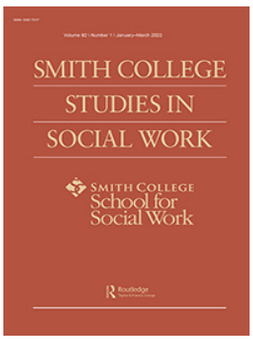

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Understanding and Working with the Effects of Parental Pathological Projective Identification

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ABSTRACT

The present paper outlines parental pathological projective identification as a form of childhood adversity that some patients attempt to address in psychotherapy. This phenomenon involves a parent's unconscious relocation of an unbearable state of mind, combined with the interpersonal evocation of such in the child. A child's effort to deal with this experience may involve the development of pathogenic beliefs about the self. These beliefs subsequently cause difficulties in living and considerable distress. Through understanding the dynamics of parental pathological projective identification, clinicians may help patients to develop insight into the origins of their pathogenic beliefs, along with appropriate corrective experiences. The integration of Control-Mastery Theory with the concept of parental pathological projective identification can facilitate such understanding. A clinical example is provided to illustrate these concepts and their relevance to psychotherapy with adult patients.

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Patients who enter psychotherapy often do so to address powerful beliefs or schemas that distort their sense of what is possible and inhibit their efforts to achieve personally meaningful goals (Gazzillo et al., 2019; Silberschatz, 2008; Weiss, 1993). Conceptualizing the development of such pathogenic beliefs is an important part of considering what will and will not be helpful for a particular patient. Many psychoanalytic theories presume that some form of trauma – usually involving significant relational experiences – contributes to the adoption of pathogenic beliefs about the self, relationships with others, and one's interface with the world at large (Bromberg, 1996; Stolorow et al., 1987; Weiss, 1993). In order to understand and conceptualize their patients, therapists often listen for markers of these beliefs and the developmental contexts in which they took shape. Pathological parental projective identification during the patient's childhood is one such traumatic context. The present paper will describe the role of pathological parental projective identification in the child's development of pathogenic beliefs, integrating the object relations concept of projective identification (Hinshelwood, 1991; Ogden, 1979) with

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insights from Control-Mastery Theory (Silberschatz, 2005; Weiss, 1993). A clinical example will illustrate the phenomenon of pathological parental projective identification in the context of a patient's effort to disconfirm his pathogenic beliefs. The therapeutic process involved the therapist's communication––through attitude and technical intervention––that the patient's pathogenic beliefs were traumatic sequelae that were at odds with present reality.

Control-Mastery Theory: a way to conceptualize patients' traumas and pathogenic beliefs

Control-Mastery Theory (CMT) asserts that patients come to therapy with the motivation to disconfirm beliefs that constrict their personal development and diminish their capacity to live creatively (Gazzillo et al., 2019; Nolet al., 2008; Silberschatz, 2005; Weiss, 1993). In other words, patients typically seek treatment to resume the pursuit of developmental goals that had to be sacrificed earlier in life, and which remain unfulfilled. Such goals are often relinquished due to "key traumas" that occurred in relationship to an important caregiver (Fimianiet al., 2020; Silberschatz, 2005). A key trauma refers to "any situation that overwhelms a person with anxiety or fear, or that leads a person to believe an important goal must be renounced in order to avoid the danger of hurting loved ones or the danger of being hurt by them" (Silberschatz, 2005, p. 4). If a caregiver does not and/or cannot demonstrate well-intentioned, non-possessive, and responsive care to a child, then the child may experience the key trauma of doubting the security of the caregiver's attachment to him or her (Bowlby, 1979; Brandchaft, 2007; Rappoport, 1996). In these cases, the child must find a solution designed to restore or at least maximize the caregiver's goodwill toward that child. CMT suggests that children can show great flexibility in adapting their thoughts, feelings, and behaviors to do so (Weiss, 1990).

These adaptations include the formation of pathogenic beliefs designed to elicit as much of the caregiver's willingness to care for the child as is possible (Rappoport, 1996), to minimize the damage inflicted by an abusive caregiver (Weiss, 1990), and/or to reduce the child's awareness of the caregiver's deficits in this regard (Silberschatz, 2005). For example, one patient named "Emily" came to therapy complaining that she did not know what to do with herself on nights and weekends. These times left Emily, a woman in her thirties who lived alone, feeling depressed and unable to organize her thoughts to pursue the relationships and activities she enjoyed. In contrast, she functioned exceedingly well at her job where she identified and solved problems with efficiency and aptitude in ways that benefited her coworkers. Emily experienced several key childhood traumas. First, she was dependent on a mother who was chronically anxious, self-absorbed, punitive, and concrete in her thinking.

Emily's mother would often approach her with problems for Emily to solve but was unable to show sustained interest or appreciation for Emily's independent interests, needs, and ways of being. Second, Emily's father did not involve himself in the emotional goings-on of the family. She described him as offering glib and subtly critical responses to her when she tried to tell him how she was feeling. For example, when she told him that she recently learned she met criteria for a depressive episode he told her that he could never personally understand how someone be so weak as to feel depressed but he hoped she felt better soon. As such, Emily could not count on her father to shoulder some of the intense emotional demands of her mother nor for him to intervene and absolve her of responsibility for her mother's emotional wellbeing. Third, Emily possessed a great capacity for emotional depth, introspection, and clarity. She experienced a deep sense of unrest when she was forced to behave in ways that were contrary to her inner feelings. Emily's emotional depth stood in contrast to her family's often dismissive attitude toward emotional experience. As a result of these key traumas, Emily developed the pathogenic belief that her feelings, needs and interests are not as important as others'. In so doing she had to renounce her developmental goal of appropriately individuating from her family and developing a healthy attitude of worth and esteem toward herself. Emily's difficulty knowing how to use her free time and of what she wanted for herself came to be understood as a way of complying with the pathogenic belief that her own needs and desires are inconsequential.

Emily's childhood pathogenic belief accomplished three functions in the context of her family. First, it allowed Emily to remain open to and motivated to solve her mother's problems, thereby facilitating the main available pathway of relatedness between mother and child. Second, it reduced the incidence of her mother's punitive bouts of anger when Emily did not comply with her mother's implicit expectation of being put first. In therapy, Emily recalled learning from a very early age that she dare not break her mother's rules. By prioritizing her mother's rules as more important than Emily's own interests, she spared herself the shame and worthlessness she felt when her mother grew hostile toward her. Last, it reduced Emily's awareness of how little she was receiving from her mother and father because she did not believe she deserved anything more from her (or anyone else). In this way, Emily's sense of undeservedness provided an explanation of her reality that minimized the pain and fear associated with recognizing her parent's lack of responsiveness.

Children who are forced to adopt such pathogenic beliefs in the face of key traumas often have to sacrifice important developmental goals such as feeling deserving of reciprocal care and attention in relationships and feeling free to pursue one's own unique potential in life (Fimiani et al., 2020; Silberschatz, 2005; Weiss, 1993). Pathogenic beliefs typically warn against the pursuit of particular developmental goals, especially those involving the expansion of one's sense of self and the enlargement of possibilities within one's world.

Indeed, pathogenic beliefs tend to constrict an individual's expectations, initiative, and sense of deservedness (Aafjes-van Doorn, McCollum, Silberschatz, & Snyder, 2021; Weiss, 1997). For the developing child, such beliefs are involved in compliance with a traumatizing caregiver's expectations and behaviors. Thus, pathogenic beliefs reflect the nexus of conflict between the individual's developmental strivings and the impediments against them imposed by traumatic developmental experiences. In adapting to inimical circumstances with parents––essentially to maintain relatedness with them––the child is faced with constricting her or his pursuit of developmental goals and guarding against experiences that might encourage their emergence. A primary danger for the child is the recognition of being unable to reliably secure a caregiver's empathically responsive care. However, once s/he adopts a pathogenic belief about himself or herself––as an adaptation to this scenario––a new threat emerges: the appearance of information that does not comply with this belief. For example, Emily had to deny and/or minimize evidence that her friends noticed and cared for her. Acknowledging such evidence of genuine caring for her would have undermined her adaptation of denying her own deservedness in the service of attending to all of her mother's emotional needs. Children saddled with such constricted ways of thinking about themselves––and what they deserve in life––often have difficulty fully realizing important developmental goals, such as the pursuit of meaningful work and mutually satisfying love relationships.

According to CMT, individuals remain motivated to pursue their relinquished developmental goals, though only upon determining that it is safe to do so (Gazzillo et al., 2019; Rappoport, 1997; Weiss, 1993). By "safe" we mean that the person can conclude the key trauma(s) will not recur if he defies a pathogenic belief (Weiss, 2005). Thus, individuals who develop pathogenic beliefs typically experience conflict between following the developmental strivings that have been suppressed and heeding the pathogenic beliefs that perpetuate their suppression. This conflict is brought into therapy, where patients "hope" the therapist will co-create conditions of safety with the patient for overcoming pathogenic beliefs and pursuing developmental goals (Gazzillo et al., 2019; Weiss, 1998). Indeed, patients are thought to have an unconscious "plan" for how they will use treatment to make new inferences and conclusions about their traumas and pathogenic beliefs, so that they may resume progress toward adaptive goals in their lives (Gazzillo et al., 2019; Weiss, 1993).

Therapists are helpful if they provide conditions and respond in ways that are compatible with the patient's plan (Silberschatz, 2008). For example, Emily seemed to use three aspects of the treatment to reinforce conditions of safety that allowed her to bring in and test the validity of her pathogenic belief. First, she seemed to register and find her therapist's clinical attitude toward her to be helpful. She used his interest in her thoughts and feelings, his lack of need for

her to take care of him, and his attitude that she was a deserving person to talk in a more candid and experience-near manner. To illustrate the last point, at the start of her treatment she would talk about her experience with the pronoun "you" rather than "I" (e.g. "You often feel scared like you don't know if what you're saying is going to be understood by someone else"). Her therapist would playfully ask her after such statements: "You are saying 'you' but you mean 'I,' right?." After six months, she organically spoke in the first person and used the "I" pronoun regularly in describing her experience. This may have been a test of her pathogenic belief that her needs are less important than others' needs in the following way: by omitting herself in her own narrative via transposing "you" for "I" she may have been complying with the belief that she does not deserve to present herself in front of someone else and tell that person information that is intended to benefit herself rather than the other. The therapist's gentle confrontations on her use of the more dislocated "you" pronoun offered contradictory information that he wanted to understand *her* experience and did not want her to obfuscate herself in the therapeutic relationship. She seemed to have profitably used this information in her shift to using "I" when she described her experience.

The second aspect of the treatment that seemed to reinforce Emily's sense of safety was the therapist's use of interpretations that linked Emily's current states of inner desertion with the implicit neglect and emotional deprivation she endured in relationship to her parents. These interpretations defied the dimension of her pathogenic belief that her problems were her fault and she should not "burden" others with them. When Emily would lament that she was unable to do anything interesting or engaging over the course of her weekend with an air of self-castigation, her therapist would try to get a moment-to-moment understanding of her inner experience during such episodes. She would describe a fugue-like state where she could not engage her executive functions ("I'm not thinking when this happens"), would feel somewhat numb, and could only engage in repetitives "mindless" computer games or internet video-watching. After Emily and her therapist gained a shared and articulated understanding of her experience through such episodes, he would offer interpretations that linked her current inability to pay caring attention to herself with the way she went unattended in her relationship to her parents. Over the course of three years of treatment, Emily made incremental use of such interpretations to blame herself less for such problematic experience and feel more entitled to others' interest and support in helping her address ways she was suffering in her life.

The third aspect of treatment Emily used to disconfirm her pathogenic belief was the therapist's steadfast and emphatic stance of advocacy toward her. When Emily would volunteer ambitions or goals she might have for herself she would often follow this by reciting a list of reasons why pursuit would end in abject failure. Her therapist would interpret how this sequence of

hope followed by hopelessness functioned to keep her prospects dimmed as she needed to as a child. What seemed more therapeutically effective, however, was the therapist's statements that supported – even championed – her stated ambitions. On several occasions, Emily would revisit her originally stated ambition and reconsider pursuing it. These kinds of interactions countered Emily's pathogenic belief that her needs and/or goals did not deserve priority. We infer that Emily's resumed pursuit of her goals in light of her therapist's advocacy toward her reflected a heightened sense of safety she felt in challenging the pathogenic belief that had been interfering with full-fledged pursuit of what she wanted in her life.

Taken together, this new information obtained through her experience of the therapist's behavior and attitude toward her helped her gradually feel safe enough to pay more attention to herself in and out of session. Critically, in opening herself to information that contradicted her pathogenic belief, she experienced a safer outcome – sustained support, respect and interest – than the trauma of her mother's insistent demands and neglect of her desires and needs. This allowed her to feel more confident in acting against her pathogenic belief in accepting the attention of others and engaging in a richer way of living, in which her own needs and interests were at the center. She began to engage in artistic activities she enjoyed at night and to schedule more time with friends on weekends.

Adapting to the key trauma of parental pathological projective identification

A parent's reliance upon pathological projective identification can serve as a key trauma that renders a child vulnerable to develop particularly pernicious pathogenic beliefs. Because children are highly motivated to adapt to their reality (Weiss, 1990), they are prone to accepting parental projections and believing them to be true. Moreover, in the service of maintaining ties to parental figures, pathogenic beliefs can increase the child's identification with a parent's pathological projections. Although such identifications––and associated pathogenic beliefs––may not feel "real" in the sense of being of one's own creative growth and development, they may be clung to as a way of preserving the parent-child bond. The possibility of relinquishing such beliefs may be wished for, yet feared as resulting in the dissolution of the relationship to the parent. We contend that pathogenic beliefs adopted to comply with a parent's pathological projective identification create a way of relating to oneself that feels artificial and malignant but also staves off the trauma of knowing oneself in a way that would have left one feeling unknowable to the one person they wanted to be known by – their parent. As such, we regard

parental pathological projective identification as a key trauma that a child may adapt to by believing – often unconsciously – painful and constricting conclusions about themselves.

The concept of pathological projective identification

Projective identification refers to the process whereby one individual employs projection of emotional experience while evoking, through interpersonal behavior, an analogue emotional experience in another individual. Projective identification was originally introduced by Melanie Klein and elaborated by psychoanalysts working in the Kleinian tradition (Heimann, 1950; Hinshelwood, 1991; Klein, 1946). It is thought to be a common – and often benign – occurrence when relational communication needs to happen without language. For example, imagine a dog who makes eye contact with his owners, then turns around and deliberately walks away while keep his eyes locked on the owner as if the owner is about to give chase. The owner finds himself in a sudden playful state and gives chase. Ogden cites ways that an infant with a "good-enough" parent might perceive his distressful states in the parent instead of himself and act accordingly (1979). This process allows the receptive and care-minded parent to respond in a way that shows s/he is not damaged by the infant's distress and remains motivated to care for the child. In this way, the infant may learn that his distressful states are not destructive and can still be responded to. Thus, projective identification is a useful and needed mode of relating in relationships that are marked by a disparity in power – such as parent and child – when the more powerful party's care for the other allows for him or her to be used as needed by the less powerful party. This has been referred to as a process of containment, whereby one person functions as a "container" for the "contained" (i.e., that which is projectively identified), in order to render intolerable affects more digestible and amenable to reflection (Bion, 1962; Ogden, 2004). The process can also be useful in relationships of more equal footing – objectively speaking – between patient and therapist. In this context, a patient may use projective identification to "relocate" feelings that have been historically intolerable by evoking them in the therapist (Seligman, 2018). Then the help-minded therapist can experientially understand the patient's experience and respond in ways that allow the patient to know his experience is survivable and comprehensible (Chescheir, 1995; Kealy, 2013; Ogden, 2004).

Projective identification has not featured prominently in the CMT literature. However, the concept bears some similarity to a particular type of testing activity described by CMT as "turning passive-into-active." In this kind of testing, aimed at disconfirming pathogenic beliefs associated with traumatic experience, a patient "does to the analyst those traumatizing things a parent had previously done to him" (Weiss & Sampson, 1986,

p. 107). An optimal therapeutic response would provide the patient with an experience of "containment" (projective identification) and/or "mastery" (turning passive-into-active) of that which the patient had been struggling with and enacting in relation to the therapist. However, projective identification is not always benignly employed for the purpose of mastery. Some individuals may use projective identification to deal with difficult affects in a more destructive manner, to the detriment of those around them. Indeed, many patients may experience themselves on the receiving end of pathological projective identification (e.g., from a parent), and may benefit from the therapist highlighting and explaining such phenomena. In this way, the concept of projective identification––particularly its maladaptive expression––may be useful for therapists practicing from a CMT perspective. Understanding the effects of pathological projective identification in patients' development can alert therapists to this potential source of pathogenic beliefs. Moreover, therapists can explain how pathological projective identification works to facilitate the patient's insight that the mistreatment they received from a parent was not their fault. Therapists can also consider ways in which the patient might test and attempt to overcome pathogenic beliefs stemming from a parent's use of pathological projective identification. The patient may not necessarily reenact this in therapy. While some patients may turn passive-into-active to help the therapist understand their plight, others may work to dispel their deep confusion about what is true about themselves versus a sense of self adopted in compliance to the trauma.

Projective identification can become pathological when the more powerful individual––not necessarily the psychologically healthier party––employs it upon the less powerful and more dependent participant. Consider a psychologically compromised parent who has his or her own intolerable affective states that s/he must find in his or her child and then influence that child to identify with such feelings. Projective identification brings a compelling mandate to comply with what the initiating party is finding––and evoking through behavior––in the other. Factor in the parent's authority and the child's need to maintain the relational tie to that parent and the child may have no option but to identify with the parent's unwanted feelings. The valence and intensity of the projected feelings can also elevate the pathological nature of this process. If the more powerful party has coped with their own traumatic experience by dissociating from the often associated feelings of worthlessness, abandonment, and undeservedness, then such contents may be projected onto the less powerful party. In these cases, a child could be induced to think about himself or herself as worthless, abandoned, and/or undeserving in order to give the parent what s/he psychologically needs in that moment (i.e., to see this experience in the child instead of himself or herself).

Being the chronic recipient of a parent's pathological projective identifications can undermine the child's sense of connection to and self-worth in relationship to the parent. The child's self-worth suffers by going unresponded to for who s/he really is, treated as though his or her needs do not matter to the parent and sent the message that the relationship is contingent upon the child experiencing himself or herself as the parent dictates. Moreover, the parent is implicitly unavailable to be used for the *child's* attempts to communicate via projective identification. Bion (1959) describes an infant-mother scenario where the feeling behind the infant's cries can't find a psychological home in the mother who is either too destabilized by the infant's feeling or denies it. As a result, the child is left profoundly alone with a feeling that is overwhelming, with no one to contain it with him.

Features of parental pathological projective identification

The parent MUST be right

A parent who employs pathological projective identification in relation to his or her child has to be right about his or her perceptions of the child (Ogden, 1979). There is a lot at stake for both parties when a parent dislocates an internal state into his or her child. The parent may fear psychological extinction if s/he had to consciously claim this aspect of self, with the intensity of shame, terror, or despair feeling too great to bear. The parent may be convinced at a deep level that s/he would have nobody to safely express these feelings to so that s/he could feel more regulated and able to be soothed. Instead, the feelings must be ejected and found––communicated with absolute certainty––in the child. There is no set of verbal counterarguments that can convince the parent otherwise in such moments. As Ogden succinctly puts it, the parent's logic goes something like: "I can only see in you what I put there, and so if I don't see that in you, I see nothing" (1979, p. 360). In order to occupy a shared reality with a parent under these circumstances the child must go along. Refusal to comply would threaten to obliterate the only form of connection that is available––something the child must avoid at all costs.

Negation of the child's subjectivity

The child may feel abjectly negated as a subjective self in the course of a parent coercing him or her to identify as something intolerable to that parent. Part of the demand that the child think about himself or herself the way the parent insists is that anything the child independently feels, thinks, or cares about is wholly disregarded by the parent. All that can matter is the parent's psychology and what s/he needs to stay intact in these moments. The parent does not have the capacity to notice her own feelings and remain responsive to the child's subjectivity. This can lead to a chronic sense for the child that relationships require a great deal but offer little in return. The child may also be

compromised in his or her ability to recognize and relate to his or her self. In the child's compliance with the parent's pathological projective identification, his or her subjective self becomes a liability. In order to adapt successfully – i.e. identify with what the parent cannot – the child must find a way to inhibit his or her own agency and subjectivity. S/he may have to practice this so thoroughly that it becomes difficult to know what they really desire, believe, and find personally meaningful.

Feeling harassed from within

The child's experience of the relationship with a parent who uses pathological projective identification may involve feelings of being invaded, in that the parent's projections are unbidden yet the child has little choice but to absorb and abide by their content. Thus, the child is prevented from establishing and asserting boundaries regarding what will and will not be taken in. Rather, the mandate to comply with the parent's projective perceptions requires the child to feel defined from the outside––often in noxious terms––rather than from within. In this way, the child is in a position of repeatedly granting entrance to something that is alien to the self: the parent's projective content. Such content becomes internalized, manifesting as thoughts, feelings, and beliefs about the self. Children may then have the experience of being harassed, intruded upon, and captured by very distressing thoughts about who they are––a kind of internal harassment.

Impact on the child's identity

Despite inordinate pressure to identify with the parent's projected, unmetabolized state of mind, the child may retain some sense of this identification being unreal, or not of his/her own making. Thus, feelings of inauthenticity may set in as an additional outcome of parental pathological projective identification, reflecting the coercion to adopt feelings or thoughts that are not truly his or hers. As a result, the child's actual qualities go ignored as s/he is responded to as if s/he is someone s/he is – in truth of fact – not. Winnicott's concept of the 'false self'[1] reflects this process, whereby the child suppresses the actual core of the self for protective purposes, building up in its place a compliant "version" of the self to deal with the impingements of the parent. In extreme cases where the child has few other relationships with a trustworthy adult or peers, this may be the only identity available to the child. Just as a bad relationship is preferable to no relationship with a needed other, an inauthentic identity is far better than no identity (Fairbairn, 1952).

[1]By "false" we do not mean artificial but rather a reflection of the child's self fragmenting in order to meet the two contradicting needs of complying with the parent's projections and protecting his or her true seat of subjectivity. Winnicott makes plain that the "false self is no doubt an aspect of the true self" (1956, p. 387).

Resulting dysphoria in the child

The entirety of parental pathological projective identification makes for a grim life for the child. S/he is faced with the Catch-22 choice of accommodating foreign noxious states and claiming them as his/her own or rejecting this alien intrusion and feeling unknown to the parent and bereft of a parent who is capable of knowing him/her. The child may experience a range of dysphoric reactions to this predicament and may feel depleted, listless, numb, ineffectual, and/or aimless. Such feelings could be the product of becoming "someone" to the parent through the process of the parent's pathological projective identification, briefly relieving the terror of having and being no one––though with the cost of a despairing and joyless experience of his/her internal life. Conversely, if the child seeks to hold onto his own experience in the face of his parent's attempt to induce feelings in the child that the parent cannot bear then s/he could feel a panicked sense of estrangement, fear an annihilating retaliation, and/or grow enraged at the way s/he is being deprived. To the child, the predicament of these overwhelming affects involves having no one to help make sense of and regulate these feelings. The very moment when the child needs an ally to help contain overwhelming affect may be fraught with danger as a consequence of the parent's psychological unavailability (i.e., the parent's reliance on projective identification precluding empathic responsiveness). Masterson and Rinsley (1975) have termed this set of dysphoric reactions the "abandonment depression" marked by feelings of panic, rage, guilt, helplessness, depression, and emptiness.

Through repeated cycles of being induced into his/her parent's pathological projective identification, the child's dysphoria may take hold as chronic affective disturbances that continue through adulthood. The strategies used to cope with this dysphoria may offer immediate relief but make for a constricted quality of life. One such strategy involves the maintenance of beliefs about the self that preserve the fragile sense of relatedness organized around the parent's projective identification. Associated strategies may include impulsive self-regulatory behaviors aimed at transient relief, though often with self-damaging consequences (e.g., substance misuse). The ongoing dysphoric affect and associated constriction of living can lead to the seeking of treatment. If therapists can be aware of these effects and their origins they may facilitate opportunities for patients to heal and free themselves from such constraints. The following case example attempts to illustrate this possibility.

A case example

Terry was a man in his late-20s who sought therapy complaining of low self-esteem and anticipating rejection from women he showed interest in. Accompanying these concerns were intrusive and distressing thoughts that he was a sexual deviant (although his reported sexual fantasies were well within the*

normative range), and a dysmorphic body image that left him fearing that others would view him the way he viewed himself – to be disgustingly out of shape and repulsive.

From the start of treatment, his therapist (JR) overtly communicated to Terry how at odds his self-perceptions were from his likely reception in the world. Terry came across as a very intelligent, highly articulate, introspective, funny, good-natured, and handsome man. In gathering information about Terry's childhood and adolescence, his therapist learned about Terry's parents, including their relationship with Terry, one another, and their own families-of-origin. Terry's mother came from a very well-heeled family. She idealized her tycoon father who was professionally successful but seldom present and lacking in warmth and empathy. Most of her interactions with him were characterized by his use of her to ally with him in various quarrels with other family members. In short, this history painted the picture of a woman who complied with her father's designation of her as his "special little girl" and could not access her own anger at him for being so unavailable and dismissive of her needs. Indeed, her feelings of frustration over desperately needing yet not receiving real contact seemed to have been disavowed––perhaps to preserve her idealization of her father––and later evoked in others, such as her husband (the patient's father) and her son Terry.

Terry saw his father as his only ally in the family. His therapist understood his father to be far less malignant toward Terry than his mother, yet also unable or unwilling to intervene protectively on Terry's behalf. His father worked in law enforcement and would be expressive with Terry when it was just the two of them but would defer to his mother whenever they were all together. Terry could not recall ever appealing to his father for help with his mother's abusive behavior and this was understood to reflect Terry's anticipation that his father would minimize the offense and tell Terry not to misbehave. His parents divorced when he was ten years old.

After his father left, Terry recalled an adolescence of struggling to cope with the awful fact that it was a matter of "when" not "if" his mother would decide he had done something "selfish" and then scream at him for being uncaring and irresponsible. In therapy we worked to reconstruct what had triggered his mother's attacks at him. Rather than Terry being a "selfish kid" as he was coerced to conclude growing up, his therapist inferred that his mother was relocating her own intolerable feelings of worthlessness and finding them in Terry. Recognizing how badly she felt about herself throughout her life may have seemed unbearable, thus prompting her use of pathological projective identification to relocate this state into Terry and influence him to identify with her feelings.

Terry would describe how a seemingly trivial oversight in his completion of a nightly chore would often evoke her attack. She might perceive him to have hastily loaded the dishwasher after dinner and then scream at him for only

caring about himself and being completely ungrateful for how hard she works to care for him and his sisters. Importantly, Terry's mother did not seem to consciously contemplate whether Terry was "being selfish" – rather, she "knew" he was selfish. His mother seemed completely certain in her accusations and condemnations of his character. She was absolutely "right" and conveyed a sense of conviction that defied challenge from anyone – including Terry. He had no choice but to comply with her projection of him and experience himself as selfish and inconsiderate. Doing so allowed him to continue being with his mother in an important way. He would typically walk away from her tirades in tears and go up to his room with panic-stricken wishes that he could just die.

Pathological projective identification in Terry's relationship to his mother

Terry's experience in these nightly attacks illustrates his mother's use of pathological projective identification. She perceived Terry, with absolute certainty, to have committed transgressions that warranted her unhinged hostility toward him. Terry knew in these moments that all he could do was endure her rage. He knew there was nothing he could say or do to change her mind about him. He had to implicitly agree that he was as bad as she was claiming. Terry and his therapist grew to understand that he feared his mother's heightened retaliation––and her potential collapse––if he did not comply.

Terry developed an understanding of himself that allowed him to accommodate his mother's ongoing use of him as a container for her pathological projective content. He became practiced in dismissing his needs, desires, and perceptions in relationship to others and within himself. This dismissal of himself adaptively allowed him to more readily comply with his mother's pathology. Over time, however, he experienced an emptiness within. This vacuum was often filled with self-condemnatory ways of thinking about himself (e.g. the body dysmorphia and/or worry that he was a sexual deviant). Terry would describe being intruded upon by such distressing thoughts often when he was enjoying a good outcome in his life. The emptiness within, followed by the barrage of unbidden perceptions of himself as grotesque, mimicked his mother's implicit abandonment of him in the course of filling him up with her own noxious self-states.

Terry found it difficult to experience himself the way most people found him to be. Instead, he would think of himself as someone undeserving and defective as described above. More accurate – and thereby positive – appraisals of who he was in the world could feel intangible or unreal to him. While this shifted over time in therapy, this dynamic reflected Terry's fusion with the malignant projective identity induced through early interactions with his mother, lest he have no identity at all.

Terry endured bouts of dysphoria corresponding to how he suffered in reaction to his mother's pathological projective identification; he experienced tears and panic at each of her nightly tirades. Terry reported feelings of low-

level despair and meaninglessness as he related to himself in ways that mimicked his mother's maligning of him. When he felt emboldened to act and think of himself in ways that defied her malignant definition of him, he would become more anxious. In therapy we grew to understand how this anxiety reflected the historical danger of being in the "dead" space he would have occupied in his childhood if he had not complied with his mother's abuse. The difference between then and his current life, was that he now had people in his life (in and outside of therapy) whom he could rely upon to help him feel understood in his anxiety and thereby see it as something that could be survived rather than a deterrent.

Terry's pathogenic beliefs

Terry's pathogenic beliefs were collaboratively identified early in treatment. He believed that he was undeserving of acceptance from others – especially women – and he believed himself to be defective physically and sexually. Both of these beliefs left him feeling incapacitated to meet the demands of his life and less able to dis-identify with his mother's earlier hostile projections. His belief that he was undeserving of acceptance made it seem like the wider world treated him with the same rejection he felt inside his family. This rendered as false any feedback from others that contradicted the sense that he deserved to be rejected. As an affable, articulate, and good-natured person, he had to distort his perceptions to comply with this belief. He might interpret a peer's glance away as evidence that they did not really want to be talking with him. When his positive reception from others became difficult to deny he would invoke his more privately held beliefs about his sexual and physical defectiveness. For instance, he might receive welcoming feedback from a woman he was interested in but later would reason that he was too out of shape to possibly attract such an attractive woman, or that she would reject him once she found another man who was in better shape. Similarly, he would worry that his purported sexual deviancy would be discovered and that he would be shunned by her. This pathogenic belief left him fearful that there was something within himself that would prevent him from having and participating in the kind of relationship he wished for.

For Terry, it had been easier to identify with his mother's projections of her own worthlessness when he developed the pathogenic belief that he was undeserving and defective in these ways. This belief led to his developing a way of thinking about and experiencing himself as a detriment to himself and others, deserving of rejection and in need of correction by someone else. Such a pathogenic belief further opened him to his mother's attacks because they could be experienced as intended to fix something very bad within him. In this way, Terry found a way to "fit" into his mother's psychology and avoid the abyss of psychological estrangement he may have otherwise suffered.

Therapeutic process

Therapy focused on supporting Terry's efforts to disconfirm his pathogenic beliefs about himself. After reviewing his history, his therapist emphasized how undeserved, unusually systematic, harsh, and cruel his mother's emotional abuse of him seemed to be. Terry found this extremely relieving because no one in his family had recognized his mother's behavior toward him as inappropriate. Terry quickly realized that he had faced the choice of either thinking he deserved her mistreatment or having a reality that no one else in his family would endorse. He and his therapist linked his experience of himself as defective as reflective of the ways in which he complied with his mother's accusations. In conjunction with validating Terry's history of traumatic emotional abuse, his therapist adopted an attitude toward Terry that reflected the therapist's actual reception of Terry which was genuinely quite positive. The therapist's attitude[2] stood in contrast to Terry's mother's fault-finding attitude toward him. Terry seemed to test whether this attitude of goodwill and respect toward him was trustworthy. In the first few months of treatment, the therapist noticed a sense of feeling invited – in fleeting moments – to join Terry in criticizing himself. That is, the therapist noticed having moments of imagining joining Terry in his criticism of himself with Terry not batting an eyelash. The therapist had the feeling that this would be congruent with Terry's expectations, and that he would not defend himself. The therapist then used this understanding of his countertransference imaginings to more emphatically and consistently express an attitude of acceptance, respect and compassion toward Terry.

The therapist's exhibited an attitude toward Terry that he was just fine "as-is" with the hope that Terry could gradually use this as evidence that he did not need to think of himself as defective for this relationship to survive. This attitude was conveyed in a variety of ways in the treatment. First, his therapist re-contextualized his patient's fears of being sexually deviant as a manifestation of Obsessive-Compulsive Disorder. He recommended a popular book that discussed OCD and this particular form of obsessive content. Terry's body dysmporphia was addressed by emphasizing the state that his conclusions about being so "out of shape" left him in. He described feeling defeated and wanting to hide after entertaining such thoughts about himself. His therapist would repeatedly link this state of resignation and shame with earlier adaptations to his mother's attacks, through compliance with her perceptions of him "or else." The therapist emphasized how isolated he had been in attempting to navigate her attacks: finding a way to receive and contain what she could not tolerate was his only option. Finally, his therapist emphasized the psychological flexibility, resilience and strength of character that

[2]"Treatment by attitude" (Sampson, 2005) refers to the therapist's genuine conveyance of attitudes that facilitate the patient's efforts to disconfirm a pathogenic belief. To be effective the therapist needs to ascertain the kind of pathogenic belief the patient is seeking to disconfirm and align his or her attitude accordingly.

Terry exhibited. In summary, the therapist explicitly and implicitly challenged Terry's claims that there was something flawed about him. Over time, Terry made increasing use of this information to make choices that reflected an evolving sense of deservedness.

The therapist's understanding of pathological projective identification helped to make sense of how his mother's accusations seemed so believable to Terry at the time. In so doing, they were able to challenge and repudiate her fallacious claims about who he was as a person. His pathogenic beliefs regarding his perceived defectiveness also significantly reduced. Finally, Terry felt freer in his interactions with women, had bolder expectations of his relationships with them, and ultimately established a successful intimate relationship.

Conclusion

Pathological projective identification from parent to child compels the child to either comply with the forced-upon identification or suffer an intolerable state of estrangement from the parent. As such, the child may comply while carrying the knowledge that they are not *really* known by the parent, thereby doubting the parent's attachment to them. Pathogenic beliefs aid the child in complying with the parent's projections to share the only reality with the parent that is available, maximize whatever form of care the parent is willing to offer, and help the child manage his/her distress at feeling so implicitly alone and abandoned.

We hope that this understanding of the relationship between pathological projective identification and pathogenic beliefs can increase therapists' repertoire in helping patients whose problems stem from these issues. First, understanding how this defensive process works can assist therapists in helping their patients better understand what happened to them in dysfunctional relationships with parents. In essence, this may help the therapist serve as a witness for their patient's past traumatic experience (Miller, 1986) by being able to name and explain specifically to what the patient was subjected. For patients, this is a critical first step toward experientially realizing that they were not to blame for the ways their parents mistreated them. Second, therapists may be able to curate genuine attitudes toward their patients that contradict the devaluing, demeaning, and/or pathologizing attitude of the abusive parent toward the patient. By understanding the specific pathogenic beliefs a patient adopted to hasten compliance with the parent's pathological projective identification, the therapist may work to treat the patient in ways that demonstrably run counter to these beliefs, providing corrective experiences (Sampson, 2005; Weiss, 1993). The therapist who can respond in such ways can afford the opportunity for the patient to realize that being regarded as "less than" or deficient––by oneself and/or by the therapist––is not a requirement for a sustained, salutary

therapeutic relationship. This may then be generalized across other relational experiences in the patient's life.

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