Birth of a Self in Adulthood

SEPARATION ISSUES AND PROCESS

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During the course of psychotherapy, patients change their view of their parents. First, patients lift the denial surrounding the pathological interactions sustaining enmeshment. Then patients see, for the first time, the limitations that result from the maintenance of a close family. Patients then recognize the commands and myths, feel anger, see why their parents imposed such restrictions on the family, and gradually turn to the task of repairing the incompleteness within themselves. This chapter explores the step-by-step change in thinking and feeling necessary for the birth of a self.

THE DIFFERENCE BETWEEN BEING NEEDED AND BEING LOVED

The biggest and most painful issue that must be clarified with patients is the difference between being *needed* (psychologically) and being *loved.* Impinged-upon adults rarely use love to describe the relationship between themselves and their parents. For example, they say, "My parents *needed* me" or "We were *very close."* These are the words that describe the symbiotic dependency of children who were never allowed to grow up.

One hallmark of this phenomenon is that the parents are frequently

referred to as “Mummy” and “Daddy” rather than by a more mature appellation. Retention of these childhood titles by adult patients suggests that they still feel like children in the family of origin rather than like adults at the head of their own family. Likewise, parents reinforce dependency by speaking of their toddlers as infants and of their grown offspring as children rather than as sons or daughters.

Patients describe their relationship with their parents in several ways.

Alice, an articulate female lawyer, observed, “To feel weak, inadequate, and special at the same time is meant to send you to the loony bin.”

Tom reflected, “My mother gave the gift of life, but only on the condition that I serve her needs before my own. I have spent my life at her altar.”

Alice said sarcastically, as she showed me a copy of the family Christmas photograph, “See, I am one of my parents’ Christmas tree ornaments.”

Another patient, Karen, said, “My parents’ bottom line was always 'What is yours is ours, what is mine is mine.’ ”

Jan’s mother came to visit. The visit went well at first, and her mother was even able to be supportive of the new home Jan had bought. Then some out-of-town friends called asking if they could stop by briefly for a visit. Her

mother's mood suddenly changed; she became cold and distant. When the friends arrived they began to chat with Jan and her mother. Her mother disappeared into the bedroom. Jan went after her and asked, "I don't understand; What is wrong?" Her mother responded, "You don't care about me anymore. I should have gone back home. I can see that I am not needed. You shouldn't have invited them to visit when I was already here."

This mother's comments reveal her need for her symbiotic rather than loving relationship with her daughter, and her extreme discomfort in watching her daughter relate to anyone else.

Some parents are able to say "I love you" as part of their superficial knowledge of the permissions. Other parents apparently do not use these words.

Philosophers, psychologists, authors, and poets have all attempted to define love, yet its meaning remains elusive. It is necessary to conclude, however, that loving is a more mature phenomenon than the interaction that takes place within patients' families. That is not to say that these patients receive less than the best that their parents have to offer in terms of shelter, clothes, education, or money. Their parents often excel in meeting such basic needs. However, a prerequisite for loving is a sense of wholeness and separateness as a person, with enough respect and responsibility for oneself

to feel comfortable being intimate with someone else. Loving includes being able to respect and support another person's growth. Loving implies reciprocal healthy giving without demanding or obligating the recipient to respond out of guilt. Sullivan sees intimacy occurring "when a person feels that the welfare of another individual is as important as his own well-being" (Chapman 1978, p. 204).

The interactions reported in therapy hours suggest that the patients were deprived of mature loving. This is painful to realize, but the hurt is mitigated by the patients' new understanding that love was not withheld because they were unlovable but because their parents did not feel psychologically complete enough to engage in mature intimacy, either with their children or with each other.

In addition, impinged-upon adults have difficulty with caring about themselves because they do not feel any more psychologically complete than did their unentitled parents. Impinged-upon adults have remained an extension of their parents. If they are able to face their incompleteness and self-sabotaging behavior, they find that they can create a whole, separate self that enables them to respect and love both themselves and other people. This is a formidable task. It is one of the reasons why psychotherapy takes a long time.

Patients describe incidents that suggest that they are aware of this lack of loving.

Richard did a fine job with a number of difficult interviews and secured a top-notch job with a good salary. He was competing against many qualified applicants. When he went home, he was surprised that he felt no joy but instead wept for hours. He realized he would no longer need his parents' money, which he had been accepting for years as a substitute for love. He wept because he felt that no one had ever loved him and that the new job meant that no one ever would. He was grieving the loss of his only substitute for love.

The issue of loving and needing is further complicated when separation issues get mixed up with oedipal issues. Sometimes mothers of an impinged-upon adult, instead of providing love and support, teach their sons to be totally dependent upon the mothers' adoration as a substitute for a positive sense of self they should have helped their sons build. This adoration is never fully given but is held out like a carrot, subtly and secretly promised in the form of an eventual, perfect sexual union. The sons continue to return for this forbidden fruit as their way of reaching for an external adoration they can never seem to obtain within themselves. When the mothers continue to tease but never offer their sexuality, the sons are constantly frustrated and may turn to various forms of perverse sexual experiences as a substitute, acting

out both their longing and their anger at this frustrating situation. No other woman looks as perfect sexually as their mother. In addition, the sons cannot like themselves well enough to become intimate with anyone else. Unless a psychotherapist intervenes, the mothers continue to promulgate their perfect image. Their sons return to them for life and never marry. It is extremely difficult for sons to admit that this interaction is taking place and give up their angry quest for their mothers.

MANIFESTATIONS OF PATIENTS' ANGER

Impinged-upon adults become angry about the commands, the lack of loving, and their sense of failure. This anger originates long before the psychotherapy, though it may be blocked from conscious awareness. In fact, impinged-upon adults are often puzzled by seemingly unrelated external circumstances that activate their anger. For instance, they feel more infuriated by rush-hour traffic than the situation warrants. The slowed mass of cars feels like their parents stopping them from going on with life. They have the same reaction to extended waiting for a doctor's visit. They usually laugh when the similarity is pointed out to them.

What can impinged-upon adults do with their anger before they understand it? Prior to psychotherapy, they tend to choose pathological alternatives that compromise their lives in some way. Each action serves the

purpose of trying to escape the commands, act out the anger, or express it through rebellion. Some impinged-upon adults blow up over trivial things. Others staunchly and routinely rebel by refusing to do something small that would help life to run more smoothly.

Some impinged-upon-adult patients are fortunate in their ability to rediscover the anger that they have been forbidden to express. It comes out in the psychotherapy hour, in dreams, in behavior toward friends and co-workers, or sometimes transferentially. It is not as frightening as the patients might have expected. It is the therapist's responsibility to see to it that anger is brought into awareness in small, manageable amounts.

Other impinged-upon-adult patients have learned to express their anger in an unconscious, passive manner or by acting out in a way that results in maintaining failure. This anger is harder to reach. The therapist often senses the passive expression of anger in the therapy hour. The therapist may observe patients understanding the content and process of each session but not doing anything more with their life than before. These patients prefer to let things ride with no obvious sense of discomfort. The therapist begins to feel frustrated, as if the patients were pulling against the therapist. The patients plead innocent and ask the therapist to say it again, even though the patients can articulate easily what has transpired in the therapy. In fact, patients may mildly enjoy the confusion and not want to understand why

they are not using the new knowledge. The therapist feels pulled to work harder. Nothing happens.

Gradually, the confusion subsides, and the therapist learns from each patient's acting out. Patients have themselves provided the following reasons why they have acted out their anger by failing in life. Some patients fail

1. because they prefer the defense of remaining stagnant rather than experiencing the anger they feel about being held back.

2. so that "nothing is going on" for their parents to sabotage.

3. because they are afraid to succeed, for fear that their past deprivations will be forgotten by their parents.

4. to prove that their parents failed.

5. because they do not want their parents to "live off" their success. They wish to pay back their parents by their failure in a deeply retaliative gesture, even if it means sacrificing part of their own life experience. They are not aware of the fact that this sort of retaliation ties them down as severely as over-compliance.

6. because they desire the attention and contact they feel they have learned to get through failure.

7. because they fear that success will take them away from the supportive therapeutic relationship. (Most patients realize

the supportive component in a therapist's confrontation. They fear that success would take away the need for this kind of support.)

Any one of the above ways of handling anger makes the psychotherapy extremely confusing and difficult for the therapist to manage. Furthermore, if therapists collude with patients in this avoidance, the trouble is compounded, since the patients have already heavily invested in keeping their anger disguised.

Amy knew that she was resisting her anger but did not yet understand why. In the middle of feelings of despair and sadness she said, "I am pitiful in my inability to do anything with my life. My resistance is like a piece of armor surrounding me. I cannot find the door or a crack of light to see my anger. Everything looks dark, hidden by the resistance."

Later, Amy succeeded in working through her anger and went on to explain herself to me. A summary of her thoughts from two psychotherapy hours follows:

I am spiteful. By that I mean I am willing to hurt myself to get back at someone else. I am angry because I have never been in control of my life. Other people have used it for their own benefit. I was taught as a child that a good person is someone who does things only for other people. A bad person

considers her own needs and that is selfish.

I'm thinking of an example. As a seven-year-old girl, I heard the ice cream truck come down the street for the first time in our neighborhood. I got my money and ran outside and got myself a cone. I felt so proud that I could do that all by myself. When I went back into the house, my parents came down on me really hard because I had forgotten to ask anyone else in the family if they wanted a cone too, as if they couldn't hear the ice cream truck themselves. I remember feeling so confused and deflated.

I'm so mad and spiteful that I will even hurt myself to get even. The phrase 'taking charge of your own life' has only been a useless jingle to me. I've had to spend my life resisting what other people need me to do for them. I never got a chance to evaluate my life beyond that simple principle. It never occurred to me that I *could* do something I wanted or something that someone else wanted me to do, if it also happened to be good for me.

Several hours later, she went on to define her passive-aggressive anger further as "deliberate incompetence." She came into her hour both angry and crying. She had just been taught to use a complex typewriter at work, and she had done extremely well. She was proud of herself but also realized that if her father had been the one to teach her, she would be doing very badly. Through her tears, she blurted out, while she stamped her foot on the floor for

emphasis,

My father kept trying to make me learn to play chess. He wanted me to play so that he could beat me. He would have taught me badly so I never would have had the knowledge I needed to win. He also needed me to play because it was an educated thing for me to do and he would be embarrassed if I couldn't. But I beat him. I refused to play!

If I was angry, I was made to feel helpless and incompetent. No one ever asked why. By developing my deliberate incompetence, I got to be angry passively. I got to make him feel helpless and incompetent. I also got to protect my talent from his humiliation. If I had done well with the game, I would have been sent away as if I were a leper.

If patients succeed in working through their anger, there is often a period of time when they have to endure feeling angry, all of the time, at everything. During this period, it is important for therapists to urge patients to take especially good care of themselves. Sometimes the anger turns inward, and patients feel hopeless about continuing life or the enormous task of psychotherapy. There is usually no definite suicide plan but a temporary feeling of wanting to get away from the pain. It becomes easy for patients to run a red light, for example. The support and the therapist's availability by phone during this period are helpful and sometimes essential.

A difficult circumstance can occur when patients act out their anger, accumulated from many parental interactions, transferentially with the therapist. This acting out serves patients as a defense so that they can avoid conscious awareness of their anger.

Jim, a teenager, was angry at his mother for failing to give him the love and support to which he felt entitled. He tried unsuccessfully to engage her interest in him by lounging around the house, doing nothing, hoping that she would notice him and urge him to go out and play hockey. Then he tried for sexual love, instead, by being flirtatious. When he discovered that his therapist was also unwilling to provide either kind of love, he acted out by punishing-type behavior. For a time, he tried to "destroy the psychotherapy" by preventing a successful outcome. He claimed, "The psychotherapy work you do with me is the only thing of yours that I can reach out to hurt." He allowed the psychotherapy to stay in a state of impasse for a number of sessions, while we wrestled with understanding the reason for this behavior. Understanding allowed him to give up the punishment.

Tom felt the need to rebel in therapy in the same way that he had with his mother. He would guess what he thought I wanted him to do. Then he would state the guess as his own feelings. When I reflected the feeling back to him, he took it as a command from me and rebelled against it. In the process, he became very confused about what he wanted to do for himself. He was

doing things he didn't wish to do in order to continue to rebel. It did not seem to matter that his life was not moving in the direction he wanted it to.

These bouts of anger can be long-standing and tiresome for the therapist to handle; understanding makes the critical difference. In the process, the therapist has to suspend the wish for progress. If patients detect that the therapist needs them to get well, their rebellion tends to be stronger and lasts longer.

PATIENTS' CONCERN ABOUT THEIR PARENTS

Patients are concerned not only about themselves and their ability to survive as separate people, but they also worry excessively about their parents. Patients are afraid that their parents will die (psychologically), as maternal command 11 predicts, if they disobey a command.

During the separation-individuation process, patients frequently report a period of time when their parents respond with a recurring illness of unusual severity. The parents will dwell both on this problem and on their aging, as a means of reengaging the patients in the old ways. Sometimes the parents threaten that they might die while the patients are away (Masterson and Rinsley 1975). The patients feel worried and guilty but continue to progress, and the parents eventually feel well again.

Nancy received a call from her mother, who sounded cheerful and well at the beginning of the telephone conversation. Then her mother requested that Nancy come and spend the night. Nancy responded, “I don’t know yet, I’ll have to see how I feel.” Each time she gave this kind of response, her mother sounded “sicker,” complaining of a bad headache and the large number of pills she was having to take.

In reality, most parents benefit from patients’ emerging independence. The parents’ exhausting crises, which occurred with regularity and forced the patients to remain psychologically attached, often decrease in frequency. Ill parents may learn to seek more appropriate medical treatment for their illnesses, so that episodes of sickness are less frequent and severe. Toward the end of psychotherapy, patients may be approached by friends of the family who comment that their parents are looking very well, in fact much better than usual. When patients hear this, they know that their parents are beginning to benefit from the separate lives that the patients have achieved.

In addition, parents have frequently denied themselves objects of pleasure, such as a new car or a summer home. The money has been spent instead to pay the children to stay enmeshed. The parents may have also denied themselves fun items because these luxuries were in conflict with the image of needing help that they wished to present to their children. It is gratifying to see patients’ growth allow them to turn down the “payoff” for

security and instead encourage their parents to buy that new car or take that trip to Hawaii. When the parents can accept this invitation, they also make possible a new relationship with their offspring in which their grown children can meaningfully encourage and advise them. The patients once again help their parents, but this time, in a constructive, positive way for them both.

Donald, a competent banker, took over the husband role in his family of origin when his father died in a plane accident. Then he began to date and came into psychotherapy to work through the issues preventing his marriage. As he moved away from being his mother's "boyfriend,'' this freed his mother to begin dating again. She met a man and scheduled her wedding a few months before the patient himself married. His mother might never have had the opportunity to remarry without the patient's psychotherapy.

As patients establish a separate, independent self, they realize the ways in which they have been invited to take advantage of their parents. They begin to treat their mothers and fathers more fairly.

Ilena moved away from her parents. She saw the extent to which she had been letting her mother pay the rent, cook the meals, baby-sit for her younger child, and do the laundry for her. She came to see that her mother was tired and too old to do so much work. Now that Ilena was more independent, she took on many of these tasks herself and began to pay her

mother for baby-sitting.

Unfortunately, but rarely, there are a few examples in which parents make the existential decision to let their lives worsen. There are cases in which parents continue to pour all of their energy into letting their lives run downhill as a way of attempting beyond reason to reclaim their children's lives. It is more difficult for the offspring to continue to grow toward independence under these circumstances. However, many patients have succeeded.

PATIENTS' TEMPORARY WISH TO CONFRONT OR ABANDON THE PARENTS

There is usually a period of time, while working through the anger, when patients contemplate cutting off their relationship with their parents permanently. It is advisable for therapists to dissuade patients from doing this, because the ties to family are deep and meaningful. During this stage, therapists should caution patients not to make a premature decision until all the working through is completed. Sometimes it seems appropriate to support a temporary separation from family when the patients' anger is so strong that these feelings may be destructive to their parents. However, patients retain the right to choose what relationship, if any, they will maintain with their family. There are occasionally patients for whom the cost of maintaining contact with an enmeshed family may be too high.

The patients and the therapist must wade through the patients' acting out and bring the rage, disappointment, and pain to the surface where it may be used constructively. In the working-through phase, the therapist should try to help patients confine their anger to the psychotherapy hour rather than unload it on their parents. The patients may not be able to resist the temptation to "let the parent have it" in one experimental go-around. This often occurs out of the patients' need to see if they can actually confront their parents. The therapist needs to explain that the parents are not in a position to understand what the patients are attempting to communicate, any more than the patients would have been able to understand in the first hour what the therapist is talking about many hours later. Sometimes the patients and their parents battle it out anyway. Parents react as if they had been thunderstruck. They may retreat in depression and hurt or may be over-adaptive, expressing "undying love and concern" for the patients. In some cases, confrontation of this kind may not be excessively harmful because the parents are able to successfully defend against what they are not ready to hear. The patients see, once again, the unwritten rules and the parents' psychological incompleteness. Sadness and empathy begin to replace the anger.

Tom said, "As I watched my wife take on my mother, I was glad that she could finally do it. I felt the anger, too. I also felt a sadness for my mother. She looked so unable to handle the situation. That feeling allowed me to say to my

wife, ‘Save your breath because Mother is not understanding.’ ”

This patient was surprised to learn that he can make use of two opposing emotions at the same time. Contradictory feelings no longer need to be split apart. Anger can be used to set constructive limits, and empathy and understanding can be utilized to negotiate the parental relationship instead of totally rejecting it.

Patients may feel a temporary despair when they realize that their parents’ psychological incompleteness may not be healed by the patients’ new understanding and response. All impinged-upon adults ultimately hope that the psychotherapy will cure not only themselves but their parents as well. In reality, they will still have to continue to handle the demands from their intrapsychic parents. They may also have to manage the manipulations from their real parents by maintaining an awareness of, and acting constructively upon, their own needs and feelings.

PATIENTS REVEAL THE PARENTS’ HISTORY

After patients’ anger has surfaced and the separation-individuation process is taking place, the patients bring in some information about their grandparents. It is difficult to obtain a full picture of the parents’ history because the parents may have said little about the painful or confusing aspects of their own childhood. Usually, however, there are some well-known

family legends that contain enough information to let both the patients and the therapists know that the parents have suffered with the same commands that they gave to the patients. These stories are every bit as poignant as the examples given by the patients themselves. When patients can begin to reveal their family history, it becomes possible to deepen respect and understanding for their parents' psychological incompleteness, vulnerability, and suffering.

It is easy to lose track of the parents' competence within their profession or community and talk with patients only about their parents' psychological shortcomings. This becomes a detriment to the therapeutic process because the patients lose track of their parents' actual strengths and lose respect for their parents. When the psychotherapy process is able to acknowledge the parents' assets, the patients eventually come to believe that their parents' ability and capacity for growth can ultimately resolve the symbiotic relationship. The competent side of their parents allows the patients to hope for a new and better relationship.

EXPLAINING TO THE PARENTS

In the process of gaining psychological independence, patients feel very uncomfortable about making changes in their lives without informing and explaining to their parents, because they want to protect themselves from further rejection. They hope that an explanation will help their parents to

change in a way that is more gratifying, and they want to protect their special status within the family.

Unfortunately, explaining often accomplishes very little. In fact, more often than not it is detrimental, as is evident in patients' accounts of their discussions to understand separation-individuation issues with their parents. The patients feel a need to test-prove their progress with a successful, rational discussion with their parents. Unfortunately, the parents generally hold up their end of the discussion with skillful sidetracking of any understanding.

These accumulated experiences suggest that the most successful way to tell parents to separate from their children is through consistent action that is the product of working through. Patients take a critical step forward when they can view their parents as fragile and tenacious in their need for psychological support rather than all-powerful. Then the patients can consistently and respectfully resist invitations to continue the enmeshment. The changes in the relationship are delivered behaviorally to the parents through the same channel by which the commands were sent.

PATIENTS RECONNECT WITH THE FAMILY

Many parents have to survive a temporarily difficult period of hostility and rejection from patients during part of the psychotherapy. Parents not

only feel the loss of usual contact, but also psychological incompleteness at the absence of their children as extended selves.

Parents tend to respond to the patients' wish for greater independence and separateness in characteristic ways well known to therapists but confusing for patients. For instance, when patients return home to visit, their parents may well have scheduled so many engagements that there is no time to be with the patients. Perhaps it is their way of saying "If you can go away, I can too" or "I can survive without you" (an important message, even if stated childishly through acting out). Patients may feel confused and hurt by this new behavior. The parents may maintain their busy schedule as long as the patients respond with hurt. However, if the patients can understand and take it in stride, the parents may become more available for a more separate relationship.

Parents may also handle the separation by offering a large, enticing gift in apparent but spurious support of a growth step. Perhaps it is their way of saying "I want to be part of the action if you are going to go away, and I want to experiment to see if you will still accept my gift of sabotage." Patients usually feel sorely tempted to accept the gift, especially if it is money, but decide to refuse it. At this point, patients invariably ask, "What kind of relationship is it possible to have with my parents now that I understand who they are and what has happened to me? I can't think how to talk to them.

What is there to say?"

All patients long to find a way to go on with life and not leave their parents behind. After all, family is family, and there is no substitute for that. In almost all cases, there is a positive answer.

After this combination of doubt, rejection, and counter-rejection has run its course, the parents are ready to end the era of disturbed interaction. They may be so happy about resumed contact that they accept the relationship on new terms. The patients visit without an ax-to-grind because they have come to terms with the fact that their parents are unlikely to meet their needs any more now than in the past. It is ironic that once patients stop asking for love their parents cannot give, a better relationship often results.

Experience suggests that the most successful way to introduce a new, more healthy relationship between patients and parents is through consistent action that is the product of working through. Continued nonverbal action, rather than explanation, is the avenue by which the commands were sent to the patients and therefore is a well-known way to communicate to the parents.

The patients quietly sort out the undermining remarks from the rest of their conversation with their parents and then respectfully decline all invitations to continuing enmeshment. With satisfaction, the patients are able

to sidestep, ignore, or make light of psychopathological interaction instead of getting sucked into it. They can avoid starting a useless fight over their parents' manipulative complaints about life problems or physical illnesses. A sabotaging comment can frequently be halted by simply saying nothing or by quietly excusing oneself. When patients' reactions are accompanied by real respect and understanding for their parents' psychological frailty, the parents will gradually accept these new limits.

It takes time, sometimes years, for parents to catch on. In the meantime, there is no way around some awkward stumbling, some defensive anger, hurt feelings, worry, blame, guilt, and rejection. In the midst of the separation process, parents often feel helpless and try to blame the psychotherapy; the patients' new behavior is labeled as "sick."

In patients' initial attempts to alter the enmeshed relationship with their parents, the patients may present limits in a harsh and rejecting manner. This is likely because they still view their parents as very powerful. When patients can view their parents as actually fragile psychologically, they can set limits in a more kindly, respectful, and supportive manner that compassionately encourages their parents' expanded abilities to handle psychological independence. As the parents function more successfully within their marriage and in general, the patients celebrate quietly, because the parents will not be ready to be complimented. It takes time for the parents to

risk revealing their success in place of advertising their fragility. Therapists need to guide patients through these various stages toward a mature adult relationship.

In the long run, the parents can even feel proud of, and compliment, the patients' new steadiness. They experience their offspring as coming back into the fold, but they accept the fact that this time, it is pretty much on the patients' terms.

Alice was trying out her new ability to set limits with her family. After a considerable period of silence, she was ready to engage with them. She came back to her next therapy hour after a phone call with her family and said, "It really felt good to call them again. It made my day and theirs too, I think. But it was also very hard, and an unusual way to relate to them. I felt like we were both engaged in a fencing match. Both sides put out what we wanted and both sides protected their territory. I'm not used to relating to Mother as another adult instead of just my mother. It will take some getting used to, but now I am ready to try. I wanted to explain things to them, but I forced myself not to do that because I knew that it wouldn't work."

When patients become assured that nonverbal reactions are effective, they are no longer so fearful of a relationship with family members. The patients do not have to avoid or dread every minute of a family gathering. The

parents, in turn, become more responsive when they sense that the anger toward them has dissipated. The time together is often cordial, mildly nurturing, and even fun.

This new contact is less frequent, more superficial, and oriented toward the nonpathological needs of the parents. In-depth conversations about the psychological dynamics of the family usually remain off limits. This becomes acceptable to patients because they have had the therapeutic relationship in which to address such thoughts. Instead, many patients are able to do small things to support their parents' independent growth and achieve some satisfaction from that. When the parents are convinced that they need no longer effectively sabotage their children, they usually begin to see their children's growth steps as useful to them because they can finally feel like proud parents. They are still regarding their children as an extension of themselves, but the sabotage is attenuated.

The following analogy has helped patients understand how their relationship with their parents has changed. When the patient withdraws his or her availability as an extension of the parent, it is as if the parent has a broken leg and must hop or use crutches. The resultant hopping is annoying, since trips together are decidedly limited and slowed down. The parent keeps asking the patient to be a new leg. The patient can decline to do that without knocking the parent over or refusing to visit. Time together can be limited in

length and restricted to the kind of activity suitable for a broken leg. However, the parent will never be able to climb hills to see the patient's accomplishments. The patient and parent may have to live with the parent's broken leg because the parent may not choose to, or feel capable of, fixing it. That does not mean that the patient has to fix it for the parent; the patient is only responsible for repairing his or her own incomplete self.

As the relationships with family members improve, patients will want to respond with a loving gesture. It is easy to forget command 9 (I will reject any offer of intimacy or love. I am not interested in understanding the difference between symbiosis and intimacy).

Martha bought her mother a lovely Christmas present. She wanted her mother to enjoy it. Her mother called to thank her but seemed withdrawn and distant. She spoke without pleasure about the gift and preferred to talk about the wrapping paper and presents she had bought for another sibling who was experiencing financial difficulty. Martha had probably acted too competently and made her mother feel uneasy. She would have done better, in terms of her relationship with her mother, to buy a present of lesser quality. However, Martha's understanding of why her mother withdrew helped her not to feel hurt. Several months later, her father reported that "Mother really enjoyed the gift."

Everyone feels relief as the patients restore a relationship with their families. The patients, and the parents too, feel some sense of sadness at the hours spent feeling hostile and apart while working to understand and gain the necessary freedom. This sadness can serve as a signal to help both parties realize that they are willing to work to keep their relationship with each other.

There are moments in psychotherapy that make all the work worthwhile for therapists. One is seeing a patient reclaim and use a feeling previously forbidden by the commands. Another is hearing about a successful family gathering in which both the patient and the parents enjoyed themselves.

PATIENTS LEARN TO LOVE AND TO BUILD THEIR OWN FAMILIES

As impinged-upon adults achieve independence and begin to feel their own separate selves, they want to try out their ability to be loving. A pet can be a useful adjunct to the psychotherapy at this point.

Arleen learned that she could have a baby without necessarily repeating the enmeshment that had happened within her own family. However, she needed to test out her ability to be an appropriate caretaker first. She bought a puppy and began her relationship with the dog by feeding and grooming it, training it, and caring for it through a severe illness. During this time she

received several sabotaging letters from her family. She felt confused about her ability to lovingly care for the dog. Her confusion was expressed when she brought the dog in her car to her therapy hour. She wanted me to see that the dog was alive and healthy. I invited the dog into the therapy hour. Arleen declined, fearing damage to my office, but remembered the invitation as a statement of confidence in her ability to be a nurturing parent. The dog was a pilot study. Arleen went on with her psychotherapy and was eventually able to have her own baby.

Andy accepted his therapist's suggestion that he buy a dog when he moved into his own apartment in the city and felt the need for protection and company. He bought a puppy and brought her to a therapy hour. I went outside to see the dog during the last five minutes of the hour and was openly affectionate with the animal, letting the dog lick my face. Andy was surprised. In the following hour, he revealed that he was unable to let the dog touch him above the waist. He was afraid that the expressed love from the dog would be intrusive.

Gradually he was able to let the dog into his life. He went on a vacation and decided to put the dog in a kennel where the animal would be "sure to be safe." He cried when he left the dog, and the dog was "ecstatic" to see him when he returned. The two of them had managed loving and separation.

Once Andy felt competent to love, he was able to have a girlfriend. They lived together and later married.

CONCLUSION

Although the patient's extended family rarely seeks psychotherapy, therapists should always keep them in mind and hope that the work done by patients and therapists will eventually have beneficial results for the rest of the patient's family. Occasionally, I hear about a family that seems to have made outstanding progress apparently merely by being the recipient of a patient's behavioral changes.

As a result of Mary's psychotherapy, her sister stopped being suicidal and ceased calling her every week. Her mother no longer assumed full responsibility for the care of Mary's grandmother who, in turn, was able to buy her own food and clothes for the first time in forty years. Mary's mother returned to school. Her brother fell in love despite family disapproval. Mary's father and mother became more affectionate with each other and even flaunted their renewed marriage.

Of course there is no mathematical proof that all this resulted from Mary's therapeutic experience, but Mary was aware of no other variable producing the changes. When this happens, it is the final lesson for patients. Enmeshment activities are destructive not only to the patient but to each of

the family participants.

Glossary

Clarification: those dialogues between patients and therapists that bring the psychological phenomenon being examined into sharp focus. The significant details are highlighted and carefully separated from the extraneous material.

Entitlement: rights given at birth to decide what to do and what to share or withhold.

False self: the patient's facade of compliance and accommodation created in response to an environment that ignores the patient's needs and feelings. The patient withholds a secret real self that is unrelated to external reality (Hedges 1983).

Impingement: the obliteration of psychological and sometimes physical separation between individuals without obtaining permission.

Insight: the ability to perceive and understand a new aspect of mental functioning or behavior.

Interpretation: the therapist's verbalizing to patients in a meaningful, insightful way material previously unconscious to them (Langs 1973).

Introjection: the taking into oneself, in whole or in part, attributes from another person (Chatham 1985).

Object: a psychoanalytic term used to represent another person, animal, or important inanimate object (Chatham 1985).

Object constancy: the ability to evoke a stable, consistent memory of another person when that person is not present, irrespective of frustration or satisfaction (Masterson 1976).

Object relations theory: a theory that focuses on the earliest stages of life when children become aware of the difference between the self and the external world. This theory describes accompanying developmental tasks and also explains the difficulties that result if these tasks are incompletely accomplished.

Observing ego: the ability to stand outside oneself and look at one's own behavior.

Oedipal: a stage of childhood development that begins at about 3 years of age. After a stable differentiation of self, mother, and father has been achieved, children engage in a triangular relationship with their parents that includes love and rivalry.

Preoedipal: the period of early childhood development, ages 0 to 2, which occurs before the oedipal period. The developmental issues are the formation of constant internal memory of others and a separate sense of self.

Projective identification: fantasies of unwanted aspects of the self are deposited into another person, and then recovered in a modified version (Ogden 1979).

Reframing: the therapist's description, from a different perspective, of an event in the patient's life, providing new insight.

Separation-individuation: separation includes disengagement from mother and the creation of separate boundaries, with recognition of differences between mother and self. Individuation is ongoing achievement of a coherent and meaningful sense of self created through development of psychological, intellectual, social, and adaptive coping (Chatham 1985, Rinsley 1985).

Splitting: the holding apart of two opposite, unintegrated views of the self or another person, resulting in a view that is either all good and nurturing or all bad and frustrating. There is no integration of good and bad (Johnson 1985).

Symbiosis: an interdependent relationship between self and another in which the

energies of both partners are required for the survival of self and other (Masterson 1976).

Transference: the inappropriate transfer of problems and feelings from past relationships to present relationships (Chatham 1985).

Transitional object: a soft or cuddly object an infant holds close as a substitute for contact with mother when she is not present. A transitional object aids in the process of holding on and letting go and provides soothing qualities. It represents simultaneously an extension of self and mother (Chatham 1985).

Working through: the second phase of therapy involving the investigation of origins of anger and depression through transference, dreams, fantasies, and free association. Patients satisfactorily relate elements of past and present relationships. As a result, patients risk giving up old behaviors no longer needed in order to adopt new behaviors.

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