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# On Curiosity: Intrapsychic and Interpersonal Boundary Formation in Family Life

EDWARD R. SHAPIRO, M.D.

In my research and clinical work with families in interaction, one trait stands out as a hallmark of psychological health. Its absence in pathological families is profound; its cultivation as an element of treatment is critical; and the reasons for its development, or lack of it, are perplexing. This element is interpersonal curiosity.

In my experience, families whose members manifest major character pathology demonstrate a striking lack of curiosity about one another. Instead, these family members are often extraordinarily certain that they know, understand, and can speak for the experience of other family members without further discussion or question. The infrequent attempts on the part of individuals within such a family to challenge this certainty are regularly met by bland denial, unshakable conviction,

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or platitudinous reassurance. Despite the fact that this pathological certainty is usually incorrect and frequently leads to stereotyped arguments and escalating disagreements within the family, it is difficult to interrupt. My various attempts to understand this phenomenon and its origins are the sources of this paper.

Classical Freudian analytic theory is rich in details about the connections between the general trait of curiosity and the child's ceaseless quest for sexual information (particularly in regard to infantile theories of birth, sexual differences, and intercourse) (Freud, 1905; Nunberg, 1961). In this classical view, curiosity is a manifestation of a drive (either sexual or aggressive) and, as such, directed toward gratification of the self. Only with the integration and neutralization of these drives and the consequent mastery of ambivalence can more sublimated forms of curiosity evolve, particularly the more object-related openness to and empathic interest in another's experience, so necessary for the mature capacity for love and intimacy as well as for adequate parental functioning.

In this paper, I shall focus on the implications for the developing child of this more sublimated form of interpersonal curiosity in the parent. I will explore the relationship between the capacity for object-related interest and the formation in the child of stable boundaries around himself, which allow him to differentiate his intrapsychic and interpersonal experiences as they evolve in family life.

It is my impression that the capacities of the parent to tolerate ambivalence, ambiguity, and uncertainty, and to maintain a flexible open-mindedness in listening to the child's experience, are important elements in the child's healthy psychological growth and development. Parental openness, lack of premature closure, and continuing interest in the child's experience provide the opportunity for the child both to develop stable boundaries around himself and to maintain flexible interactions with others.

Although the parent's capacity for accurate empathy and



the resultant ability to respond with confidence to the child's anxiety and confusion are essential stabilizing factors and important elements of good parental functioning, in many disturbed families premature parental certainty and so-called "understanding" of the child's experience can interfere with his development. This pathological quality of parental certainty provides a false support based more on unresolved needs of the parent than on an accurate understanding of the child. In the following, I will present data both from psychoanalysis and family treatment to illustrate the ways in which this pathological development of certainty about the experience of others, and the resultant lack of openness and curiosity, contribute to the subjective feelings of isolation, emptiness, and futility that dominate family life in these disturbed families.

## The Origins of Curiosity and the Maternal Response

The active, autistic, oral curiosity of the early infant is manifest in his efforts to feel, smell, and mouth everything within reach. Melanie Klein (1975) suggests that an aspect of this early oral incorporative behavior, which may remain unneutralized in parents, reflects a driven primitive infantile urge to appropriate the contents of the unknowable maternal body; this later develops into an intensive curiosity about it and an aggressive unconscious wish to penetrate and incorporate its contents. In some persons with specific oral frustrations during infancy, by displacement of the constellation "hunger" to the mental field, curiosity may become the representation of an oral trait of character and, under certain conditions, assume all the aggressive voracity of the original oral appetite (Fenichel, 1945).

The quality of the child's interpersonal curiosity is limited during the symbiotic period by his egocentricity, in which others are either ignored or perceived only in their roles as disturbers of or rivals for the essential mother/child dyad. The mother is not yet perceived as having an independent existence. Instead,

she is experienced symbiotically as an aspect of the child's experience of himself, usually in terms of a role omnipotently assigned to her within the framework of the child's needs and wishes (A. Freud, 1965).

In this symbiotic fusion, every preoccupation of the mother, her concerns with other members of the family, with work or outside interests, her depressions, illnesses, absences, even her death, are transformed by the infant into experiences of rejection and desertion. It is during this symbiotic period and through the early stages of separation-individuation that a shift from the child's necessary developmental certainty to the capacity for interpersonal curiosity occurs, as the infant begins to recognize the true separateness of another person.

Prior to the achievement of separateness, the infant remains painfully and narcissistically certain that he knows why the mother is doing things to him (i.e., because he is "good" or "bad"). This period, which runs from approximately 2–18 months, is a preambivalent stage during which the infant cannot tolerate the experience of his own active aggression against the mother without feeling overwhelmingly alone and abandoned (Parens, 1979).

During this period, splitting is used as a normal defense against the loss of a positive experience through being overwhelmed by aggression. The infant's frustrating experience becomes omnipotently reshaped and aggression projected so that he feels himself to be the victim of the mother's hatred. As the child matures in the presence of an adequate holding environment, he begins to notice his anger at the limitations of the maternal response and gradually dares to experience his anger at his loved mother. Her emotional survival of his anger demonstrates to the child her independent existence and allows him to recognize both his loving and angry feelings toward the same mother who both gratifies and frustrates him. This critical step leads to the recognition and mastery of ambivalence and the development of object constancy in the child.

The response of the mother during this period is a crucial



determinant of the child's capacity to develop a rich intrapsychic experience, which can later be communicated interpersonally. Her mature capacity to tolerate his aggression and to remain open to his experience provides the opportunity for the child to develop his own capacity to be unique and creative.

The quality of parental curiosity being described here is the result of the parent's own successful passage through these early stages, resulting in an interest in and readiness for being surprised by the infant's internal experience. While this kind of curiosity is clearly related to sublimated forms of intellectual curiosity, it represents a more basic quality derived from this early two-person experience. Aspects of this curiosity correspond to what Bion describes as "reverie"—that state of mind open to all responses from the loved object and "therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad" (Bion, 1962, p. 36).

Bion (1962) suggests that projective identification is "an early form of that which later is called a capacity for thinking" (p. 36). His notion is that the infant's incapacity to tolerate frustration and aggression leads to the use of what he calls "omnipotent mechanisms" like projective identification. With these mechanisms, the infant is able to get rid of or disavow frustrating experience by behaving in such a way as to evoke a congruent experience in the mother. The mother's capacity to receive and metabolize these projective identifications is determined by her own regression and reverie during her child's infancy; demands of her own early infantile impulses are reawakened and tolerated, resulting in a continuing empathic responsiveness to similar impulses in her child without withdrawal or retaliation. Through introjective identification, the infant is able to internalize the mother's capacity for openness as well as her capacity to accept, contain, work over, and manage these aggressive experiences (Bion, 1962; Shapiro, 1981).

## THE "GOOD ENOUGH MOTHER": AN EXAMPLE

A mother offers her infant her breast and he screams, spits, and refuses to take it. This occurs at the end of a long day when the mother is exhausted, irritable, and upset. The infant's repudiation of her and her own regression and identification with the infant preconsciously evoke a childhood memory in her of feeling unaccepted and unloved by her own parents.

At this moment, the mother has an unconscious choice: to pathologically blur the image of her child with that of her parent and react with her own rage evoked by this overlapping experience and memory, or to suspend her reaction long enough to consider the possibility that the infant's repudiation might be precipitated by something other than her inadequacy, something within her child that remains unknown to her. In this moment of suspension, many areas of the mother's maturity are tested: her frustration tolerance, her capacity to tolerate uncertainty, her own mastery of ambivalence and separation anxiety, the stability of her own boundaries and reality testing ("this is an infant, not my parents"), her capacity to observe and delay, and her curiosity and interest in her child.

The "good enough mother" responds automatically in a complex manner. On the one hand, she must allow the regression in herself so that she can reexperience the sensation of being poorly loved (fed), and understand this aspect of her child's response. With this understanding, she can both evaluate her own actions ("Am I being unaccepting?" etc.) and comfort her child. On the other hand, she must be able to suspend her conviction about the accuracy of her empathy (i.e., suspend her certainty) in order to provide *an open space in her mind* into which her child's more differentiated image can develop. In this undefined and potential space the child is given the freedom to define himself in his own way, with his own capabilities.

This neutralized and nonintrusive parental quality of curiosity and receptivity lies midway in the spectrum of normal parental responses, between the mirroring, accepting, and empathic qualities described by Kohut (1971), and the parental



validation of the child's "true self" described by Winnicott (1960a). Kohut describes the parent-child interaction prior to the formation of a cohesive self, when the child is as yet unable to stabilize his own sense of himself without the presence of an idealized, mirroring object who provides the child's as yet missing capacities. With this parental response, the child first learns to recognize aspects of himself within the parent.

Winnicott (1960a) describes the later parental task of responding to and validating the child's "true self." His notion is that the mother "meets" at the boundary between them the infant's spontaneous gesture that arises from his true self. Prior to the child's need for this validation, however, Winnicott (1960b) suggests that "if (the mother) knows too well what the infant needs, this is magic and forms no basis for an object relationship" (p. 50).

What I am attempting to describe here is this prior parental response in which the mother does *not* "know too well what the infant needs." During these periods, the parent who can tolerate uncertainty and remain open to new information provides an implicit message for the child that there can be a territory belonging exclusively to him, over which he can have total control. Such a parent communicates at a very basic level the limits of his or her omniscience, offering the child the freedom to create his own internal world, which he can ultimately choose to share with the parent and others on his own volition.

The origins of this ultimately private space lie in the intermediary transitional zone between mother and infant in which each member of the dyad is free to play and be creative (Grolnick and Barkin, 1978). Originally described by Winnicott (1951), the creation of this transitional space is provided by the ongoing openness of the mother. The mother who manifests defensive narcissistic certainty will intrude into this potential space, exerting excessive control and an inability to respect the child's attempts ultimately to create the necessary boundaries for what Masud Khan (1974) calls "the privacy of the self." In the presence of this defensive certainty, the child is unable to

define the boundaries of his territory, since he is left with no opening within which to define it.

Parents who are unable to tolerate the ambiguity, uncertainty, and relative helplessness of this experience often exert anxious efforts to control their interactions with the child. Not infrequently, parental outbursts of child abuse are precipitated by the child's efforts to hold onto a separate experience. Vulnerable parents, overwhelmed by tense interactions with the child that they can neither control nor understand, may react with anxious aggression, telling the child, in effect, "If I can't understand what is upsetting you, then I will do something to you so that you (and I) will *know* what you're crying about."

Ideally, in such situations, the parent will be able to communicate to the child both his continuing interest and his ability to tolerate the relative impotence, ambiguity, and uncertainty resulting from his recognition of the child's separateness. I am suggesting that this neutralized, nonintrusive interest is a basic parental attribute, which the developing child uses for the formation of stable self boundaries and an increasingly complex internal world. A symbiotic relationship with such a receptive parent provides for the child a model for creative relationships, where introjective identification of parental responses leads to the capacity to tolerate impulses and to susstain new ideas and information about other people and their experiences. Persons who have developed stable self boundaries out of such a healthy symbiotic experience are able to sustain images of others that correspond rather accurately to the reality of the other person, and which are continually reshaped and reworked as new information is perceived and integrated (Shapiro, 1978).

If the freedom of the normal symbiotic experience is constricted by unresolved parental conflicts, dystonic aspects of which are projected into the child, the parents will develop a rigidity and certainty about the way they perceive their child. These rigid perceptions may evoke in the child a defensive constriction of his sense of self as it emerges from this early fusion. Motivated in part by his need to protect his parents from anxiety (Winnicott, 1960a; Friedman, 1975; Shapiro, Zinner, Shapiro, and Berkowitz, 1975), the child may develop a rigid artificial "false self" organized around responses to his parents' needs rather than his own.



## CLINICAL ILLUSTRATION

A schizoid patient as an adolescent had written in her diary that one basic rule for living is never to tell anybody more than he or she can understand. The youngest child of a depressed mother, this patient experienced her mother as demonstrating a "pseudocuriosity" about her. When she was upset, her mother would insist that she talk to her about it since, as her mother put it, "talking helps." If she then attempted to describe her feelings to her mother, she was met with platitudes as her mother attempted to "cheer her up" rather than to listen to her. She described this experience as "like speaking in an empty room," recognizing at some level that her mother was so preoccupied with her own depression that she was unavailable to be interested in her daughter.

Analysis of her "rule" revealed the patient's desperate attempt to protect herself from this experience of emotional abandonment by a decision to present to her mother only what fit her mother's capacity to respond. The consequence of such a defensive rule was the patient's development of an overexpanded capacity to be sensitive to the needs of others to the exclusion of a capacity to pay attention to herself.

In a manner similar to many patients who grow up in the presence of pathological parental certainty, this patient was extraordinarily sensitive to so-called "supportive" comments from those around her. If someone said, "I understand," her response was not one of feeling accepted but rather of isolation and emotional abandonment. She knew at some level that such "understanding" was not possibly accurate, since she never revealed enough of herself for anyone to understand. Similarly, a so-called "supportive" comment like "That must have been

hard for you" evoked in her not feelings of comfort and relief but those of panic and of being obliterated, since she understood such a comment as saying to her that she *must feel* that it was "hard" for her. To the extent that she felt otherwise, her perception was that such feelings could not exist and be accepted.

In the analysis, the patient's own contributions to those experiences could be examined. She readily developed negative transference fantasies that the analyst was not interested in her and that he did not believe or accept her. She was extraordinarily sensitive to minor cues from the analyst (his silence, shifting in his chair, occasionally premature interventions) which supported the accuracy of her fantasies. With continual clarification of her own fear of presenting herself and her wishes in the analysis, however, she gradually began to recognize that she had, in fact, very little evidence for her interpretations of the analyst's intent. She began to notice that she was not interested in herself, and that in relation to the analyst, she was presenting the same kind of pathological certainty she'd experienced from her mother.

The patient's sensitivity required continued self-monitoring of the analyst's negative countertransference responses to her projections. This monitoring and continuing interest in the patient's more differentiated experience allowed the analyst to distinguish projections from accurate perceptions, and facilitated his clarification to the patient of her certainty that she could "read" his hateful intent in the absence of data. These clarifications allowed the patient to recognize her fantasies as fantasies with origins inside of herself, and helped her to recognize the boundary between her own experience of reality and the mystery of the analyst's own separate and unknowable experience.

Over the first two years of the analysis of the transference, the patient was able to develop an increasingly complex view of her childhood experience. This development was seen most graphically in the sequential analysis of a dream presented in



the first year. In the dream, the patient's father divided a watermelon and gave her the smallest piece. Her initial associations revealed her fury at the analyst and her father for not asking her how much she wanted, and for not reading her mind and knowing that she wanted more. She associated to childhood memories of both parents telling her what she wanted without checking with her, certain that she would agree.

As the patient became more conversant with her own wishes and anger, she noted that, in the dream, she had not *told* her father how much she wanted and that he could not, therefore, have known. She recognized that her fear of *noticing* how much she wanted (and of noticing her anger at the possibility of frustration) contributed to her wish that others know her wishes without her taking responsibility for them. She recalled that the largest piece of melon in the dream had been given to her mother, and then gradually began to recognize her anger and competitiveness with her mother and her oedipal wishes and fury at her father for his limited involvement with her.

The initial confusion experienced by this patient between her needs (which must be understood and gratified without words) and her wishes (which could be spoken into the space between two separate people, with the possibility of being both experienced and not gratified), is characteristic of patients who have difficulties at the end of symbiosis and the earliest stages of separation-individuation. Boundaries around their self-experience remain tenuous and easily lost in the presence of narcissistic intrusions from others. These patients have serial dyadic relationships in which they are continually searching for, and being buffeted about by, the needs of those around them. Their own separate experiences of genuineness, depth, and complexity remain unavailable, since they have found no safe interpersonal space in which to recognize them.

## The Oedipal Period

Successful resolution of the earlier symbiotic and separation-individuation stages, with resultant intact boundary formation

around a complex internal world, prepares the child for the oedipal period and the stage-appropriate need to model his further development on his identifications with his parents. The healthy oedipal child has a well developed capacity to define his own territory and, in the absence of firm parental boundaries, can readily invade the parents' space, claiming it as his own. It is the task of parents during this period to model for their child their own capacity to create firm boundaries around themselves, both as a couple and as individuals, each with his own gender identity.

The existence of these firm adult boundaries in healthy parents conveys to the child that there are elements of the parental experience which they as children cannot know, and from which they are excluded. The child's resultant longing, envy, jealousy, and curiosity, particularly the sexual curiosity about the mysterious relations between his parents, lie behind the subsequent development of his own active search for an idealized oedipal object who comes to represent the repository of this unknown and heretofore unknowable experience.

Parents of oedipal children are often affected by the child's powerful sexual curiosity and interest, and surrender the privacy of the marital coalition, either by getting involved in dyadic interactions with the child that actively exclude the other parent, or by behaving defensively and superficially as a single undifferentiated parent unit. The maintenance of both parents' individual identities as adult sexual beings who sustain individual interest in and engagement with each other during this period is an essential model for the child's further development of his self-experience.

Parents who are capable of sustaining such boundary formation in their adult love relationships maintain an awareness of their permanent separateness, an awareness which brings about a sense of loneliness, longing, and fear about the frailty of all relationships. As Kernberg (1977) suggests, in a mature love relationship between two such individuals there is a painful intersection between desire and reality, in which there is both



a passionate wish to become one with the other (destroying the boundaries between self and object) as well as the painful recognition of the indestructibility of such boundaries. In a healthy parental union, there is a persistence of a discrete sense of self, while an identification with someone beyond the self is accomplished through the marital pairing. The consequence of this awareness is a simultaneous persistence in the mature parent of both interest in and uncertainty about the inner experience of his or her spouse.

Failures in the stabilization of these parental boundaries, resulting in inappropriate seductive involvement of one or both parents with the child, contribute to the child's inability to approach the oedipal dilemma. Consequent fixation at the preoedipal level of dyadic involvement deprives the child both of the mysterious and everchanging complexity of the oedipal search and the flexibility of adult relationships with their triadic interconnections of jealousy, competitiveness, and surprise. The child's subsequent relationships, which are heavily colored by these preoedipal conflicts, often remain fixed, stereotypic, and ultimately uncreative repetitions.

## ADOLESCENCE

Adolescent development is characterized by new cognitive and affective capacities (Inhelder and Piaget, 1958), with resultant reorganization of childhood internalizations, new experimentation, and a redefinition of the boundaries of the self. The healthy adolescent requires from his family both a recognition of the territory he has already developed and an interest in its changing and creative new elements. Parental flexibility, curiosity, and interest in creative change helps to provide the adolescent with the freedom to continually expand and redefine the self as his identity evolves.

For some adolescents, either impoverishment in the internalizations of childhood experience, or lack of parental support of current adolescent experience, may interfere with their nor-

mal ego reorganization and increasing autonomy. In such cases, failure in the coherent differentiation of the self may result, with chaotic boundaries and a clinical picture of identity diffusion (Shapiro et al., 1975; Shapiro and Zinner, 1976). Clinical studies of families of borderline and narcissistic adolescents (Berkowitz, Shapiro, Zinner, and Shapiro, 1974; Shapiro et al., 1975) suggest that in many cases the parental coalition is unstable due to shared unconscious assumptions derived from unresolved childhood conflicts. The index adolescent in these families appears to be chosen unconsciously both by his parents and siblings to represent disavowed aspects of these unresolved conflicts. This occurs in a powerful coercive manner that results in a quality of certainty about who the adolescent is in specific areas of the family's interaction.

These pathological interactions, which appear to repeat significant childhood internalizations, have a powerful impact on the adolescent's experience of himself, contributing to the maintenance of unstable self boundaries as well as stereotyped patterns of behavior between the adolescent and his family.

## CLINICAL ILLUSTRATION

The following excerpt from a family therapy session illustrates the impact of this shared defensive certainty and lack of curiosity. In this family, as is so common in families of borderline adolescents (Shapiro et al., 1975), the parents appear to unite in a defensive avoidance of their own isolation and loneliness, projecting these aspects of themselves onto the index adolescent and avoiding her as a representation of their needs.

In this excerpt taken from the tenth month of therapy, the adolescent, Lisa, is discussing her fantasy about being abandoned by her family as she makes plans to leave the hospital. In response, the parents unite in a premature attempt to reassure her. Lisa's furious reaction to this reassurance evokes confusion in the parents until the therapist clarifies the boundary between them. Only then can the adolescent's sadness and isolation be recognized.



*EXCERPT I*

| | |
|---|---|
| Lisa: | I feel like I'm going to leave here and never see the White family again. |
| Mr. White: | Why the White family? |
| Lisa: | 'Cause I have no idea where I'm going. |
| Mr. White: | You're not going anywhere where you're not going to be able to see the White family—perhaps not all together at the same time . . . |
| Lisa:(angrily) | I'm sorry I said anything. |
| Mrs. White: | Lisa, in order for us to arrive at a decision, we need . . . |
| Lisa: | I'm kind of pissed off right now. |
| Mrs. White: | Why? |
| Lisa: (loudly) | Because you guys are always telling me, "Tell me what you're thinking, tell us what you're feeling, tell us your ideas on the subject. . . . " I just said something and you just shot it to hell and that just pisses me off! |
| Mr. White: | You said that you felt you might not see the White family again after you left here. |
| Lisa: | Right! And you just shot it to hell, like there's no consequence in it—that couldn't possibly happen—forget it! |
| Mr. White: | I guess I can't—I can't see how a situation could arise . . . |
| Therapist: | It's not your thought; it's hers. |
| Mrs. White: | We're never going to leave you where you don't see us, Lisa. |
| Therapist: | There's no curiosity about how Lisa could happen to have such a thought. |
| Mr. White: | I was about to ask that. I would've asked that if I could've thought of a way to say it. |
| Lisa: | I don't know . . . It feels to me like every time I get shipped out I get farther and farther, I mean both geographically and other ways. At the first hospital I was close to home and used |

to visit on weekends and now I'm further away and don't come home at all. It seems to me that the next logical step is to move farther away and see you once a week and then to move farther away and not see you at all. (lengthy silence)

Mr. White: That's sad that I've been part of a situation where you feel that way; I feel badly about it.

In this family, the White parents are themselves facing an imminent separation and probable divorce. They have been unable to face their own isolation and sadness around this decision, in part because such an acknowledgment would evoke painful memories of their own childhood experiences of abandonment. Lisa's fantasy about never seeing the White family again evokes anxiety in both parents about their own separation, and they respond with an attempt to cling to an external reality for which they can claim certainty. Their own anxiety contributes to their defensive attempt to rule out any need to understand the internal reality with which both they and Lisa are struggling. Their attempt to reassure her represents both an effort to reassure themselves as well as to protect themselves from their own guilt about their decision to hospitalize Lisa and to separate from each other.

The therapist's interventions and the family's previous therapeutic work have allowed some beginning boundary formation between family members. Mr. White's comment that he would have been interested in his daughter's experience if he could have "thought of a way to say it" illustrates this beginning recognition. With the help of the therapist he is able to reclaim his own guilt and recognize his daughter's separate feelings of sadness.

Mr. and Mrs. White's comments of reassurance are premature responses to Lisa's statement based on their "certainty" that they understand her. Out of their own anxiety about this issue, the Whites engage in an interaction characterized by pathological certainty in which an area of the adolescent's experience cannot be expressed or recognized without a response of emotional withdrawal.



Although Lisa's own affective instability and unacknowledged needs contribute to her inability to sustain herself in this interaction, she is highly dependent on their views to consolidate her developing sense of herself (Erikson, 1956). In the absence of adequate boundary recognition and respectful interest and curiosity at times of stress, Lisa's experience of her parents' responses requires her to choose either to remain in an undifferentiated relationship with them by capitulating to their certainty, or to tolerate the kind of emotional estrangement and alienation captured by her initial withdrawal ("I'm sorry I said anything"). Her own uncurious, angry response precipitates comparable disorganization in her anxious parents. The resulting shared internal experiences of isolation, emptiness, and futility about intrafamilial relationships are characteristic in families in which interpersonal curiosity cannot be utilized as a creative support for facilitating the development of the self experience of its members.

## Treatment

The stifling nature of pathological certainty in family life is evident. Family members chronically exposed to such annihilating interactions develop stale, shallow, mechanical investments in themselves and in each other. Often the thin social veneer in these families is shattered by eruptions of violence, barely concealed contemptuousness, or flight from the family itself. These outbursts can be understood as defensive attempts to avoid the feelings of isolation and emptiness generated by the lack of depth and general nonresponsiveness of the family environment.

Individuals who have developed in such families are difficult to engage in a deepening analytic therapy. The risk of being prematurely "understood" by an overeager therapist too ready to find aspects of himself in his patient is great. It is, I think, a constant danger faced by those therapists who are ready to see themselves as "empathic" without corroborating evidence from the patient.

Premature or superficial understanding, like "words in an empty room," can make a patient feel intolerably alone. In the analytic case illustration quoted earlier in this paper, for example, premature interpretation of the oedipal nature of the watermelon dream would have constituted an unempathic intrusion, and the patient would have either resisted or compliantly and meaninglessly accepted it. It was essential for the analyst to listen with interest as the patient worked through her preoedipal difficulty in tolerating ambivalence, uncertainty, and separation before her *own* oedipal wishes and her previously obscured triadic experience could be elaborated.

Many of these patients, who diagnostically fit the categories of schizoid and "false self" personality disorders, must be sustained for significant periods of time in a therapeutic interaction dominated by the analyst's respect for their needs for privacy and control. These patients, inordinately sensitive to the intrusions of the needs of important others in their lives, can be driven further inside themselves by the pressures of a required free association (Kanzer, 1972). It is only through sustained experience with an interested analyst, who can tolerate the uncertainty created by the patient's unwillingness to risk exposing himself, that the possibility of creative interaction can be initiated. The open space provided by the analyst's genuine and sustained willingness to learn and to be surprised can be entered by such patients with great caution, allowing them a new place in which ultimately to pay attention to themselves.

## Discussion

There remains a central difficulty in the thesis elaborated in this paper. While inferences from therapeutic experience with troubled adult and adolescent patients may suggest the childhood origins of developmental failures, the data remains inconclusive. With regard to the relationship of parental interpersonal curiosity to the development of the self experience of the child, one must note that deeply curious and vital



individuals appear to develop within families with solid, but seemingly uncurious, platitudinous parents. Therefore, one cannot extrapolate directly from these therapeutic observations to notions of adequate parenting.

It is possible, however, that either certain patients require in a remedial way what the normal, developing child does not ordinarily require, or that certain children have the capacity to find other people in their lives who offer them the needed interpersonal space in which to develop themselves. My guess is that both of these alternatives apply.

I have attempted, nevertheless, to illustrate some of the complex ways in which the fit between parental responses and the child's developmental capabilities may affect the development of stable boundaries around the self and the capacity for creative interactions. Using clinical examples, I have suggested how individuals who develop premature and defensive certainty about the inner experience of others may interfere with the potential deepening of their relationships. It is my impression that the continuing presence of openness and sustained interest by both parents and therapists is important in allowing those who rely on them the space in which to create and communicate their own unique experience.

## Summary

Research and clinical work with disturbed families in interaction have consistently resulted in the finding that members of these families have a striking lack of curiosity about one another. The relationship between the parental capacity for openness and interpersonal curiosity and the child's formation of stable boundaries around himself that differentiate his intrapsychic and interpersonal experiences in family life are examined. The author's thesis is that the continuing capacity of the parent to tolerate ambivalence, ambiguity, and uncertainty, and to maintain an attitude of openness and curiosity about the child's experience, is an important element in the healthy psychological

growth of the child. With clinical data from both psychoanalysis and family treatment, a relationship is illustrated between so-called "pathological certainty" and the subjective experiences of isolation, emptiness, and futility that dominate family life in these disturbed families.

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