Dependency on the Psychotherapist

NORMAN A. CLEMENS, MD

People depend on one another in most human relations, especially those involving professional services. Mental health care, and psychotherapy in particular, are characterized by various degrees of patient dependency, which can be managed to advance the purposes of diagnosis and treatment. The initial therapist-patient relationship can evolve into a working alliance that may come to resemble a partnership based on mutual respect and trust, in which the patient achieves a growing independence and sense of agency in directing his or her own life effectively. Some patients, whose earlier lives have left them with intense anxiety, feelings of inadequacy, and need for support and direction by others, place heavy and inappropriate demands on their therapists. Strategies for dealing with these situations start with recognizing them as unconsciously determined manifestations of underlying dynamics. These can be controlled by engaging the patient in learning why they happen and in gaining a sense of mastery through building internalized ways to regulate affects and meet needs appropriately. Success in this effort can have salutary effects on patients' sense of self, differentiation of self from others, sense of security with being in charge of their own lives, self-esteem, and relationships with others. *(Journal of Psychiatric Practice* **2009;16:50–53**)

KEY CONCEPTS: dependency, self-esteem, internal controls, regulation of affects, anxiety, supportive psychotherapy, cognitive-behavioral therapy, psychodynamic psychotherapy

Human beings are interdependent. From the earliest known eras of human social development, people lived in extended family groups and villages where their needs could be met much more effectively than coping with life as lone individuals. In our relations with others—spouses, grocers, teachers, doctors, accountants, clergy, police, lawyers, or auto mechanics—there is a division of labor in which we depend on someone with special skills to fulfill a need, and in return we offer our own gifts or the currency of exchange. We look for people we can trust, we then feel less anxious about them meeting our needs, and we depend on them.

Attachment and Dependency in Psychotherapy

So it is when a patient enters psychotherapy. Initially, the relationship reflects the dependency that occurs with any healthcare professional, and this dependency is protected by the ethical code of the profession. Consider the sanctions against abandonment, seduction, or exploitation of a patient. In psychotherapy, the attachment gradually deepens as the patient opens the realm of feelings and private thoughts. For a time, the professional becomes a very important person in the patient's life, and the treatment relationship itself may become a focus of the therapy that leads to understanding the patient's core dilemmas as they appear in a real-time context.

Some therapies are designed to keep that trend in check, through very structured procedures or a defined agenda that the therapist controls, as well as a predetermined limit on the length of sessions or the duration of therapy. Other therapies are designed in a more open-ended way, with free flow of associated thoughts, to allow further engagement in work with very personal issues and to uncover psychological processes of which the patient had previously been unaware. These opposing intentions are not mutually exclusive: even in the most rigorously structured cognitive-behavioral therapy, there must be an exploratory phase to determine where the problems lie; and even in classical psychoanalysis, there is a framework of boundaries that makes it safer for the analysand to deepen self-exploration without disintegrating or engaging in damaging behavior. In any case, the success of therapy depends upon forging what has been called a "therapeutic

NORMAN A. CLEMENS, MD, is a clinical professor of psychiatry at Case Western Reserve University and training psychoanalyst in the Cleveland Psychoanalytic Center.

alliance" or a "working alliance"—two people working together to resolve a significant problem in thought and feeling.

Factors Affecting the Therapeutic Relationship

The way in which the therapeutic relationship evolves depends greatly on the nature of the patient's illness, the stage of the disorder, the therapist's approach, the progress of therapy, and the patient's personality makeup. Frank, a patient struggling with chronic schizophrenia, depends on the doctor to objectively assess his mental status and psychosocial support systems, educate him about his illness, manage medications, arrange protection during a crisis, and to give him understanding, an active way of dealing with his illness, and hope. Alice, in her third major depression after a lengthy manic episode, depends on the doctor for the same things, along with techniques for managing relapses and a prescription for a light box during the dark months. Both are grateful to have a steady psychiatrist who will stick with them through episodes of psychosis, affective instability, oppositional behavior, or profound denial of their condition.

Hopefully, from that basic relationship of a patient depending on a caring and competent physician will emerge more of a working alliance—a partnership based on trust and mutual respect in which the patient, now understanding more about the illness, more actively takes charge of managing it while the psychiatrist, respecting the patient's autonomy, now acts more as guide and coach. Psychotherapy will generally focus on the here and now—challenges and problems in the patient's everyday world with a focus on current relationships. Although sometimes the therapist and the patient will stumble onto insight about issues that originated in childhood and relationships with parents, this is not the main focus of treatment. The therapist's response may be practical attention to how to handle the resultant patterns of feeling, thought, and behavior in present-day life.

Although such a supportive psychotherapy may be conducted in shorter, less frequent sessions, it is grounded in a strong attachment to the therapist over the years. In the past year, I have handed on a number of such patients to other psychiatrists in preparation for my approaching retirement, and I have been deeply moved to be reminded how attached they were to me and how difficult the change has been for them—and in turn, how much I missed them. The attachment worked both ways. A World War II veteran in his mid-80s with bipolar disorder stated, "You've been my lifeline."

Therapy with Patients Who Have Disturbances of Attachment

When patients with more neurotic and personality issues enter therapy, the framework may be more psychoanalytic—but the working alliance is just as important. Sessions are longer and more frequent, patients are encouraged to follow their thoughts and speak freely, and more primary attention is paid to what is happening between the patient and the therapist. Repetitive patterns of attachment get played out in the relationship with the therapist. The patient may relate to the therapist in a more needful and dependent way than he or she ordinarily does with important people outside the office. It becomes apparent that the pattern goes back to the crucial years of early life, and that it is being expressed in the patient's transference with the therapist.

The pattern may elicit the repetition of old ways of relating in the therapist's early development. In other words, the therapist may be influenced by his or her own counter-transference. These interactions transcend the reality-oriented, adult partnership of the working alliance. Because of the mutual enactment of patterns of feeling and behaving by the two parties, it may take a little time for the therapist to discern what is happening and to use it to foster insight and gradual change in the patient's patterns. (The therapist must work out his or her side of the transference–counter-transference interaction through self-reflection, consultation with a colleague, or personal analysis or psychotherapy—it is not the patient's burden. Some therapists have a need to be needed, perhaps related to their own unmet needs, which it would be valuable to work out in their own therapy as early in their career as they can.)

When such issues result in an intensification of the patient's dependence on the therapist, this development is not often welcomed with open arms. It may show up as the patient's very high sensitivity to perceived slights, oversights, or lack of consideration of his or her feelings. The therapist is made to feel guilty, anxious, and vigilant lest something else happen to offend the patient. Frequent phone calls outside the

scheduled hours, demands for more time or special favors—projecting a sense of being insatiable—may cause the therapist to feel burdened, annoyed, or harassed. In a hospital setting the patient may be perceived as clinging, demanding, histrionic, or scheming to get attention and special care.

As a result, dependency gets a bad name in the mental health professions. Terms such as "dependent," "needy," "manipulating," "acting out," "borderline," "hysterical," "regression," and so on become words loaded with derision and contempt for the patient. In a teaching conference, a resident presented a particularly sticky patient who had much difficulty leaving the office at the scheduled end of a session or accepting direction of any kind. The resident felt frustrated, guilty about not holding firm to the therapeutic frame, and helpless to set limits on the patient's controlling, demanding ways. The other residents bounced around the term, "Tar-Baby" (thank you, Br'er Rabbit). Therapists and nursing units may be tempted to find subtle ways to unload or punish such patients, which compounds the problem because, for the patient, the perceived rejection and abandonment begins to have substance in reality.

It is easy to forget that the patient's behavior at that moment is not under his or her conscious control. It is an expression of deep-seated need and a desperate feeling of inadequacy to deal with anxiety, sadness, aloneness, confusion, rage, and other feelings that overwhelm the patient's more adult ways of coping. We have to avoid compounding the problem by repeating the hurts that led to it in the past. Rather, we are challenged to help the patient gain control through understanding what is happening and building new ways of mastering the situation. This requires patience, persistence, and a manifest desire to join the patient in gaining a new perspective, while holding firm on boundaries and a decisive stance on what is or is not appropriate in meeting needs. Perhaps the patient's experience of working with a caretaker who is patient but firm and has a drive to understand will be a new life experience that has its own developmental value.

Such constellations are more common in working with patients with severe anxiety disorders or with dependent or borderline personality disorders. These disorders are all commonly associated with marked disturbances of attachment in early childhood that predispose to anxiety, low self-esteem, poorly developed distinction between self and others, failure to regulate affects, limited self-awareness, and lack of confidence in one's own resources. Patients don't feel good about themselves, and they expect to be hurt or abandoned. Many were neglected and isolated in situations in which early caretakers were absent, neglectful, distracted by their own problems, and unable to be empathic with their children. Some, especially those with borderline tendencies, were in fact mentally, physically, or sexually abused as children. Because of the tendency to repeat patterns and problems, the patients may have connected with people in their current life situation who behave in a similar fashion.

Patients with pronounced borderline personality disorder are often handled with dialectic behavior therapy (DBT) or specialized variants of psychoanalysis (transference-focused psychotherapy or mentalization-based therapy), usually in a residential setting with a team approach and a variety of therapeutic activities. However, some gifted therapists do well with these patients in individual treatment.

In ordinary office practice with very anxious and dependent patients, I have found it most helpful to keep a steady hand and begin by helping the patient tolerate and express the underlying flood of emotions. Often we work with the fear of emotions themselves. This is part of helping the patient build an internal means of self-regulation, so as not to panic and desperately importune someone else to take charge. Regression to clinging and demanding behavior is a humiliating experience for a patient. Gradually the patient gains confidence as well as some pride in self-mastery. We are dealing with narcissistic issues here, having to do with self-esteem and a coherent sense of being an individuated person who can manage an adult life. Anxiety and feelings of inadequacy subside as this approach gradually succeeds.

The external manifestation of frequent calls and demands can be approached behaviorally, but the therapeutic goal is for the patient to internalize the task of regulating affects and reduce his or her dependence on other people to do so. This requires the patient's full participation in deciding the steps to be implemented. They begin with the patient's coming to grips with the fact that the therapist cannot be infinitely available 24/7, and indeed shouldn't be called outside of therapy sessions except for extreme situations once the steady support of regular sessions has been established. The patient can identify close family or friends or a 12-step sponsor to whom he or she can turn in a crisis, but the patient also has to be rea-

sonable about what to expect from these individuals. The patient can also learn techniques of relaxation and self-soothing for use in a crisis; some therapists provide patients with tapes of the therapist's own voice with reassuring phrases and reminders of how to cope with an affective storm.

Graduated steps include setting progressive limits on the frequency of telephone calls to the therapist, family, friends, and other supports; scheduling calls at fixed, regular times instead of random calls at all hours; setting limits on the length of calls and range of topics to be discussed in calls rather than during therapy hours; and other parameters appropriate to the situation. The situation is not unlike the developmental steps involved in weaning. With it comes the task of object constancy—knowing the therapist (primary infantile caretaker) still exists even when not with the patient in person or by telephone.

The patient's own motivation is an important factor in moving this process along. The therapist's encouragement and positive feedback supplements the patient's own relief from shame and humiliation about being so needy and dependent, coupled with pride in achieving growing mastery of the anxiety. This is accompanied by the patient's recognition of his or her hunger to be cared for and chronic rage at the external world, which the patient perceives as depriving and leaving him or her in a perpetual state of need. Hopefully these feelings can be mitigated by relating them to times earlier in life when the patient was helpless and the needs were very intense, while realizing that he or she now has ways of appropriately fulfilling needs and modulating emotions, using the therapeutic partnership to solidify that developmental step.

Termination of Therapy

When does one terminate therapy? That varies widely, according to the patient's history and capacity to grow beyond it. Some people are so damaged, or have a sufficiently severe underlying biological disorder, that they will benefit from supportive therapy titrated to a relatively low frequency for most of their lives. They have a trusted working alliance in a well-modulated attachment. Others strive to master the remnants of childhood deprivation or entitlement, using their understanding, and taking pride in going on with their lives alone. An exceptionally gifted child psychoanalyst, Erna Furman, wrote a memorable paper titled, "Mothers have to be there to be left," at a stage when her own children were nearing adulthood.[1] It was reported that she had tears in her eyes as she read it to an audience. We as therapists may have similar feelings as some of our patients graduate, but we know we had to be there both as a person and a therapist for this achievement to occur.

References

1. Furman E. Mothers have to be there to be left. Psychoanal Study Child 1982;37:15–28.