As a consequence, their own emotional needs had been ignored. Attempts at separation and differentiation engendered feelings of guilt regarding what the patient experienced as an abandonment of her mother. The patients also experienced feelings of anger and hopelessness, since in order to continue to meet their mothers' needs, they had to deny their own needs and desires. Denial of their own needs resulted in the patients remaining alienated from their own subjective inner states and unable to develop an adequate sense of an independent, cohesive self. This left them dependent on their mothers and unable to achieve separation.

In addition, while continued emotional connection to the mother was equated with the need to relinquish autonomy and feelings of self-differentiation, they continued to long for a merger with the mother, since separation was experienced as total object loss. This dynamic was apparent in all aspects of their lives. Being out of touch with their own inner needs and desires made it difficult for them to identify and pursue

satisfying goals. Their conflicted feelings regarding relationships resulted in a hunger for emotional responsiveness and intimacy coupled with a simultaneous avoidance of closeness. Involvement in other intimate relationships was experienced as conflicting with their primary bond to the mother and triggered merger fantasies and fears of loss of self-differentiation.

These fears had a significant effect on the therapeutic relationship, since these patients desired closeness but feared an emotional connection to the therapist. They appeared to anticipate a duplication of their relationship with the mother, in which they would be required to meet the emotional needs of the therapist. As a result, they were able to develop a bond with the therapist, but tended to use distancing behaviors to ward off too close an involvement. The conflict frequently manifested itself in periods of relatedness alternating with periods in which defensive maneuvers were utilized to prevent the patient's fantasized loss of self-differentiation. At times, they displayed provocative or aggressive behavior, an indication of an attempt to complete the separation process and prevent a re-traumatization in the therapeutic relationship.

The cases that follow involve two long-term treatments which illustrate the mother-daughter dynamic I have been describing, and outline the progression of the treatment, which at times was dominated by the patient's fear of having to meet the therapist's needs and desires rather than her own. I hope to show that it was at first through the tolerance and acceptance of the patient's need to act-out her unresolved separation issues, and then through the interpretation of the patient's fears, that the patient was ultimately able to achieve a more cohesive sense of self and the ability to feel comfortable in intimate connection to others.

CLINICAL ILLUSTRATIONS

Melissa

Melissa was referred to me for treatment when she was twenty-three years old, by the guidance counselor of the master's program she was then attending in early childhood education. The reason for the referral was the difficulty Melissa was having in her student teaching placement and in completing her final assignment. The treatment, which consisted of twice-a-week therapy sessions, continued for seven years.

Melissa is the second oldest child and only daughter in an Irish-Catholic family with four children. Her father, an executive with a large corporation, was prone to unpredictable angry outbursts directed at the children. As a result, Melissa's main emotional connection was with her mother, a somewhat passive, dependent woman. Melissa's mother's narcissistic vulnerability was exacerbated by the relocation of the family, when Melissa was three years old. This move took Melissa's mother away from her extended family, who had lived in the same town, and away from her job as a music teacher in the local school. Removed

from the support of her family, Melissa's mother became depressed and progressively more dependent on Melissa for emotional support and companionship. Melissa's mother would talk about her unhappiness in her marriage, but told Melissa that she did not feel able to leave because of her inability to manage alone financially.

Melissa saw herself as her mother's supporter and confidante, a role which provided her with a feeling of importance in her mother's life. Because of her intermittent depression and self-involvement, Melissa's mother was unable to be responsive to Melissa, and Melissa's feelings and talents were ignored.

During her adolescence, Melissa attempted to separate from her mother by rebelling, engaging in marijuana use, which was "accidentally" discovered when she left some marijuana in a school bag at home. After high school Melissa left home for an out-of-town college, a move that seemed to be a desperate attempt to finally escape her mother. In college, she functioned well academically but was socially isolated. She at times used marijuana and alcohol, and her relationships were primarily with other students who were equally alienated from the social mainstream. She had two somewhat inappropriate relationships with men and one brief homosexual relationship while in college. Just prior to completing college, Melissa's mother, who had been diagnosed with breast cancer two years before, died of her disease. After graduation, primarily by default, she entered a master's program. She stated that she did this because she did not know what else to do. Although she had fantasies about becoming a writer, she did not feel that this was a realistic career plan.

During the beginning phase of treatment it became apparent that Melissa's role as her mother's protector and defender was the only way she felt she could maintain a relationship with her. This feeling of connection was based on providing for her mother's emotional needs, and I believed that she felt that if she failed to provide for her mother, her mother would withdraw into depression and all connection would be broken. What also became apparent quite early in Melissa's treatment was that, while desiring closeness, she was extremely fearful of becoming too close. The first manifestation of the negative tranference came when I realized that Melissa was withholding information. While engaging in destructive behavior outside of the treatment, such as the excessive use of alcohol, she would fail to reveal this during her therapy sessions. When the behavior had already put her in some jeopardy, she would finally discuss it, but was unable to explain not having brought it up earlier.

Although I was aware that her destructive behavior had pre-dated her treatment, I saw the behavior, now within the context of the treatment, as an acting-out of the transference, since it would manifest itself whenever Melissa felt herself becoming too close to me. I believed that her destructive behavior, revealed "accidentally" and reminiscent of the "accidental" discovery of her adolescent marijuana use, was an attempt to elicit an emotional response from me, but also a way of maintaining a distance from me, flaunting her immunity from my influence over her. A dramatic example of this behavior occurred early in the treatment. Melissa had left school and gotten a job as a teacher in a preschool program. During her first year of therapy, she was vague about her work situation, behavior which engendered in me feelings of being kept in the dark and excluded. However, as it turned out, Melissa had been failing to go to work regularly and after about a year was fired.

When she told me she had been fired I was shocked, since she had never mentioned her absences from work, nor the fact that her job was in jeopardy. My first impulse was to confront her with her secretive behavior and to point out

how all this could have been avoided had she only discussed her work situation in her therapy. These struck me as feelings typical of the frustrated and angry response of a parent to a wayward and rebellious adolescent. These feelings, so reminiscent of the parent-child struggles of separation, alerted me to the possibility that Melissa's primary motive for not telling me about her job situation was that she was protecting herself from my influence and from having to change her behavior based on what I would want her to do. I conceptualized her behavior as being aggression expressed primarily in the service of differentiation and self-cohesion. In addition, I believed that Melissa felt that I had an investment in her succeeding at work, and she did not want me to have this satisfaction. In Melissa's fantasy, she believed that her success would be a treatment success for me, and thus she would once again be used, as she had been by her mother, to regulate my self-esteem and feelings of well-being. In fact, at this point in the treatment, an idealized depiction of her mother began to crumble, and what began to emerge was her perception that her mother had "duped" and "exploited" her for her own needs.

The dynamic of destructive behavior, which included several abortions, was particularly evident in her relationships with men, which were characterized by sexual promiscuity. Melissa would develop an intense need for a particular man, who always ended the relationship, leaving Melissa to feel rageful and abandoned. After each relationship, she withdrew into isolation only to resume the search when being alone became too intolerable. During the early part of the treatment, my interventions were primarily directed at helping Melissa to see that her actions had some underlying meaning. Eventually, I was able to interpret her sexual behavior as her search for someone who could provide her with all that had been missing in her relationship with her mother. My understanding of Melissa's separation struggles, enacted in the transference, led me also to interpret to Melissa the way in which these relationships served to keep our relationship from becoming too close. The fact that the men she picked were functioning on a marginal level was reminiscent to me of the behavior of adolescents who, engaged in separation battles with parental figures, choose inappropriate objects as a way of asserting their autonomy and of taking revenge on the parents. I believed that Melissa's behavior was a reflection of her fear of being used by me as she had been used by her mother.

During the middle years of treatment, I continued to interpret Melissa's behavior in the maternal transference as her attempt to accomplish a separation from her mother and to develop a cohesive sense of self, which had been prevented by her mother's pathological need for Melissa's responsiveness to her needs. By not retaliating in response to Melissa's provocation, I became progressively internalized as a holding "good" object. However, I believe that in the treatment I served two functions, (1) as the responsive mother, different from her own mother; and (2) as the mother of separation, who could tolerate Melissa's aggressive and self-assertive behavior, which although at times self-destructive, I conceptualized and interpreted both as a way of eliciting emotional response and as serving to further separation.

Over the course of treatment, Melissa became able to establish relationships with women, make some career decisions, and ultimately establish a healthier relationship with a man. She had also developed a more realistic and empathic attitude toward her mother, and while recognizing her mother's failures, she also felt that her mother would have wanted to see her happy. Her relationship with me was characterized by a feeling of closeness, while at the same time she appeared at ease in asserting and expressing her own desires. I believed that this

was accomplished by the continued interpretation of her fears of being used and exploited by me, as well as by my recognition that Melissa's provocative and distancing behaviors were, at least in substantial measure, an attempt to complete a separation process and develop a cohesive sense of self.

Amy

At the time of her first interview, Amy was an attractive, stylishly-dressed adolescent of 18 who was referred for therapy by the guidance counselor of the local college she was attending. Her treatment consisted of once-a-week psychotherapy for a period of five years, with a two year break between the third and fourth years of treatment. The initial complaints were phobic and somatic in nature. She had difficulty going too far away from her house and would experience "anxiety attacks." She described palpitations, sweaty palms, and fear that she was about to have a heart attack. In addition, she experienced stomach pains which made her fearful of going too far away from her home in case she would have to use the bathroom. Amy had gone for extensive tests and nothing organically wrong was found. She seemed to be quite psychologically minded and did not have any trouble believing that these pains and symptoms had a psychological component.

She revealed that she was the youngest of four children. A sister one year older, another three years older, and a brother four years older had grown up in a separate household. Amy's parents had separated when she was two, and while her father retained custody of her siblings, Amy was left in the custody of her mother. She continued a relationship with her father and siblings until she was about five years old, but then saw them only rarely since her father remarried and moved to another state.

Amy's mother appears to have been quite passive and, having been brought up in a traditional Italian household which encouraged homemaking as a career and discouraged work outside the home, the loss of her role as wife and homemaker was a particularly hard blow to her self-esteem. After her husband left, Amy's mother seems to have devoted herself to the care of her own mother, with whom she and Amy lived, and to have relied on Amy, even when Amy was a small child, for emotional support and validation.

What became apparent in the initial interviews was that Amy had never had a real childhood, and, in fact, had always felt more like the mother to her mother. As a result, little attention had been paid to Amy's emotional needs. At times Amy's mother would behave in a childlike manner, forcing Amy to assume the role of parental authority. Amy's mother also relied on Amy to provide soothing and comfort when she felt depressed and lonely. Amy liked and did well in school, which gave her satisfaction, but her academic achievements were colored by the fact that she saw them as belonging to her mother. In Amy's mind, her achievements would prove to her father and to the world that her mother was a successful parent. In her fantasy, this would make her father regret that he had ended the marriage.

Early in the treatment what began to emerge was the conflict between Amy's desire to separate from her mother and her fantasy that if she separated from her mother one or both of them would die. However, Amy was able to articulate the paradox that she was unable to live because of the smothering tie to her mother. During this time she began to make efforts to reconnect to her father, with whom she had had only minimal contact, and with these efforts she

began to express her feelings of anger toward her mother in her sessions. These alternated with other sessions in which her mother was depicted as a "saint."

It was at this point that Amy's conflict began to play a significant role in the therapeutic relationship. Although she had rapidly developed a bond with me, she began to express her fears of becoming too dependent on me, and at times became very irritated and annoyed at something I said. I began to feel bored and distracted, feelings which led me to recognize that I was supposed to listen and show interest in Amy's ideas and opinions, while my remarks or comments were experienced by Amy as an attempt to deflect the attention away from her and onto myself. As in the case of Melissa, I conceptualized Amy's behavior as fear that her attempts at separation would be thwarted.

My interpretations were again focused on Amy's enactment in the transference of her attempt to separate from her mother. Her behavior seemed to be a result of her fear of becoming too close to me and her belief that her progress would be taken away and claimed as my therapeutic success. My response to Amy's feelings was to suggest that her anger toward me was a reflection of her fear of duplicating her relationship with her mother. I told her that I thought that maybe she was concerned that a relationship with me would be moving her from "the frying pan into the fire," in that she would be required to meet my needs as she had always had to meet her mother's or risk abandonment by me.

During this time, Amy began to talk more about her somatic symptoms, began visiting the doctor for all sorts of aches and pains, and complained about her stomach, which was preventing her from traveling very far from home. It seemed to me that this upsurge in her somatic symptoms reflected her fear of abandonment as the picture of her mother as a saint became increasingly more difficult to maintain and her conflict about separation became more acute.

In time, Amy began to see her own symptoms as being induced by fear of separation from her mother as well as being an expression, probably dating from earliest infancy, of the feelings of overwhelming anger and need which probably had not been responded to at that very early time. Her somatic complaints forced her to remain at home and connected to her mother, but served a protective and self-defining function, warding off Amy's fear of engulfment. McDougall (1989) talks about the phenomenon reflected by somatic symptoms in which the patient is involved in a relationship in which there is the fantasy of "one body instead of two," and Amy's physical pain seemed to serve the function of defining the boundaries of her own body, and symbolically differentiating her body from her mother's.

As the therapy progressed, Amy began to express her fears about hurting me, and her feeling that she was responsible for my well-being. She stated that she was fearful of not accepting an interpretation of mine since in her mind I needed her to accept what I said in order to feel competent as a therapist. This was connected to Amy's need to do well in school so that her mother could look competent as a mother. Following this admission, Amy began to make progress, expressing her recognition that I could take pleasure in her achievements without this being antithetical to her experiencing these achievements as belonging to her. She began to note that I clearly had achievements of my own, and that maybe I didn't need her to bolster my self-esteem. As this emerged, Amy began to evidence a growing feeling of closeness to me, and the anger and distancing behavior began to subside.

At this point in the treatment I made the decision to leave the agency where I had been seeing Amy. She declined to continue her treatment with me privately, announcing that she had been thinking of ending her therapy anyway,

and wanted to see if she could manage on her own. I understood this as Amy's fear of becoming more dependent on me, but failed to recognize that Amy's fantasy had in some sense come true. She had begun to test out separation and had been abandoned.

About two years later, Amy called me and we agreed to resume her treatment. My continuing with her after this break seemed to be experienced by Amy as a willingness on my part to allow her to separate, and my continued existence without her seemed to reassure her that attempts at separation would not result in my deterioration and/or death. In fact, she commented on how well I had withstood the aging process. In addition, she was able to express her anger at my having "abandoned" her, while also recognizing that the decision to discontinue treatment had been hers. This was an important acknowledgment for her in that it allowed us to explore her decision in the context of her fears of becoming too close to me. This was important preliminary work since I had occasion to call upon her insights during subsequent declarations on Amy's part that she had better terminate her treatment for fear of "never being able to leave."

The second phase of the treatment was characterized by a deepening of her emotional involvement with me and by a willingness on her part to engage in a re-enactment of her separation struggles. She fluctuated between her feelings of closeness to me and feelings of anger, which were often displaced onto other figures such as her supervisor in the social work program in which she was now enrolled. However, what characterized this part of the treatment was a greater trust in my ability to withstand her aggressive and assertive behavior and her willingness to begin to accept interpretations which were aimed at illuminating the re-enactment in the transference of her separation conflicts with her mother.

In the last phase of her treatment, Amy became involved in a relationship with a man, which seemed to be one of mutual love and caring. Although this relationship at first presented Amy with a conflict, since her mother at first reacted despondently to her new relationship, over time she was able to resolve this. After graduating from social work school and getting a job, Amy moved in with her boyfriend and they became engaged. Amy was able to develop a relationship with her mother which, while characterized by closeness, did not preclude Amy's being able to begin an independent life.

The final phase of her treatment was worked out during her termination, in which her separation from me seemed to resolve further her issues regarding my need for, and dependence on, her. Amy brought up separation in a unilateral and somewhat abrupt manner, which caused me to experience feelings of concern, and I suggested that we further explore the reason for Amy's abrupt decision to terminate. However, I was also forced to examine my own feelings regarding Amy's separation, specifically feelings of reluctance to end her possibly "unfinished" treatment. In confronting my own feelings regarding separation, I was able to recognize Amy's need to be allowed to experience my willingness to allow her to go. In fact, the mutual setting of a date for termination, and the positive note on which it was accomplished served as further confirmation for Amy that separation could be growth-enhancing, rather than destructive to the parties involved.

As in the previous case, my willingness to engage in Amy's separation battles, while not being "destroyed" by her aggression, made it possible eventually to interpret Amy's fears of being utilized by me as she felt she had been by her mother. It was the acknowledgement of Amy's fears and the encouragement of her assertive strivings that, I believe, accounted for the successful resolution of Amy's separation difficulties.

DISCUSSION

These two cases have several features in common. In both cases, the mothers of these patients showed a predisposing narcissistic vulnerability which was further exacerbated by their life situations. In the case of Melissa's mother this was characterized by a loveless marriage, exacerbated by a separation from her extended family, while for Amy's mother it involved the loss of her marriage, which was her only source of self-esteem and emotional connection.

In both cases, these patients were utilized by their mothers as sources of emotional support and responsiveness. This resulted in their inability to identify life goals and experience their achievements as belonging to them, and precluded intimate emotional involvement with others. In both cases, the treatment was characterized by negative transference phenomena which I believe resulted from the patients' fear of being utilized by me as they had been by their mothers. In the case of Melissa, this manifested itself in destructive acting-out outside of the treatment and a withholding of information, while for Amy it was characterized by emotional distancing and a decision to interrupt her treatment. In both cases, I conceptualized this behavior as reflecting, at least in part, a positive developmental thrust and an attempt to prevent further traumatization in the treatment relationship. In both cases, the treatment strategy was conceptualized as at first tolerating and "surviving" these patients' enactment of the separation and individuation struggle, which then made it possible to begin to interpret their fear of being required to meet my needs.

These cases illustrate a dynamic evident in some mother-daughter relationships. In situations in which the mother is not receiving emotional responsiveness and/or admiration from outside sources, the need for her daughter to provide the missing emotional responsiveness may lead her to impede her daughter's separation efforts. Her own overwhelming need for her daughter to perform these functions may prevent her from adequately responding to the needs and feelings of her daughter, a dynamic which may have profound consequences for her daughter's ability to establish a cohesive sense of self.

It is important to recognize this dynamic in clinical practice and to consider the possibility that various forms of resistance may in fact be an expression of the patient's fear of being re-traumatized by having to meet the emotional needs of the therapist. In these cases the conflict between a desperate need for closeness and a fear of loss of autonomy may play a prominent role in the transference, and the recognition and eventual interpretation of these fears may substantially enhance the possibility of more successfully resolving these patients' separation conflicts.

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Roberta Kabat, Ph.D.
3200 Netherland Avenue, Apt. 5K
Bronx, New York 10463