The Lost Role of Dependency in Psychotherapy

AVRUM GEURIN WEISS, Ph.D.

This article critiques prevalent cultural understandings of dependency, and attempts to present a more rounded, de-pathologized conception of the experience of dependency in psychotherapy. Dependency is conceptualized as a developmental process, with the capacity for independence resting on the achievement of a “mature dependency.” Excessive self-reliance is taken up as the counter-part to problematic dependency. A case study is presented in which the therapist initially varies the therapeutic frame to help the patient to develop a greater capacity to tolerate interpersonal dependency, and later implements a more traditional therapeutic structure.

“I have always depended on the kindness of strangers.”
Blanche DuBois in A Streetcar Named Desire

When the word dependency appears in an article about psychotherapy, it is almost a given that the author’s focus will be on the patient’s dependency as a therapeutic problem and the therapist setting limits as the solution. For example, in a review of the literature on dependency and psychotherapy, Bornstein and Bowen (1995) cite a number of studies that suggest a correlation between dependent persons and elevated rates of depression (O’Neill and
Bornstein, 1991), alcoholism (Vallient, 1980), eating disorders (Bornstein and Greenberg, 1991), anxiety disorders (Reich, Noyes, and Troughton, 1987), and psychosomatic disorders (Heyward and King, 1990). While Bornstein and Bowen (1995) do eventually talk about “a healthy balance between . . . strivings for dependency and connectedness on the one hand, and for autonomy and independence on the other” (p. 531) they tend to pathologize the experience of dependency by considering only those problems that result from excessive dependency and not considering excessive psychological self-reliance or the impaired capacity for dependency. For example, while they cite psychotherapy outcome studies that suggest that patients who are more dependent do better in psychotherapy than patients with lower levels of dependency needs (Borstein & Bowen, 1995) they attribute this to the higher levels of therapeutic compliance (i.e., fewer missed sessions, remaining in therapy longer, complying with therapeutic directives) found in patients with higher levels of dependency.

Dependency in the Culture

The original sin of 20th century men and woman is the sin of self-sufficiency.

Rabbi Harold Kushner

Psychology’s pathological view of patient dependency is situated within a broader sociocultural context. In western culture we tend to venerate independence and look down on dependence as a weakness, a dangerous vulnerability. We think of infants as completely dependent at birth, and the job of parents is to socialize them into increasing independence. We mark developmental milestones by the achievement of new levels of independence. While these values are taken for granted and we think of them as universal, they are culturally relative. For example, in Japan, the infant is considered to be completely independent at birth, and the cultivation of the capacity for appropriate dependency is one of the important tasks of the parents (Kobayashi, 1989; Jordan et al., 1991).

Stiver (1992) suggests that dependency is so negatively valued in our culture because it is stereotypically identified as a feminine characteristic. She cites a study by Pollack and Gilligan (1982) in which men saw potential danger in intimate situations depicted in TAT cards (a projective test), while women saw danger in the potential isolation of achievement. “The danger men describe in their stories on intimacy is a danger of entrapment or betrayal—being caught in a smothering relationship or humiliation by rejection and deceit” (Stiver, 1992, p. 145).
Perhaps in our patriarchal culture we have confused independence with self-sufficiency. We are, after all, the nation of the great frontiers. Our myths are about those hearty souls who settled the west, homesteaders who claimed a piece of land, built a cabin, and made their own way. From this perspective, dependency is dangerous, something to be avoided. Relying on others is a luxury, a dangerous over-extension from the safe base of self-reliance.

The cost of this aversion to dependency in our culture is readily visible to any practicing psychotherapist, or to any student of the culture. Our patients come to us complaining of feeling empty, isolated, disconnected. They talk about feeling overwhelmed by life problems they are attempting to manage on their own that clearly would best be handled with the support of a community. When we become ill, we try to manage our affairs so that we will not become “a burden to anyone,” depriving not only ourselves of the love and comfort that may be necessary for recovery but also depriving our loved ones of the opportunity to give in a meaningful way and to feel helpful. When we are in financial trouble, we borrow money from a bank because it’s “a bad idea to borrow from friends.” When we are sad, or in pain, we isolate ourselves, convinced that no one would want to be around someone who feels the way we do. We create social institutions (Medicare, insurance, social service agencies, psychotherapy, etc.) to protect ourselves from the experience of dependency.

Reconceptualizing Dependency

Man [sic] must learn to think of himself as a limited and dependent being; and only suffering teaches him this.

Simone Weil

Part of our pathologizing of dependency stems from our linear understanding of the relationship between dependence and independence, i.e., that dependency is something you have to “get over” in order to be truly independent and that becoming independent means no longer being dependent. Guntrip (1969) suggests that the capacity for a mature dependency is what makes the experience of independence possible, and that independence without a mature dependence is only pseudo independence, or what I suggested earlier is self-sufficiency. In this framework, the achievement of the capacity for psychological independence does not replace the need for dependency, but can only be achieved along with the ongoing capacity for mature dependency. Feminist authors have echoed these thoughts in suggesting that dependency is the requirement for the experience of mutuality (Jordan, 1991).
This suggests that both the capacity for dependence as well as the capacity for independence are necessary for a full, healthy life. Dependency can be understood as a relational experience, changing during the course of individual development and during the course of psychotherapy. When a child is young, we attempt to be as available as possible. When the child cries in the middle of the night, we hold him. When he is hungry, we feed him. Most parents are not overly concerned about their infant becoming “too dependent” on physical or emotional sustenance at this point of life. As the child grows older, we begin to differentiate between what he is capable of doing for himself and what we still need to do for him. These decisions are highly context-laden and change frequently. We would not artificially withhold a response to the child’s dependency needs, just as we would not consider responding indefinitely to those needs at the same level of care.

My son is someone who, in analytic terms, might be understood as having strong oral dependency needs. When he was four years old, he was still very attached to his nighttime bottle. At some point we decided, with strong urging from our pediatrician, that the time had come for him to give up the bottle. We prepared him by explaining why this was necessary, and counting down the days with him until the big night. On the night he was to give up his bottle, I lay in bed with him and told him what a hard thing this was he was doing, and that I would stay there with him and do whatever he needed me to do to help him fall asleep. This experience did not magically transform his strong dependency needs. He remained very attached to his “blanky” and reluctant to spend the night away from home. Years later, however, he came home from school and announced quite casually that he would like to go to sleep-away camp that summer, which he did, and with a lot less distress than his mother and I experienced.

**Dependency in Psychotherapy**

To depend upon a profession is a less odious form of slavery than to depend upon a father.

Virgin Woolf

We might apply the same developmental formulation to the therapeutic relationship. Clinicians make ongoing differential judgments about those patients who are more in need of developing their capacity for autonomy and those who are more in need of developing their capacity for a mature dependency. There is no question that excessive dependency on the part of the patient can be a significant problem in psychotherapy. After all, in any fee-for-service relationship one of the
goals is likely to be the termination of the relationship when the service has been satisfactorily received. If the therapist cultivates dependency on the part of the patient there is a potential conflict of interest. Managed care companies have accentuated this aspect, publishing articles such as “Therapist Dependent No More” with a list of tips for patients to learn to be less dependent on their therapist (Vista Health Plans newsletter, 1996).

At the same time, the inability to allow sufficient levels of interpersonal dependency can be just as problematic as excessive dependency. While we focus almost exclusively on the former, I am not aware of any data suggesting that excessive dependency is more common than a restricted capacity for dependency.

In the 1960s, with the emergence of a Third Force in psychology, many therapists began using the term client rather than patient. This shift reflected the antiauthoritarian climate of the times, a movement away from the hierarchies and power differentials of the medical model toward a more egalitarian, collaborative relationship. The term client describes what is essentially a business relationship, an exchange of fee-for-services. The word is derived from the Latin “cliens,” meaning a freed slave who retains an economic dependency on his former master (Felder & Weiss, 1991). The term patient implies a dependency, giving oneself over to a process that is bigger and more powerful than the individual. Whitaker and Malone (1953) used the phrase accepting patient status to describe the stage in psychotherapy when the patient begins to shift his focus from protecting the psychological status quo that has failed him some time ago and begins to consider the frightening possibility that he doesn’t understand everything that is going on and may not be able to get where he wants to go without getting help. I am a client to my accountant, a client to my attorney. I prefer to be a patient to my psychotherapist.

There are essentially three relational stances that a therapist might take in response to the dependency needs of the patient. Some therapists may consistently choose to take one of these positions regardless of the needs of a particular patient, while others might vary their relational stance in response to the patient’s individual needs.

The first relational position is to intentionally provide no gratification of the patient’s dependency needs. This perspective stems from the belief that the patient may be developmentally fixated and functioning at a level of dependency needs that is not commensurate with his chronological age. From this perspective, the therapist would not respond to the dependency needs of the patient believing that attempting to gratify these needs will precipitate a regression and diminish the patient’s motivation to gain greater understanding and resolution of those needs. Underlying this position is the belief that independence
supplants dependence, and that dependency interferes with achieving independence.

The second relational position is to attempt to provide a literal gratification of as many of the patient’s dependency needs as possible, based upon a belief that a literal reexperiencing of early dynamics is required to ameliorate early childhood trauma. There is an underlying belief in independence emerging from a satisfactory experience with dependency needs; however, this perspective assumes that the therapeutic relationship is a literal reenactment of the gratification of those needs in the original parenting relationships.

The third position is that the therapist attempts to provide a symbolic gratification of the patient’s dependency needs, believing that a literal reparenting is not possible or advisable, but that a failure to respond to the patient’s needs at some level will recapitulate earlier interpersonal traumas. This position also recognizes the natural emergence of independence through satisfactory resolution of dependency needs, but differs from the second position in a recognition that the nature of the therapeutic relationship dictates that the responses are symbolic rather than literal, and that any attempt to literally gratify those early needs will perpetuate infantile reparenting fantasies and often recapitulate earlier traumas.

To summarize the three positions:

- to withhold gratification of the patient’s dependency needs
- to attempt to respond literally to those needs
- to respond symbolically.

The more wounded the patient the more likely he is to experience his needs in literal rather than symbolic terms. Some patients enter psychotherapy uncomfortable with the potential dependency of the therapeutic relationship. Many therapists comfortably encourage these patients to experiment with allowing increasing experiences of interpersonal dependency in the therapeutic process, such as an occasional phone call or getting help from the therapist for specific life difficulties. Other patients enter psychotherapy with the fear that they are overwhelmingly dependent and will exhaust the therapist’s capacity to care. The patient distrusts the early evidence of his or her therapist’s apparent availability, believing that their unending neediness will eventually wear down any lingering beneficence. These are the patients with whom we are likely to have a difficult time holding on to the symbolic nature of the relationship.

These patients may experience internal pain that is overwhelming to them. The relatedness of the therapy hour may barely penetrate the extreme isolation they feel, and even then they struggle to hold on to
that connection once they walk out the door. We may respond initially to the presentation of these patients’ dependency needs as a challenge, an opportunity to prove to be the better parent, reworking perhaps some of our own earlier deprivation. We are convinced that we will not fail our patients in the ways we judge their parents to have failed them (or ways we judge our parents to have failed us). We set about trying to convince our patients of the same. This generally works well enough as long as the patient is polite enough to contain his or her needs within the confines of a traditional therapeutic framework as we define it. It is when the patient pushes beyond the symbolic and into the arena of literal that the therapist may feel pushed out of his or her comfort zone and things may go significantly awry.

Countertransference and Dependency

Therapy today has become a commodity, a means of social control.

From The Radical Therapist Manifesto

Carter Heyward’s (1993) book When Boundaries Betray Us is an excellent example of these dynamics. Heyward and her therapist both became interested in the concept of mutuality in relationships, and they began to study and talk together about how they might enact that in their work together. Heyward experienced this as an invitation to bring more of her needs forward into the relationship. From her perspective, the more open and vulnerable she became about expressing her needs, the more withholding her therapist became until the relationship ultimately ended in a way that was horribly painful for Heyward.

I believe these dynamics are actually more common than one might expect. In dealing with patients with very strong dependency needs our focus seems to shift away from understanding the patient’s experience toward protecting the therapist through the establishment of “appropriate boundaries.” We seem surprised when patients present their dependency needs in a socially unacceptable, or even an interpersonally intrusive manner. We may gossip to each other about such patients, complaining self-righteously about their attempts to manipulate us. The solutions proposed by peers usually involve some tightening of the therapeutic structure, a reduction in the availability of the therapist that can often seem punitive. In this odd dance, the more needy the patient becomes, the more withholding we are.

Clinically, we might understand this “blaming the victim” as a countertransference response stemming from our own unresolved issues about dependency. Countertransference is generally understood as the process whereby the intrapsychic dynamics of the therapist interfere
with the therapeutic process, and it is typically assumed that it is the therapist’s responsibility to ameliorate the situation. In the case of dependency, however, the responsibility seems to shift to the patient (Gilbert, 1987). Bornstein and Bowen (1995) suggest that “patient dependency can lead certain therapists (particularly those who cannot tolerate strong needs for intimacy on the patient’s part) to engage in various maneuvers which permit the therapist to distance him or herself from the patient” (p. 527). This is written without any suggestion that the therapeutic impasse might be the result of the therapist’s impaired capacity for intimacy rather than the patient’s excessive dependency needs.

The greater the repression of our dependency needs, the more likely we are to act out those needs as countertransference in response to the dependency needs of the patient. However, we have been reluctant as a field to acknowledge the dependency needs of the therapist because of concerns about potential conflict of interest. Almost as a reaction formation we have attempted to eliminate from our theoretical models any dependency needs that the therapist may have, creating an idealized picture of a therapist who can enter the relationship devoid of needs. At the same time, the therapist’s unmet needs provide her primary motivation for the work and are the basis for an empathic connection with the patient, a requisite for effective psychotherapy (Jordan, 1991). Experiential therapists have suggested that the therapist’s unmet needs set the emotional ceiling for the therapeutic encounter, that the patient will only be able to explore material with which the therapist experiences some intrinsic motivation to come to terms (Felder and Weiss, 1991). If this is so, then our disregard of the therapist’s own dependency needs would have significant implications for our clinical effectiveness.

The most immediately apparent issue of therapist dependency is the dependency that almost inevitably exists in psychotherapy, and that is a financial dependency. My living depends almost entirely on my patients valuing my services sufficiently to pay me for them. This is a dependency that we are often reluctant to acknowledge, much less to discuss.

Additional areas of therapist dependency might include

- The therapist may depend on the patient for feeling worthwhile, and the patient may respond by getting better.
- The therapist may depend on the patient for feeling like a good person, and the patient may respond by being appreciative.
- The therapist may depend on the patient for voyeuristic excitement, and the patient may respond by talking about exciting things that the therapist only dreams about, like exotic vacations or sexual liaisons.
• The therapist may depend on the patient for safety, and the patient may respond by not suing.

Mary is a woman in her late 40s who experiences herself as having overwhelmingly strong dependency needs. Her mother’s repeatedly told her “there is no love available for you in the world except from me,” and Mary has lived her life by what she calls her mother’s curse. She assumes, rather than expects, that abandonment is the inevitable outcome of any significant relationship, and devotes most of her waking energy to forestalling that inevitability. Her strategy is to never let anyone be aware of the strength of her needs, and to devote herself to the task of anticipating and responding to any unmet needs in others, whether they are expressed or intuited. Mary experiences herself as having dependency needs so strong that they would overwhelm anyone’s capacity to care for her, so she presents herself as someone devoid of any needs whatsoever. It is extremely difficult for her to acknowledge her own dependency needs, and almost intolerable for her to accept any giving in response to those needs.

Mary’s early history is marked by the absence of secure attachments. Mary was born two to three months premature and considered nonviable at birth. She spent most of her early life in the hospital, and upon returning home at approximately six months, Mary refused all food. She understands this as a primitive suicide attempt in response to the realization that there was no love available to her in the world.

Mary first saw a therapist in her early 20s for 2 years until that therapist moved out of state. Her most recent psychotherapy was with a female therapist whom she saw for ten years and with whom she became very attached. The therapy terminated precipitously when this therapist also moved out of state.

When Mary phoned to set up her first appointment, she asked for a therapist specializing in Borderline Personality Disorder. While it is true that she does meet the diagnostic criteria for this disorder, diagnostically as well as dynamically she might best be described as suffering from complex Post Traumatic Stress Disorder.

It is generally my practice to reconsider the structure of a psychotherapy in response to the unique needs presented by each patient, much in the sense recommended by Jung. In this case, I decided to modify the structure of the therapy to help Mary to tolerate increasing levels of dependency. For many years, Mary brought a gift with her to every session. Given her lifelong pattern of ingratiating herself to others by giving, I could have reasonably refused these gifts because they represented a repetition of an interpersonal pattern that has been very destructive for her. However, I came to believe that Mary could not tolerate the psychotherapy without the giving of these gifts. If she did not give
me a weekly gift, she was unable to tolerate accepting anything in return. I allowed the repetition of a historically maladaptive pattern so that she could tolerate the dependency of the psychotherapy.

In the same vein, I experimented with a variety of other ways to help Mary increase her capacity to tolerate dependency. Most of these strategies were a part of an effort to help her to maintain an internal representation of the connection made during the therapeutic hour. For example, Mary tape recorded all of her sessions and listened to each one again and again during the week. She would also sometimes come to the office on days when she did not have an appointment and sit in the “quiet room.” I have a teddy bear in my office that she often held in her lap during sessions. We talked openly of the fact that holding the bear was a symbolic representation of the physical nurturance that she so desperately wants and needs, but that is not available to her within the confines of the therapeutic relationship. When I was away, or when she was in crisis, the bear was entrusted to her care for a “home visit.” This helped her to retain the positive introject of the therapeutic relationship. It also communicated my trust of Mary to care for an object of emotional significance to me, and my trust of her to care for her own more primitive needs.

For many years, this symbolic gratification of Mary’s dependency needs was very effective. Rather than increasing her dependency and helplessness, it seemed to help increase Mary’s independence and effectiveness. Although Mary had been agoraphobic for years, she joined a health club, experimented with new friendships, sometimes with disastrous results, but she did not give up or overgeneralize due to these painful experiences.

After several years of slow but consistent progress, things went terribly awry. Mary’s father died, precipitating a crisis. All of the strategies we had employed to respond symbolically to her dependency needs became completely ineffectual. Mary lost almost all capacity to retain any positive experience of the therapeutic relationship outside of the actual session, and in her desperation began escalating her demands for a more literal rather than symbolic relationship. Sessions became angry power struggles, and I felt we were at significant risk for enacting her most dire prediction, that eventually I too would tire of her neediness and ultimately reject her.

I called in a consultant, a close colleague who had often seen Mary during my vacations. We told Mary that we were committed to resolving the impasse, and were going to change the structure of her psychotherapy to do so. The three of us began to meet only in conjoint sessions. I no longer accepted gifts from Mary, or allowed her to come to the office when she did not have an appointment. She continued to tape record her sessions and to listen to them at home. Predictably, Mary
was horribly wounded by these changes, but she now acknowledges that the changes have been extremely helpful, perhaps even lifesaving. Her therapy has stabilized, we all agree that she is doing extremely productive work in session, and her life seems to be stabilizing as well.

What can we learn from this? Were my original experimentations with the structure of the psychotherapy in response to Mary’s dependency needs misguided? Is her therapy more productive now only because I returned to a more traditional therapeutic structure? Alternatively, is it possible that the experimentation was just what was needed at that time, and that as Mary grew and her needs changed over time that the structure became increasingly problematic? Did that initial flexibility help Mary to develop the capacity for a mature dependency that then allowed us to begin work on developing the capacity for true independence?

Conclusions

Our professional literature and clinical theories are situated within, and contribute to a culture that venerates self-reliance, and pathologizes dependency. Clinically, we have focused primarily on the therapeutic difficulties inherent in working with the excessively dependent patient, while paying little attention to the consequences of a restricted capacity for interpersonal dependency. Our clinical strategies focus on containing the neediness of the patient and protecting therapists from countertransference responses.

References


