January 1988

Accepting Dependence

Julia Zawatsky, MD

Sheppard and Enoch Pratt Hospital, Towson Maryland

Follow this and additional works at: <https://jdc.jefferson.edu/jeffjpsychiatry>

Part of the [Psychiatry Commons](#)

[Let us know how access to this document benefits you](#)

Recommended Citation

Zawatsky, MD, Julia (1988) "Accepting Dependence," *Jefferson Journal of Psychiatry*. Vol. 6 : Iss. 1 , Article 4.

DOI: <https://doi.org/10.29046/JJP.006.1.002>

Available at: <https://jdc.jefferson.edu/jeffjpsychiatry/vol6/iss1/4>

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's [Center for Teaching and Learning \(CTL\)](#). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in Jefferson Journal of Psychiatry by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

Accepting Dependence

Julia Zawatsky, M.D.

There is an increasing emphasis on short term treatment in Psychiatry. Short term treatment may not provide the time necessary to permit the regression and foster the dependence necessary for successful treatment.

THE THEORY

Winnicott (1) asks the question, "What do people want of us as doctors and nurses, what do we want of our colleagues when it is we ourselves who are immature, ill, or old?" (p. 113). Pointing to the common state of dependence inherent in all of these conditions, Winnicott concludes that what is needed is reliability, "As doctors, and also as nurses and social workers, we are called upon to be humanly (not mechanically) reliable, to have reliability built into our overall attitude" (p. 113).

Winnicott's conclusion is based on the assumption that health professionals have the capacity to recognize and adapt to patients' dependence, "... for the moment I must assume that we have a capacity to recognize dependence and to adapt to what we find. . . ." (p. 113). Looking back on my initial experiences with long term patients, I now realize that Winnicott's assumption is correct. In order to achieve this realization, however, I had to overcome some doubts about long term treatment and overcome certain institutional biases.

I had heard that long term treatment "made" patients dependent and that dependency was something to be avoided. I had heard anxiety-provoking stories of patients who were rehospitalized after a year or more of previous hospitalization. The subsequent hospitalization was offered as proof of the uselessness, or even destructiveness, of long term treatment. What I have come to learn, particularly through my work with a young chronic patient whom I will call Jill, is that long term treatment does not "make" a patient dependent any more than a mother "makes" her infant dependent. Patients already are dependent, and the dependency should be accepted (i.e., adapted to). With respect to Jill, effective treatment began once I made this realization.

Jill came to my care after spending the better part of two years at another hospital in the Midwest. Prior to her initial hospitalization there she was

Julia Zawatsky is a fourth-year resident at The Sheppard and Enoch Pratt Hospital and a candidate at the Washington Psychoanalytic Institute. This paper was presented at Scientific Day at Sheppard Pratt on April 4, 1987 and was awarded the first annual Clarence G. Schulz Prize.

functioning fairly well with the help of an out-patient therapist. Jill had completed college and she was steadily employed. Over the four years of outpatient therapy, Jill was feeling better than she had ever felt previously. She worried, however, about her dependence on her outpatient therapist and devalued herself because of it. She feared that all her happier moments and all her accomplishments were fraudulent because they were so deeply dependent upon her therapist's presence. She believed that she should function completely independently. She also feared the feelings of anxiety and emptiness generated by any separation from him. Consequently, she abruptly terminated therapy.

Shortly after quitting therapy she became psychotically depressed, lost her job and was hospitalized for suicidal preoccupation. After three months of being hospitalized she was discharged, but one week later she attempted suicide. She was then rehospitalized and discharged after one month. She was able to stay out of the hospital for four months, during which time she saw her therapist again. When he took a vacation, Jill was rehospitalized with suicidal preoccupations for another two months. The day she was discharged she attempted suicide and was readmitted.

By this time, the treatment team felt that Jill needed to undergo some sort of special evaluation period to determine whether or not she could benefit from further hospitalization, or whether it might be more useful for her to go to a longer term facility. One of the conditions of the evaluation period was that she was to stop seeing her out-patient therapist in order to facilitate a more intense involvement in the hospital. Soon after hearing of this requirement, Jill attempted suicide by hanging. She was unconscious when the nursing staff found her, but recovered without any permanent physical consequences.

It seemed clear that this patient entered therapy at both her current and previous hospitals with a large reservoir of dependency needs. She confirmed this by telling me early in her treatment a little bit about her twin brother who, incidentally, was an alcoholic. In an anxious and inhibited way, she told me that she liked to joke about her brother, the second born of the two, as being the "afterbirth." Consciously, she was expressing shame about such a seemingly derogatory thought about her brother. Unconsciously, she was conveying to me how her twin functioned as a placenta for her, as a source of attachment, as a supplier of oxygen and other vital life-sustaining nutrients. Now her brother had some semblance of a life of his own, and she needed to find another placental attachment.

When Jill arrived on my ward she was placed on intensive suicide observation with private duty nurses around the clock. She spent her first sessions with me pleading to decrease these suicide precautions and discharge the private duty nurses. Slowly over the next ten weeks, I discharged the private duty nurses and allowed a stepwise reduction in suicide observation. At the same time she was seeking, and I was granting, this increased independence, she burned herself with a cigarette, had images of hanging herself, and slept in the quiet room for

self-protection. Once there however, she began banging her head and biting and scratching herself. Finally, she attempted suicide by hanging.

After her suicide attempt I re-evaluated my treatment plan. I finally realized that although she desperately had verbally requested increased independence, through her behavior she was communicating a need for more dependence. In fact, she had risked her life to teach me to accept her dependence.

Through my experience with Jill, I realized that adapting to the patient's dependence means, above all, the therapist's accepting it. Therapists must accept such dependence in the same way that internists accept the diabetic's dependence on insulin or the cardiac patient's dependence on vasodilators. After my experience with Jill, I realized that it had been my need to cure her which interfered with my capacity to accept her dependence.

In treatment which recognizes a patient's chronic dependency needs, caring becomes at least as important as curing. Winnicott examines the word cure:

There is this good word in our language: CURE. If this word be allowed to talk, it can be expected to tell a story. Words have that kind of value, they have etymological roots, they have a history: like human beings, they have to struggle sometimes to establish and maintain an identity.

At a most superficial level, the word 'cure' points to a common denominator in religious and medical practice. I believe cure at its roots means care. About 1700 it started to degenerate into a name for medical treatment, as in water-cure. Another century gave it the added implication of successful outcome; the patient is restored to health, the disease is destroyed, the evil spirit is exorcised (p. 112).

Seeing Jill progress off suicide precautions fit well with my rescue fantasies and my need to cure, but her actions demonstrated to me that such "progress" was not useful to her. I began to wonder what would be of use to Jill, so I asked that often-asked question of the inexperienced resident: "What should I do for my patient?" The answer I received was that I needed to be with my patient. A more experienced resident suggested that I read Lewis Hill's (2) essay on "Being Rather Than Doing in Psychotherapy." Hill's thesis is that:

... *being* and *doing* in therapy cannot be in fact separated. A therapist is what he does. Conversely put, what the therapist does is an expression of what he is. Being and doing are not two disparate things, separate and isolate from each other. There cannot be a real choice between being and doing, that is, a choice of one or the other in therapy. The choice of what to do, what patients to treat, what goals to set, what techniques to use, the choice from moment to

moment whether to say something or not, or to do something or not; the choice of strategy for the long pull or the tactic of the moment is a choice which is made by the therapist as a predetermined expression of what he is, both as a person and as a therapist (p. 116).

Hill describes the useful therapist as a person who is psychologically available both to his own inner thoughts, feelings and fantasies, as well as to those of his patient. The useful therapist is free of inhibitions, compulsions, reaction formations, and denials which prevent understanding the patient's inner and outer difficulties, as well as the patient's assets and abilities. Hill warns against the dangers of therapists who need to cure:

. . . many therapists have an urgent need to rescue themselves and others with whom they identify and a compulsion to save certain persons whom they have loved or about whom they feel guilty. Psychotherapy becomes the means of saving one's own inner world of self and objects from destruction. . . . When such motives as these are operative and unknown to the therapist, it follows that his awareness of the patient before him is clouded and his whole therapeutic activity becomes something less than practically useful. He is almost certain to set his goals in terms of his subjective ideals to the neglect of reality. Also he is liable to get across to his patient an urgency and pressure which arouses all the defensiveness of the patient (p. 121).

Many therapists believe in independence as a subjective ideal and set their goals for the patient to the neglect of reality. There seems to be an increasing emphasis in psychiatry for short term work. Insurance companies are not paying for long term work. JCAH requires therapists to write treatment plans with objectives and goals demonstrating a patient's improvement. JCAH and insurance companies employ their own subjective ideals when assessing a patient's treatment plan and progress.

When I first began my work with Jill, decreased suicide precautions, an improved "escort level" in our parlance, seemed to be a good marker for my goal for her of increasing autonomy. An improved escort level, however, resulted in a suicide attempt. I needed to change my goal to something which took Jill's illness into account in a more realistic way. It gradually became clear to me that maintaining a constant and lower escort level would be a more useful objective for Jill. Her illness consisted of her inability to trust others enough to form a mutually dependent relationship. Therefore, a more appropriate goal for Jill would be to foster her ability to trust and depend in a more mature way.

One approach to foster a patient's ability to trust and depend maturely may be suggested by Peter Blos's (3) finding in normal adolescents. Blos points to a normal regressive phase in adolescence which he refers to as the second individuation phase. During this phase the adolescent sheds his family dependencies and loosens his infantile object ties by regressing to infantile drive and

infantile ego positions. Infantile object relations reappear in their original ambivalent state. The adolescent's ego regresses and reexperiences abandoned or partly abandoned ego states that were once adaptive and useful in times of stress. In these repeated confrontations with a previously stressful situation, the ego gradually develops mastery over the danger situation. This strengthens the adolescent's psychic structure. Self and object representations become more stable and more firmly bound. Reality testing improves. New extrafamilial love objects can be found. Blos concludes that "in a paradoxical fashion one might say that progressive development is precluded if regression does not take its proper course at the proper time within the sequential pattern of the adolescent process" (p. 169). He suggests that allowing a similar regression in patients may also foster similar development, but points to the bias against regression:

Based on our experience with the neurotic child and adult we have grown accustomed to concentrating on defenses as the major obstacles in the path of normal development. Furthermore, we tend to think of regression as a psychic process that stands in opposition to progressive development, to drive maturation, and to ego differentiation. Adolescence can teach us that these connotations are both limited and limiting (p. 168).

The attitude that regression opposes progressive development was exemplified by many staff discussions regarding cold wet sheet packs for Jill. The benefit of packs to the patient was debated. Some staff members were concerned that the packs were so "gratifying" that the patient would never want to give them up. I found that Jill communicated better during her sheet packs. In pack, Jill would relate to me after a particularly difficult separation, "I missed you. I couldn't have said that if I weren't in pack." She was more aware of feelings like "whenever I try to kill myself I think of her" (her mother).

The fear that a form of treatment is too gratifying and dependence-generating could be explained in a number of ways. Melanie Klein would suggest that a reluctance to give is born out of envy. It may be that gratifying patients' dependence needs stirs up too much in those of us who feel lacking in the gratification of our own dependence needs. Some staff complained that the packs were too time-consuming. They worried about having enough personnel to go around. Fairbairn (4) has a theory that on an unconscious level, giving of one's time, or thoughts, or feelings, becomes equated with giving of oneself. Therefore, the danger in giving one's time, or feelings, or thoughts, is equivalent to the danger of losing oneself. This theory would explain the patient's fear of closeness, as well as the staff's resistance to giving packs.

Dr. Schulz (5), who supervised me during much of my work with Jill, once told me that it is not our feelings which bring on psychological misery, but rather our attempts to deny such feelings. This certainly seems to be true in our need to oppose the dependence and vulnerability inherent in all relationships. The more we try to fight dependence and achieve some fictional state of independence, the

lonelier, more isolated, and more troubled we become. In the case of Jill, it was not until she rebelled against her dependence on her outpatient therapist that she required hospitalization. Throughout the majority of the eighteen months of my work with Jill, she expressed her fear of, and resistance to, becoming dependent on me. She said that she did not want me to have such "power" over her. Her defense against dependence was to strive towards independence. This defense had always failed for her. For her, as for most of us, life requires interdependence.

Fairbairn defines such interdependence as mature dependence. Mature dependence differs from infantile dependence in several ways. The maturely dependent person relates to others whom he sees as separate, differentiated objects. Such a person has the ability to choose his object upon whom to depend, and he can spread his dependence over a number of objects. This form of dependence is also conditional, meaning that he can survive without it. The infant in his infantile dependent relationship cannot view the object upon whom he depends as separate or differentiated from himself. He has no ability to choose his object (his mother), he has only one object upon whom to depend, and his dependence is unconditional in that he cannot survive without the object.

Fairbairn sees the infant as normally progressing from infantile dependence through a transition stage to mature dependence. The infant, through successful symbiosis with the mother, begins to feel loved and good about himself and his object. He develops a sense of trust in having his needs met. This security enables the infant to expand his world. He begins to look from the mother to other people. He develops a sense of adventure. He and his mother derive pleasure from his increasingly autonomous functioning. The danger of losing his mother is balanced by the pleasure in gaining himself.

Fairbairn sees the key to a successful transition to mature dependence as maternal approval. Only when the child feels genuinely loved as a person and feels his love to be genuinely accepted by his parents can he renounce infantile dependence. Without such reassurance there is too much separation anxiety. The child fears never having his emotional needs met.

Jill was not able to depend safely on her mother. Her mother was both physically and psychologically unavailable during Jill's childhood. I first saw her mother on the hall during visiting hours. She stood near the nurses' station where very needy patients hover, maximizing their chances for an encounter with a staff person. She looked at me with such a vulnerable expression, looking younger than her daughter, and even more helpless. Her own childhood was one of impoverishment in every sense of the word and included sexual abuse by her mother's boyfriends. She was hospitalized for depression when Jill was three years old. She had six children in eight years. Two of these children had life threatening illnesses, one of whom required frequent medical care. Jill remembers her mother being gone from the house for several days at a time, but never

having any clear idea of where her mother was. Jill's father had several affairs, and the marriage finally ended in divorce when Jill was nine years old.

Because Jill was never able to depend safely on her mother, she never developed the basic trust and feeling of reassurance which allows a person to form relationships based on mature dependency. Edith Weigert (6) points out that mature relationships begin with an unconscious risk and a dive into uncertainty, and that the patient who has been deserted and misunderstood in the past recoils from such a risk. Consequently, relationships are transformed into perpetual searching for security and reassurance.

This search for reassurance was a major theme in Jill's interpersonal relationships. Her first memory was of hiding behind the couch for hours in her childhood home, "hoping someone would find me, or even wonder where I was. But no one ever did." At boarding school when she was seventeen years old, she repeated this behavior by hiding on the roof of the school for two to three days at a time, waiting to be discovered. A variation of this theme could be seen in her requests for a higher escort level, a sign out, or work therapy. Unconsciously, to her these things meant hiding from me. Letting her have her request meant not looking for her. Not letting her have her request meant finding her. This is the same game as "catch me" or "peek-a-boo" that the child plays in trying to develop a separate sense of identity.

The need for reassurance seems to stay with a person throughout life to one degree or another. Bettelheim (7), while imprisoned in a German concentration camp, recognized that most prisoners who could not feel reassured that someone in the outside world still cared, soon gave up hope and died.

Only a very clear demonstration that one was not abandoned—and the SS saw to it that one received this only very rarely, and not at all in the extermination camps—restored, at least momentarily, hope even to those who otherwise by and large had lost it. But those who had reached the utmost state of depression and disintegration, those who had turned into walking corpses because their life drives had become inoperative—the so called "Muslims"—could not believe in what others could have viewed as tokens that they had not been forgotten (p. 106).

Of those who felt forgotten, it was only the ones with enormous self respect and inner security who could survive such disagreeable and destructive life circumstances.

In many ways, the patient seeking reassurance carries around with him his own personal SS, which devalues any demonstration that someone cares about him. The child who cannot generate a positive response from his parents believes, in his egocentricity, that it is his fault. He fears that he is too horrible to love or to accept. These images of his unlovable self and rejecting objects he internalizes and carries forever to some degree.

Bad self and object representations prevent intimacy with another person. It is inconceivable to the patient with a poor self-image that another person could value him. Worse, he fears that his "horribleness" could destroy the other person. Jill occasionally would express concerns of "contaminating" me; she would fear letting me too close to her thoughts or to her feelings. With her poor self-image she had no ability to take joy or pride in what she had to offer. She devalued any self-expression. She would complain frequently of being empty and dead, and expressed the futility of her existence. She conveyed this sense of futility in her art work with pictures of herself trying, but failing, to climb an insurmountable mountain. Mature dependence was impossible for her because she had nothing but "poison" to offer.

THE PROCESS

The first section of this paper presented the theory that accepting a patient's dependency needs can be a necessary step in successful long term psychotherapy. The remainder of this paper discusses the treatment of patients in general, and Jill in particular, based on the principles inherent in this theory.

Upon arriving at the hospital, a patient is invited to regress to an infantile dependence upon the therapist, the treatment team and the hospital in general. The external structure provided for the patient gradually becomes internalized by a process of identification with the therapist and other staff members. Through this identification, the patient's self and object representations become integrated and stabilized. Reality testing improves. The patient develops an increased capacity to observe himself as he experiences himself and his environment. Primitive defenses, including splitting with rapid cycling between devaluation and idealization, denial, projection and projective identification become modified.

In many ways, long term psychotherapy is maternal work. Louise Kaplan (8) describes the mother's role in creating and modifying her infant's emerging identity:

The newborn brings only a physical self, the mother, a psychological self. It is not without import that an infant is ushered into the new world into the arms of a mother who has a psychological past consisting of fantasies, memories, a capacity to tolerate loving and hating, an understanding of the dimensions of the world of time and space, and a sense of herself as a person with a separate and unique identity. From the very beginning moments of her baby's life, a mother's psychological past will enhance her infant's slowly evolving sense of psychological selfhood (p. 60).

The therapist uses his own psychological self in a similar way to help foster the patient's psychological growth. The therapist allows himself a kind of

psychological fusion and symbiosis with the patient. The therapist uses this symbiosis to understand and communicate with the patient.

In my work with Jill, I found that she had minimal self-awareness and that she could not communicate directly with words. Instead, she relied on indirect behavioral communication. Her use of projective identification enabled me to understand how she felt. For example, her hanging attempt induced such rage in me that I really wanted to finish the job off properly. My awareness of this fantasy gave me an immediate and unprecedented apprehension of the extent of Jill's rage and frustration. I then was able to help her become aware of these feelings. Over time, she could identify with my observing capacity and thereby increase her own awareness of her feeling states.

Eight months after the suicide attempt Jill still was using nonverbal communication, but she now valued her actions as meaningful. She gave me a Christmas present, but the real gift was her explanation that she realized that her gifts carried symbolic meaning of how she was feeling. What she gave me was a wreath she had made from branches, dried flowers and pine cones. I wondered with her, in what way it might be symbolic. After a few days the symbolism became clear. The wreath began to fall into bits and pieces around my doorstep. It could not withstand the constant battering of my three year old slamming the door, or the December wind and rain. So by this wreath, Jill let us know how fragmented and fragile she felt. She was depending on me to help her become aware of these feelings and to help her gradually integrate these fragments.

Jill mobilized her unintegrated fragments of self and object representations within the context of her relationships with various staff members. For example, Jill had a very intense relationship with one of the nurses on the hall. In this nurse she deposited many of her own feeling states related to the relationship she had with her mother. On the other hand, I sometimes carried for Jill many of the feelings she had in relation to her father. In the former relationship she saw herself as helpless, hopeless and forever wanting. In the latter relationship she saw herself as a person with unlimited possibility and potential.

The degree to which she kept these two aspects of herself separate was demonstrated by her anxious response to seeing the nurse and me together while she was in pack. I unexpectedly had come into the room where she and the nurse were. She expressed incredulous disbelief that the nurse and I actually could be in a room together. It was inconceivable to her that we communicated with one another. She said she felt that "there should be a wall between you two."

I asked Jill if maybe she tried to put a wall between different aspects of herself. She agreed, explaining that she felt like she was really two people whom she called "good Jill" and "bad Jill." In her more psychotic moments she believed that she was these two different people.

"Bad Jill" consisted of any thoughts, feelings or fantasies which carried even the faintest tinge of hostility or anger. "Good Jill" was all loving and all

giving. When she first came under my care, her major defense against her anger and hostility was to split off those aspects of herself by becoming psychotic. Whenever she felt angry towards her mother, me, or anyone upon whom she depended, her voices would begin making violent threats and accusations against those people.

Her capacity to tolerate anger and hostility improved as she identified with my acceptance of those feelings. Also, seeing me survive her anger helped her feel less frightened by her anger. Realizing that her thoughts were not omnipotent freed her capacity to think and explore herself. She gradually became able to have a range of angry and hostile thoughts without becoming psychotic.

Through her successful infantile dependence, Jill was able to internalize the external structure and thereby give up the Xanax, Lithium, Stelazine and Norpramin which she was taking at the time of admission. To give up the medications, Jill had to deepen her awareness and acceptance of her dependence on other people. Before giving up the medication she had to realize that unconsciously she was maintaining a relationship with the past therapists who originally had prescribed the medication. She had to develop new intrapsychic ways to keep these previously important people alive to her. Since I wrote the orders for the medication, I was represented to her by the medication. She had to feel a stronger psychic bond with me to replace the medication's physical representation of me. Sometimes the voices she heard were friendly and comforting in lonely moments. When she was able to remember my voice, she no longer had a need to hallucinate these comforting voices.

Giving up the medication also meant giving up scheduled and ordered staff contact. I remember learning one day in a psychopharmacology seminar that there is no point in giving Lithium on a tid schedule, because such frequency only creates extra work for the staff, and trips to the medication window for the patient, but the hospital service chief had other ideas. The patient, she said, gets more than just medication. Another context is provided for an encounter with a staff person. Since all patients suffer from impoverished and painful relationships, such encounters form the essence of milieu therapy and provide the patient with the reassurance that trusting and dependence are safe. These repeated benign interpersonal interactions become internalized and gradually modify the patient's all-or-none infantile self and object representations. By the time Jill was ready to give up medication she could more easily initiate staff contact on her own. She was more perceptive of her internal state and knew how to seek comfort from others, as well as from within herself.

In the first eleven months of Jill's hospitalization, seven months were spent on restrictive suicide precautions. This holding provided her with enough of a feeling of reassurance and acceptance that she began to let go a little bit. Not only did she give up the medications, but she also began to become involved in activities further off the hall. Eventually, she began working away from the hospital at a local day care center. Each step forward, however, was followed by regression.

It seemed that progress in autonomous functioning frightened her. The repetition of the cycle of advancement and regression confirmed this. Progress to her seemed to generate severe separation anxiety. She feared that improvement would isolate her and lead to unbearable loneliness, so she would regress. This also caused anxiety. Giving up her autonomy made her feel more vulnerable and helpless. The anxiety that the progression-regression cycles generated prevented her from becoming aware of the pattern until there had been many repetitions.

After fourteen months of such repetitions, there finally occurred a moment when Jill could grasp the nature of her conflict. One day she returned from work therapy in very good spirits. She told me how well things were going in work therapy and in general. That night she ran away from the hospital, bought some razor blades and spent the night in a motel. The next day she returned unharmed, acting as if nothing had happened. She used splitting and denial to avoid the anxiety of trying to integrate such impulsive behavior with her more controlled behavior. When I tried to explore the incident, she said, in her most all-or-none manner, "But nothing happened!", meaning she had not actually committed suicide. She was denying the intensity of the feelings which led her to go as far as buying the razor blades. After two weeks of my persistent efforts to maintain the reality of the incident, she said, "But that was two weeks ago!", as if the passage of time somehow removed the meaning of those desperate feelings which led her to that motel room. She seemed to feel no sense of continuity of herself over time.

My reminding her of how she felt in the past, as well as my clarifying how she currently felt, helped her to maintain simultaneous awareness of different feeling states. My helping her to establish a sequence of events leading up to running away put meaning into her impulse. Keeping her on staff escort provided her with a secure feeling of reassurance which could increase her anxiety tolerance enough to permit some integration. At last, she began to talk about how frightened she felt going to her work therapy. Once these fears were verbalized we could begin to look at the reality distortions which generated the fears. Her all-or-none way of looking at things translated success with work therapy into absolute success, instantaneous cure, and complete independence. Such absolute success, cure and independence left Jill feeling afraid of being utterly alone and abandoned. This work was just the beginning of improved reality testing. Similar experiences would need to be repeated over and over for Jill to develop her own ability to experience herself over time, observe herself, modulate her extreme thoughts, and integrate her feelings.

Repeated experiences of separation provided another context for arousing Jill's fear of autonomy. Early in our work, weekends and vacations generated in Jill intense anxiety and psychosis. This occurred during the period of time when she was too afraid to talk about her feelings. She believed then that "if I talk about my feelings I will lose control of myself," and that "talking about feelings makes them too real. It hurts too much and makes me feel worse." Repeated

sheet packs, by providing external control, enabled Jill to verbalize her feelings in spite of her fears. Eventually, after many experiences of talking about her feelings, she came to see that she really did not lose control by talking and that understanding her feelings helped her feel more in control. Towards the end of our work together, prior to a vacation I was about to take, she was able to say to me, "I almost didn't come today. I wanted to get back at you for going on vacation. But I know it won't hurt you as much as me, and I'd really miss not seeing you. It doesn't really make sense to not come and complain about not seeing you enough. Once I realize that I'm angry, I can keep myself from doing something like that."

As she talked about her feelings, she could begin to clarify what separation meant to her and why it was so terrifying. About five months into her hospitalization, a vacation I was about to take seemed to remind her of separations from the sister who required intermittent medical care. She explained that "my sister and me are the same. I'd rub her [injured] legs and I'd feel better because I thought she was me, so I had to make her stronger. We were the same because I knew how she was feeling. I felt her depression. But then she'd be away at the hospital and we weren't the same person." Because Jill lived to such an extent through another person, she essentially feared losing herself when separated from the other person. Increased abilities to observe herself, increased awareness of her feelings and thoughts, and increased abilities to communicate verbally, all contributed to Jill's increasingly autonomous sense of self. With a more differentiated sense of self, separation gradually became less threatening.

The more often Jill experienced brief, temporary separations, the more evident became the idiosyncratic, fear-inducing meanings she attributed to separation. By modifying her distortions of the reality of separations, separations gradually became less terrifying. When a favored nurse was about to depart on a vacation, Jill said, "she wants to get away from me. She will have a good time and not want to come back." Once, before I left on vacation, she said, "I wonder if you're going to look for another job. You can't stand working with me. I'm afraid you won't come back." With her all-or-none way of thinking, any temporary separation was seen as a permanent separation. Repeated experiences of seeing myself and other staff members return after a vacation modified her extreme view, and gradually lessened her anxiety.

On another, later occasion, after faring well during a vacation (and by this I mean that she did not become psychotic), she expressed anxiety upon my return and required a sheet pack for our first session. She began by telling me she missed me: sadness had replaced rage and fragmentation. Klein would describe Jill here as having moved from the paranoid-schizoid to the depressive position. In this situation increased sadness was quite an achievement. (How would JCAH or Jill's insurance company feel about an objective of "patient shall feel much sadder within five months?") Jill explained her anxiety in the following way, "I

did OK while you were gone. I'm afraid you'll think I don't need you anymore."

She seemed to need to do poorly during separations to express her loyalty to me. She seemed to be afraid I would fragment if she were to be the least bit independent of me. She had a similar fear in her relationship with her mother. In fact, her mother became increasingly anxious as Jill improved. During Jill's most difficult time, when I was leaving the service, her mother offered her seductive invitations to return home. Margaret Mahler (9) points out that

It is the specific unconscious need of the mother that activates out of the infant's infinite potentialities, those in particular that create for each mother 'the child' who reflects her own *unique* and individual needs (p. 60).

Jill's mother seemed to need Jill to be infantilely dependent on her. By becoming aware of my own unconscious needs as recommended by Lewis Hill, I could be more helpful to Jill in her discovery of her own needs and her own identity.

Another reason for Jill's excessive separation anxiety stemmed from her rage and her belief in the omnipotence of her thoughts. She felt so frustrated by my leaving her, that her fears of my never returning were also rageful, revengeful wishes that I would die and never return. Seeing me repeatedly return safely from weekends or vacations diminished her fear of her rage. Reality indicated that her thoughts were not omnipotent.

Jill still has a long way to go in her struggle towards mature dependence. In no way does this paper present her continued turmoil as she begins her third year of hospitalization, but I believe she has made significant progress. The time of my leaving Jill, after the completion of my too limited time with her, was a real trial for her. Her ability to remain in the hospital while I left the service, demonstrated her increased tolerance to separation anxiety and her improved sense of self. She continuously threatened to leave the hospital, but never did. She hatefully and sadistically devalued me, but stayed in therapy, exploring the source and function of devaluation. The night before our last session she had a dream. In the dream she had a child who was sick, and she could not decide whether to go to work or stay home with the sick child. She finally decided to stay home from work until her child was healthy again. She told me she thought she was the sick child and that her first priority was to take care of her problems. She had told me many times before that all her problems would simply vanish if she "could just be discharged from the hospital and get a job." This magical thought of hers was based on the splitting off of her previous experiences of profound psychosis even while employed. Her dream indicated that she was becoming integrated enough to be able to face her conflicts and her current, severe limitations.

Perhaps, once Jill has been discharged from the hospital, she will require rehospitalization. This would not mean that her treatment has been a failure.

Diabetics, cardiac patients and others with medical illnesses, often are rehospitalized without previous hospitalizations being considered as failures. This is the nature of ongoing care. The infantilely dependent patient is a severely impaired patient, for he is missing his psychological self. He uses other people to make contact with the reality of the external world, as well as the reality of his inner world of feelings, thoughts, wishes, and fears. Freud (10) once observed that "the individual perishes from his internal conflicts" (p. 299). The individual suffering from a conflict over dependence, and hence, identity, does not perish from his internal conflict. This is a conflict that prevents his very existence.

REFERENCES

1. Winnicott DW: *Home is Where We Start From*. New York, Norton & Co, 1986
2. Hill L: *On Being Rather Than Doing in Psychotherapy*. *The Int J of Group Psychother* 1958; 8:115-122
3. Blos P: *The Adolescent Passage: Developmental Issues*. New York, International Universities Press, 1979
4. Fairbairn WR: *An Object Relations Theory of the Personality*. New York, Basic Books, 1952
5. Schulz CG: *Personal Communication*, 1986
6. Weigert E: *The Courage to Love*. New Haven, Yale University Press, 1970
7. Bettelheim B: *Surviving and Other Essays*. New York, Random House, 1952
8. Kaplan L: *Oneness and Separateness: From Infant to Individual*. New York, Simon & Schuster, 1978
9. Mahler M: *The Psychological Birth of the Human Infant*. New York, Basic Books, 1975
10. Freud S: *Shorter Writings*. Standard Edition, 1938; 23:297-303