DEPENDENCY PROCESSES IN THE PSYCHOTHERAPY OF SCHIZOPHRENIA[1]

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There is widespread agreement concerning the fundamental importance of dependency processes in schizophrenia.[2] For the patient who is involved in a schizophrenic illness, probably there is nothing that is harder to endure than the circumstance of his having intense dependency needs which he cannot allow himself to recognize, or which if recognized in himself he dare not express to anyone, or which are expressed by him in a fashion that, more often than not, brings an uncomprehending or actively rejecting response from the other person. For the therapist who is working with such a patient, certainly there is nothing that brings more anxiety, frustration, and discouragement than do these processes in the schizophrenic person with whom he is dealing. This paper endeavors to delineate these processes in a fairly comprehensive fashion.

The dependency on which this paper is focused, throughout, is that which has its closest analogue, in terms of normal personality development, in the experience and behavior of the infant or of the young child. The dependency-needs, -attitudes, and -strivings which the schizophrenic manifests may be defined in the state-

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[2] See references 1, 4, 5, 6, 7, 8, 13, 14, 16, 17, 20, 21, 25, 26, 27, and 30.

ment that he seeks for another person to assume a total responsibility for gratifying all his needs, both physiological and psychological, while this other person is to seek nothing from him.

Of the *physiological* needs which the schizophrenic manifests, those centering about the oral zone of interaction are usually most prominent, analogous to the predominant place held by nursing in the life of the infant. Desires to be stroked and cuddled, likewise so characteristic of the very early years of normal development, are also prominent in the schizophrenic. In addition, desires for the relief of genital sexual tensions, even though these have had their advent much later in the life history than have his oral desires, are manifested on much the same level of an early, infantile dependency. That is, such genital hungers are manifested in much the same small-child spirit of "you ought to be taking care of this for me" as are the oral hungers.

The *psychological* needs which are represented among the schizophrenic's dependency processes consist in the desire for the other person to provide him with unvarying love and protection, and to assume a total guidance of the patient's living.

In the course of this paper, further characteristics of the schizophrenic's dependency processes will be defined much more fully.

The points which will be offered in this paper in regard to schizophrenia refer, with rare and specified exceptions, to schizophrenia in general, irrespectice of diagnostic subtypes. That is, in my own experience the points which are to be put forward here possess validity in work with schizophrenic patients, whether of catatonic, paranoid, hebephrenic, or other diagnostic subdivisions.

It is to be emphasized further that no one of the dependency processes to be described here is characteristic only of the schizophrenic, is qualitatively different from processes which are operative at some level of consciousness in persons with other varieties of psychiatric illness and in normal persons. With regard to dependency processes as well as with regard to other aspects of personality functioning, we find that research in schizophrenia has its greatest potential value in the fact that the schizophrenic shows us in a sharply etched form that which is so obscured, by years of progressive adaptation to adult interpersonal living, in human

beings in general. Thus the writer hopes that this paper may be useful not only to workers in the field of the psychotherapy of schizophrenia, but to some degree also to other students of human experience and behavior.

I. Sources of the Patient's Anxiety about His Dependency Needs

A. As nearly as one can determine, the patient is unaware of pure dependency needs; for him, apparently, they exist in consciousness, if at all, only in the form of a hopelessly conflictual combination of dependency needs *plus* various defenses—defenses which render impossible any thoroughgoing or sustained gratification of these needs. These defenses (which include grandiosity, hostility, competitiveness, scorn, and so forth) have so long ago developed in his personality, as a means of coping with the anxiety attendant upon dependency needs, that the experiencing of pure dependency needs is, for him, lost in antiquity and to be achieved only relatively late in therapy after the various defenses have been largely relinquished.

Thus it appears to be not only dependency needs per se which arouse anxiety, but rather the dependency needs plus all these various defenses (which tend in themselves to be anxiety-provoking) plus the inevitable frustration, to a greater or lesser degree, of the dependency needs.[3]

Hostility was mentioned above as one of the defenses against awareness of dependency needs. Certainly repressed dependency needs are one of the most frequent bases of murderous feelings in the schizophrenic; in such instances the murderous feelings may be regarded as a vigorous denial of dependency. What frequently happens in therapy is that both patient and therapist become so anxious about the defensive murderous feelings that the underlying dependency feelings remain long unrecognized.

[3] So far as I have been able to determine, this principle applies to other repressed affects as well as dependency needs—namely, that what is anxiety-provoking is the repressed affect *plus* the attendant defenses. Szalita-Pemow (28) touched upon this principle in a limited sense in saying, "While the term regression is used primarily to designate a definite defense mechanism, I consider that regression in its main structure is what we defend ourselves against."

Every schizophrenic possesses much self-hatred and guilt which may serve as defenses against the awareness of dependency feelings ("I am too worthless for anyone possibly to care about me"), and which in any case complicate the matter of dependency. The schizophrenic has generally come to interpret the rejections in his past life as meaning that he is a creature who wants too much and, in fact, a creature who has no legitimate needs. Thus he can accept gratification of his dependency needs, if at all, only if his needs are rendered acceptable to himself by reason of his becoming physically ill or in a truly desperate emotional state. It is a frequent occurrence to find that a schizophrenic is more accessible to the gratification of his dependency needs when he is physically ill, or filled with despair, than he is at other times. Thus, because of the presence of self-hatred, and guilt, one ingredient of the patient's over-all anxiety about dependency needs has to do with the fact that these dependency needs connote to him the state of feeling physical illness or despair.

In essence, then, we can see that the patient has a deep-seated conviction that his dependency needs will not be gratified. Further, we see that this conviction is based not alone upon unfortunate past experience of repeated rejections, but also upon the fact that his own defenses, called forth concomitantly with the dependency desires, make virtually certain that his dependency needs will not be met.

B. The dependency needs are anxiety-provoking not only because they involve desires to relate in an infantile or small-child fashion (by breast- or penis-sucking, being cuddled, and so forth) which is not generally acceptable behavior among adults, but also, and probably more importantly, they involve a feeling that the other person is frighteningly *important,* absolutely indispensable to the patient's survival.

This feeling as to the indispensable importance of the other person derives from two main sources: (a) the regressed state of the schizophrenic's emotional life, which makes for his perceiving the other as being all-important to his survival, just as in infancy the mothering one is all-important to the survival of the infant; and (b) certain additional handicapping features of his schizo-

phrenic illness, which render him dependent in various special ways which are not quite comparable with the dependency that is characteristic of normal infancy or early childhood.

I shall now mention a number of points in reference to source (b) above.

First, one can perceive that a schizophrenic who is extremely confused, for example, is utterly dependent upon the therapist (or other significant person) to help him establish a bridge between his confusion and reality. Second, one can see also that the patient who is in transition between old, imposed values and not-yet-acquired values of his own, has only the relationship with his therapist to depend upon.

Third is the consideration that, in many instances, the schizophrenic appears to be what one might call a prisoner in the present. He is so afraid both of change and of the memories which tend to be called forth by the present that he clings desperately to what is immediate. He is in this sense imprisoned in immediate experience, and looks to the therapist to free him so that he will be able to live in all of his life, temporally speaking—present, past, and future.

Fourth, one might surmise that an oral type of relatedness to the other person (with the all-importance of the other which this entails) is necessary for the schizophrenic to maintain, partly in order to facilitate his utilization of projection and introjection as defenses against anxiety. Bychowski (5, p. 79) says, "The separation between the primitive ego and the external world is closely connected with orality; both form the basis for the mechanism which we call projection" (and, I would add, for introjection). Stärcke (24) earlier commented, "I might briefly allude to the possibility that in the repeated alternation between becoming one's own and not one's own, which occurs during lactation, there lies . . . a path for the later psychic process of projection . . . the situation of being suckled plays a part in the origin of the mechanism of projection."

C. The patient has anxiety lest his dependency needs lead him either to take in harmful things, or to lose his identity.

The schizophrenic does not have the requisite ability to tolerate the frustration of his dependency needs so that he can, once they

emerge into awareness, subject them to mature discriminatory judgment before seeking their gratification. Instead, like a voraciously hungry infant, his tendency is to put into his mouth (either literally or figuratively) whatever is at hand, whether nutritious or harmful. This tendency is thus at the basis of some of his anxiety concerning his dependency needs, for he fears that they will lead him blindly into receiving harmful medicines, bad advice, electroshock treatment, lobotomy, and so forth. Schizophrenic patients have been known to beg, in effect, for all of these, and many a patient has been "successful" in obtaining a remarkably long series of such supplies in response to his dependency desires. A need for self-punishment is, of course, an additional motivation in such instances.

A statement by Fenichel (9, p. 39) is relevant here: "The pleasure principle, that is the need for immediate discharge, is incompatible with correct judgment, which is based on consideration and postponement of the reaction. The time and energy saved by this postponement are used in the function of judgment. In the early states the weak ego has not yet learned to postpone anything."

The paranoid position, in which the environment is seen as totally rejecting, has as one of its functions the avoidance of one's seeing the totally devouring quality of one's dependency needs. This urge to devour is anxiety-provoking not only because it threatens to lead one to destroy other persons,[4] but also because one fears that if he takes in too much, he will no longer be himself—his identity will be lost. And this anxiety is augmented, moreover, by the schizophrenic's tendency to identify unconsciously with other persons in the environment as a way of keeping out of awareness various emotions stirred up by those other persons. It should be noted that, in so far as the patient utilizes this latter type of defense against anxiety, his fear that he will lose his identity if he comes too close, emotionally, to another person (and dependency needs tend, of course, to bring one closer to the other

4 A variation of this is the anxiety of the patient lest he pull the therapist into his own dangerous world. Fromm-Reichmann has presented material about this (12, p. 105).

person) is a realistic fear. It is commonplace to find schizophrenic patients helplessly identifying with various behavior traits of persons around them.[5]

In the same vein, one finds that to the extent that the schizophrenic projects onto other persons his own needs to suck and to devour, he feels threatened with being devoured by these other persons.

To elaborate now in a somewhat different direction upon this fear of loss of identity: the schizophrenic fears that his becoming dependent upon another person will lead him into a state of conformity to the other person's wishes and life values. A conformer is just about the last sort of person the schizophrenic wishes to become, since his sense of individuality resides in his very eccentricities. He assumes that the therapist (for example) will not allow him to enter into a state of dependency without, in the process, requiring him to give up his individuality. All too often, this is the kind of price which the parental figures in his past have attempted to exact from him, and whatever healthy ego he has been able to salvage has refused to pay this price.

Many schizophrenics are all the more ready to assume that dependency entails such a kind of automaton-like conformity since they confuse genuine dependency with a kind of pseudo dependency, based largely upon unconscious hostility, in which the person manifests a puppet-like obedience in lieu of becoming aware of hostility toward the other person. Many schizophrenics have had the experience either of finding themselves engaged in such behavior, or of seeing such behavior manifested by one or another parent. They tend then to label such behavior as dependency and to avoid it like the plague. They cannot conceive of the dependent state as being one in which they can retain the ability to exercise discriminatory judgment and to initiate action.

D. The other person—the object of the dependency strivings—is perceived as hostile and rejecting. There are several bases for this, in addition to the obvious consideration that the parental

[5] Robert Bak (2) has presented some interesting material concerning the dissolution of the ego boundaries in schizophrenia.

figures in the schizophrenic's past life have often met his dependency manifestations with hostility.

First, the schizophrenic commonly projects upon the other person (the therapist, let us say) his own hostility. When one considers that frustrated dependency needs are probably the major source of hostile feelings, one can see how much the working through of the dependency needs is complicated by this element of projection. If the dependency needs are deeply repressed, the frustration anger is likewise so successfully repressed that it need not be dealt with by projection upon the therapist, and the patient can succeed in viewing the therapist as being of about the same order of importance to him as a spot on the wallpaper. But as the dependency needs come, in the course of therapy, closer to the patient's awareness, the frustration anger associated with them also comes to the fore, and in so far as this latter has to be projected upon the therapist, the therapist is then viewed as a hostile person upon whom it would be folly to depend. This sequence of processes is often reflected in the course of psychotherapy in which the patient commonly brings his dependency feelings into the open precisely after a particularly stormy period during which he had been convinced that the therapist was oriented thoroughly against him.

In actuality, it is probably more accurate to say that the schizophrenic tends to project, at any one moment during the therapeutic hour, either his hostility *or his positive feelings* (tender, friendly, loving feelings) upon the therapist. The ambivalence of the schizophrenic is so great, and the need so great to keep the hostile feelings and the positive feelings from coming into awareness simultaneously, that the schizophrenic tends to perceive the therapist as being in the nature of someone approximating either a devil or a saint, depending upon whether the hostile or the positive side of the ambivalent feelings is being projected.

Rosenfeld (18), writing of confusional states in chronic schizophrenias, says, "The confusional state is associated with extreme anxiety, because when libidinal [positive] and destructive impulses become confused, the destructive impulses seem to threaten

to destroy the libidinal impulses. Consequently the whole self is in danger of being destroyed."

In my experience, the schizophrenic is equally afraid that the hostile side of his ambivalent feelings will be destroyed by the positive (libidinal) side. When one considers that the patient's potentially healthy self-assertiveness is bound up in the hostile feelings, this fear becomes quite understandable.

So then, the schizophrenic's ambivalence, his need to keep his hostile feelings and his positive feelings from simultaneous awareness lest either one destroy the other and so destroy the self, is one source of his anxiety about his dependency needs. He cannot expect to gain satisfaction for his human dependency needs from someone so distant and other-wordly as either a devil or a saint.

A second basis for the schizophrenic's perceiving the therapist as hostile and rejecting is to be found in the patient's suspicion. He has such a degree of suspicion that he cannot believe that the therapist will give him anything without there being an ulterior motive behind the gift. He fears that this suspicion, accompanying his dependency needs, will be perceived by the therapist and reacted to with resentment.

Third, to the schizophrenic there is no distinction between feeling and acting, in the sense that he assumes that a dependency desire on his part, for instance, to suck the therapist's breasts or penis will inevitably lead him to attempt this in action. He senses that the therapist would react with hostility to such a move.

Fourth, he projects upon the therapist his own tendency to reject dependency needs. It is to be emphasized that the schizophrenic is a person who has a tendency to be severely rejecting of dependency needs not only in himself but also in others, for various reasons: (a) the other person's dependency needs are so reminiscent of his own that he has to react against them with hostile rejection, because of the anxiety they create in him; (b) often, he feels so starved and empty himself that he cannot bear to give; (c) he assumes the other person's gain to represent, automatically, a loss to himself; and (d) throughout his life he has felt his position to be so insecure that he has been afraid to release

hostility except when the other person has been dependent upon him—so, at least with many schizophrenics, the rejection of a dependent other person has been the most frequent means of consciously discharging hostility. This rejectingness of his own the schizophrenic projects upon the therapist; hence he assumes that if he allow himself to become dependent, the therapist will vengefully reject him.

Fifth, and closely related to the factor just described, the schizophrenic projects upon the therapist his own undependability in interpersonal relations. There is probably no person more undependable than the schizophrenic, who for a variety of excellent reasons (having to do with his ambivalence and his great anxiety about interpersonal intimacy) cannot be depended upon to make consistent and determined efforts toward the maintenance of an interpersonal relationship. The schizophrenic attributes to the therapist, by projection, his own undependability and assumes that the therapist will let him down.

Sixth, the schizophrenic has so much guilt feeling associated with his hostility that, in order to justify the hostility, he strives to prove that the therapist is depriving, neglectful, and generally hostile toward him. This striving, of course, interferes greatly with his dependency strivings.

Seventh, he assumes that the dependency needs of himself on the one hand, and of the therapist on the other hand, are mutually exclusive; he cannot conceive of a collaborative relatedness from which both persons derive satisfaction simultaneously. He assumes that anything he obtains from the therapist will foster feelings of deprivation and hostility in the therapist.

Eighth, he (particularly if he is strongly paranoid) cannot let himself be aware that he really needs anything from anyone, cannot allow himself to feel that he gets anything really valuable from anyone, and hence anything which the therapist (for example) asks of him makes him feel that he is being exploited. This same feeling has an additional basis in the total, or almost total, absence of any sense of personal worth. The latter quality, strongly characteristic of all schizophrenics, makes it impossible for one to

entertain the possibility that the therapist has one's *own* welfare in mind.

Ninth, he is likely to be so unable to communicate his thoughts and feelings, in general, in a sufficiently understandable fashion so as to make his need known to the other person. In such an instance, satisfaction for the need is impossible and, even more painful to him, its very existence will go unacknowledged despite his efforts to communicate it.[6]

E. His repressed dependency needs are closely associated with his repressed feelings of loneliness; so his recognition of the dependency needs brings with it a devastating realization of how terribly alone he is.

Probably there is no greater threat to the schizophrenic than the repressed knowledge of his aloneness, the realization that he, who yearns so strongly for oneness with another person, not only possesses the same inevitable aloneness which every human being has, but in addition is even more completely cut off from his fellow human beings by reason of his isolation within his schizophrenic illness.

A deeply psychotic young male patient was able to tell his therapist after several months of intensive psychotherapy, "I feel as though I'm on a deserted frontier." One might speculate that, earlier, he had felt not even this tenuous contact with civilization, so to speak—had felt even more alone; still earlier, his schizophrenic symptoms (delusions, hallucinations, and so on) may have protected him from the awareness of his loneliness.

I have never found a more moving expression of the loneliness within the schizophrenic who overtly is convinced that he needs nothing from anyone, than is conveyed in a poem composed at about the age of eighteen, during a schizophrenic illness, by Eithne Tabor (29):

> Break, crested waves;
> On the sheer cliff of onyx break
> In wild foam—and fall back, powerless.

[6] This point has been found to be of much operational importance in the management of a disturbed ward, as reported by Schwartz, Schwartz, and Stanton (19).

Lash, O wild winds,
'Gainst the unbending oak, aye, lash
In high fury—it is feelingless.

Beat, O deep drums,
Thunder your message fearsome—beat
Your dark rhythms—into soundlessness.

Speak, O strong Voice,
Speak peace, security—aye, speak!
Only You can fill this loneliness.

F. In so far as the schizophrenic becomes aware of his dependency needs, he must relinquish the fantasied omnipotence which serves as a defense against manifold anxieties, and which provides him with tremendous gratification in itself. The importance of this gratification (even though it lies within the realm of fantasy), and the importance of the very real feelings of loss which the patient must undergo in the relinquishing of his infantile omnipotence, should not be underestimated. This position of infantile omnipotence is untenable when the patient reaches an awareness of the intensity of his dependency needs; an omnipotent god does not have needs.

Certain speculations concerning the early development of the future schizophrenic are rendered highly plausible by the evidence which intensive psychotherapy with schizophrenics produces in regard to the relationships between dependency needs and fantasied (i.e., infantile) omnipotence.

In normal development, it appears that gradually, during infancy and very early childhood, the subjective omnipotence which seems to exist in that phase of life is gradually relinquished, concomitantly with a fortunate, continuing experience of reasonable gratification and reasonable frustration of the dependency needs, such that the child grows toward a fairly accurate awareness of his own real power and of the limitations upon it. It is as though he can clearly see that he is not omnipotent, specifically because of the fact that he has *needs* for which he is *unable*—impotent—to acquire instant and full gratification.

It is widely accepted that, in normal development, the phase of infantile omnipotence is succeeded, in infancy or very early childhood, by a conception of the mothering one as being omnipotent.[7] Silverberg (23) has emphasized that this provides for a continuing subjective feeling of omnipotence on one's own part: in so far as one can manipulate this omnipotent mothering figure, one is omnipotent.

Now, as regards the early development of the future schizophrenic, it seems likely that the infantile omnipotence is perpetuated and elaborated as later development proceeds, for two main reasons. (a) The normal dependency needs of infancy and early childhood meet with unendurably intense and prolonged feelings of frustration, so that the needs themselves have to become more or less repressed, and the initially normal feeling of omnipotence is greatly strengthened to form a defense against the awareness of dependency needs—in effect, a denial of the needs. (b) The mothering figure has never relinquished her own infantile omnipotence, feels therefore that she should be able to satisfy all the child's needs, feels guilty whenever she does not do so, and thereby conveys to the child the impression that the mothering figure is omnipotent and that he, as her child, an extension of her, is also potentially omnipotent if he could only "get the combination."

In relation to (b) above, we can see how the "omnipotent," guilt-ridden parent fosters in the child an expectation of receiving, in effect, the whole world as his rightful due. Thus the patient's normal dependency strivings have had added upon them limitless grandiose demands for which, in the light of his own upbringing, he has a quite reasonable right to expect gratification.

Such a parent has, by the same token, behaved possessively toward the child, has given the child to feel that he must turn his dependency strivings toward no one other than this parent. The parent who has not relinquished her (or his) own infantile omnipotence cannot bear to find that the child's dependency needs can be better fulfilled by someone other than herself, as would inevitably be seen if the child felt free to turn his depend-

[7] See Fenichel (9, p. 40).

ency needs toward all available persons in his environment. A more emotionally secure parent would assume that, oftentimes, other persons in her child's life are better equipped, or in a better position, to meet the child's dependency needs, and would help the child to feel that it is thoroughly acceptable to turn to them. But as regards the child of this other sort of parent previously described, we see that the infantile omnipotence is perpetuated and becomes firmly entrenched for the additional reason that it serves as a defense for the child against the anxiety engendered by the parent's possessiveness. Save for this fantasied omnipotence, the child might feel utterly at the mercy of the possessive parent.

With such a child, as later in the adult schizophrenic, the dependency demands and strivings which are manifested are probably voiced much more in the service of the pathological grandiosity—which is, of course, insatiable—than in the service of such basically normal dependency needs as the need for physical closeness, the need for gratification of physiological hungers, the need for guidance, and so forth. It is as if the schizophrenic were saying, "If you would only give me enough, then I could assume my rightful position of omnipotence in the Universe," rather than simply, "I need you as a little child needs its mother."

It should be clearly seen how very much the fantasied omnipotence interferes with the patient's obtaining whatever gratification is available for his ordinary, normal human dependency needs. He is so caught up in grandiose expectations of himself and of the therapist (for example) that his basic, normal dependency needs are very thoroughly warded off, as either being of no importance or posing a great threat to his fantasied omnipotence. Many an aloof schizophrenic patient, caught up in grandiose fantasies, seems to be conveying by his manner, "What need could *I* have for closeness with *you,* a mere human being?" We can often find abundant evidence that such a patient has had, during his developmental years, a relationship with a parent in which each was so involved in grandiose conceptions, of himself and of the other person, that the relationship involved very little of gratification for the basic dependency needs of either individual.

So, in the therapy of the adult schizophrenic, we find that as his

dependency needs become manifested they (a) can be found to include not only basically normal dependency strivings, but also, and very prominently, grandiose strivings (demands for the therapist to help one become the world's greatest scientist, or painter, or what not); and (b) all these strivings (those referable to normal dependency needs plus those having an infantile-omnipotence basis) become focused exclusively upon the therapist. To be sure, the patient actually does receive partial gratification of his dependency needs from other persons, but from the viewpoint of his infantile omnipotence he strives to make the therapist alone gratify all of them, because were he to face the fact that he is *unable* to make the therapist gratify all of them and the fact that the therapist is inherently *unable* to gratify all of them, his conception of both himself and the therapist as omnipotent would have to be relinquished.

II. The Patient's Ways of Dealing with His Dependency Needs in Therapy

In an effort further to delineate the processes under discussion, let us now examine them in terms of how the patient deals, in the therapeutic relationship, with his dependency needs. In what follows here, it is assumed that his "dealing with" them operates at a level which is completely, or very largely, unconscious.

What perhaps deserves first mention is the schizophrenic's very prevalent *projection* of his dependency needs upon the therapist. The patient functions much of the time in such a way as to make clear that he feels the therapist, not himself, to be the one who has the greater need, or even the only need. He may behave solicitously toward the therapist, offer sympathy, exhibit the manner of a host toward a guest, or—very often—show great anxiety at what he feels to be the therapist's demands upon him. His ego boundaries are so very fluid that if the therapist, in an effort to encourage him to express his dependency needs, speaks of such needs in the patient, the patient is very prone to assume that it is the therapist's needs which are being expressed and he may then anxiously shy away from the subject. I wish to emphasize that all

this may, and very often does, hold true by reason of the schizophrenic's innate psychopathology, without being in any major part attributable to countertransference—although, as will be pointed out in the next section of this paper, all this will be greatly complicated if the therapist is actually largely repressing his own dependency needs and the schizophrenic is then responding, not so much projectively as realistically, to these needs in the therapist.

In line with the above considerations about projection, a schizophrenic may maintain a vigorous, incessant demandingness toward the therapist as a means of defending himself from supposed (i.e., patient-projected) demands by the therapist.

Second to be mentioned are the patient's *competitiveness and contempt* toward the therapist, both of these feeling states often functioning as unconscious defenses against the dependency needs. For instance, rather than consciously experiencing how greatly he needs the therapist, the patient may strive to prove that he is a better therapist (better mother or father) than the therapist.[8] Or he may exhibit such intense scorn toward the therapist as to make it clear that he feels the therapist to be beneath competition. Such scorn serves to help him keep his dependency needs under repression, for who could possibly feel any need for so worthless a creature as the therapist? Incidentally, a very full awareness of the prevalence of this defense can be extremely helpful to the therapist's maintenance of his own self-esteem in the face of the persistent and prolonged buffeting to which it is subjected in the course of therapy with schizophrenic patients.

In the same category belong *awe* and *adoration* of the therapist, which may serve the same function for the schizophrenic as does contempt, placing the therapist at such a distance that the patient's dependency needs are hindered from being consciously

8 One wonders whether the term "competitiveness" is accurate here. Perhaps that which feels to the therapist like competitiveness is, from the viewpoint of the schizophrenic, more a matter of his being unable to conceive of any other than two possible roles in living, the role of infant and the role of mother, so that in so far as he strives to avoid or to grow beyond the role of infant, he must operate as a mother. There is in the background of so many schizophrenic patients such a close symbiotic relationship between patient and mother person, that this explanation seems more likely.

directed toward the therapist. In my patients I have seen these latter two defensive feeling states much less frequently than I have found competitiveness or contempt.

In the history of many a schizophrenic patient, we find evidence that he reacted to severe frustration of his dependency needs by the development of a secondary, defensive grandiosity, which in turn led him, as his development proceeded, into esoteric and highly learned hobbies and career activities. These activities were of a sort in which the parent figures, so important in terms of his repressed dependency needs, could not possibly be expected to be able to participate with him. There has been, such a history shows, a progressive process of his isolating himself in such activities more and more, feeling consciously more and more scornful of his benighted parents, and unconsciously becoming more and more starved as regards his basic dependency needs toward them. In such a case, the defensive grandiosity finally has to become so predominant that a frank schizophrenic psychosis ensues.

To return to the therapeutic relationship, a third consideration to be emphasized is that the schizophrenic patient is unable to conceive of gratification (for his dependency needs) in terms of long-range, adult, experiential (emotional-intellectual) gratification; what he feels a need for instead is immediate, concretely tangible gratification of his infantile (largely physiological) hungers. It is inevitable, then, that he will quickly find that the awareness of needs will lead to intense dissatisfaction with the therapist, for the therapist's major potential usefulness lies in the realm of very long-range gratification of an impalpable and relatively abstract sort. Specifically, psychotherapy is not a tangible thing, it is not easy for anyone to develop a clear conception of what it actually is—and it is quite impossible for a schizophrenic to perform such a conceptual feat; and psychotherapy is, finally, a process which generally takes a long time to yield major results in terms of the gratification of the patient's urgent dependency needs.

One pertinent consideration here is that many a schizophrenic possesses, certainly at the beginning of psychotherapy, far too much hopelessness about himself for him to be able to perceive

the therapist as someone who holds out any strong hope that he, the patient, may be able, with the therapist's aid, to establish a far more satisfying way of life. He can believe that the therapist may give him a cigarette or a key to the door, or may side with him against the persecutors, but this other he cannot conceive of.

Fourth, the patient may keep his greatest needs under repression by means of experiencing in awareness, and expressing, other needs which are thus of a defensive nature and which one might call irrelevant. Often a patient will, for instance, make numerous requests for the therapist to perform for him various functions which he, the patient, is quite able to do himself (such as finding an ashtray, or asking the nurse for some fruit juice), whereas the same patient will vigorously resist becoming dependent upon the therapist's therapeutic functions which he, the patient, is unable to carry out himself.[9] The former kind of requests do not carry the threat of any real dependency of the sort which would be connoted by his conscious recognition of the therapist's therapeutic importance to him. Of course, at times these requests by the patient may represent tentative, preliminary efforts to bring forward more important but at least partially *conscious* needs for the therapist's therapeutic functions. Only a therapist's intuition can help him to know, in any given situation, whether the satisfying of a patient's request for a concrete gratification would further the expression of the deeper lying needs, or whether on the other hand it would turn the focus away from them. This matter will be dealt with more fully in the final section of the paper.

In other instances, the deeper-lying (repressed) need may be of a relatively infantile nature, and hidden behind an overt request for an adult type of gratification. For instance, the patient may beg the therapist to allow him to return home and take up an (overtly) adult life, while at the moment the patient is striving to keep under repression a desire to sit on the therapist's lap and be cuddled.

[9] The patient has especially intense anxiety at recognizing how dependent he is upon the therapist's sheer *presence*.

Fifth, whenever the patient does consciously express dependency needs, he tends to present them in some fashion which precludes their gratification by the therapist. For instance, he may beg the therapist to do something which is not within any human being's capacity to do; or he may present a request just at a time when he has been making the therapist so infuriated with him that the therapist is vigorously disinclined, at that moment, to accede to any request from the patient; or he may plead with the therapist to do something for him which, if done, could only have the connotation that the patient is, in the therapist's estimation, a less capable person than the therapist actually considers him to be. A frequent example of the last-mentioned type is when the patient asks the therapist to bring some near-lying item to him, just at a moment when the therapist feels it important for the patient to find within himself the capability to do this. At such a moment, then (and only the therapist's intuition can tell him what is useful to do at a particular moment), the therapist may find that to serve the best interests of the patient's therapy, he must refuse the request.

This matter of soliciting rejection serves several functions for the patient. (a) It reassures him that life is, for him, just as he has always—or at any rate for a very long time—known it to be. We must not forget that whereas new experience tends to be disconcerting to a neurotic, it tends to be frightening to a schizophrenic. (b) In at least one respect it would be a greater source of anxiety to the schizophrenic to obtain some gratification, than to obtain none. Any gratification he might get would be only partial, since no human needs are ever gratified both thoroughly and consistently, and certainly the schizophrenic's dependency needs, with the grandiose elements which complicate them, are not. So a little gratification is all too apt to affect the schizophrenic as a crumb would affect a starving man, making him even more keenly aware of the intensity of his hunger. Thus a total rejection is, to the schizophrenic, in a sense more tolerable. (c) Any conscious conflict about dependency is temporarily put out of mind by a rejection from the therapist. This I shall immediately explain.

The patient may be in a state of conscious, extremely distressing conflict between desires to be dependent upon the therapist and strong desires to avoid this at all cost. If he can then "succeed" in feeling rejected by the therapist, the distressing conflict is, at least for the moment, no longer occupying his conscious thoughts: he is now fully absorbed in wholehearted, consciously unambivalent, resentment or hurt feeling about the therapist.

III. Manifestations of Anxiety in the Therapist with Regard to His Own, and the Patient's, Dependency Needs[10]

Up to this point we have been discussing the *patient's* anxiety with regard to his dependency needs, and his unconscious defenses against this anxiety as we find them operative in the therapeutic relationship. In this section of the paper we shall concern ourselves with the *therapist's* anxiety about the dependency needs in the patient and, basic to this, his anxiety about his own infantile and early childhood dependency needs.

While the following comments pertain especially to the therapist who has had little or no personal analysis and who has had little experience in the therapy of schizophrenics, I wish to emphasize that any therapist, however well analyzed and long experienced in this field, is likely to evidence, at some phase in the course of his work with one or another of these difficult patients, some of the characteristics of the anxiety-ridden therapist to be described below.

For a number of reasons, therapy with schizophrenic patients tends, even more than does the analysis of neurotic patients, to stimulate anxiety in the therapist with regard to dependency needs.

First, both the schizophrenic's dependency needs and his anxiety about them are greater than are those of the neurotic.

Second, the schizophrenic has, usually, very strong identifications with the early mother. These identifications become manifest in therapy as strong maternal qualities which tend to call forth

10 This section, modified and somewhat abbreviated, was read at the Midwinter Meeting of the American Psychoanalytic Association, New York, December 5, 1953.

infantile dependency feelings in the therapist.[11] If the therapist is prone to experiencing anxiety with regard to such feelings in himself, he is then particularly likely to undergo such anxiety in this field of psychotherapeutic endeavor.

Third, the schizophrenic has such an inability to make distinctions among thinking-feeling-and-acting that he tends to express his dependency needs in seeking for physical contact. This is much more likely to stir up anxiety in the therapist than is the neurotic's *verbalized wish,* for instance, to suck the analyst's penis or breast.

Fourth, because the therapy of a schizophrenic usually requires a very considerably longer time than does the analysis of a neurotic, the therapist is faced with a relationship in which the patient's dependency will be not only more intense but also longer-lasting, even if the therapy goes well.

Fifth, if the therapy is taking place within a hospital setting, the therapist is under a special kind of pressure: the patient's level of daily-life interpersonal functioning is clearly there for all his colleagues, upon whose esteem he is to a degree realistically dependent, to see. This situation often places a considerable burden upon the therapist in the process of working with a patient who is loudly proclaiming (often most effectively in nonverbal ways) how utterly uncaring his therapist is.

Now I shall mention briefly those vulnerabilities which the therapist himself brings into the relationship with his schizophrenic patient, vulnerabilities to anxiety about dependency needs. My main effort is to describe various indicators of the presence of such anxiety in the therapist, rather than to explain why this anxiety is present in him. Very briefly, then, it can be said that the therapist is vulnerable to experiencing such anxiety in

11 Ruth W. Lidz and Theodore Lidz (15) offer an interesting discussion of the symbiotic needs of schizophrenic patients in relation to therapy. A portion of their summary shows the theme of the article: "A developmental problem common to many schizophrenic patients, the symbiotic relationship to a parent who utilizes the patient to complete her own life, has been related to some of the problems of maintaining a therapeutic relationship in a manner that can lead to a successful outcome. The problems stressed revolve around the passive seeking for a new protecting figure who is not only necessary to the patient but for whom the patient is essential." Abrahams and Varon (1), in their volume describing the course of events in a therapeutic group comprised of schizophrenic daughters and their mothers, describe this same symbiotic relatedness in rich detail.

proportion as (a) he has to maintain under repression his own infantile and early-childhood dependency needs; (b) he has to retain the fantasied omnipotence which dates from the same early period of his life as do his repressed dependency needs, namely, infancy and early childhood; and (c) he has not yet developed confidence in his therapeutic technique in this field.

The therapist's own difficulty here possesses a most valuable facet, on the other hand. There is much evidence to indicate that it is this very problem with regard to infantile and early-childhood dependency needs which forms one of the strongest motivations, in therapists, for undertaking this kind of work and for persisting in it.[12]

The manifestations of anxiety in the therapist will be presented in two categories: (A) his compulsion to be helpful, and (B) his failing to hear, or actively discouraging, the patient's expression of dependency needs.

A. The Therapist's Compulsion to be Helpful

He has a compulsion to be helpful to the patient, experiencing chronic anxiety and guilt in relation to a feeling that he is not helping the patient, or not helping him as much as he should. This compulsion is very likely to have, as at least one of its bases, the projection of his own dependency needs upon the patient. In such an instance, failure to satisfy "the patient's" (actually the therapist's own, projected) needs carries with it the threat of his having to recognize his own repressed needs.

He experiences a frequent, uncomfortable feeling of "not knowing what to say" in response to the patient's communications. He feels called upon to make immediate responses, does not allow the patient time to come forth with elaborative statements, nor time for himself to allow his own associational processes to operate with the freedom necessary to a useful intuitive response. He tends, therefore, to adhere to the literal content of the patient's

12 Whitaker and Malone (30, p. 101) point out that "The enthusiasm and elation felt when contemplating the possibility that schizophrenic patients may be amenable to psychotherapy may reflect a perception that some residual needs can perhaps be answered only in therapeutic experience with the schizophrenic."

productions, for his intuition is not operating freely enough to bring to light their symbolic content.

In this connection, we can often see that the therapist's overly-abundant interpretations represent his way of anxiously trying to satisfy the patient's oral needs, much as if he were plying the patient with cigarettes or milk. The more panicky and ego-fragmented a schizophrenic is, the more likely he is to meet with this kind of thing from some therapists. In such instances, the patient may well be sensing that he is being called upon to satisfy the therapist's dependency needs (which the therapist is repressing and projecting upon the patient), and the anxiety which this causes the patient may have much to do with prolonging or augmenting the panic.

The therapist is particularly anxious whenever the patient is silent and withdrawn. He may try desperately somehow to keep the patient from going out of contact, rather than focusing upon what sequence of events leads to the patient's doing this.

His "therapeutic curiosity" may assume a voracious aspect.[13] This is all the more important when we consider that the most essential attitude for a therapist to maintain is one of therapeutic curiosity. Such voracity in the anxious therapist (who is consciously experiencing merely a very eager concern to get more data from the patient in order to be more helpful to him) strongly reinforces the schizophrenic's anxiety about closeness, with the threat which that always poses to him, namely, the loss of his ego boundaries.

The therapist experiences guilt in connection with his not meeting the patient's dependency needs fully—even those needs which could not possibly be fully satisfied by anyone. The therapist's need to retain, at an unconscious level, his own fantasied infantile omnipotence, is a potent source of such guilt: he cannot accept his human limitations. He tries unduly much to help the patient by giving advice and reassurance, by manipulation of the patient's environment in order to shield him from anxiety and

[13] In this connection a statement of Fenichel (9, p. 491) is of interest: "By displacement of the constellation 'hunger' to the mental field, curiosity may become an oral trait of character, and under certain conditions assume all the voracity of the original oral appetite."

frustration, by having extra hours with him on an emergency basis, and so forth.

He gets into frequent tangles with administrative and nursing personnel, feeling that they should be doing more for the patient. In so far as his protests are successful, his own repressed and projected needs are more fully satisfied, in a vicarious fashion. It should be noted, however, that the schizophrenic's psychopathology places great pressure upon any therapist to get into such tangles; the patient generally presents his needs-toward-the-therapist in such an indirect and obscure fashion that it is easy to misinterpret the needs as being directed toward better administrative and nursing care.

He may greatly underestimate the patient's ego strength, as contrasted to the estimates of other personnel members who are working closely with the patient. This is likely to be in the service of his maintaining a relationship with the patient in which the therapist's own repressed dependency needs can be unwittingly gratified; so long as he can perceive the patient as having an extremely weak ego, as being utterly dependent upon him, then he need not fear that he will lose the patient. Real progress on the patient's part poses, of course, a great threat to such a therapist and he is likely, therefore, to be much slower to see this progress than are the other personnel members.

B. The Therapist's Failing to Hear, or Actively Discouraging, the Patient's Expression of Dependency Needs

Paradoxically, this same therapist who has a compulsion to help the patient often fails to recognize the patient's expression of dependency needs, or actively—though unconsciously—discourages such expression. It is as though he unconsciously keeps himself preoccupied with his compulsion to help the patient in order not to let himself see and hear the patient's actual expression of need for help. It appears that there are two main bases for his unreceptivity to such communications by the patient.

First, the patient's expression of dependency needs would, if heard, sound too uncomfortably close, so to speak, to the expression of his own repressed needs. Second, when he hears these com-

munications from the patient, the therapist's unconscious fantasy of omnipotence is threatened. If he were omnipotent, the patient could not possibly be hungering for more from him than he can provide. This same unconscious fantasied omnipotence causes him to feel guilt: since there are no limitations upon what he, the therapist, can do, he *should* be satisfying all the patient's needs.

So, then, he often fails to recognize his patient's disguised, indirectly expressed pleas for help. He unwittingly fosters the patient's continued use of highly disguised language in the expression of dependency needs, because such direct, simple statements from the patient as, for instance, "I missed you over the week end," make him feel anxious and guilty.

He does not recognize how tremendously important he is to the patient. When (as so often happens in any therapist's work with schizophrenics) the patient treats him with scorn, he is too ready to accept this as a reality evaluation rather than looking upon it as being, very probably, an unconscious defense in the patient against the recognition that the therapist is of tremendous importance to him.

He seldom, if ever, finds his patients expressing any desire for a change of therapist; this kind of material he unconsciously discourages, on the basis of his own repressed, fantasied omnipotence and of his repressed dependency upon the patient. Likewise, he tends either to disrupt the relationship prematurely, in order to avoid a state of prolonged dependency between himself and the patient, or to prolong it beyond the time when it would be in the patient's own interest for it to be terminated.

Although he at times underestimates the patient's ego strength, he as often overestimates it. This is often representative of the striving of his repressed infantile needs toward an omnipotent parent to lean upon. Hence, he is slow to realize how very confused, in how very poor contact with reality, his schizophrenic patients are. He is likely to react, when his patients express fragmentary and highly symbolic communications, as though he were being personally abused, as though the patients really have it within their ability to speak more intelligibly if they so desired. Moreover, it may well be that this very confusion, which the

therapist is overlooking, constitutes the patient's most urgent problem, the symptom for which he most desperately needs help.

The therapist reacts with dismay, discouragement, irritation, or scorn to conscious expressions by the patient of dependency feelings, rather than welcoming them. He interprets them as signs of increasing pathological regression, as indications that the patient's clinical state is worsening and the prognosis is growing gloomy. He does not realize, or keep in mind, that the patient's dependency needs were largely subjected to repression at a very early age and have not, therefore, had the opportunity to mature along with other areas of the personality. Thus, when they emerge into the patient's awareness during the course of therapy, they are bound to appear in a very early state of development. The patient himself is so prone to meet this emergence with great dismay and humiliation, that it is all the more important for the therapist to see clearly the positive quality of this therapeutic development.

Lest I give the impression that it is easy for one to avoid the kind of antitherapeutic attitude described here, consider how difficult it may be to encourage the patient's expression of such a feeling as was expressed to me on one occasion in the following words: "*I go to the trouble to want* to see Miss R. [a nurse to whom the patient was intensely attached]," he said in an outraged tone, "so I should see her all I want!" To be sure, what at times may be needed in therapy, in response to such a statement, is the therapist's firm pressure upon the patient to help him see the unreasonableness of his demands. But at other times, the patient may instead need encouragement toward the further expression of such feelings, which a portion of the therapist's self tends to react to as being intolerably presumptuous. This patient made it clear, with this and other statements, that he felt that the environment should meet his needs without his having to *want* anything, let alone having to *ask* for it. We can without animosity visualize an infant's having some such feelings, but it may be genuinely difficult to avoid reacting against a chronologically adult person when he voices them.

To return to the hypothetical therapist under discussion, we find that he tends to become preoccupied with the patient's *de-*

fenses against dependency needs, rather than perceiving the *needs themselves* as the centrally important focus at the moment. Thus, he may become preoccupied for a long period of time with the patient's scorn in itself, or murderous feeling in itself, or genital-libidinal interest in itself, at a time when the affect in question is functioning in a predominantly defensive capacity, in the service of keeping dependency needs under repression.[14]

He may become anxious at relating in a person-to-person fashion with the patient, may endeavor to present himself to the patient, scrupulously, in some limited doctor-role, may need to maintain a limited view of the patient as being only a patient rather than basically a person who bears the label, so to speak, of patient.

In summary, let me emphasize that all those unconscious defenses against anxiety in the therapist, described above, interfere with the free exercise of his therapeutic intuition. Because of his having to maintain his own dependency needs under repression, he cannot let himself freely experience his own desire to receive. Thus his *receptivity,* both to the patient's communications and to messages from his own unconscious intuition, is greatly interfered with.[15] Further, his awareness of what is transpiring in the therapeutic relationship is clouded by his preoccupation with the compulsion to help the patient. One can see, in seminars or supervisory hours, that as a therapist becomes freer from this compulsion, he becomes increasingly aware of significant sequences in the patient's reporting, of the timing of increases in the patient's anxiety, and of the nuances of his own varying inner responses to what is going on between himself and the patient. His intuition is now freer to function in the service of the therapeutic relationship.

14 I do not mean to imply here that I consider the dependency needs to be the central issue always; in fact, it is common enough experience to find repressed murderous feeling, for example, disguised within overt infantile-dependent behavior.

15 In such an instance, the therapist's inability freely to receive (verbal and nonverbal communications, gifts, and so forth) from the patient tends to perpetuate the patient's feeling that he himself has nothing worth while to offer. Moreover, the schizophrenic feels so worthless, and so hopeless about himself, that he often has to participate in therapy on a basis of doing it for the therapist's sake; he cannot conceive of doing something for his own sake. If the therapist is so anxious about his own dependency needs that he must insist that therapy takes place for the sake of the patient, this is then a major hindrance to the therapeutic process.

IV. Therapeutic Technique in Dealing with the Patient's Dependency Needs

One cannot formulate detailed rules which are applicable to the complex and changing conditions of a therapeutic relationship, rules by which one can know when to help a patient to become aware of a need which he has been acting out, when to offer gratification for his dependency needs, when firmly to pursue an investigative path, or when bluntly to refuse a demand as being unreasonable and presumptuous.

But there are several general principles which I have found to be consistently useful guides. Moreover, each of these principles is valid, in my experience, in both the early phase of therapy during the development of a workable psychotherapeutic relationship and in the later phases, when therapist and patient are working toward the final goal of the patient's recovery with insight—recovery based upon the patient's own personal integration rather than upon the shaky foundation of an unresolved transference dependency toward the therapist.

A. The therapist's major task is not to attempt to make up to the patient for past deprivations, but rather to help the patient to arrive at a full and guilt-free *awareness* of his dependency needs (in the course of which process he must help the patient to recognize a variety of feelings about the past deprivations—feelings of rage, disappointment, grief, anxiety, and so forth).

In the literature, one often finds statements which imply that the primary requisite of successful therapy is for the therapist to be a superhumanly loving individual, a person so endowed with love as to be able to make up for the lack of love in the patient's relationship with the mother of his infancy and early childhood. This hypothesis is seldom so explicitly stated as it has been by Rosen (17):

> The governing principle of direct analysis is that the therapist must be a loving, omnipotent protector and provider for the patient. Expressed another way, he must be the idealized mother who now has the responsibility of bringing the

> patient up all over again. This duty must be undertaken because the patient has been forced, under heavy psychic threat, to become again for the most part an infant. Since direct analysis holds that this catastrophic collapse is the consequence of unconscious malevolent mothering, it could have been predicted, even in the absence of overwhelming clinical evidence, that the antidote would have to be a benevolent mother . . . [pp. 8-9].
>
> He [the therapist] must make up for the tremendous deficit of love experienced in the patient's life. Some people have this capacity for loving as a divine gift. But it is possible to acquire this the hard way—by psychoanalysis. It is the *sine qua non* for the application of this method in the treatment of schizophrenia [p. 73].

To be sure, Rosen (17) also emphasizes that "Being an indulgent parent when deprivation is indicated does no service to the patient and may undermine successful treatment" (p. 152). But he still leaves an over-all impression that he is advocating a type of therapy in which the therapist is somehow omnipotent and possessed of a healing love toward the patient.

My own experience indicates, by contrast, that to the very degree that the therapist can freely accept his own human limitations, he can help the patient to relinquish his infantile omnipotence and accept his human dependency needs. Once the therapist has been able to help the patient to reach a full awareness of the dependency needs, the patient is now able to turn to any suitable figures in his environment for such gratification as it may be possible to acquire, and he will undoubtedly find other figures to be better able than is the therapist to gratify many of his needs. Even this process, however, cannot possibly make up for past deprivations; they can only be integrated by the patient as irretrievable losses to which the therapist has helped him to become reconciled.

B. Special emphasis needs to be placed upon the importance of helping to resolve the *guilt* which is regularly associated, in the schizophrenic, with dependency needs.

In my own work, when a patient expresses a dependency need to me, I seldom find it indicated for me to set about trying to

gratify the need, even though I may promptly feel sympathetic with the need and may feel that I could, without going far out of my way, supply gratification for it. Instead, what repeatedly seems to be more helpful to the patient is for me either to encourage him to express his feeling of need as fully as he can, or to convey to him by a brief comment my acknowledgment of his feeling of need, often adding something to the effect that I can see how, under the circumstances, he of course does feel that way.

In this response, I believe, one is doing more for the patient than when one gives gratification for the need itself: one is helping the patient to become free from the guilt which has imprisoned his dependency needs, so that he can see them more clearly, accept them into his conscious personality functioning, and henceforth seek gratification for them from persons in his daily life.

I find it unfeasible for the therapist to fulfill the function which I have just described and, at the same time, to do very much in the way of trying to gratify the dependency needs. To a considerable degree these two modes of functioning are incompatible. What often happens, as was described in Section III, is that the therapist sets about trying to gratify the patient's need in an unconscious effort to avoid looking, with the patient, at the full intensity of the ungratified need.

Oftentimes when a patient is being most obnoxiously demanding, he is trying to express a basically valid and understandable need about which he, however, feels guilt and self-hatred. Here again, then, the therapist's effort usually should be directed neither toward gratifying the need nor toward chastising the patient for being so obnoxious, but rather toward uncovering the guilt and self-hatred, and helping the patient to see the irrational quality of these affects which are causing him to express his need in such an alienating manner.

Next I shall turn to a consideration of the work of Sechehaye, since this is pertinent to the matter of the schizophrenic's guilt in relation to his dependency needs.

In 1951 appeared the English translation of the important book by Sechehaye, *Symbolic Realization* (21), in which she described

her method, of the same name, for the psychotherapy of schizophrenia. With it appeared the very interesting companion volume (22) containing an account by the patient, in the therapy of whom Sechehaye had developed her method, of her illness and of her treatment by Sechehaye.

Sechehaye's own conception of the essence of her symbolic realization technique, and of its rationale in terms of the pathogenic early experience of the schizophrenic, is most clearly expressed in the following passages:

> The tragedy of the situation is that maternal love is indispensable to the baby, and its deprivation leads to hopeless clinging of the child, who does not want to die; there results a fixation to this stage which he cannot outgrow. Deprivation, in this case [i.e., that of Renee], had fastened our patient to this stage of her evolution and thus kept her ego from growing, from becoming distinct from that of her mother's.
>
> Renee could not recover, because, between the unaccepted facts [of psychological trauma in her infancy] and the delirium [i.e., the psychosis] there was a legitimate desire, the insatiability of which caused the fixation, the aggressiveness and the guilt.
>
> The whole problem consisted in realizing this desire, so that it would not be compensated any more by the delirium, and permit a normal development of dynamic growth.
>
> Direct realization, however, was impossible: Renee could not return to the infant stage in order to satisfy the needs of this age. It was necessary to take a substitute, the symbol, since she asked for satisfaction in this form [21, pp. 136-138].

Here, then, Sechehaye has been pointing to the *deprivation* of maternal love, and the *insatiability* of the patient's desire for maternal love, as the central problems. She refers to *guilt* only as one of the products of the insatiability. She then goes on to state, "The whole problem [in therapy] consisted in realizing this desire. . . ." Most unfortunately, she never makes entirely clear what she means when she uses the term "realization." Her very strong implication in the above passages, and in others, is that she means *gratification.*

But in other passages, she seems to consider—more correctly, in

my opinion—that the guilt is the central problem, and that gratification by the therapist is therapeutic not in terms of any making up for past deprivations of maternal love, but rather in the sense that the act of gratification helps, at crucial moments, to relieve the patient's guilt and so helps him to experience his needs as being legitimate and no longer, therefore, requiring repression:

> I constantly came up against a feeling of indomitable guilt which enclosed Renee in a vicious, impassable circle. . . . This guilt feeling, attached to the primitive stage of moral realism, was certainly the most difficult to uproot. At this stage, the estimation of feelings and acts usually can be traced to the mother's judgments: what mother gives is good, what she refuses is bad. Deprivation is a refusal; therefore, a desire which was refused is bad: the desire for maternal love, which seemed to have been refused, became a guilty tendency; it is forbidden to desire love [21, pp. 135-136].
>
> [Sechehaye has just described a calming of Renee's agitation upon her being put to bed, to the accompaniment of a sedative and of soothing, permissive comments by the therapist, in a green room.] I understood suddenly why Renee was relieved by the "green setting." The retreat into autism, which is a refusal of life's responsibilities, comprises a violent feeling of guilt. And this guilt of the autism, like all unconscious guilt feelings, keeps one from detaching oneself from a fixation of this state. In order to remove guilt feeling, it is necessary to give permission to do the thing. One must therefore be authorized to retreat into autism, in order to be rid of this guilt feeling and thus get out of it. The reason is simple: there follows guilt in retreating into the maternal body, since the mother wants to force the child to live and does not want her in her body.
>
> I had to go with Renee to the ultimate regression—autism —and grant her in this way, symbolically, the right to take refuge at the maternal bosom, when she suffered too much [21, pp. 73-74].

In my opinion, Sechehaye places far too much stress upon gratification, and far too little stress upon the often equally therapeutic value of timely, judicious frustration coupled with a primarily investigative approach.

Whitaker and Malone (30), in their highly unorthodox but, like

Sechehaye's book, thought-provoking volume on psychotherapy, published in 1953, speak much of symbolic gratification by the therapist:

> [In the "core stage" of the psychotherapeutic process] the patient demands complete symbolic gratification. [As the "core stage" proceeds into the ending phase of the process, the patient] has satisfied some of his more fundamental infantile needs and begins to have more mature and real needs. Part of his testing of the relationship results from a loss of interest in a symbolic relationship and a demand for a real, adult relationship with the therapist. The mature therapist responds to this by a rejection of these real demands, leaving the patient with the need and opportunity to end the symbolic relationship constructively. This frees the patient to secure these gratifications in other areas. In the transition from the core stage to the ending phase, the motivations of the patient toward ending increase almost geometrically as he secures more and more satisfaction in his real-life experience" [30, p. 103].

Their most detailed description of what they refer to by the phrase "symbolic gratification" is contained in the following passages:

> Behaviorally, at any rate, silence comprises the framework within which regression occurs and core satisfactions are achieved. The authors have found that regression may, at times, be facilitated by certain props or auxiliaries. Thus, the therapists have used bottle feeding, physical rocking of patients, and other aids which stimulate in both therapist and patient the requisite affect for infantile satisfaction of the patient. It reproduces in therapy aspects of the mother-child relationship. More recently, the authors have found that if aggression is utilized at this point of therapy it most appropriately takes the form of spanking. These, however, are auxiliary techniques which compensate for the therapist's inadequacy by inducing the deep affect which the patient seeks for the satisfaction of his infantile and dependent needs. Theoretically, the authors are convinced that these regressive and core satisfactions can be provided without any props or auxiliary techniques since the process of therapy is essentially an intra-psychic one. Technical implementation must

only reflect certain immaturities in the intra-psychic functioning of the therapist.

In the core stage of therapy, the experience is primarily a non-verbal shared fantasy experience. . . . The forced joint fantasy may, in its inception, be verbal. It is presented by the therapist as an experience in the present tense in which he relates to the patient with feeling and affect appropriate to the nursing mother who responds to a hungry child. The fantasy need not seek refuge in metaphor or allegory. The fantasy forced at this point becomes direct and primitive. If the patient is ready for the core experience in therapy, and the therapist is capable and sufficiently involved, the forced fantasy proceeds easily from the verbal presentation of it to the non-verbal experience itself. The verbal inception, or precipitation into the feeding experience, may be further implemented by techniques involving physical contact, changes in body posture, and a very frank, face to face relationship [30, pp. 211-212].

Here again, as in the volume by Sechehaye, an impression is given that the nucleus of the therapeutic technique is the *gratification* of the patient's infantile dependency needs. It is interesting that even Whitaker and Malone do not consider, apparently, that the patient achieves *full* gratification of these needs: in the "core stage," they say, "the patient demands complete [N.B.] symbolic gratification," but that as the ending phase ensues, the patient has satisfied only "some of" his more fundamental infantile needs. In their way of phrasing it, however, they do imply that at least these needs which he has satisfied are *permanently* satisfied.

In my opinion here, as in reference to Sechehaye's work, the therapeutic effect of the technique described lies in the patient's having acquired, partly through timely symbolic gratifications, a fuller *awareness* of the infantile dependency needs as being legitimate, rather than their being a continuing source of guilt and requiring repression. The needs themselves are never permanently satisfied, or otherwise eradicated, so long as life goes on; but the patient is now freer to experience these needs and to seek their satisfaction, either in a direct form if the situation at the moment allows for infantile behavior, or in a reformulated form adapted to

adult modes of behavior. An excellent case could probably be made for the hypothesis that it is these very basic, primitive needs which constitute the wellspring of energy that enables human beings to accomplish their most highly complex, adult personality functions.

C. In therapy with schizophrenics, just as in analysis with neurotics, the therapist's most consistently appropriate "gift" to the patient is his psychological presence, alert and with an ever-alive therapeutic curiosity. Material gifts have a very limited place in the analysis of neurotics, and an only somewhat less limited place in the therapy of schizophrenics. The therapist helps the schizophrenic patient to deal with infantile dependency needs much less by material gifts, however timely, than by his consistent, attentive, receptive psychological presence with the patient during the therapeutic hour.

I hope that this will not be taken as suggesting that the therapist's thoughts, during the long periods of silence that occur from time to time in the work with any schizophrenic, should be clearly centered always on the patient. I have heard a number of therapists express guilt at finding their thoughts to be "straying far away from the patient." The free use of the therapist's intuition in the service of the patient requires that he be as open as possible to free-associational processes within himself throughout the hour, during both silences and periods of verbal communication.

D. The position in which the therapist finds himself, in either being asked to gratify the patient's dependency needs or being offered dependency supplies by the patient, is often an inherently, inevitably conflictual position.

Oftentimes, for instance, when a patient offers the therapist some candy, the therapist may sense that if he declines it the patient will feel rejected, but that if he accepts it, this will substantiate the patient's fantasy that the therapist is totally, frighteningly dependent upon the patient. Thus, there is no action which the therapist can take which will meet the patient's over-all needs at the moment, since these needs are basically ambivalent.

I do not mean, of course, that for the therapist to participate in

either receiving from or giving to the patient is always so conflictual a business. Very frequently, the therapist's intuition will quickly tell him what is clearly the appropriate thing to do at the moment. But often the patient's own desires in this regard are so very ambivalent that the therapist senses this ambivalence and feels that neither activity—declining or accepting— is appropriate at the moment.

This is equally true, of course, as regards the patient's requests for dependency supplies from the therapist. Frequently, the therapist senses that if he does not grant a patient's plea (for advice, for information, for orange juice, or what not), a genuine hunger in the patient will go unsatisfied, but that if he supplies what is asked for, on the other hand, then the patient's self-esteem will be further lowered by the implication that the patient cannot meet this need adequately himself.

My main point here is that whereas a therapist may oftentimes, upon finding himself feeling conflictual in answer to a patient's request or proffered gift, feel that his conflictual state is an indication of inadequacy as a therapist, actually this state in which he finds himself is very often inevitable, in view of the patient's own conflictual feelings about dependency. This observation ties in with the emphasis which I shall place, shortly, upon the importance of the investigative response as the one which is most consistently appropriate for the therapist to make, in such situations.

But in returning for the present to this matter of the patient's conflictual feelings about dependency, I shall mention a few relevant items from the literature.

Sullivan described these feelings in the patient quite accurately in a recent volume (27), in a chapter entitled, "The Later Manifestations of Mental Disorder: Matters Paranoid and Paranoiac." Of what he terms the "indirect exploitative attitude," he says,

> . . . . there is a sort of continuous offer that one can be found to be dependent. It suggests to me the expression 'come-on'; one offers, but one does not quite deliver. One cannot bear to be regarded as dependent . . . [27, p. 352].

In my experience, one sees this quality in many schizophrenic patients in general, not merely in those whose illness is predominantly paranoid in nature.

The schizophrenic patient's ambivalence about his dependency needs is probably one factor which makes for the striking lack of agreement, among therapists who work with schizophrenics, as to how far the therapist should endeavor to go in gratifying or frustrating the patient's dependency needs.[16]

Rosen and Schwing may be cited as therapists who represent (markedly though their techniques differ in many respects) one end of the scale of this disagreement, so to speak, in advocating the therapist's actively assuming the position of an omnipotent, loving figure to the patient. Some of Rosen's comments in this respect have already been quoted. Brody (4) describes Schwing's therapy as follows:

> .... As she put it, she gave the patients instinctively what had been lacking in their child-mother relationship; motherliness. Sometimes this involved long hours of sitting in silence, permitting a patient to proceed at her own rate in establishing contact. She often brought her patients bits of candy or fruit. Sometimes she offered substitute gratifications—small heaps of chocolate substituted for eating feces, and the manipulations of plasticine substituted for fecal smearing. When circumstances required she would comb her patient's hair, and wipe their perspiration, and when a patient asked her for a kiss she gave it [4, pp. 49-50].

Schwing is clearly in accord with the following statement by Federn: "... with psychotics one must preserve the positive transference and avoid provoking a negative one" (8, p. 171).

Certain other therapists—and it is these with whom I myself agree—advocate much more moderation on the part of the therapist as regards the gratifying of the patient's dependency needs, and place considerable emphasis upon the patient's anxiety about closeness and need for firmness from the therapist. From some of these therapists I shall quote in the section immediately below.

[16] For an interesting survey of the same disagreement in the field of analysis with neurotics, see Berman's article (3).

E. It is well for the therapist to maintain, for the most part, a degree of emotional distance between himself and the patient. This is important for three main reasons. First, it is essential to his fulfilling the observer portion of his over-all function as a participant observer. Secondly, although the patient's dependency needs are intense, his anxiety about them is likewise intense, for the numerous reasons which were given in Section I of this paper. Thirdly, the therapist must remain, most of the time, at a sufficient emotional distance so as to allow the patient freedom to express hostility as it arises and to meet such expressions by the patient with firmness.

The therapist who is afraid of the patient's hostility, and of his own counterhostility, is likely to function in an overindulgent, smothering manner which is repetitive of the schizophrenic's pathogenic early experience with the original mother person.

In addition, as Eissler (7) has pointed out, an overly indulgent approach by the therapist may increase the guilt which, as mentioned before, is associated with dependency needs. In commenting upon Schwing's therapeutic approach, Eissler says,

> Gertrud Schwing leaves no doubt that she considers love as the main road to get access to the schizophrenic personality. . . . Schwing's work with schizophrenics deserves greatest appreciation. [But he then adds:] I should like to mention some factors which may contribute to an appraisal of her work with schizophrenics. Schwing worked at a hospital in which the utter lack of consideration and love for the patient was the outstanding feature. I surmise that in such an environment a loving attitude as recommended by her has the best chance of success. The patient, after having been mistreated and exposed to severe mishandling, will take the loving stroke as the gesture of a savior and react favorably to such gestures. However, I wonder if this approach would be equally successful in a hospital of more affectionate and understanding background. . . .
>
> Schwing's patients had gone through a kind of treatment which, I surmise, had relieved them from feelings of guilt due to the punishing attitude of nurses and physicians. Hence, they were prepared for love, and they could accept it without guilt reaction. But it is safe to say that loving indulgence may

drive schizophrenics into deeper withdrawal if it increases feelings of guilt [7, pp. 386-387].

Knight, in his extraordinarily moving account of his successful therapy with a seventeen-year-old catatonic youth (13), emphasizes not only the importance of the therapist's optimism and affection for the schizophrenic but also

> . . . . the necessity, in such a case as this, of active firmness on the part of the therapist in breaking through the barriers of the [catatonic] trance and defiance. Firmness has further values. It makes the patient feel more secure from his own "bad" impulses if he can count on the therapist's adding his considerable strength in the struggle against the "bad" impulses. Thus a too permissive or indulgent attitude on the part of the therapist may lead the patient to feel that he is without an ally, helpless against his own overwhelming hates, defiant feelings, and primitive erotic wishes, and a prey to the intolerable anxiety they cause him. The protective strength of the therapist may thus be experienced by the patient as reinforcement of his own enfeebled ego, making it possible for him to contemplate eventual success in his struggle if this good ally will stay in the fight [13, p. 339].

Similarly, in a recent paper on borderline schizophrenic states, Knight (14) says that of the three pitfalls which are likely to be encountered in psychotherapy, one is the "unwise employment of an overpermissive therapeutic attitude."

Fromm-Reichmann's recent comments (12) in this regard are so useful that I shall quote extensively from them:

> Violence in action should be prohibited, and verbalized hostile outbursts should be first listened to and then responded to with a therapeutic investigation of their causes. Silent acceptance of violence in word or action is inadvisable, not only in self-defense, but also in pursuit of the respect due to patients, and in protection of their self-respect. Retrospectively, schizophrenic patients loathe themselves for their hostile outbursts, and do not respect the therapist who lets them get away with it [12, p. 94].
>
> In our therapeutic endeavors we [referring to herself and her associates at Chestnut Lodge] try to address ourselves,

if it is at all feasible, to the adult part of the patient's personality, regardless of how disturbed he is. . . .

Trying to initiate or facilitate treatment of a schizophrenic by making friends with him, or by other attempts at turning the strictly professional relationship into a pseudosocial one, may, according to our experience, turn into a serious threat to successful psychotherapeutic procedure. As we know from psychoanalytic work with neurotics, such attempts are inacceptable there. They may destroy the central core of psychoanalytic psychotherapy, which is to utilize the vicissitudes of the doctor-patient relationship as a mirror of patients' patterns of interpersonal relationships at large, hence as the most informative therapeutic means of investigating and understanding their psychopathological aspects. In the case of schizophrenics, there are several additional serious difficulties connected with any falsification of the professional character of the doctor-patient relationship. This must be definitely kept in mind in the presence of the temptation to try to reach a very disturbed psychotic schizophrenic by offering closeness, friendship, or love.

. . . . my suggestion of elimination of nonprofessional contacts in psychoanalytic treatment is not intended to imply a repudiation of all the very valuable attempts to create an atmosphere of acceptance, comfort, understanding, or elimination of anxiety-arousing factors from these patients' environment. Such efforts are most commendable as means of speeding patients' emergence from acute psychotic states, and, if administered by persons other than the psychoanalyst, as most useful adjuncts to the psychoanalytic treatment proper [12, pp. 101-104].

[She continues, regarding] the specific reasons for our warning against offering nonprofessional warmth to a schizophrenic patient in the setting of psychoanalytic treatment—first, the schizophrenic is afraid of any offer of closeness. Closeness in the present entails the danger of rebuff in the future to the early traumatized schizophrenic. Also, he will not be able to hide his "ugliness," his "meanness," his hostile and destructive impulses, from a person who comes close to him. . . .

Again, closeness increases the schizophrenic's ever-existing fear of having lost or of losing his identity, of losing the sense of the boundaries between himself and the outside world [—a fear which is a quite rational one, since an uncon-

scious, uncontrollable process of identifying with the other person is one of the schizophrenic's major defenses against anxiety].

There is one last reason, which makes me warn against the attempt to start psychotherapy with a schizophrenic on the basis of any relationship other than the realistic professional one, that is his alert sensitivity to and rejection of any feigned emotional experience. As one patient bluntly expressed herself upon being offered friendship in an initial interview by a young psychoanalyst, "How can you say we are friends? We hardly know each other" [12, p. 105].

It is interesting to see described, in a paper by Fromm-Reichmann in 1948 (11), the evolution which had taken place in the psychotherapeutic approach at Chestnut Lodge since a paper by her in 1939 (10). In the earlier paper she had stressed the importance of the therapist's approaching the schizophrenic patient with extreme delicacy, permissiveness, and caution so as to avoid causing the patient to feel rejected. By 1948, she indicates, she and her colleagues had come to feel that "this type of doctor-patient relationship addresses itself too much to the rejected child in the schizophrenic and too little to the grown-up person before regressing."

She went on to give additional reasons for the changed orientation, an orientation which now substantially coincides with that described in her 1952 article, quoted at length immediately above.

F. In intensive psychotherapy with schizophrenics, as in analysis with neurotics, the most consistently useful therapeutic approach with respect to the patient's dependency needs is one of neither gratification nor rejection but rather investigation. In general, the therapist's effort should be toward helping the patient to recognize and explore dependency feelings.

For instance, although upon occasion the therapist may sense that at the moment it is therapeutic for him to extend some oral gratification (such as a cigarette or a glass of fruit juice), he will much more often be giving the patient a far more valuable gift if he holds firm in exploring the patient's need with him, and the frustration rage which is attendant upon the therapist's investigating rather than gratifying. It is well to note that a simple

rejection per se (of a patient's request for a cigarette or what not) is not what I am recommending here; the therapist's focus should be upon investigating the patient's need, rather than either simply gratifying or simply frustrating it.

Quite regularly, both patient and therapist find it less uncomfortable when the patient is blaming the therapist for failing to satisfy infantile needs, than when both patient and therapist are clearly seeing the naked needs as such, for this latter process carries with it a realization of their mutual helplessness to satisfy the needs at all fully. Yet it is precisely in the therapist's helping the patient to recognize clearly the intensity of the patient's own infantile needs, unalleviated by protective feelings of blame and angry demandingness, that he is being of most real service as a therapist.

Again, a therapist may often become preoccupied with the question, "Should I or shouldn't I acquiesce to the patient's request?" rather than maintaining an investigative attitude, focusing upon the sequence of events in the hour which led up to the patient's making this particular request. Once more, the probability is that the therapist can be of most use to the patient by neither granting nor declining the request as such, but rather by helping to uncover its meaning in their relationship. Oftentimes, the patient most urgently demands an answer just when he is trying (unconsciously) most vigorously to avoid an area of anxiety which needs investigation, and for which his request is a defense.

G. The therapist's own intuition, his sensing of what need the patient is expressing and what is therapeutic for him to do or say in response at the moment, is his most reliable guide as to whether to meet the patient's dependency needs with gratification, frustration, or investigation.

The more inexperienced a therapist is in this field, and the less aware he is of his own feelings, attitudes, and interpersonal processes, the more he will need to rely upon rules as to what to say or do in response to his patients' manifestations of dependency needs. For him, such rules are necessary and thoroughly legitimate. I refer here, for instance, to such a rule as never to accept a gift

from a patient without first investigating what the giving of the gift means to the patient.

But gradually, through experience in psychotherapy with schizophrenics and through increasing ability to trust his own unconscious processes, the therapist finds that he can dispense with such rules and utilize his intuition as a much more dependable guide to his therapeutic functioning. In his doing this, he will undoubtedly find that the patient will complain that the therapist is being inconsistent—that he does this or that one way now, and another way at another time. But, as Fromm-Reichmann says, "There is one point where you are consistent, namely, that you try to do always and by all means that which you consider therapeutically valid in any given situation with any given patient. The realization of this principle may, at times, result in the most glaring psychotherapeutic 'inconsistency' any psychiatrist could dream of. We must have the courage to be 'inconsistent,' if need be, without developing anxiety, pangs of conscience and conventional guilt feelings."[17]

Rosen (17, pp. 8-9), with some of whose therapeutic philosophy and technique I strongly disagree, nonetheless makes some comments which are very well put and are relevant here:

> The conscious, tangible needs of the patient which anyone can recognize, such as food, warmth, and protection, are the easiest for the therapist to provide. Much more difficult is providing the proper instinctual response which the benevolent mother must make to the unconscious needs of the patients. For this response, the therapist's own psyche must be in order. His instinctual drives of love, hate and aggression must have come into such a balance that, as he relates himself to the patient, the patient will thrive. This balance. . . . cannot be forced by conscious effort alone. . . .

Steinfeld (25, pp. 103-104) likewise emphasizes the central importance of the therapist's intuition:

> . . . . wherever any results are achieved [in psychotherapy], creative efforts, consciously or unconsciously, must be com-

17 Personal communication.

bined with scientific understanding. The therapist must allow himself to be guided by an intuitive or "sympathetic" understanding of the patient, while he also uses the intellect and its systematized body of abstract knowledge as a complementary tool. The intellect alone in psychotherapy is as inadequate as Bergson would have it in all dealings with the living, creative stream of all reality.

Knight's statements on this subject merit quotation at length. In an article concerning borderline schizophrenic patients (14, pp. 149-150), he makes some comments which may be considered to apply to the more severely ill schizophrenic patients as well:

> With the borderline schizophrenic patient, the therapist often has some difficult decisions to make regarding what is the proper attitude to take with respect to firmness and permissiveness. Put another way, this is the question of need gratification versus need frustration, the frustration being a preliminary step to interpretation. In psychoanalysis, need gratification is at a minimum, and definite limits are set by the technique per se. Length of appointments is maintained fairly strictly, the patient may not even face the therapist, extra-analytic remarks at the beginning and end of each hour are minimal, extra appointments are rare, physical contact is ruled out, and communication is through verbal channels primarily. We know that many psychiatric patients are too ill to adapt themselves to these technical strictures and must have a preliminary period of greater or lesser duration in which certain needs are gratified. For example, the patient is permitted to sit up and face the therapist, supportive and encouraging remarks are made by the therapist, some active advice may be given, and the like. The borderline schizophrenic patient especially cannot tolerate the isolation of the analytic couch, and needs visual as well as increased auditory demonstrations of support and understanding. He needs *proofs* of emotional support, of trusting and trustworthiness, and of genuine human interest rather than merely detached professional interest.
>
> It becomes necessary, therefore, for the therapist to gauge these needs qualitatively and quantitatively with some accuracy, and to make judicious decisions as to what needs should be met and what needs may be frustrated by limit setting followed by interpretation. The overmaternal, over-

permissive therapist may encourage regressive tyranny in the patient by meeting too many needs, while the overrigid detached therapist may put his patient on what, for this patient, is a starvation diet. Such attitudes in the therapist are partly temperamental, partly a matter of difference between the sexes, and partly a matter of training. Ideally a therapist should be capable of considerable flexibility in his responses so that he can adapt himself with genuineness and spontaneity to the widely varying therapeutic situations arising in work with different patients.

Eissler (7, p. 387) sums it up in an excellent statement: "The entire gamut of emotions from hatred to love should be at the psychiatrist's disposal and applied in accordance with the patient's instantaneous needs."

In my own work with schizophrenic patients, I have frequently found that my response to a patient's expression of dependency needs and demands may usefully range from tender solicitude to harshness to imperturbability, all within the same hour.

Berman (3, pp. 164-165) places an extremely valuable emphasis upon the positive aspect of the circumstance that the analyst will inevitably fail at times to supply a therapeutic response. Although Berman is writing of analysis with neurotics, his remarks are applicable to therapy with schizophrenics also:

The "analytic attitude" varies considerably as regards how much warmth and subtle "giving" is blended with the simultaneous remaining "outside" of the patient and his problems. Probably, analysts intuitively try to hit the appropriate dosage of genuine "giving" and of proofs of their friendliness and dedication with each patient according to the point each has reached in the analysis. There are many indirect ways in which this is effectively done. The analyst may vary the amount of friendly discussion of some real life problem or interest—for example, the patient's work. There may be more or less laxity in allowing a session to run beyond its official end. There may be a greater or lesser deviation from a previously agreed upon statement as to when the patient would be charged for a missed session, and so on. However, it seems it is not really possible for the analyst to be consistently so keenly attuned to the patient as to achieve an

> accurate dosage of what the patient needs all the time. This "failing," if it does not become too marked, probably also plays a part in the therapeutic process. The patient has occasion to experience the reality of a person who dedicates himself to the task of helping him to grow up and who comes through reasonably well in spite of obvious difficulties.

Lidz and Lidz (15, p. 173) comment on this same point: "The strength in the therapist that must be conveyed to the patient may well derive from sufficient integrity not to need to be infallible."

My own experience has indicated that as therapy with a schizophrenic patient progresses, he becomes increasingly able to assume responsibility for discerning his own needs, for seeking satisfaction for them, for dealing with his feelings of frustration when satisfaction is not forthcoming, and for redirecting his needs into more adult or symbolic channels when circumstances require this. The therapist finds it less often appropriate, as therapy proceeds, to extend the gratifications which he may have felt it therapeutic to extend earlier in the treatment. But this process can advance to a successful outcome, in which the patient can come to accept both himself and the therapist as human beings rather than omnipotent beings, only in so far as the therapist can accept his own human needs—most importantly, his own infantile dependency needs.

In closing, I wish to emphasize that this subject is one which we need to investigate much more fully. This paper, representative of an effort to deal fairly comprehensively with the subject, probably constitutes in actuality no more than the beginning of such a task, in view of the complexity and pervasive importance of dependency processes in the psychotherapy of schizophrenia.

Particularly in the matter of relevant therapeutic technique there is, at present, a striking lack of agreement among reports in the literature. Among the authorities with long experience in psychotherapy with schizophrenic patients, there is no subject about which there is a wider dispersal of viewpoints than this one, the psychotherapeutic approach to the schizophrenic's dependency needs. Currently there are nearly as many different technical approaches as there are psychotherapists reporting them.

We have as yet insufficient evidence to demonstrate convincingly that there is any one teachable psychotherapeutic approach which yields better, more durable results than do other approaches. To fill this void in our knowledge, we need careful studies of the psychotherapeutic process as participated in by therapists utilizing somewhat the approach of, for instance, Schwing or Rosen or Whitaker and Malone, with, for comparison, similar studies of the psychotherapeutic process as participated in by therapists using approximately the approach recommended by, for example, Fromm-Reichmann, Knight, and the present writer. Such studies should throw much light upon the actual quality of the two contrasting therapeutic relationships, the quality of the personality integration effected in the patients, and the comparative long-range treatment results, including the quality and durability of recoveries.

SUMMARY

This paper has been concerned with dependency processes in the psychotherapy of schizophrenia. It describes what I consider to be the major sources of the patient's anxiety about his dependency needs; the major unconscious defenses which the patient utilizes, within the context of his relationship with the therapist, to ward off awareness of these needs and of the anxiety associated with them; and indicators of the presence of anxiety in the therapist with regard to such needs in the patient and, basically, in himself. The paper concludes with a number of points in regard to pertinent therapeutic technique.

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