"The Family" in Individual Psychotherapy
- Family in Reality and Fantasy as observed in Concurrent Child-Mother Therapy by the same Therapist -

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Summary

This paper considers the therapeutic relationship with the family in adult psychotherapy. The practice of individual adult psychotherapy has a psychoanalytical orientation, basically, the individual’s inner world is explored in order to alleviate or resolve his or her problems. In individual adult psychotherapy rather than family psychotherapy, the therapist rarely involves the family. In the case of a client with a serious condition, however, the therapist cannot avoid involving the client’s family. This paper considers therapeutic relationships in adult psychotherapy. The author analyzes the following three patterns of family involvement in individual psychotherapy relationships.

<Pattern 1> The client sets up a meeting with a family member who plays an important role in his or her pathalogy.

<Pattern 2> The client and a family member both come to therapy trying to control each other.

<Pattern 3> The family member whose input is required refuses to participate to help the client.

Working with these three patterns, the author analyzes the relationship between the client and the family, the relationship between the client and the therapist, and the relationships between the therapist and the client’s family. Three case studies are presented, each conforming to one of the patterns. In the case conforming to <Pattern 1>, that is, concurrent interview with the client and an undifferentiated family member, the family member was the client’s mother. Creating a therapeutic relationship with the mother-child unit led to the dissolution of the pathologic mother-infant fixation. Through the therapist’s separate sessions with mother and child, a new mother-child relationship that promotes development was formed, and the client’s ego was re-trained. In the case conforming to <Pattern 2>, both the client and the family member participating in therapy were trying to control each other. The therapist supported the client’s fragile ego so that her sense of being controlled was alleviated. In the case conforming to <Pattern 3>, the emotional bond between the client and the family was unable to be fixed.

These kinds of therapeutic relationships work well for clients with serious pathologies. The author has three other observations to share. First, the therapist’s involvement with the client’s family helps make the therapist ready to start psychotherapy. Second, the therapist is in a position to model a successful family, or a successful individual without a family, to the client. Third, the therapist can play the role of a mediator who enables the client and the family to rebuild their relationship.

Keywords: 個人心理療法、現実の家族、幻想の家族、同一治療者による母子並行面接

Individual Psychotherapy, Family in Reality, Family in Fantasy, Concurrent child-mother therapy by one therapist

Introduction

Individual psychotherapy, especially that with a psychoanalytical orientation, basically consists of exploring an individual’s inner world in order to alleviate or solve that individual’s problems. The author is engaged in this profession, and frequently uses dreams and images in therapy, targeting the relationship between client and therapist. In the process, theoretically, at least, various forms of relationships with real family members emerge.

Generally, clients’ families are dealt with in multilateral ways: the client and a family member may receive therapy simultaneously in the same session,
family members may receive parallel therapy with another therapist, or the whole family including the client may receive family therapy. Although a relationship with the client’s family is essential in the psychotherapy of children or adolescents, it is often difficult to obtain the cooperation of adult clients’ family members. As a result, individual psychotherapy of youths and adults does not usually include their families. Yet the psychotherapist cannot avoid some involvement with the client’s family, especially when the client is in a serious state.

Though the author mainly works with youths and adults in their 20’s or 30’s, the author has had contact with clients’ family members in various ways other than family therapy.

Clients’ symptoms and suffering impact their relationships with their families, and can be cured through these relationships. Family relationships are critical, especially for clients who have been suffering since infancy, though they only started psychotherapy upon reaching adulthood. It can be said that both a client’s actual relationship with his or her family and the fantasized version of the family relationship that exists in the client’s inner world reflect the core of the client’s problems, the family problems which are related to the client’s personal situation and experience in therapy, and the universality of the family relationship and any problems with it.

I. Purpose and method

This paper considers therapeutic family relationships in the psychotherapy of adults. The author analyzes the following three patterns of family members’ involvement in a client’s psychotherapy.

＜Pattern1＞ The client sets up a therapy session including a family member who plays an important role related to his or her pathology.

＜Pattern2＞ The client and the family member come to the therapy session trying to control each other.

＜Pattern3＞ The family member refuses to help the client in the context of psychotherapy.

Considering these three patterns, the author analyzes the relationship between the client and his or her family, the relationship between the client and the therapist, and the relationship between the therapist and the client’s family.

Three model cases, which were constructed from elements of typical real cases, are introduced in Table 1 below. All three of these clients are assumed to exhibit psychotic anxiety and emotional instability during the early periods of their psychotherapy. The client in Case A has been in psychotherapy for 15 years. The client in Case B was in psychotherapy for 10 years after which time the therapeutic relationship was considered closed; currently, this client receives occasional therapy sessions on demand when she is feeling confused. The client in Case C has been in psychotherapy for 12 years and is now in stable condition. All of these clients had at one time quit school or a job and withdrawn from society.

II. Involvement of family members in psychotherapy

<table>
<thead>
<tr>
<th>Case</th>
<th>SEX</th>
<th>AGE</th>
<th>Assessment</th>
<th>Outline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case A</td>
<td>Female</td>
<td>19</td>
<td>Schizophrenia</td>
<td>She has serious depersonalization and social phobia. She cannot go to university. A psychiatrist referred her to the therapist.</td>
</tr>
<tr>
<td>Case B</td>
<td>Female</td>
<td>24</td>
<td>Borderline Personality disorder</td>
<td>She has serious anxiety and cannot go to work. She becomes domestically violent. She has suicidal ideation and compulsion as well as hypochondria. A psychiatrist referred her to the therapist.</td>
</tr>
<tr>
<td>Case C</td>
<td>Female</td>
<td>30</td>
<td>Narcissistic Personality disorder</td>
<td>She has serious anxiety and gets confused. She becomes domestically violent. She has attempted suicide many times.</td>
</tr>
</tbody>
</table>
Each of the three Patterns described above and the therapeutic processes used to deal with them are considered here.

1. <Pattern 1>

The client sets up a therapy session with a family member who plays an important role in his or her pathology.

In this pattern, the client introduces a family member who plays an important role in his or her pathology to the therapist. In most such cases this family member is the client’s mother. Clients with serious pathological conditions usually have a family member, often the mother, who is afflicted with the same serious condition. In many of the cases seen by this author, the client is unable to differentiate himself or herself from others or to differentiate between reality and his or her own fantasy. In other words, the boundary of this type of client’s ego is vulnerable. In most such cases, however, the client brings his or her mother to one session but rejects the idea of sharing joint therapy sessions with her. The suggestion that the mother receive simultaneous therapy with another therapist is also usually rejected by both the client and the mother. The client wants the therapist to hear about her daily experience and about that of her mother, and seeks help from the therapist not only for his or her personal suffering but also for the family’s. In these cases, the therapist interacts with the client’s family member in an unusual situation.

a. Outline of the case

The model case representing this pattern is Case A. Client A came to her intake session with her mother. She suffered from serious depersonalization and reported that she could not feel her own ego in herself. Her mother reported that the client wanted her mother to receive counseling as well, so the therapist suggested that the mother receive counseling from another therapist, but the client wanted her mother to receive counseling from the client’s own therapist. On the condition that what each client revealed in her own therapy session would be kept confidential from the other, and with the understanding that the mother and the therapist were co-supporters of the client’s treatment, the therapist began concurrent therapy with both the original client and her mother.

Under this arrangement, the client received psychotherapy and her mother received counseling once a week for seven years. In the early stages of this relationship, the therapist also counseled the client’s father and brothers several times each. Although the therapist suggested that the entire family receive family therapy in order to support the client and improve the family relationship, they declined on the grounds that they didn’t have the time. They seemed to think that if the client would become stable, her mother’s confusion and the whole family’s problems would also be resolved.

The therapist and the client discussed the matter and agreed to begin a therapeutic relationship with the help of her doctor, a relationship that would continue for years and be supported by her family members. Since that time, none of her family members except her mother have participated in therapy sessions.

b. Process

Concurrent therapy of client A and her mother continued for seven years. It was gradually revealed that the mother’s behavior was based on her own psychotic anxiety and her tendency toward paranoid thinking. The mother had projected her pathology onto her daughter, client A, and confused her. In the mother’s sessions, the therapist heard the mother’s explanation of A’s daily life experience and how she had been raised. Here, the focus was on the mother’s behavior which had confused the client. In client A’s sessions, in contrast, A told the therapist about her inner experience, rather than her daily life which was the subject of the mother’s sessions. At one point, the client fell into a temporary state of auditory hallucination and delusion. During this state, the therapist supported the mother, who was scared by A’s confusion. Five years later, the client became able to talk about her daily life and her experiences with her mother with ease. At the same time, the mother began to talk about her relationships with her own former family members and how she had been raised. She became able to verbalize her own insecurity and sufferings. Gradually the client and her mother each became able to distinguish their own
problems and experiences from those of the other. At this time the client insisted that the concurrent sessions with her mother be closed, and they were. It had been seven years since the concurrent therapies had started.

After that, the therapy sessions continued for more than ten years. Client A became able to notice how her mother’s pathology affected her daily life. She periodically experienced several other states of delusion, but eventually rebuilt her relationships with her brothers and became able to take responsibility for her own future.

c. Considerations
The author considers this case to exhibit the characteristics of Pattern 1, in which the family members of young-adult clients also receive therapy sessions.

In cases corresponding to Pattern 1, family members have significantly influenced the client’s pathology. Client A took her mother to therapy in an attempt to separate her own ego from her mother’s, both in reality and in her inner world.

For the first five years of the therapy process, the therapist took the mother-infant fixation as a unit in which the child could not leave the mother, nor could the mother leave the child, and in which the mother’s stability contributed to A’s stability. Figure 1 illustrates this stage.

The small oval represents the undifferentiated mother-child unit, which was the state of the relationship in the client’s inner world. Figure 1 represents a scenario in which the therapist gives concurrent therapy to both mother and child. The big oval indicates the idea that the therapy itself is a unit of the therapist-client relationship and that the therapies are given in parallel. This means that the therapeutic relationship exists between the mother-child unit and the therapist.

During this stage, the mother stated that the client’s pathological responses were caused only by her “sickness”, but in this conversation the therapist could not determine whether the mother was talking about the client or about herself. The client and her mother seemed to regard themselves as undifferentiated. When the mother talked about her concerns about the client’s physical condition, she was actually worried about her own physical condition. The client, in contrast, said nothing about the mother during her sessions. Although she spoke only of her own thoughts and her own will, the therapist recognized that these were identical to the mother’s thoughts and will. The client was thus unable to differentiate herself from others, or to differentiate her reality from her fantasy.

In this stage, it was critical to listen with care to both the client and her mother and to attempt to determine whose words they were using and whose will and whose physical state they were talking about in any given conversation.

As the healthy ego of client A grew, the mother-infant fixation began to dissolve, and she came to express her own feelings about her mother. The therapeutic relationship in this stage is illustrated in Figure 2, and its mechanism in Figure 3.

The small oval represents the undifferentiated mother-child unit, which was the state of the relationship in the client’s inner world. Figure 1 represents a scenario in which the therapist gives concurrent therapy to both mother and child. The big oval indicates the idea that the therapy itself is a unit of the therapist-client relationship and that the therapies are given in parallel. This means that the therapeutic relationship exists between the mother-child unit and the therapist.

Figure 2 depicts the structure of the therapeutic relationship in the second stage, during which the pathologic mother-infant fixation dissolved. The therapeutic relationship between the undifferentiated
mother-child unit and the therapist was divided into two parts, the child-therapist relationship and the mother-therapist relationship. In the second stage, therefore, the therapist became committed to treating the mother and child separately though in parallel. The client began to talk about what she was experiencing personally and to talk about her mother as a person distinct from herself. The mother likewise began to talk about her child's experiences in a way that indicated recognition of the child's distinct status as an individual. During this process of separation, the client was often observed to fall into a state of confusion; when this happened, the therapist would explain the client's confusion to the mother and advise her on how to cope with it. This provided support to the mother, who was feeling insecure. It also contributed to the formation of a new close relationship between the client and her mother which was totally different from their former relationship. One could almost say that through this process the client was brought up all over again. After the dissolution of the pathologic mother-child relationship, client A went through several critical periods, but the mother was now able to provide helpful support for the client during these times.

In a case like this, in which a single therapist counsels both mother and child, the development of a trusting relationship between the therapist and the client contributes to the healing of the relationship between the mother and the child. The therapist plays the role of a mediator.

The client in case A eventually wanted her mother's counseling to end. The therapist and the mother discussed this and concluded their counseling relationship. Only the client's individual psychotherapy was continued. On the basis of the new family relationships which were created during these processes, client A was now being raised all over again in her individual psychotherapy.

In <Pattern 1>, in order to dissolve his or her own psychotic disorder, the client asks the therapist to mediate the client's relationship with a family member in concurrent individual psychotherapy with that family member. This involvement with the client's family often develops beyond anything the therapist could predict. In case A, the mother's therapy ended prematurely; in order to resolve the mother's problems, concurrent therapy with another therapist should have been substituted. She was referred to a psychiatrist, however, and treated pharmacologically.

When the mother-infant fixation is deepened, psychotherapy which treats only the client sometimes causes more suffering for the client. <Pattern 1> could serve as a better method by which to support the mother-child unit as a whole.

2. <Pattern 2>

Both the client and a family member come to therapy trying to control each other.

<Pattern 2> has two vectors. One is that the client tries to control the family member consciously and unconsciously, and tries to make the family member see the therapist. The other vector is that the family member tries to control the client and comes to a therapy session with the intention of controlling the therapist. The model case representing this pattern is Case B.

a. Outline of the case

Due to hypochondriac anxiety, Client B was unable to maintain appropriate interpersonal relationships in her workplace, and accordingly had quit her job. After her resignation she withdrew into herself. She frequently resorted to violent language and behavior toward her family, and attempted suicide several times. Her father attended counseling with the client's own therapist once or twice a month until the client's psychotherapy ended.

Since her infancy, she had been brought up under strict discipline and taught to be obedient to the people around her. Throughout her life, she had followed the paths which her father had chosen for her. In her workplace, things had gone well during her training period, when all she had to do was follow her boss's instructions. Later, however, when she was expected to use her own judgment, she was not able to control herself or direct her own life.

b. Process

Client B received psychotherapy for a total of ten years. Her family, and especially her father, had intervened
in the therapy from the beginning. The father had proposed that he should see the therapist on a monthly basis to consult regarding how he should deal with his daughter. Client B agreed to this suggestion, and thus the framework of her therapy was created. Throughout her time in psychotherapy, she repeatedly experienced suicidal compulsion and frequently attempted or threatened to commit suicide. During these periods, she was carefully looked after at home, according to the instructions offered to her father during his sessions with the therapist. Once her father learned to care for her at home, the client learned to articulate the feelings which she had been formerly been able to express only through suicidal behavior. She finally developed a plan for her future through dialogue with her father.

c. Considerations
Pattern 2 is often seen in clients from families dominated by obsessive personalities, in which each member of the family tries to control the others. To members of such families, following the rules of society and the family is more important than realizing their own wants and needs. Client B was not able even to recognize her own needs, and the pressure of her anxiety and fear for her future caused her to panic. Growing up under unspoken pressure that she would be cut off and abandoned unless she did as she was told, the client learned that it was dangerous to realize her own desires or to develop a strong sense of self. It was gradually revealed that the father had been raised in a similar family.

Figure 4. The First phase of Pattern 2

The small oval represents the function of the therapist who is supporting the fragile ego of the client through client-therapist unity. This reduces the client from feeling controlled. Watch the development of an early sign of self assertion of client. The big oval means acceptance of father's discontent and anxiety.

Figure 4 The First phase of <Pattern 2>

The therapeutic relationship in the first stage of Pattern 2 is illustrated in Figure 4. The small oval represents the connection between the vulnerable ego of the client and the therapist working to protect her. This framework alleviates the client's sense of being controlled and helps her be assertive. The big oval represents the therapeutic framework between the father and the therapist which embraces the father's dissatisfaction, anxiety and desire to control his daughter.

The members of Client B's family are connected through their attempts to control each other. In response to this situation, the client and the therapist form a unit in which they share the client's obsessive anxiety and try to alleviate it. This unit also alleviates the father's insecurity and various other feelings including his desire to control, and transforms them into feelings that will benefit the client.

Reestablishing the client's bonds of emotion with her father was the primary goal of the therapist who counseled both of them. The client expected that the therapist would control her father, making him behave as she wanted him to behave. The therapist acknowledged this expectation and shared the sadness that she experienced upon learning that she could not realize this expectation.

In cases that conform to Pattern 2, it is critical to the success of the client-therapist relationship that the therapist never attempts to control the client but rather respects any refusals or protests, so that they can establish a relationship in which the client's needs are openly discussed. As the client's self-assertion grows, the family will try harder and harder to control her. This is because the client is becoming less like what the family expects her to be. The therapist must accept this judgement on the part of the family as well as the anger and the hurt that they will experience when they can no longer control the client. In this process, the client's family members may begin to talk about their own anxieties and their own relationships with their parents. As they gradually come to feel accepted,

Figure 5. The Second phase of Pattern 2

they can create new relationships with their children. Figure 5 depicts the second stage of the therapeutic
relationship in Pattern 2. The small oval represents the therapeutic unit of the client and the therapist. The big oval represents the therapeutic unit of the father and the therapist. In this stage, these two units revolve around each other. The relationship between the father and the therapist embraces the relationship between the client and the therapist. The client’s relationship with the therapist serves to protect her as she grows.

Pattern 2 proves that an Ireo-framework (MIFUNE, 1993, a,b, 2008) is easily formed when a client’s family members receive therapy, regardless of whether it is intentionally therapeutic or merely reflects the family relationship. The family’s desire to control the client signals their affection for the client. The therapist should try to see it in this light, and should strive to help them express their commitment in ways that promote the child’s development.

This pattern can also be seen in relationships between spouses, when the client’s spouse comes to counseling seeking ways to control the client. This can lead to a joint psychotherapy session with the client and the spouse, or to couples’ counseling. If the client is in a serious condition, however, the therapist must speak with the spouse in a separate session, listening to both of them, continuing to embrace the client, and trying to weaken the spouse’s control. The same process can occur when the family member is the client’s parent.

3. <Pattern 3>
The client’s family abandons the client and refuses to be involved in therapy.

Although individual psychotherapy targets the individual, most clients have a key person, usually a family member, who is committed to the client in an important way. As stated before, the families of targeted individuals often intervene in therapy. Yet even abandonment of the client is a way in which a family can influence the psychotherapy process.

Pattern 3 is considered to represent a failed attempt at reproducing Pattern 1 or Pattern 2. Perhaps the client tries to involve a family member whom the client supposes to share his or her pathological suffering, but the family member either does not respond at all, or refuses with such vehemence that the client becomes confused. Or perhaps the family member initially comes to a therapy session seeking a way to solve the client’s problems for the client, but instead of seeking a solution they end up requesting that the client be hospitalized or institutionalized, that is, appealing to the therapist to rid them of their burden. Once they realize that the therapist will not do what they want, however, they instantly abandon the client. The model case representing this pattern is Case C.

a. Outline of the case
Client C came to the intake session accompanied by her parents. Her mother spoke of C’ s long-term problems and of the parents’ worries, and claimed that she wanted to commit to supporting her daughter’s therapy. In practice, however, she spent three sessions talking about her own anxieties, then never came to another session. During the period of her mother’s involvement, Client C acted out at home, though the mother never mentioned this. This episode made a strong impression on the therapist.

After starting psychotherapy, the client continued to act out violently, crying, rampaging around and frequently attempting suicide. Her mother, finding herself unable to control the client, made a telephone call to the therapist demanding direct intervention. After this incident, the therapist decided to bypass the mother and instructed the client to call the therapist directly when she felt confused. Of the three clients discussed in this paper, Client C was the oldest at the time of intake. She had withdrawn herself starting at the age of twelve and eventually became unable to attend college. After leaving college she attempted to study abroad and then to hold a job, but neither of these endeavors lasted long before failing. Client C’ s experiences were similar to those of Clients A and B except that Client C’ s family did not make any commitment to support her in therapy. It took her a long time to give up her desire for emotional support from her family and to decide to face her own problems without their support. When she finally did, she became able to receive individual psychotherapy in the ordinary manner.

b. Process
Client C received therapy for more than ten years. At the time of intake, she was pleased by her mother’s
willingness to commit to therapy. But the mother talked only about her own plight, as she had done in a previous attempt at treatment which C had stopped after several sessions. As in Pattern 1, the mother insisted that the client’s pathology originated with the client alone. At the beginning of the therapy and even after her family had stopped coming to sessions, C kept appealing to them to come again. Although the mother indicated that she was willing to come, she never came. As in Pattern 2, the mother wanted the therapist to control the client. There seemed to be no dilemma or suffering in her approach to the situation. A primary goal for C in therapy was therefore to give up her desire for her mother to come to sessions. Previously, she had shared the family’s fantasy that she alone was the origin and cause of her own pathology. In fact, she had been feeling guilty for years about bothering her good mother and father. In the therapy sessions, however, she faced the reality of her family and gradually understood it.

For several years after starting therapy, she continued to act out and to suffer from psychosomatic illnesses, and remained house-hospitalized. As therapy progressed, she gradually became able to start a new job using her expertise. She felt anger and sadness about her lack of emotional bonds with any of her family members, but she came to accept this situation. She gradually became able to understand her mother’s narcissistic personality and learned to keep an appropriate distance from her.

c. Considerations

When Client C’s family intervened in her psychotherapy, Client C fantasized that her family was doing so because they desired her. Yet every time she projected this fantasy onto her real family, she was disillusioned. In practice, her family cut off mental and emotional involvement with her and tried to exclude her in various ways. Parents of clients who are involved in pattern 3-type situations tend to see themselves as good parents, like Client C’s mother did, though she was actually narcissistic and devoid of sympathy. She lost touch emotionally with her child. In order to maintain stable relationships with her other family members, Client C’s mother yielded to the unconscious impulses in her mind which encouraged her to exclude her child, who caused a lot of trouble and required a lot of help.

Figure 6 illustrates this framework. The small oval on the left represents the therapeutic relationship between the client and the therapist. The big oval outside represents the fantasized family which the client holds. The small oval on the left represents the family in reality.

Given the mechanism of Pattern 3, it is thought important that the therapist carefully cut off his or her own relationship with the client’s family. Although a family exhibiting this pattern is not necessarily a family without love or concern for the client, the family has already cut off its emotional relationship with the client, so that continued family intervention in therapy can actually cause various problems for the client, although it can also be instructive for the therapist. The author considers it important to embrace the client’s attempts to introduce her fantasized family into her relationship with the therapist. In Case C, for example, the client called the therapist her ‘therapy mother’ and the psychiatrist her ‘therapy father’. She projected her fantasized family onto the therapist for a certain period. During this period, the therapist was encouraging the client to distinguish her fantasized family from her real family. Specifically, she had to realize that her ‘fantasized parents’, her therapist and psychiatrist, would not do the same things for her that her idealized family would do. For the first time in her life, therefore, this client was able to protest against her ‘parents’. She took her anger out on the therapist and acted it out in the therapeutic relationship. All the while, her projection was fading little by little. A process like this takes a long time to complete; as the client’s treatment
continues, a new relationship with the real family in being formed.

III. Comprehensive Conclusion

So far, three patterns of therapeutic relationships with the client’s family in individual psychotherapy have been introduced, and their therapeutic mechanisms considered.

Speaking at a recent case study conference in the U.S., the author acquired a new perspective on the relationship between clients and their families when a description of the therapeutic process of a client in her 40’s who had withdrawn into her home, where she lived with her family, was met with confusion. Many listeners expressed surprise through comments such as ‘I cannot understand the situation where the child in his or her 40’s is living together with the family.’ Many participants were surprised to find that a number of clients who had serious conflicts with their families nevertheless could not move out and live by themselves. Cultural and social differences were responsible for different therapists’ various responses to this situation. In the following section, the author considers the meaning of the therapist’s involvement in the client’s family, both in reality and in the fantasy within the client’s inner world.

Family in reality and family in fantasy

The author has a number of clients who, for economic or social reasons, cannot live apart from their families although they have conflicts with other family members.

There is some speculation that one of the reasons why such clients continue to live with their families is that their proximity makes it less likely that the family will abandon the client as a scapegoat. An alternate explanation that may be considered meaningful is that they cohabitate because the family has not yet achieved an appropriate relationship with the client. At the time of the conference, the author reflected that even clients who continue to live with their families can become independent in a characteristically Japanese way.

The fact that a grown-up child lives with his or her parents is not nearly as important as how the child relates to the parents. Independence does not mean isolation. Many of the author’s clients are mentally isolated even though they are living with their families. All of the clients in this paper, for example, are living with their families and are also at risk of becoming mentally or emotionally disconnected.

Client A (pattern 1) was trapped seeing herself as indistinguishable from her mother and was in danger of losing herself. She could not differentiate herself from others, or her reality from her fantasy. Theoretically, she was in a state in which she had no ‘family in reality’. This is why the therapist supported her family’s involvement and helped separate the client from her mother.

Client B (pattern 2) was under the strong control of her father; she herself was helpless, and she had never been emotionally connected to her mother. She was threatened by her ‘family in fantasy’ and tried to control that threat. The goal of her therapeutic process was for her to become aware of her family’s concern for her. At the same time it was important that her family became aware of her real state.

Client C (pattern 3) had had many experiences of being deserted by her mother, who looked so kind and understanding on the surface. Her mother accepted an ideal daughter but not her real daughter, who didn’t meet her expectations. She neglected her daughter in reality. So the goal of this therapeutic process was for client C to withdraw her own projection of her ‘family in fantasy’.

Thus each client involved her family in her own individual psychotherapy, describing them to the therapist and acting out family relationships in therapy. In this way each client began to understand her family’s pathology in her struggle with her own problems. The author believes that this is the clients’ way of achieving independence regardless of who they live with and what their way of living is like.

In most similar cases, one or both of the client’s parents has been deeply hurt by their own ex-family members. The parents described in this paper were no exception: they had had entanglements with their ex-family members. Their children’s pathologies led them to attend psychotherapy sessions with their children and offered them a chance to begin to solve their own
problems through their children. In other words, it is considered that, no matter how old the child is when he or she becomes a client, brings new therapies and approaches to the family’s plight. Although the author hasn’t been involved with every member of every client’s family, she can’t help having some kind of relationship with them. As the author observes the problems of individuals, she must also analyze each family’s mechanism.

Functions and limitations

The involvement of the families of clients in individual adult psychotherapy can take unusual forms, as in the cases presented in this paper. These kinds of involvement work well for clients with serious pathologies. There are three points which should be considered.

One is that the therapist’s involvement with a client’s family helps the therapist feel ready to start the client’s psychotherapy. The family’s commitment can make it clear that the client has her family’s pathology; this helps the therapist understand the client and contributes to her psychotherapy. Omata (2002) has delivered many papers reporting concurrent therapy of mother and child with the same therapist. All of the clients are children, even in their adolescence.

The second point is that the therapist is in a position to show the client a model of a healthy family, or a model of not having a family. Sometimes, a client’s family will tell the client what they talk about in their sessions with the therapist. They may disparage the therapist, telling the client that the therapist is incompetent, or they may perform a ‘tug of war’ with the therapist trying to keep the client and the family trying to pull the client away. When a client realizes that this is happening, the therapist’s attitude can be a model for her. One client, facing her mother’s usual response, said “I could not stand it, but could not let her win either”.

The third point is that, as mentioned in the discussion of each pattern, the therapist can play the role of a mediator who facilitates the building of a new bridge between the client and the family. Specifically, the family image in the client’s fantasy is gradually corrected. Their relationship is restored while the therapist translates the true meanings of what the parent says or does to the client, and translates what the client says or does to the parent (Omata, 1998, 1999, 2001, 2002).

On the other hand, treatment of the family’s or the mother’s problems must be limited, because the client’s individual psychotherapy does not target them. Concurrent child-mother therapy often leads to individual psychotherapy of the mother, according to many reports (Yano, 2006). A’s mother, for example, often discussed her own problems in her meetings with the therapist. Sometimes interviews in concurrent child-mother therapy ranged beyond the boundaries, making it difficult to draw a line between keeping the framework and proceeding the way it is (Hashimoto, 1998).

Furthermore, our task in the future will be to consider the connections between family relationships and their mechanism by analyzing each case carefully.

Psychotherapy begins with meeting people who are already in a difficult situation. Some of them cannot go to school. Some cannot go to work. Some cannot do the house chores. They are in bad physical condition, cannot find the meaning of life, and sometimes deny living. The families surrounding these suffering family members are also deeply hurt. The author would like to believe that there is a remedy for this, which can only be used once the client has been diagnosed with a serious condition. Its function is to create new family relationships.

Reference


Journal of Center Child and Family Faculty of Life Science, Osaka City University pp. 43-55. (in Japanese)
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個人精神療法における「家族」
－同治療者による親子並行面接に見る「現実の家族」と「幻想の家族」－（和名）

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要旨：本論は、成人期の心理療法における家族との治療関係についての考察である。一般に、成人を対象とした心理療法では、クライエントの心理的問題の緩和と解決のために、個人の内面の探索が行われる。成人個人を対象とした心理療法では、その家族と直接関わることは、家族療法などの場合を除いてほとんどない。しかし、重篤な状態にあるクライエントとの心理治療においては、治療者がクライエントの家族とのかかわりを持つことは避けられていない。そこで、本論文では個人心理療法に現れる家族とのかかわりの特徴を次の3つのパターンに大別してその分析を行っていくことを目的とした。

＜パターン1＞クライエントが自身の病気に関する重要な家族をセラピストに会わせる
＜パターン2＞家族とクライエント双方が相手のコントロールを求めて来談する
＜パターン3＞家族がクライエントを放棄する

この3パターンの特徴について自験例をあげて、クライエントと家族の関係、クライエントと治療者の関係、さらに治療者と家族の関係について分析を行った。その結果、＜パターン1＞ではクライエントと未分化な状態にある家族（主として母親）との同一治療者による母子並行面接が行われ、母子一体ユニットに対する治療関係形成から、病的な母子融合状態が解消され、分離した後でも同一の治療者が関わることにより、以前とは異なる発達促進的な母子関係が形成され、クライエントの自我の育てなおしが進んでいった。＜パターン2＞ではクライエントと家族が双方のコントロールを求めて治療に参加する事例を示し、治療者はクライエントの弱体な自我を支えながら、クライエントの自己コントロールを求めていく。また家族との面談では、クライエントに対する家族の不満や心配、コントロール出来ない苛立ちを抱えながら、クライエントの成長を見守る機能を果たすことが出来た。＜パターン3＞では、クライエントと家族の情緒的関係は修復不可能な状態にある事例を示し、家族の治療への介入を遅ら、クライエントの幻想の家族イメージを治療者が担いつつ、徐々に現実への直面化を促進し、現実の家族との関係の修復を果たしていた。以上、取り上げた事例はいくつかの典型的な事例を合成した事例である。

家族とのこのような関わりを持つことは特に重篤な状態のクライエントの個人心理療法を行っていくうえで、次の3点において有意義であることを明らかにした。

1. クライエントとの心理療法を始めていくための準備を行うことができた点である。それは、家族を引き受けたことによって、クライエントの抱える家族の困難がより鮮明になり、その後の心理療法において、クライエントへの理解が深まる。

2. 家族とのかかわりを持つこと、もしくは持たないことを通して、クライエント自身に家族に対する関係のひとつのモデルを治療者が実際に示すことによる。さらに、そのことによって、治療者が家族とクライエントの新たな関係のつなぎの役割を果たすことができる点である。

(12)