ON THE IMPORTANCE OF DEPENDENCY IN PSYCHOTHERAPY

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Not only are patients generally afraid of becoming dependent upon their therapists but many psychiatrists, psychologists and social workers who are actively involved in the practice of psychotherapy are themselves also troubled by such a prospect. Being dependent on another person immediately evokes nowadays the horrible spectre of Guyana, with all its tragic consequences. This central issue is of the greatest importance and directly relates to the outcome of psychotherapy, but it is generally not understood fully enough. Very few references could be found in the professional literature specifically addressing this problem. The many articles dealing with the transference neurosis are somewhat relevant, but since it is postulated here that dependency relationships in psychotherapy must be much more intense to achieve the desired results--issues beyond the transference neurosis must be addressed. Theoretical models are constructed by individuals who may themselves not have fully resolved their own conscious or unconscious fears of dependency. It is quite understandable, therefore, that a rich variety of theories exist to explain that psychotherapy can be successfully conducted without the need to get intensely and deeply involved in the process. But such scholarly works on psychotherapy may well reflect the desire to give acceptable legitimate and "scientific" explanations to the only attitude that the authors subjectively experience as safe for their work. The lay-public, including the press and television, are also generally misinformed about the issue, and they often accuse the psychiatric profession of fostering dependency, as if it were obviously for the practitioner's own pleasure or to advance his financial or carnal interests. This article is an attempt to explain

to patients and to therapists alike (1.) why it is necessary for patients in psychotherapy to become dependent, (2.) what are the safe conditions for dependency upon a therapist, and, what is of greatest concern to many, (3.) how dependency is ever resolved without harm to the patient. The basic, underlying assumption that must be proven first is that no lasting results are achievable in psychoanalysis or in psychotherapy, regardless of approach, without an intense dependency relationship.

On the origins of anxiety

Patients usually seek psychotherapy believing that the presenting symptom is the illness itself, when in fact it generally is no more than the observable tip of the iceberg of psychopathology. Rarely, if ever, do the symptoms represent the entire difficulties of a person. We know enough now about the functioning of the human personality to go beyond Freud's brilliant formulations, and even beyond the complex metaphysical theories that have been promulgated by his followers. Careful and systematic clinical and other observations since Freud's days suggest the urgent need to modify the essential assumptions about the centrality of the Oedipus complex and the fear of castration. The following theory of personality based on observations of infant development is presented in abbreviated and simplified form as a more accurate and suitable basis for any psychotherapeutic work:

When a newly born infant emerges into the world he or she must suddenly adjust from a liquid to a gaseous environment and from a physical attachment in which all his needs are continually monitored and continually met to living as a physically separate entity. The physical reality of each person is one of separation from all other human beings, once the umbilical cord is cut, and the existential philosophers are essentially correct in reaffirming our alone-ness in the universe. It is inconceivable that the harsh new reality of loud sounds and bright lights, of sudden

temperature changes and, mostly, of not being constantly enveloped firmly and gently--that these would not be perceived by the fragile and helpless newly born infant as at least unpleasant and probably dangerous stimuli. The concepts as such are, obviously, completely out of his or her reach, but the sensations are not. Even the simplest forms of life, such as one-celled amoeba, react by avoiding noxious stimuli by physically distancing themselves from it, a freedom which a newly-born human infant does not have, not yet possessing the freedom of motility. Although even the rudimentary beginnings of cognitive understanding are yet far away, it is impossible but to assume that such literally shocking stimuli which lie completely outside and beyond the understanding of the newly-born organism would not in some way leave memory traces in its body, even though its brain and its memory are not yet capable of processing these experiences in cognitive and integrating modes. The common dream of falling into empty space and the almost universal sensation of sudden and unexplainable physiologic jerking for no apparent reason (both in sleep and in the waking state) are suggestive confirmations of these hypotheses. So is the sense of unexplainable anxiety and unreasonable fears that are the lot of all men and women from time to time. They clearly suggest that such early life experiences are not simply lost, as nothing ever is in nature.

Neuro-anatomic research may yet confirm which of Man's primitive brain-nerve bundles are essentially involved in recording such very early fear-filled experiences, since not all of the brain's more complex parts are yet fully functional. It is even possible to hypothesize that such experiences leave memory traces directly in the musculature and in other body tissues and organs, and when these are re-activated and stimulated in later life, they then trigger the release of chemical mediators and/or enzymes which give rise to such clinical syndromes as free-floating anxiety or essential

hypertension. Freud introduced the concept of the unconscious, but he obviously did not invent un-conscious living. Un-conscious and non-conscious living typify existence in the animal world and they are the lot of all humans before they develop consciousness. If such earliest life experiences leave memory traces in the tissues of all living things, it would explain why animals and humans in all cultures and climates have similar physiologic responses to situations which they experience as dangerous.

Humans differ from animals in the sense that our more complex and vastly different brain and higher nervous functions eventually allow us to explain cognitively even those sensations which we experience within ourselves. In an attempt to preserve this rational existence which gives us certainty and from which we derive safety--we tend to anthropomorphize and explain what lies outside and beyond human understanding by rationalizations that fit with the concept of the world as we can know it. Primitive man explained natural phenomena that we now scientifically understand, measure, and control in metaphysical terms such as God's wrath or grace. If the wonderous order of Nature and the existence of life itself also suggest the existence of a God to less primitive men and women, the simple-minded attempts to ascribe to Him human characteristics are nevertheless evidence of the tendency to make God (and everything else) in Man's own image. Such anthropomorphic explanations of nature have proven to be very useful in constructing for Man a moral system that he would abide by for reasons of fear, long before he was capable of making conscious ethical choices. Similarly, psychotherapy based on psychoanalytic assumptions and theories appears to have been a necessary and useful modality for gaining understanding about the functioning of the psyche and the origin of unconscious motivation. It explains Man in general in the anthropomorphic terms of

Freud's particular world. But, it also prepared the ground for a further and more accurate understanding of character formation, which must lead to improved methods for treating the dysfunctions and distortions of the personality. This we can do now. But, since progress requires relinquishing and giving up of old beliefs and positions, it always proves to be difficult and painful. It is also frequently experienced as a threat to the safety which is derived from the ability to explain one's experiences by a known theoretical framework, upon which one may have become dependent.

That which lies beyond our reasoning and conscious experience is very difficult for us to comprehend. We may have no difficulties when sub-atomic physics is expressed in mathematical formulas, but when we try to explain cognitively the co-existent duality of the wave versus the particle theory of light we must use approximate analogies to comprehend concepts which are basically different than our physical experiences with matter. In modern physics we have learned to accept that reality is essentially different than our gross human experiences would suggest. Since our abstract concepts are able to predict actual physical happenings with great accuracy we have learned to trust them as reliable indicators. Not so in the realm of the psyche. Einstein's relativity theory differed from the static assumptions of Newtonian physics in recognizing that the position of the observer determines what he observes. This is especially true when the field of observation includes anxiety-filled conflicts in the psyche of patients, which may closely resemble the unresolved conflicts within the observer. Intellectualization and the "scientification" of the observed data to lower such observer-anxiety are common ways of self-help, but they retard real scientific progress in psychotherapy.

Man depends so much on intelligence and understanding that any suggestion that these are not always applicable raises anxiety and is often

experienced as extremely threatening. Becoming a psychotherapist does not in itself isolate us from such fears, even when we professionally subscribe to such concepts as over-determinism and unconscious motivation. As we observe ourselves and look inside, we can only afford to see that which we do not experience as a threat to ourselves. We "blind" ourselves to issues which evoke so much anxiety that our sense of security becomes unsteady as we face them. A situation is then created which resembles fainting, but in an emotional sense only.

No one's earliest life experiences could have been free of many terror-filled moments, even under ideal circumstances, and since that is the time of life when each person is most dependent, dependency itself is often associated with enormous fears. Since dependency is also evocative of the deepest and most powerful yearnings, it is even more frightening. The issues around dependency are, therefore, understandably associated with much anxiety. This must first be recognized and at least cognitively neutralized before the subject can be discussed objectively.

(1.) WHY IS DEPENDENCY NECESSARY?

Anyone considering these issues is, in a very real sense, a survivor, having undergone not only the rigors of being born but also many painfully frightening experiences soon thereafter. As will be demonstrated in the following clinical example, the real traumas that must be treated in psychoanalysis and in psychotherapy are not those which patients complain about or which they eventually remember consciously. Screen memories and dreams often contain suggestive clues of early life experiences, but most images and symbols that have adult meaning must be considered and treated as resistive, unconscious, attempts to explain the unexplainable, in order to gain some control over the sense of horrible dread that usually accompanies such

experiences. Whatever was "done" to us by parents (who themselves may not have been ready for parenting) may indeed have been clumsy, careless or even cruel. But as long as we can associate any adult meaning with such remembered experiences, no matter how horrible, they are never as frightening as meaningless terror, having no purpose, no limits, no end. We can hope to control that which we understand, but even as adults we fear mysterious and unfathomable calamities the most. The fascination with science fiction books and movies probably represents thinly disguised adult attempts to reduce the terrifying grip that such feelings have upon us at unguarded moments, by placing them in an adult framework that gives them some meaning. What lies below all memories are the earlier fears and pain which must be neutralized if real personality change is to occur, the terrifying experiences before cognition and consciousness existed, when the infant was totally vulnerable and completely at the mercy of those caring for him.

The period of greatest dependency upon others contains the scars of Man's greatest fears, the ones in response to which he adjusted his personality, character and life style. Since adjustments always represent compromises to help the organism survive under adverse conditions, they never come into being without extracting some price. This price usually takes the form of some limitation of the organism's freedom, very often involving its freedom to choose its values and to develop as it would under different circumstances. To undo such damage, the psychotherapeutic setting must be such that in it patients will have opportunities to re-experience similar fears in a similar dependency situation, but with a totally different outcome. Repeated experiences of this kind eventually lead to lasting personality change that undercuts the psychopathological symptomatology.

The demands made by those who experience dependency upon the objects of their yearnings are always extreme, repetitious and "unreasonable", when fear does not interfere. Those inexperienced in such situations find it extremely difficult to handle such demands properly and without impatience or anger. Many psychotherapists try, therefore, to evade the situation altogether. But, unless the fears and suspicions about getting deeply involved in a trusting relationship are addressed experientially and not only cognitively, a person's basic attitudes about intimacy would never change. The ability to be temporarily dependent upon another person is central to intimate relationships. Since difficulties in this area are crippling in their effects, they are best resolved in spite of all fears, provided the setting is really safe and that all reasonable safeguards have been taken to assure the welfare of patients at all times.

When dependency yearnings are finally resolved to a sufficient degree, individuals can relate to each other with essentially adult expectations, thus avoiding the unrealistic disappointment and hurt that are responsible for the failure of so many marriages and other important relationships. Perhaps the real reason why much of psychotherapy fails to achieve basic changes in the personality is because the issues around dependency are avoided, or addressed with insufficient intensity.

Clinical example

Judy is a thirty-five year old frail-looking woman, who in the course of her therapy slowly recalled many horrible incidents about her childhood. Her mother was a hysterical, immature and tempermental woman given to violent outbursts, clearly jealous of the mothering that her own children were receiving and, having poor impulse control, physically abusive of them. Judy speaks of herself as an abused child grown up, which describes her exactly. The father left the family when she was one-year-old, and the

mother eventually ended up with another man who was in the habit of exposing himself and masturbating openly in front of Judy and her older sister, usually when the mother was out of the house. This step-father had later allegedly had sex relations with Judy's teen-age sister on a routine basis, with mother's half-knowledge and without his bothering to hide it from Judy, who got married at age sixteen to a passive and quiet man, mostly to escape from her horrible home situation.

Several years of steady psychotherapeutic efforts were needed before Judy would feel reasonably safe with her therapist, whom she had also considered with suspicion, believing him to be potentially evil and harmful, as others have always been. An island of healthy, observing ego enabled her to recognize, nevertheless, that the reality of the therapist's being was essentially different from what she was sure he was. His steady, fair and consistent treatment of her in spite of many provocative tests enabled her to stay in therapy, although she was very close to leaving on many occasions. The main work of therapy was not in neutralizing the remembered horrors of her early life but in the corrective experiences of the real relationship. These had to be more powerful than all her transference distortions. Here was one person, the therapist, upon whom she slowly learned to rely and eventually became dependent, contrary to her expectations. Since such expectations existed in the form of firm convictions, character traits and values--the real relationship with the therapist was repeatedly subjected to intense strain over a period of years before she finally developed new bodily responses to situations that previously seemed unsafe. Her therapy was conducted in a psychotherapeutic system where patients have opportunities to work with more than a single therapist (such as co-therapists in a group)--and this facilitated the reparative efforts. With the transference thus split, at least one reasonably dependable real relationship always existed in the

patient's perception at any one time. This complex subject of working within the negative transference cannot, however, be dealt with fully in this paper.

Many of Judy's earliest experiences were never really remembered, but her strong physiologic responses were indicative of what had probably happened to her long ago. The body itself remembers. The evidence was registered in the tissues which responded in predictable patterns. These were typically those experienced by anyone facing immediate danger to life itself. Her eyes would widen in terror, she would at times tremble uncontrollably and on some occasions she felt urges (almost too powerful to control) to flee and never return. She was often frozen in confusion and temporarily unable to talk or reason. These responses in the benign therapy setting must have represented terror-filled moments of physical and emotional abuse, long before the horrors that were remembered had ever occurred. If Judy is ever to be free of the distorted character formations which developed in response to such extreme fears, then such physiologic responses must be changed. This is achievable only within a relationship that is essentially trustworthy. All her relationships--to her husband, her children and all others with whom she had had reasonably intimate contact were distorted at one point in time or another by such character traits. Judy was very bright but her generalized distrust and suspicion caused her to under-achieve and function way below her capacity. In some areas which required human interaction she was at one point almost totally incapacitated.

Even long after Judy became less confused, less withdrawn and much more free personally and professionally, she was still often gripped by bouts of panic, at which times her eyes would open widely, her facial muscles would tense, and she would again automatically tend to withdraw from human contact, although this was behaviorally controlled by then. Her repeated attempts in therapy to explain the origins and reasons of such

bouts were generally unsuccessful. They had no connection with real events in her life, even if at times they served to trigger such reactions. It became clear that many minor internal and external stimuli triggered a readiness for panic that was deeply registered in the tissues of her body and which could be discharged even by a small emotional charge. Progress in her therapy was eventually measured by the progressively increasing amplitude of the stimulus that would trigger a panicky response. Her anxiety threshold was slowly rising.

The remembered mother who herself was so grossly inadequate and so grossly unsuitable for the task of mothering could not, by any stretch of the imagination, have been essentially different at pre-memory times. Some grossly immature mothers are temporarily capable of being playful and loving to an infant, as long as they consider it as not being a real person but rather a non-living doll, to be put in the closet until one wishes to play with it again. When such an infant begins to make demands at times and under circumstances that are not convenient to such a mother, it generally triggers in her tremendous rage and hatred towards it. In the absence of firm reality controls such mothers generally become physically abusive of their babies, some more, some less.

But even under the best of circumstances, when physical abuse is absent, how likely is such a mother to be capable of holding her baby calmly, tenderly and lovingly? The muscular rigidity of her arms, her jerking, the potential outbursts that she must hold in check and the internalized rage which she must constantly suppress--these tensions of her body cannot but be transmitted to, and be felt by, the young and fragile organism. Colic may have other reasons also, but it would surely be the expected response of any living organism to a sense of danger and perpetual unsteadiness, and to the absence of firm footing or grounding. Judy's later complaints about the brutalities and cruelties inflicted upon her, while

probably accurate historically, must nevertheless be regarded as occurring relatively late in the sequence of her character formation and development. Such a network of horrid experiences serves as the cognitive sieve upon which the earlier and even more horrible and terrifying traumas are held. In this sense any early childhood memories may always serve as a screen memory for even earlier experiences, and they are best treated as such in intensive psychotherapy.

The extreme brutalities visited upon Judy may be relatively uncommon, but lesser fears emanating from the early experiences of being held unsteadily by inexperienced or frightened mothers may well be the lot of every child, especially those first born who typically display such characteristics as early strivings for independence, possibly to compensate for such unsteadiness. The apparent sense of disorientation that young infants commonly experience when they lie on their backs in a bassinet or crib, not feeling the protective security of being safely enveloped, may be easily observed. Infants tend to jerk suddenly under such conditions, and they are generally quieter and appear more at peace when they hold on to, or are covered with, a blanket or when they can physically perceive the re-assuring presence of even an inanimate object next to them.

<u>The fear of dependency.</u>

It is reasonable to assume, therefore, that no one alive is completely free of anxiety in situations which the adult somehow experiences as reminiscent of the total dependency which existed in early childhood. This is easily confirmed by common knowledge. The fear of being helpless and incapacitated due to illness as well as the unreasonable pursuit of money to avoid the fear of poverty (which may require dependence upon others)--can both best be understood this way. Patients generally

fear (and therefore also secretly resent) doctors upon whom they are dependent, as children unable to control the adults around them fear their parents and teachers. Whenever possible, situations of real dependency are avoided.

The resistance by patients to becoming dependent is only rarely recognized as being due to fear. It customarily appears, instead, in the form of convictions, beliefs, and value systems, all of which must be subjected to minute and careful scrutiny to expose and isolate the hidden fear, without interfering in any way with the *freely* chosen beliefs and values of the patient.

When a dependency relationship towards the therapist finally develops, it ideally should be as intense as the one that existed towards the early mothering figure and towards important romantic "love" objects in adulthood. Such a dependency relationship is safe provided that the therapist is a relatively sane and steady person, who has also proven himself to be ethical, and who needs and wants nothing from the patient except to be monetarily compensated for his time. Patients are not expected to love their therapists, as they often were expected to love those upon whom they depended early in life, and they should also have the freedom to hate them openly, although without ever acting upon such feelings. Patients in properly structured psychotherapy settings (in which the therapists' own needs are satisfied elsewhere) are not even expected to get well *for* their therapists, who are not indifferent to the issue and wish their efforts to show results, but who would not burden their patients with such wishes. The resolution of such dependency relationships usually is entirely different, therefore, from the outcome of similar relationships in the past.

(Traditional psychoanalysis has the same goals and basically accepts the same reasoning, but its theoretical framework places the major psychic traumas much later in the developmental process, and relies heavily upon reasoning through language to resolve such traumas. The real relationship with the analyst is consequently in general of insufficient intensity to allow patients to regress emotionally to the point of re-living their earliest, pre-verbal, terror-filled experiences. Full resolution can thus not occur in that framework.)

The fear of becoming dependent is so great that patients often wish to leave therapy, or actually do so, before their dependency fully develops. Their fear is that they would end giving up completely their ability to make independent decisions and judgments, a condition that closely resembles the one that existed in infancy and which is associated with the horrible panic of total helplessness. This, obviously, is not really the situation in psychotherapy, but the strength of one's yearnings to be dependent is such that patients customarily forget the real power that they have as adults, even emotionally dependent ones. The image of Jim Jones in Guyana urging his followers to drink the purple cyanide Kool-aid, and their actually doing so is the horror-filled image that comes easily to patients' minds. They recognize correctly the real similarity between the yearnings and feelings of little children, psychotherapy patients, religious or political fanatics, men and women "in love" and the followers of any cult. They fail to understand the essential differences between those situations.

Little children, cult followers, religious or other fanatics and those "in love" commonly are expected to distort themselves to fit the wishes of those upon whom they are dependent--or else they are in danger of being rejected and abandoned. Not so in psychotherapy. As long as patients do not actually and physically endanger themselves or others--they are not only allowed to voice their disagreements with their therapists as vehemently as

possible, but they are, in fact, helped to do so. They are also expected to exercise their own independent judgment at all times. (The problem of learning to distinguish between real independent judgment and impulsive acting-out that masquerades as such is relevant here, but it requires a separate discussion.)

The potential for severe and real harm that exists in all these situations is the excuse that people in general and patients in particular use in their attempts to avoid them. Psychotherapists are not generally exempt of such apprehensions, for sharing with all others a common human heritage of incomprehensible infantile experiences--they, too, must first liberate themselves of the residuals of such early fears before they become free. It might be helpful, therefore, to consider how the dependency of psychotherapy is analogous to that of surgery. Successful achievement of the task requires in both that the patient be able and willing to take the real risk of letting another person temporarily "take over" responsibility even for vital functions, although under very clear and circumscribed conditions. In psychotherapy and in surgery alike, the patient in the last analysis remains in control. He can give limited consent and he can withdraw it. But in-between he temporarily may have to yield such control to others, if he is to benefit from their ministrations. Temporarily, the dangerous situation of early infancy is recreated in an adult reality. In psychotherapy the patient is rarely, if ever, required to yield complete control even temporarily, as he usually is in surgery. Even in moments of severe therapeutic regression at least a minute but large enough part of the ego must be present to "observe" the experience, if it is to have therapeutic usefulness.

(Psychotherapists are unlike surgeons, however, in the sense that they lack the long history and tradition of surgery, and they are, therefore, less clear about the strict codes that their work requires, as they generally are

less comfortable with the heavy responsibility that such an approach imposes. The analogy with surgery itself is not popular with those therapists who prefer to fancy themselves as humanitarian helpers, counselors and analyzers of hidden motives--rather than as healers of the sick. Diagnosis, prognosis and therapy are all affected by such self-concept, to the detriment of those seeking professional help for their debilitating illnesses. The American Psychiatric Association, for instance, still recognizes as a separate diagnostic category an entity called "Dependent Personality", as if it were not universally a tendency feared by and found in all. In doing so all hope of altering the underlying fears in those not so diagnosed is forever given up.)

<u>The real dangers of dependency.</u>

An intense dependent relationship upon the therapist obviously exposes the patient to many real dangers unless the therapist's professional and ethical standards are clearly above reproach, and unless his or her own emotional health is sufficient to guarantee that he would never take advantage of the patient's vulnerability and trust. Patients must slowly but thoroughly ascertain the real human qualities of their therapists by direct observations over time, while recognizing their tendency to find fault to avoid the dependency.

The real human attributes of the psychotherapist and his or her mental health and stability must not remain hidden, even though no statistical or biographical details need be revealed. A stance of therapeutic neutrality and a non-judgmental attitude make good sense, but anonymity which attempts to cover the therapist's real human qualities interferes with the patient's reasonable need to assure himself that the relationship is safe to take risks in. Dependency developing under conditions where patients do not really have a chance to know much about a therapist except by reputa-

tion and the testimony of others is always on the basis of blind faith; it is anti-therapeutic as it is intrinsically dangerous, even when such blind faith is not abused. Those who come with a ready-made positive transference, like "groupies", and get deeply involved without really knowing the qualities of their therapist or analyst, remain open to the possibility of abuse in situations that are less ethical and less safe. The tendency to be a "true" believer or a "blind" follower must always be challenged by ethical psychotherapists, especially when patients do not themselves bring up the issue, or when they dismiss it lightly.

There is really no greater professional crime than for one human being to take advantage of another in a relationship that must be based on trust. Medicine has traditionally imposed strict codes of ethics upon itself for just this reason. Such professional standards, hallowed by a long tradition, are less clear and not binding on non-medical psychotherapists, and they appear to have become somewhat less important even in the consciousness of many modern physicians.

Spouses, parents, children and others closely associated with psychotherapy patients often become fearful and angry as they observe the increasing dependency of the patient upon the therapist, since it usually lessens the patient's pathological dependency upon them. They usually derive security and a sense of re-assurance that they would not themselves be abandoned from having the patient need them. As if to "protect" the patient, they often warn him or her against the therapist and against relying upon him. Such obvious and other less obvious attempts to sabotage the therapy, using the real potential for danger in dependency to maintain their own pathological ties with the patient are common. They dove-tail into the patient's own fears of dependency, and unless the real relationship between

patient and therapist and their therapeutic alliance are strong enough--therapy ends before a real cure is anywhere nearby. In the name of "love" or concern for the patient, such close relatives or "friends" are sometimes instrumental in dooming the patient to existing in a crippled and pain-filled situation for the rest of his or her days.

The yearnings for dependency.

Adult men and women who understandably fear and, therefore, fiercely resist relationships that lead to dependency upon others, are nevertheless driven by anxiety into dependecny situations, since they offer relief through intimate human contact. The universal anxiety of Man is best alleviated by such contact with another human being who is believed to genuinely "care". The push towards dependency is extremely strong in life situations other than the psychotherapeutic setting, although in a camouflaged form. The yearnings to be taken care of by another are usually labeled "love", and as such the resistance to involvement in a dependency relationship vanishes. Such romantic love represents in reality a primitive wish to be cared for by an idealized mother substitute, and when it is scorned it understandably produces tremendously powerful reactions, including murder and suicide. The "security" and solace that were derived from the dependency upon the "loved" object are suddenly lost when the person who was depended upon withdraws. Many divorcing individuals desperately seek psychotherapy at such a juncture, with the hope of finding, suddenly and magically, solace and relief similar to those withdrawn.

In mature love, on the other hand, a person is basically dependent upon his own resources for love and solace and is also able, therefore, to offer sometimes loving tenderness to another, out of a sense of self-fullness, not for reasons of fear or guilt. Since one's own emotional security is

basically not dependent upon others, a person may give of himself without always necessarily expecting a return. In the absence of the fear of abandonment there no longer exists any need to distort the self by pleasing others. The essence of mature love consists of the ability to freely give of oneself to another, because one's own basic needs have been fulfilled. The joy of extending oneself and giving to the loved one is self contained in the act, not necessarily dependent on the response.

The essential task of psychotherapy.

The essential task of reconstructive psychotherapy in general is to help patients move from a position of romantic love to that of mature love in relationships to their therapists and all others. This goal is achieved as the process of separation-individuation is nearing completion, at which time the underlying, life-long, chronic depression finally lifts permanently and for good. Disappointments in mature love are painful, but they never produce the panic nor the murderous rage that are routinely the result when dependency relationships are suddenly destroyed.

Since every person must reluctantly give up the delusion of maintaining an attachment to a mothering figure who would perpetually anticipate each of our needs and always satisfy them as soon as they arise, even healthy emotional development entails a great deal of fear and pain. Each individual must, in spite of all protests, give up the notion of being the center of the universe (primary narcissism), recognizing our limitations in time as well as in space, and our essential fragility and powerlessness. It is easy and sometimes fashionable to talk freely of the serenity of existential alone-ness, but it is extremely difficult to reach this state psychologically.

Under optimal conditions the developing infant is forced to give up his delusional expectations from the environment in a gradual, firm, kind and consistent manner, so that in spite of the severe and frightening disappointments, he eventually learns to distinguish clearly his own face from the face of external reality. He gradually gains a sense of mastery in exchange for gradually giving up the delusion of omnipotence. When the process is successful, relatively little confusion eventually exists about the boundaries of the ego, and thus one can eventually trust others and become temporarily dependent upon them, without the fear of merging and becoming one with them. Only when a person has a basic trust in one's own ability to provide competently for the self, can he choose to trust and temporarily depend upon others, for in a pinch one could "take-over", if and when others fail to do so. This is the pre-condition for reasonably good mature relationships in which life's contingencies are faced only with as much trepidation and anxiety as they objectively deserve. Partners in such a relationship are able to support and be helpful to each other without desperate clinging, and they are able to be intimately involved and sometimes love each other without the fear of being taken over. This, in brief, is the desired goal to which we strive in our psychotherapeutic efforts.

When patients begin psychotherapy they are obviously incapable of such mutuality. They can neither trust nor really allow themselves to be temporarily dependent upon their therapists. Instead, they attach magic yearnings and expectations to the therapist and try to hold on for dear life. The relationship to the therapist at the beginning of therapy is like a "crush" that children have upon a parent, some teachers and other mass media "heroes". Desperate patients even strive for total dependence, as if it were possible, and basing such yearnings on unreality, they act as if it were

desirable. One of the first tasks of a serious psychotherapist is to begin breaking up such an unrealistic dependence by addressing the unreality of the magical expectations. This is best done from the initial interview on and forms the beginning of the real relationship that is based on an alliance with, and respect for, the patient's healthy and adult aspects. It is also the first step towards a partial dependency by the patient on the therapist based on realistic trust.

(2.) <u>CONDITIONS THAT PROMOTE SAFE DEPENDENCY.</u>

But, how is this achieved with those whose emotional development was interfered with in various degrees of severity early in life? Since the earliest and most terrifying traumas are all the result of mothering that failed to protect the new-born from sensations that were experienced as terrible dangers, any rational attempt to rectify this damage must be made under conditions that provide opportunities for working things out in this area. Any psychotherapeutic process that depends almost exclusively on language (such as psychoanalysis and others) and emphasizes insight and cognition can achieve only partial and superficial results. The real relationship is underemphasized since the interaction is largely intellectual and content oriented. The setting does not provide sufficient opportunities for regressive re-experiencing of early traumas, even when the analyst considers it helpful and desirable. The most primitive convictions about trust, intimacy and dependency, those with roots before, beyond and outside of cognition are, therefore, not challenged, not really tested and not changed. On the other end of the therapeutic spectrum, where the body is directly worked with but long-term, real relationships are generally absent--dependency does not develop and the necessary testing of old convictions does not occur. Although some relief is obtained from loosening chronic tensions that are bound in the body's musculature--characterologic change does not occur and the results are also limited. The real relationship has insufficient force for the necessary task.

What is needed is a system of therapy that is intense enough and safe enough, as well as long enough, so that patients would allow themselves to slowly take the horrible risks of re-experiencing life situations that in the distant past they "knew" to be literally life-threatening. A real relationship between patient and therapist that is based on genuine respect and liking for the patient but not for his pathology provides the matrix for the development of trust and dependency. Patients must agree to adhere to a strict non-acting out contract which must be enforced strictly by the therapist. The latter has a special responsibility to remain fair and firm even under severe non-acting provocations, which allows patients to fully experience and express their distorted images of reality without retaliation.

Under such conditions patients will eventually experiment with taking ever more courageous risks in facing their old horrors. The steadying and assuring presence of the therapist during such fear-filled moments would tend to foster dependency, since all powerful affects are purposefully directed at him. As the old horrors are repeatedly experienced under new circumstances without harmful consequences, early fears that determined the entire mode of adaptation to reality and that shaped the personality begin to lose their grip.

The verbalization and description by the therapist of feelings and experiences that the patient displays non-verbally but does not yet recognize as such is a most useful tool in promoting dependency. When the therapist is intuitive and sensitive and couches his words in terms that the patient can recognize, a temporary physiologic release of some sort generally occurs. Tearing, a deep sigh, a change in the body's posture or simply a non--pressured, thoughtful, silence may all result. In such cases the therapist in reality acts like an idealized Mother who understands what is happening

to her non-verbal baby and is willing to offer him or her the yearned for solace. Such behavior encourages magical expectations within the real relationship, it awakens long dormant symbiotic hopes, and it is useful, therefore, in the development of a dependency relationship. The technical problems involved in this and in other techniques mentioned here are not the main subject of this paper, and must be discussed elsewhere.

A real relationship of trust (not to be confused with any kind of social relationship) must be built between the patient and his or her therapist, based not on external assurances such a diplomas, reputation or the patient's belief in the therapist's system, but on the real experiences between the two. It requires a therapist who has become relatively free of his or her own internalized conflicts so that he can treat the patient (1.) ethically, (2.) objectively, (3.) lovingly, (4.) firmly, (5.) consistently and (6.) respectfully. These criteria include the ones usually expected of the psychoanalyst or psychotherapist, but they go way beyond them and more truly resemble what would be expected from an ideal parent.

This, however, in itself is not sufficient to produce the desired curative results. Even when these six criteria are applied properly over time, and no serious deviations from them occur even under the pressure of repeated subtle and gross testing and provocations from patients, the latter will still often interpret such fair treatment as veiled attempts to lure them, seduce them, lull them or trap them into lowering their defenses, fully expecting that some axe will then finally fall upon them. Only very slowly, often to a degree which is discouraging to many therapists and patients alike, do such damaged human beings begin to seriously wonder whether the repeated unharmful experiences are really possible, even though every fiber of their being "knows" otherwise. If and when the therapist has the wisdom, experience and endurance to stick with

a patient (in spite of all the heavily veiled and sometimes extreme tests to which he may be subjected, including the test of time), and if and when the patient has enough courage and objectivity to remain in therapy in spite of horrible conscious and unconscious fears--dependency eventually develops, and with it new and different attitudes to intimate human relationships.

The two components of dependency.

The patient's dependency upon the therapist usually consists of two separate and altogether unrelated elements, although the distinct existence of the two is not generally recognized.

1. Dependency based on the real relationship.
2. Dependency based on unrealistic yearnings and hopes "crush"-like, of transferential origin.

Patients choose their therapists by reputation, academic qualifications, location, fees, and such other peripheral criteria that may bear only minor relevance to the therapists' real trustworthiness. In the absence of real knowledge about the therapist's human qualities this is the best patients can do. If they are, or feel they are, in extreme peril when they seek therapy--they will tend, like frightened children, to attach great importance to the therapist and depend upon him beyond what the real experiences between them would justify. The situation is analogous to the trust patients must have in a surgeon who is known to them mostly by reputation.

As therapy proceeds over time, both elements of dependency become stronger. The patient usually experiences many strong feelings in relation to the therapist, including real love, since the latter may have treated the patient more thoughtfully, more sensitively, more consistently and more decently than anyone else at any other time. If loving feelings result from such treatment, it fits on the basis of the reality of the relationship.

Patients ususally also experience other powerful yearnings towards the therapist, either because of their extreme despair or because the setting had already proven itself to be a safe place for experiencing yearnings that were previously repressed and held out of consciousness. This pining is the experience of the infant child within the adult patient, feelings that the child would have felt more strongly towards the real mothering figure, had it not been so scared then. These yearnings are to be held, to be protected, to be safely enveloped, to be reassured, to be exquisitely understood and to be given solace and nourishment constantly. Unreasonable as such yearnings are from the point of view of the adult, they are, nonetheless, experienced with full intensity by all people from time to time, not only by those designated as patients. Such experiences are often denied or kept out of consciousness, since they are so unreasonable and seem so embarrassing.

No one ever grew up without sometimes experiencing extreme fears that might have been alleviated by perfect protection and nurturing by an ideal mother. The yearnings for such protection and nurturing are universal, although not always of equal strength and often not openly recognized as legitimate after infancy. In a setting that permits open expression without inducing shame or guilt, such yearnings (technically termed pre-verbal hunger) are usually expressed repeatedly, openly and powerfully--which was impossible in early infancy. When such yearnings repeatedly find full expression in a safe setting, the distortions in the personality that resulted from the need to adapt to less desirable conditions begin to give way. Extremely complex technical problems must be overcome by the therapist if he is to continuously refrain from satisfying such infantile yearnings, without interrupting their continued expression; a detailed consideration of these problems requires a separate discussion devoted to the clinical management of pre-verbal rage.

Although the yearnings strongly exist, the temptation to become dependent is usually vigorously resisted for as long as possible. Patients know that in a state of dependency they would have no guarantee that even their most urgent needs would be met, and since this is so closely analogous to the fear-filled state of early infancy, they find it difficult to cooly consider how really urgent such "needs" are, or whether they are real needs at all. Such fears are not usually conscious, but they are, nevertheless, real and determine actual behavior. As in the case of spurned romantic "love", unsatisfied "needs" are experienced as life-threatening situations, which are best avoided at almost all costs. In reality all such "needs" are only re-experiences by the adult of what the infant had felt long ago. Even if all such "needs" remained unsatisfied, no real harm would come to the patient, although he would experience a great deal of anxiety. The re-awakening of previously dormant dependency yearnings for an all powerful and all knowing object is a necessary step in changing unrealistic adult expectations and characteristics. Resolution of life-long distortions requires powerful re-experiences of such yearnings under psychological conditions that sufficiently resemble those under which the original fixations had occured, which permits a different outcome. This re-experience is basically different from the experiences of early infancy, in that it is now followed by adult rage at the disappointing figure, the therapist. Technically this is not a real transference phenomenon, since the pre-verbal hunger that is now openly expressed had in the past mostly been repressed.

(3.) HOW IS DEPENDENCY RESOLVED?

How are dependency relationships eventually resolved? Clear understanding of the outcome of dependency relationships in psychotherapy will make it somewhat easier for patients to take the enormous risks of entering into them. Cognitive understanding of the rationale for the existence of such relationships and of their natural history and

outcome is a minimal assurance that all psychotherapy patients deserve to help them in their difficult task.

Those feelings towards the therapist that are based on the real relationship between the two remain strong even as the psychotherapeutic journey finally approaches its end. The adult love that patients often feel towards a therapist who treated them patiently, fairly, consistently and even lovingly over a period of years are in no way related to the sense of need that they also often experienced towards him before. After the dust settles it becomes clear that the psychotherapist often proved himself to be the most reliable, the most sensitive and the most helpful person in the life experience of the patient. Such a central life experience is not simply erased even after termination, and a sense of thankfulness mixed with love may well persist. But, since these feelings are based on an adult experience and are relatively free of infantile yearnings, no panic but only a sense of real loss follows the cessation of regular and frequent contacts with the therapist. Such a loss is painful and real, but it does not endanger the patient's emotional integrity nor his or her capacity to manage their adult affairs realistically and well. Time heals this wound spontaneously, since in return for losing the therapist each patient finally finds an even more reliable ally: himself.

The dependency yearnings that were based on unrealistic expectations and which were expressions of infantile wishes for an idealized parental figure will, on the other hand, basically have disappeared without any special effort near the end of therapy. One reliable indicator of progress in therapy is, in fact, the gradual loss of power that such infantile yearnings have upon the patient's personality. Such yearnings lose their choking grip and eventually assume a realistic perspective as they are

repeatedly experienced and examined within the real relationship with the therapist. Patients go through long periods of intense disappointment at the therapist who proves himself to have no magic in reality. These disappointments are repeatedly and openly expressed at the therapist with intense rage from the adult's perspective, which was never possible in infancy. Unfortunately, it is still rare in psychoanalysis and in psychotherapy.

Such powerful expressions of protest and fury make it possible for patients to abandon their unrealistic dream without a sense of failure, futility or powerlessness. These three are associated at all other times with the reasons for all depressions, since they always engender a diminished sense of self esteem unless they are associated with powerful protest. In proper psychotherapy torrents of murderous rage are unleashed at the therapist, standing in as the personification of all reality, to which every person must reluctantly adjust. When such repeated explosions of pre-verbal rage also fail to alter existential reality, patients eventually begin to accept its painful limitations. They recognize, later if not sooner, what an enormous and terrible waste of energy, hope, time and money it is to dream, fantasize, scheme and plan to obtain from the therapist the magical solutions that he does not possess anyway. Soberly the deflating facts of Man's limits are being accepted. The infantile delusion of being all powerful and at the very center of the universe only yields when greater forces impinge upon it. Never again will a perfect attachment to an all-caring and ever-present mother be possible. One's real power, limited as it really is, resides within.