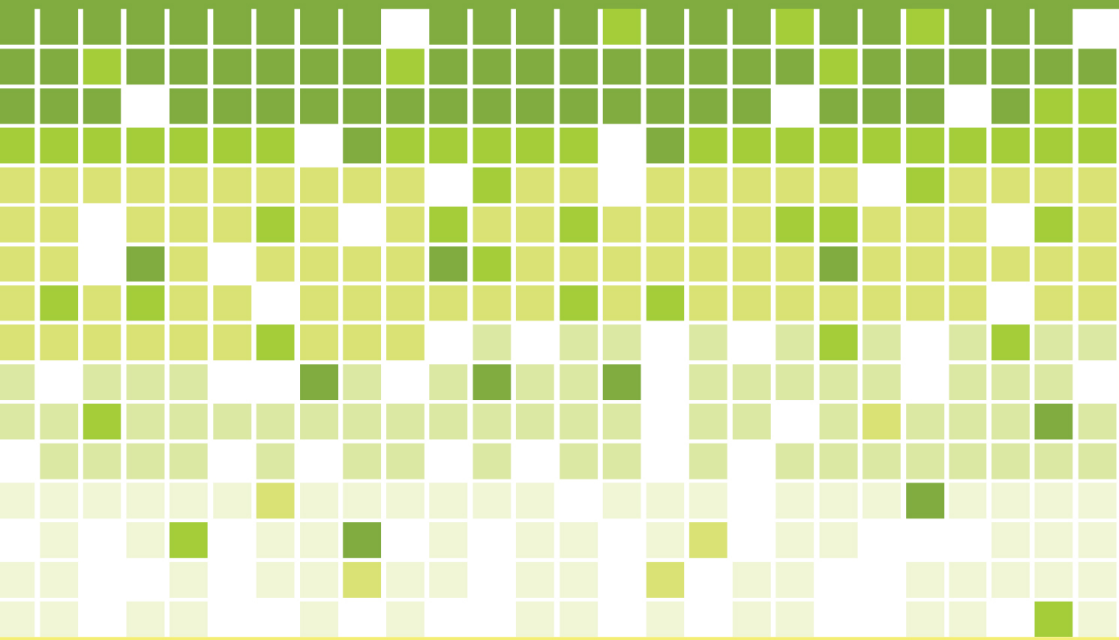
How Does Psychotherapy Work?



Martha Stark MD

How Does Psychotherapy Work?

Martha Stark, M.D.

I dedicate this to my dear sweet Gunnar, my life partner without whom none of this would have been possible; to my dear publisher, Jason Aronson, who has always been a source of inspiration to me and has so generously given me the gift of encouraging me to go wherever my heart leads me; and to all the patients, supervisees, students, and colleagues whom I have known and loved over the course of my career.

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INTRODUCTION

I have always found the following quote from Gary Schwartz's 1999 *The Living Energy Universe* to be inspirational: "One of science's greatest challenges is to discover certain principles that will explain, integrate, and predict large numbers of seemingly unrelated phenomena." So too my goal has long been to be able to tease out overarching principles – themes, patterns, and repetitions – that that are relevant in the deep healing work that we do as psychotherapists.

Drawing upon concepts from fields as diverse as systems theory, chaos theory, quantum mechanics, solid-state physics, toxicology, and psychoanalysis to inform my understanding, on the pages that follow I will be offering what I hope will prove to be a clinically useful conceptual framework for understanding how it is that healing takes place – be it of the body or of the mind. More specifically, I will be speaking both to what exactly provides the therapeutic leverage for healing chronic dysfunction and to how we, as psychotherapists, can facilitate that process?

Just as with the body, where a condition might not heal until it is made acute, so too with the mind. In other words, whether we are dealing with body or mind, superimposing an acute injury on top of a

chronic one is sometimes exactly what a person needs in order to trigger the healing process.

More specifically, the therapeutic provision of "optimal stress" – against the backdrop of empathic attunement and authentic engagement – is often the magic ingredient needed to overcome the inherent resistance to change so frequently encountered in our patients with longstanding emotional injuries and scars.

Too much challenge (traumatic stress) will overwhelm. Too little challenge (minimal stress) will serve simply to reinforce the dysfunctional status quo. But just the right combination of challenge and support (optimal stress) will "galvanize to action" and provoke healing. I refer to this as the Goldilocks Principle of Healing.

And so it is that with our finger ever on the pulse of the patient's level of anxiety and capacity to tolerate further challenge, we formulate "incentivizing statements" strategically designed "to precipitate disruption in order to trigger repair." Ongoing use of these optimally stressful interventions will induce healing cycles of defensive destabilization followed by adaptive restabilization at ever-higher levels of integration, dynamic balance, and functional capacity.

Behind this "no pain, no gain" approach is my firm belief in the

underlying resilience that patients will inevitably discover within themselves once forced to tap into their inborn ability to self-correct in the face of environmental challenge – an innate capacity that will enable them to advance, over time, from dysfunctional defensive reaction to more functional adaptive response.

Indeed the health of a system is a story about its capacity to adapt, that is, its ability to restore its homeostatic balance in the face of challenge. Ultimately, the goal of any holistic treatment – be its focus psychological and/or physical – must therefore be to restore the intrinsic orderedness and fluidity of the MindBodyMatrix and the system can thereby more effectively adapt to the "stress of life."

In the psychological realm, an example of adaptation would be handling the stress of the loss of a loved one by confronting – and grieving – the pain of one's heartbreak and ultimately evolving from anger, upset, and feelings of helplessness to serene acceptance. In the physiological realm, an example of adaptation would be handling the stress of blocked coronary arteries by developing new (collateral) ones to supply the heart with the nutrients and oxygen it needs, thereby averting a potential heart attack.

The premise of *How Does Psychotherapy Work?* is that

psychodynamic psychotherapy affords the patient an opportunity – albeit a belated one – to master experiences that had once been overwhelming, and therefore defended against, but that can now, with enough support from the therapist and by tapping into the patient's underlying resilience and capacity to cope with stress, be processed, integrated, and ultimately adapted to. This opportunity for belated mastery of traumatic experiences and transformation of defense into adaptation speaks to the power of the transference, whereby the here-and-now is imbued with the primal significance of the there-and-then.

Ultimately, the therapeutic goal is to transform less-evolved defense into more-evolved adaptation – for example, from externalizing blame to taking ownership, from whining and complaining to becoming proactive, from dissociating to becoming more present, from feeling victimized to becoming empowered, from being jammed up to harnessing one's energies so that they can be channeled into the pursuit of one's dreams, from denial to confronting head-on, from being critical to becoming more compassionate, and from cursing the darkness to lighting a candle.

Growing up (the task of the child) and getting better (the task of the patient) are therefore a story about transforming need into capacity – as further examples, the need for immediate gratification into the capacity

to tolerate delay, the need for perfection into the capacity to tolerate imperfection, the need for external regulation of the self into the capacity to be internally self-regulating, and the need to hold on into the capacity to let go.

In sum, it could be said that, as the result of a successful psychodynamic treatment, "resistance" will be replaced by "awareness" and "actualization of potential" (Model 1), "relentless pursuit of the unattainable" will be replaced by "acceptance" (Model 2), and "re-enactment of unresolved childhood dramas" will be replaced by "accountability" (Model 3).

This book represents my effort to provide a comprehensive summary of how I conceptualize the Three Modes of Therapeutic Action (enhancement of knowledge, provision of corrective experience, and engagement in authentic relationship), about which I have been writing for the past 25 years.

In an effort to make some fairly complex material as accessible as possible, I have made the exciting decision to present my conceptual overview of how psychotherapy works in two different formats. First, I offer my ideas as a narrative – tracing the evolution of psychodynamic psychotherapy from classical psychoanalysis (with its emphasis on the

ego) to self psychology and other deficit theories (with their emphasis on the self) to contemporary relational theories (with their emphasis on the self-in-relation); but the majority of the book is devoted to PowerPoint Slides, each one of which is intended to tell a story…

In this second part of the book, there are 28 Modules, each one of which has a specific focus and contains anywhere from 8 to 19 PowerPoint Slides. Many of the slides are overview slides that organize the material in what I hope will be an easy to digest and satisfyingly balanced fashion – for both those familiar with my work and those for whom this will be their first exposure.

So please settle in, buckle up, kick back, and enjoy! You'll be in for quite a ride!! Although the slides do not encompass every thought I have ever had about the process of healing, they come pretty close!!

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Part 1

HOW DOES PSYCHOTHERAPY WORK?

What is it that enables patients to get better? How does psychotherapy work? How do we conceptualize the process by which patients grow and change?

I have developed an integrative model of therapeutic action that takes into consideration many different schools of thought. It is my belief, however, that most psychotherapeutic models boil down to advocating either knowledge, experience, or relationship – that is, either enhancement of knowledge, provision of experience, or engagement in relationship – as the primary therapeutic agent (Stark 1994a, 1994b, 1999).

I will therefore begin by summarizing these three different models of therapeutic action. As will soon become clear, although there is significant overlap amongst the three perspectives, each one contains elements that distinguish it from the other two.

The models of therapeutic action are therefore not mutually exclusive but mutually enhancing. And if our goal is to optimize the therapeutic potential of each moment, we will be most effective if we have a deep appreciation for, and some facility with, all three modalities.

The Interpretive Perspective of Classical Psychoanalysis

The first is the interpretive model of classical psychoanalysis. Structural conflict is seen as the villain in the piece and the goal of treatment is thought to be a strengthening of the ego by way of insight. Whether expressed as (a) the rendering conscious of what had once been unconscious (in topographic terms); (b) where id was, there shall ego be (in structural terms); or (c) uncovering and reconstructing the past (in genetic terms), in Model 1 it is *the truth* that is thought to set the patient free.

Interpretations, particularly of the transference, are considered the means by which self-awareness is expanded.

Resolution of Structural Conflict

How do interpretations lead to resolution of structural conflict?

As the ego gains insight by way of interpretation, the ego becomes stronger. This increased ego strength enables it to experience less anxiety in relation to the id's sexual and aggressive impulses; the ego's defenses, therefore, become less necessary. As the defenses are gradually relinquished, the patient's conflicts about her sexual and aggressive drives are gradually resolved.

The Therapist as an Objective Observer

The Model 1 therapist sees herself not as a participant in a relationship but as an objective observer of the patient. Her unit of study is the patient and the patient's internal dynamics. The therapist conceives of her position as outside the therapeutic field and of herself as a blank screen onto which the patient casts shadows that the therapist then interprets.

Model 1 is clearly a one-person psychology.

Freud's Bias

In some ways it is not surprising that Freud would have been reluctant to recognize the importance of the actual relationship – because Freud never had any relationship whatsoever with an analyst. His, of course, was a self–analysis. By way of a meticulous analysis of his dreams, he was able to achieve insight into the internal workings of his mind, thereby strengthening his ego and resolving his intrapsychic conflicts.

The Transition to a More Relational Perspective

But there were those analysts both here and abroad who found

themselves dissatisfied with a model of the mind that spoke to the importance not of the relationship between patient and therapist but of the relationships amongst id, ego, and superego. Both self psychologists in the United States and object relations theorists in Europe began to speak up on behalf of the individual as someone who longed for connection with others.

In fact, Fairbairn (1963), writing as early as the 1940s, contended that the individual had an innate longing for object relations and that it was the relationship with the object and not the gratification of impulses that was the ultimate aim of libidinal striving. He noted that the libido was "primarily object-seeking, not pleasure-seeking."

Nature vs. Nurture

Both the self psychologists and the European (particularly the British) object relations theorists were interested not so much in nature (the nature of the child's drives) but in nurture (the quality of maternal care and the mutuality of fit between mother and child).

Whereas Freud and other classical psychoanalysts conceived of the patient's psychopathology as deriving from the patient (in whom there was thought to be an imbalance of forces and, therefore, internal conflict), self psychologists, object relations theorists, and contemporary

relational analysts conceive of the patient's psychopathology as deriving from the parent (and the parent's failure of the child).

Internal Recording of Parental Failures

How were such parental failures thought to be internally recorded and structuralized? Interestingly, some theorists (Balint 1968) focused on the price the child paid because of what the parent did not do; in other words, *absence of good* in the parent/child relationship was thought to give rise to structural deficit (or impaired capacity) in the child. But other theorists (Fairbairn 1963) focused on the price the child paid because of what the parent did do; in other words, *presence of bad* in the parent/child relationship was thought to be internally registered in the form of pathogenic introjects or internal bad objects – filters through which the child would then experience her world.

But whether the pathogenic factor was seen as an error of omission (absence of good) or an error of commission (presence of bad), the villain in the piece was no longer thought to be the child but the parent – and, accordingly, psychopathology was no longer thought to derive from the child's nature but from the nurture the child had received during her formative years. No longer was the child considered an agent (with unbridled sexual and aggressive drives); now the parent was held

accountable – and the child was seen as a passive victim of parental neglect and abuse.

From Insight to Corrective Experience

When the etiology shifted from nature to nurture, so too the locus of the therapeutic action shifted from *insight by way of interpretation* to *corrective experience by way of the real relationship* (that is, from *within the patient* to *within the relationship between patient and therapist*).

No longer was the goal thought to be insight and rendering conscious the unconscious so that structural conflict could be resolved; now the goal of treatment became filling in structural deficit and consolidating the self by way of the therapist's restitutive provision.

With the transitioning from a one-person to a two-person psychology, sexuality (the libidinal drive) and aggression took a back seat to more relational needs – the need for empathic recognition, the need for validation, the need to be admired, the need for soothing, the need to be held.

From Drive Object to Good Object

The therapist was no longer thought to be primarily a drive object

but, rather, either a selfobject (used to complete the self by performing those functions the patient was unable to perform on her own) or a good object/good mother (operating in loco parentis).

To repeat: The deficiency-compensation model – embraced by the self psychologists and by those object relations theorists who focused on the internal recording of traumatic parental failure in the form of deficit – conceived of the therapeutic action as involving some kind of corrective experience at the hands of a therapist who was experienced by the patient as a new good (and, therefore, compensatory) object.

From Structural Conflict to Structural Deficit

In Model 2, then, the patient was seen as suffering not from structural conflict but from structural deficit – that is, an impaired capacity to be a good parent unto herself. The deficit was thought to arise in the context of failure in the early-on environmental provision, failure in the early-on relationship between parent and infant.

Now the therapeutic aim was the therapist's provision in the here-and-now of that which was not provided by the parent early-on – such that the patient would have the healing experience of being met and held.

Experience vs. Actual Participation

Of note is that some deficiency-compensation theorists (most notably the self psychologists) focused on the patient's *experience* of the therapist as a new good object; others (the Model 2 object relations theorists) appeared to focus more on the therapist's *actual participation* as that new good object.

But what all the deficiency-compensation models of therapeutic action had in common was that they posited some form of corrective provision as the primary therapeutic agent.

A "New Beginning"

It was then in the context of the new relationship between patient and therapist that there was thought to be the opportunity for a *new beginning* (Balint 1968) – the opportunity for reparation, the new relationship a corrective for the old one.

"I-It" vs. "I-Thou"

But although relationship was involved, it was more an *I-It* than an *I-Thou* relationship (Buber 1966) – more a one-way relationship between someone who gave and someone who took than a two-way

relationship involving give-and-take, mutuality, and reciprocity.

It is for this reason that self psychology, which is a prime example of a deficiency-compensation model, has been described as a one-and-a-half-person psychology (Morrison 1997) – it is certainly not a one-person psychology, but then nor is it truly a two-person psychology.

And Michael Balint (1968) – also an advocate of the corrective-provision approach – speaks directly to the I-It aspect of the patient/therapist relationship with the following: "It is definitely a two-person relationship in which, however, only one of the partners matters; his wishes and needs are the only ones that count and must be attended to; the other partner, though felt to be immensely powerful, matters only in so far as he is willing to gratify the first partner's needs and desires or decides to frustrate them; beyond this his personal interests, needs, desires, wishes, etc., simply do not exist" (p. 23).

In other words, the emphasis in a deficiency-compensation model is not so much on the relationship per se as it is on the filling in of the patient's deficits by way of the therapist's corrective provision.

But this relationship between a person who provides and a person who is the recipient of such provision is a far cry from the relationship that exists between two *real* people – an intersubjective relationship that

involves two subjects, both of whom contribute to what transpires at the *intimate edge* (Ehrenberg 1992) between them.

And so it is that (in the past twenty or twenty-five years) some contemporary theorists have begun to make a distinction between the therapist's provision of a corrective experience for the patient and the therapist's participation in a real relationship with the patient – a distinction between the therapist's participation as a good object (Model 2) and the therapist's participation as an authentic subject (Model 3).

Give vs. Give-and-Take

We are speaking here to the distinction between a model of therapeutic action that conceives of the therapy relationship as involving *give* (the therapist's give) and a model that conceives of the therapy relationship as involving *give-and-take* (both participants giving and taking).

Empathic Attunement vs. Authentic Engagement

In Model 2, the emphasis is on the therapist's empathic attunement to the patient – which requires of the therapist that she *decenter* from her own experience so that she can immerse herself empathically in the patient's experience. We might say of the Model 2 therapist that she

enters into the patient's experience and takes it on *as if* it were her own.

By contrast, in Model 3, the emphasis is on the therapist's authentic engagement with the patient – which requires of the therapist that she remain very much *centered* within her own experience, ever attuned to all that she is feeling and thinking. We might say of the Model 3 therapist that she allows the patient's experience to enter into her and takes it on *as* her own.

Although empathic attunement and authentic engagement may sometimes go hand in hand, they involve a different positioning of the therapist and, therefore, a different use of the therapist's self.

Let me now offer a clinical vignette that I think demonstrates the distinction between empathic decentering and authentic centering.

Clinical Vignette: Empathy vs. Authenticity

Many years ago I was seeing a chronically depressed and suicidal patient who had just been diagnosed with breast cancer. Shortly thereafter she came into a session having learned that her axillary lymph nodes had tested negative (that is, no cancer). Through angry tears, she told me that she was upset about the results because she had hoped the cancer would be her ticket out.

I had to think for a few moments but then I managed to say softly: "At times like this, when you're hurting so terribly inside and feeling such despair, you find yourself wishing that there could be some way out, some way to end the pain."

In response to this, she began to cry much more deeply and said, with heartfelt anguish, that she was just so tired of being so lonely all the time and so frightened that her (psychic) pain would never, ever go away. Eventually she went on to say that she realized now how desperate she must have been to be wishing for an early death from cancer.

What I managed to say was, I think, empathic; but to say it, I needed to put aside my own feelings so that I could listen to my patient in order to understand where she was coming from. And so my response, although empathic, was not at all authentic – because what I was really feeling was horror. What I was really feeling about my patient's upset with her negative test results was "My God, how can you think such an outrageous thing!" To have said that would have been authentic – but probably not analytically useful!

Although the response I offered my patient was not authentic, it was empathic. And I think it enabled her to feel understood and then to

access deeper levels of her pain and her anguish – and, eventually, her own horror that she would have been so desperate as to want cancer.

Now, had I been able to process my countertransferential reaction of horror more quickly, I might have been able to say something that would have been both authentic and analytically useful, something to the effect of: "A part of me is horrified that you would want so desperately to find a way out that you would even be willing to have (metastasizing) cancer, but then I think about your intense loneliness and the pain that never lets up – and I think I begin to understand better."

I present this example because it highlights the distinction between an empathic response and a more authentic response, between empathic attunement (Model 2) and authentic engagement (Model 3).

From Corrective Experience to Interactive Engagement

Let us return to the issue of what constitutes the therapeutic action. There are an increasing number of contemporary theorists who believe that what heals the patient is neither insight nor a corrective experience.

Rather, what heals, they suggest, is interactive engagement with an authentic other; what heals is the therapeutic relationship itself – a

relationship that involves not subject and drive object, not subject and selfobject, not subject and good object, but, rather, subject and subject, both of whom bring themselves (warts and all) to the therapeutic interaction, both of whom engage, and are engaged by, the other.

Mutuality of Impact

Relational (or Model 3) theorists who embrace this perspective conceive of patient and therapist as constituting a co-evolving, reciprocally mutual, interactive dyad – each participant both proactive and reactive, each both initiating and responding. For the relational therapist, the locus of the therapeutic action always involves this mutuality of impact – a prime instance of which is projective identification.

Clinical Vignette: In a Heartbeat

A patient's beloved grandmother has just died. The patient, unable to feel his sadness because it hurts too much, recounts in a monotone the details of his grandmother's death. As the therapist listens, she feels herself becoming intensely sad. As the patient continues, the therapist finds herself uttering, almost inaudibly, an occasional "Oh, no!" or "That's awful!" As the hour progresses, the patient himself becomes increasingly

sad.

In this example, the patient is initially unable to feel the depths of his grief about his grandmother's death. By reporting the details of her death in the way that he does, the patient is able to get the therapist to feel what he cannot himself feel; in essence, the patient exerts interpersonal pressure on the therapist to take on as the therapist's own what the patient does not yet have the capacity to experience. This is clearly an instance of the patient's impact on the therapist.

As the therapist sits with the patient and listens to his story, she finds herself becoming very sad, which signals the therapist's quiet acceptance of the patient's disavowed grief. We could say of the patient's sadness that it has found its way into the therapist, who has taken it on as her own. The therapist's sadness is therefore co-created – it is in part a story about the patient (and his disavowed grief) and in part a story about the therapist (in whom a resonant chord has been struck).

The therapist, with her greater capacity (in this instance, to experience affect without needing to defend against it), is able both to tolerate the sadness that the patient finds intolerable and to process it psychologically. It is the therapist's ability to tolerate the intolerable that makes the patient's previously unmanageable feelings more manageable

for him. The patient's grief becomes less terrifying by virtue of the fact that the therapist has been able to carry that grief on the patient's behalf.

A more assimilable version of the patient's sadness is then returned to the patient in the form of the therapist's heartfelt utterances – and the patient finds himself now able to feel the pain of his grief, now able to carry that pain on his own behalf. This is clearly an instance of the therapist's impact on the patient.

For the relational therapist, the locus of the therapeutic action always involves mutual influence; both patient and therapist are continuously changing by virtue of being in relationship with each other.

The Patient as Proactive

Unlike Model 2, which pays relatively little attention to the patient's proactivity in relation to the therapist, Model 3 addresses itself specifically to the force-field created by the patient in an effort to draw the therapist in to participating in ways specifically determined by the patient's early-on history and internally recorded in the form of pathogenic introjects – ways the patient needs the therapist to participate if she (the patient) is ever to have a chance to master her internal demons.

Re-finding the Old Bad Object

More specifically, in a relational model of therapeutic action, the patient with a history of early-on traumas is seen, then, as having a need to re-find the old bad object – the hope being that perhaps this time there will be a different outcome.

In order to demonstrate the distinction between a theory that posits unidirectional influence (a corrective-provision model) and a theory that posits bidirectional – reciprocal – influence (a relational model), I offer the following:

Inevitability of Empathic Failure

As we know, self psychology (the epitome of a corrective-provision model) speaks to the importance of the therapist's so-called *inevitable empathic failures* (Kohut 1966). Self psychologists contend that these failures are unavoidable because the therapist is not, and cannot be expected to be, perfect.

How does relational theory conceive of such failures? Many relational theorists believe that a therapist's failures of her patient are not just a story about the therapist (and her lack of perfection) but also a story about the patient and the patient's exerting of interpersonal

pressure on the therapist to participate in ways both *familial* and, therefore, *familiar* (Mitchell 1988).

Relational theory believes that the therapist's failures do not simply happen in a vacuum; rather, they occur in the context of an ongoing, continuously evolving relationship between two real people – and speak to the therapist's responsiveness to the patient's (often unconscious) enactment of her need to be failed.

Repetition Compulsion

As with every repetition compulsion, the patient's need to recreate the early-on traumatic failure situation in the therapy relationship has both unhealthy and healthy aspects.

(1) The unhealthy component has to do with the patient's need to have more of same, no matter how pathological, because that's all the patient has ever known. Having something different would create anxiety because it would highlight the fact that things could be, and could therefore have been, different; in essence, having something different would challenge the patient's attachment to the infantile (parental) object.

(2) But the healthy piece of the patient's need to be now failed as

she was once failed has to do with her need to have the opportunity to achieve belated mastery of the parental failures – the hope being that perhaps this time there will be a different outcome, a different resolution.

And so it is that in a relational model, the therapist's failures of her patient are thought to be co-constructed – both a story about the therapist (and what she gives/brings to the therapeutic interaction) and a story about the patient (and what she gives/brings to the therapeutic interaction).

Clinical Vignette: My Refusal to Believe

I would like to offer a vignette that speaks to the power of the patient's (unconscious) need to be failed – and its impact on the therapist.

My patient, Celeste, had been telling me for years that her mother did not love her. Again and again she would complain bitterly about all the attention her mother showered on Celeste's sisters. Celeste claimed that she, on the other hand, was treated by mother with either indifference or actual disdain.

Of course I believed her; that is, of course I believed that this was her experience of what had happened as she was growing up. I wanted

to be very careful not to condemn Celeste's mother as unloving. My fear was that were I to agree with her that her mother did not love her, I would be reinforcing a distorted perception, which might then make it much more difficult for Celeste to reconcile with her mother at some later point, were she ever to decide to do that.

And so I was always very careful never to say things like: "Your mother clearly did not love you," "Your mother obviously favored your sisters over you," or "Your mother had very little to give you."

Instead, I would frame my empathic interventions in the following way: "And so your experience was that your mother did not love you – and that broke your heart." Or I would say something like, "How painful it must have been to have had the experience of wanting your mother's love so desperately and then feeling that you got so little of it."

In retrospect, it makes me sad to think that I said these things and that Celeste let me. Part of her problem was that she allowed people to say these kinds of things to her.

But one day she came to the session bearing a letter from her mother. She began to read it to me, and I was horrified. It was totally clear, beyond a shadow of a doubt, that for whatever the reason, her mother really did not love her in the way that she loved her other

daughters. It was a horrible letter and my heart ached for Celeste; now I really understood what she had meant all those years. And I felt awful that I had thought my patient's perceptions of her mother might be distortions of reality.

When Celeste had finished reading one of the saddest letters I have ever heard, I said, "Oh, my God, your mother really doesn't love you as much as she loves the others, does she? I'm so sorry that it took me so long to get that."

Celeste then hung her head and said quietly, with a mixture of anguish and relief, "You're right. My mother really doesn't love me very much." She began to sob in a way that I had never before heard her sob. I am sure that she was crying both about how unloved she had always been by her mother and about how disappointed she was now in me, that it had taken me so long to understand something so important.

On some level, unconsciously I had been defending her mother. I think I was having trouble believing that her mother would have been so heartless as to favor her other daughters over my patient; I was so fond of my patient that I could not imagine any mother not loving her.

The reality is that I had not really taken Celeste seriously when she had told me that her mother did not love her. I understood that she had

felt unloved as a child, but I could not bear to think that she had actually been unloved. And so I did her a grave disservice in assuming that she was inaccurately perceiving the reality of the situation. In doing this, I was blocking some of the grieving that she needed to do about her mother.

By the way, as Celeste grieved the reality of how unloved she had actually been by her mother, she and I came to discover something else: Although she had not been loved by her mother, she had in fact been deeply loved and cherished by her father, a man who, although severely alcoholic and often absent from home, was nonetheless very deeply attached to Celeste and proud of her. We might never have gained access to the special connection with her father had I persisted in my belief that Celeste's mother had to have loved her.

Let me add, at this point, that another way to understand what happened between Celeste and me is to think in terms of my patient as having needed me to fail her as she had been failed in the past, so that she would have the opportunity to achieve belated mastery of her old pain about not being taken seriously.

Such a perspective (a relational or interactive perspective) would see the therapist's failure of her patient as not just a story about the

therapist (and the therapist's limitations) but also a story about the patient (and the patient's need to be failed).

More generally, relational theorists believe that there are times when the patient needs not only to find a new good object but also to re-find the old bad one, needs not only to create a new good object but also to re-create the old bad one – so that there can be an opportunity for the patient to revisit the early-on traumatic failure situation and perhaps, this time, to achieve mastery of it.

The Patient's Transferential Activity as an Enactment

In Model 3, then, the patient is seen as an agent, as proactive, as able to have an impact, as exerting unrelenting pressure on the therapist to participate in ways that will make possible the patient's further growth. The relational therapist, therefore, attends closely to what the patient delivers of herself into the therapy relationship (in other words, the patient's transferential activity).

In fact, relational theory conceptualizes the patient's activity in relation to the therapist as an enactment, the unconscious intent of which is to engage (or to disengage) the therapist in some fashion – either by way of eliciting some kind of response from the therapist or by way of communicating something important to the therapist about the patient's

internal world. In fact, the patient may know of no other way to get some piece of her subjective experience understood than by enacting it in the relationship with her therapist.

Provocative vs. Inviting vs. Entitled

I use the word *provocative* to describe the patient's behavior when she is seeking to recreate the old bad object situation (so that she can rework her internal demons), *inviting* to describe her behavior when she is seeking to create a new good object situation (so that she can begin anew), and *entitled* to describe her behavior when, confronted with an interpersonal reality that she finds intolerable, she persists even so – relentless in her pursuit of that to which she feels entitled and relentless in her outrage at its being denied.

The Therapist as Container for the Patient's Projections

If the Model 3 therapist is to be an effective container for – and psychological metabolizer of – the patient's disavowed psychic contents, the therapist must be able not only to tolerate being made into the patient's old bad object but also to extricate herself (by recovering her objectivity and, thereby, her therapeutic effectiveness) once she has allowed herself to be drawn in to what has become a mutual enactment.

The therapist must have both the wisdom to recognize and the integrity to acknowledge her own participation in the patient's enactments; even if the problem lies in the intersubjective space between patient and therapist, with contributions from both, it is crucial that the therapist have the capacity to relent – and to do it first.

Patient and therapist can then go on to look at the patient's investment in getting her objects to fail her, her compulsive need to recreate with her contemporary objects the early–on traumatic failure situation.

Failure of Engagement vs. Failure of Containment

If the therapist never allows herself to be drawn in to participating with the patient in her enactments, we speak of a failure of engagement. If, however, the therapist allows herself to be drawn in to the patient's internal dramas but then gets lost, we speak of a failure of containment – and the potential is there for the patient to be retraumatized.

Although initially the therapist may indeed fail the patient in much the same way that her parent had failed her, ultimately the therapist challenges the patient's projections by lending aspects of her otherness, or, as Winnicott (1965) would have said, her *externality* to the interaction – such that the patient will have the experience of something that is

other–than–me and can take that in. What the patient internalizes will be an amalgam, part contributed by the therapist and part contributed by the patient (the original projection).

In other words, because the therapist is not, in fact, as bad as the parent had been, there can be a better outcome. There will be repetition of the original trauma but with a much healthier resolution this time – the repetition leading to modification of the patient's internal world and integration on a higher level.

A Corrective Relational Experience

It is in this way that the patient will have a powerfully healing *corrective relational experience*, the experience of bad-become-good.

In the relational model, it is the negotiation of the relationship and its vicissitudes (a relationship that is continuously evolving as patient and therapist act/react/interact) that constitutes the locus of the therapeutic action. It is what transpires in the here-and-now engagement between patient and therapist that is thought to be transformative.

And so this third model of therapeutic action is the relational (or interactive) perspective of contemporary psychoanalytic theory. No

longer is the emphasis on the therapist as object – object of the patient's sexual and aggressive drives (Model 1), object of the patient's narcissistic demands (Model 2), or object of the patient's relational need to be met and held (Model 2). In this contemporary relational model, the focus is on the therapist as subject – an authentic subject who uses the self (that is, uses her countertransference) to engage, and to be engaged by, the patient.

Unless the therapist is willing to bring her authentic self into the room, the patient may end up analyzed – but never found.

Clinical Vignette: A Provocative Enactment

Let me now present another example that I believe highlights the difference between empathic attunement (the province of Model 2) and authentic engagement (the province of Model 3).

I owe a debt of gratitude to one of my supervisees (Carole), who gave me permission to share the following vignette.

John, a very handsome 59-year-old man, had been in therapy with Carole (a very attractive 66-year-old woman) for many years. Although Carole knew that her (characterological) tendency to be hoveringly overprotective – and sometimes, even, a bit intrusive – might have been

making John feel somewhat uncomfortable, nonetheless the therapy was progressing well. Furthermore, John was clearly attached to Carole, as she was to him.

But, in 2008, when Barack Obama was elected to the White House, John made a denigrating racial remark that had a profound impact on how Carole then began to feel toward John – an impact that, although subtle, Carole simply could not shake. After Obama won the presidential election, John made the following racial slur: "I hate it that we now have a nigger in the White House!" Carole (herself white) was understandably taken aback and deeply offended that John would have thought to describe anyone in such an offensive manner.

But, by summoning up every bit of empathy that she could possibly muster, Carole did somehow manage to respond with the following: "You are concerned about the direction in which our country is going." This empathic utterance on Carole's part enabled the session to continue; and John then went on to talk about his upset, anger, frustration, and despair about the direction in which he felt the country was going and, quite frankly, the direction in which he felt his own life was going. The session ended up being a very productive one.

A price, however, had been paid. Although Carole had managed to

be empathic (which not only enabled the session to continue but also prompted John to delve more deeply into the heartfelt anguish and despair he was feeling about the course of his own life), Carole had been left with feelings of shock and revulsion; and despite the passage of time and Carole's efforts to let it go, the souring of her feelings had persisted and Carole now found herself having a little less respect for John, feeling a little less affection for him, and becoming a little more withdrawn from him during their sessions. Nonetheless, the therapy continued to progress well; and John, in his life on the outside, was making substantial gains.

And so it was that Carole's empathic remark, although enabling John to feel understood, obviated the need for the two of them to address the dysfunctional relational dynamic (Carole's overprotectiveness / John's subsequent need to distance / Carole's retreat) that was being played out between them and creating tension in their relationship.

In 2012 Carole came to me for supervision (around John and various others in her clinical practice). In reviewing John's case with me, Carole acknowledged the horror she still felt about the racial slur John had uttered those years earlier. In our supervision session, the idea suddenly came to me that perhaps Carole could use the upcoming November 2012 presidential election as an opportunity to re-visit what

had happened between the two of them in 2008.

Right after the announcement was made that Obama had indeed been re-elected to the White House, Carole – despite the fact that John had not, this time, commented on the election results – opened the next session by saying that Obama's re-election was reminding her of what John had said to her the first time Obama had won. Carole had decided not to share directly with John (at least not initially) what she had felt in response to his provocative remark. Rather, she simply asked "When you referred to Obama as a nigger, how were you imagining that I would respond?"

The Rule of Three: Hoping, Fearing, Imagining

I believe that when a patient says or does something that the therapist experiences as provocative, the therapist has the option of asking the patient any of the following: (1) "How are you hoping that I will respond?" – which speaks to the patient's id; (2) "How are you fearing that I might respond?" – which speaks to the patient's superego; and (3) "How are you imagining that I will respond?" – which speaks to the patient's ego (the executive functioning of his ego). All three questions demand of the patient that he make his interpersonal intentions more explicit – in essence, that he take responsibility for his provocative enactment.

In any event, at first John was clearly surprised by Carole's question; but, to his credit, he did pause to reflect upon what he remembered of that moment between them those four years earlier. Interestingly, John did then go on to acknowledge that he had known all along that Carole would probably be offended by his remark.

As Carole and John continued to explore at the intimate edge of their relationship, it became clear that Carole's hovering overprotectiveness (during their earlier years and prior to John's off-putting 2008 remark) had indeed been experienced by John as somewhat intrusive and was probably at least in part responsible for what had then prompted him to make what he knew, in his heart of hearts, was a provocative and offensive remark about Obama to Carole.

John also acknowledged that, in retrospect, he had felt a complex mixture of feelings after his distancing of Carole: some relief that he had actually succeeded in getting the distance he felt he needed; some shame about having said what he had in order to get that distance; and some sadness that the two of them were indeed no longer as close. It was in the context of their negotiating at their intimate edge that Carole also now admitted to having felt distanced and somewhat put-off by John's offensive remark about Obama. She also went on to acknowledge her own sadness that the two of them had then become less connected.

As John and Carole continued to examine the mutual enactment that had taken place between them and together, with shared mind and shared heart, grieved the loss of the special connection that they had enjoyed during the earlier years of their relationship, they discovered a newer connection – one that was ultimately much more solid, honest, and genuine. John apologized to Carole for his insulting comment about Obama (adding that he was still no Obama fan!); and Carole graciously accepted the apology. Carole, in her turn, also apologized for having been too maternal in her approach to John during their earlier years and for not having found a way to share with him how taken aback she had been by his derogatory 2008 remark about Obama.

At the end of the day, both John and Carole felt much better and much closer for having put more explicitly into words what each had been experiencing in relation to the other – both during the years prior to 2008 and during the four years between 2008 and 2012.

Clinical Vignette: The Capacity to Tolerate Ambivalence

I present now another vignette that speaks to the distinction between an empathic response and an authentic response and highlights the importance of the therapist's capacity to work through her countertransference in order to get to a place of being able to offer the

patient an analytically useful intervention.

Kathy has been involved with Jim, a man who appears to be very attached to her but, nonetheless, periodically has affairs with other women. It is always devastating for Kathy when she finds out, but each time Jim resolves to do better in the future and Kathy takes him back.

One day, however, Kathy discovers that Jim has had a one-night stand with someone she had considered to be her best friend. To her therapist, she reports her outrage that Jim would be doing this to her – yet again and with her best friend! Kathy tells her therapist that the relationship with Jim is definitely over.

The therapist is easily able to be empathic with how Kathy feels.

But it is much harder for the therapist to empathize when Kathy comes to the next session with a report that she and Jim have had a good talk and have reconciled; Kathy explains that Jim is beginning to see that he has a problem and has promised to get himself into therapy. Jim has told her that he feels awful about having done what he did and begs her forgiveness.

The therapist, knowing that this is neither the first time Jim has promised to get himself into therapy nor the first time Jim has promised

things will change, finds herself feeling skeptical; she is also aware of feeling horrified that Kathy would actually be willing to give Jim yet another chance! To herself the therapist thinks, "Heavens, when is Kathy going to get it!? Jim is never going to give her what she wants. Why can't Kathy just let him go!?"

The therapist considers the possibility of sharing with Kathy some of her sentiments (or, at least, a modified version of them); she decides, however, that for now her feelings are so raw and so unprocessed that she does not really trust herself to say something that would be therapeutically useful to Kathy, something that would further the therapeutic endeavor.

And so the therapist decides to respond more empathically to Kathy by trying, as best she can, to decenter from her own feelings of outrage at Jim's provocative behavior and of horror at Kathy's refusal to confront that reality. The therapist therefore offers Kathy the following: "You are outraged and devastated by what Jim has done but want very much to believe that this time Jim has finally understood that his behavior is unacceptable. You are encouraged by his decision to enter therapy, and you are thinking that he is finally beginning to take some responsibility for his actions."

Clearly feeling understood and supported by the therapist's empathic recognition of where she is, Kathy responds with, "Jim makes me feel loved in a way that I have never before felt loved. He makes me feel very special, and that means a lot to me." Later, Kathy goes on to admit, "I do know that Jim could always do it again. He has done it many times in the past. But I guess I need to believe that this time he will come through for me. This time it will be different."

The therapist's empathic response creates a space for Kathy within which she can feel safe enough, and nondefensive enough, that she can delve more deeply into acknowledging her need for Jim – that is, Kathy elaborates upon the positive side of her ambivalence about Jim. Later, she is able to get in touch with the negative side of that ambivalence, which she must be able to do if she is ultimately to work through her conflictedness about Jim.

In other words, for Kathy to be able, in time, to let go of Jim, she must come to understand both the *gain* (that is, what investment she has in staying with Jim) and the *pain* (that is, what price she pays for refusing to let go). In order to understand the gain, Kathy must be given the space to elaborate upon the positive side of her ambivalence about Jim; in order to understand the pain, Kathy must get to a place of being able to recognize, and take ownership of, the negative side of her ambivalence

about Jim.

The therapist's empathic response frees Kathy up to talk about how it serves her to be with Jim; once Kathy has had an opportunity to do this, she is then able, of her own accord and at her own pace, to let herself remember just how painful the relationship has been for her.

Now had the therapist, instead of being empathic, been able to process her own feelings of outrage and horror a little more quickly, she might, alternatively, have used aspects of this experience to offer Kathy the following: "On the one hand I find myself feeling horrified that you would be willing to give Jim yet another chance (given how much he has hurt you), but then I think about how important it is for you to be able to feel loved (because of how unloved you always felt by your father) – and I think I begin to understand better why you might be willing to give him one more chance."

The therapist, by bringing together both sides of her own ambivalent response to Kathy, is here offering herself as a container for Kathy's disavowed conflictedness. Although, in the moment, Kathy might have lost sight of the negative side of her ambivalence, the therapist is remembering and carrying (on Kathy's behalf) both sides of the ambivalence.

The Therapist Has Capacity Where the Patient Has Need

We would say of the therapist that she has capacity where Kathy has need – the therapist has the capacity to sit with and to hold in mind simultaneously both sides of her ambivalence, whereas Kathy, in the moment, would seem to have the capacity to remember only the positive side of her ambivalence and the need not to remember the negative side.

The therapist's capacity to tolerate what the patient finds intolerable is the hallmark of a successful projective identification. The therapist takes on Kathy's conflict and, after processing it psychologically, makes a modified version of it available to Kathy for re-internalization. In time, Kathy may well be able herself to acknowledge simultaneously both sides of her conflictedness – that is, both the gain and the pain.

How the Therapist Positions Herself

As noted earlier, the empathic attunement of Model 2 requires of the therapist that she decenter from her own subjectivity in order to join alongside the patient; the therapist will then be able to enter into the patient's experience and take it on, but only as if it were her own because it never actually becomes her own. The therapist, by remaining ever focused on, and attuned to, the patient's moment-by-moment experience

will be able to resonate empathically with the patient's experience, such that the patient will have the profoundly satisfying experience of being heard and understood – or, in the words of self psychology, validated. Empathic attunement is not about the therapist's experience; it is about the patient's experience.

The authentic engagement of Model 3, however, requires of the therapist that she remain very much centered within her own subjectivity, the better to allow the patient's experience to enter into her; the therapist, ever open to being impacted, will then take on the patient's experience as her own, such that the therapist's experience will come to be informed by both the there-and-then of the therapist's early-on history and the here-and-now of the therapeutic engagement. The therapist, by remaining ever focused on, and attuned to, her own moment-by-moment experience, will then be able to lend aspects of her own capacity to a psychological processing and integrating of what she is experiencing as a result of being in relationship with the patient, such that the patient will have the profoundly healing experience of knowing that she is not alone, of knowing that someone else is present with her, of knowing that someone else is sharing her experience. Authentic engagement is not so much about the patient's experience as it is about the sharing of experience between patient and therapist.

In essence, empathic attunement and authentic engagement represent different ways the therapist can position herself in relation to the patient. It is not that one approach is better than the other one or more evolved; rather, it is that these are two different, and complementary, approaches. By being empathic, the therapist will create certain possibilities for the unfolding of the therapeutic action – but at the expense of other options; by the same token, by being authentic, the therapist will create certain other possibilities for the unfolding of the therapeutic action – but at the expense of other options. I am here reminded of Robert Frost's "The Road Not Taken" (2002). The therapist is continuously choosing one path over another, all the while knowing that in making the choices she is making she will never know where the other paths might have led.

How the Therapist Listens vs. How the Therapist Responds

Parenthetically, it is important to keep in mind that there is a distinction between *how the therapist listens* and *how the therapist then responds*. In the first instance, we are speaking to how the therapist comes to know the patient; in the second instance, we are speaking to how the therapist, based upon what she has come to know, then intervenes. When a therapist is said to *be empathic*, it is therefore not clear whether the speaker is suggesting that the therapist is *listening*

empathically and/or *responding* empathically; what is meant, however, will usually be clear from the context.

The important point to be made here is that a good therapist will listen simultaneously – even though paradoxically – with *objectivity* (Model 1), *empathy* (Model 2), and *authenticity* (Model 3). In other words, a good therapist will come to know the patient by focusing on neither the patient's nor her own experience but on what she observes (Model 1), by focusing on the patient's experience (Model 2), and by focusing on her own experience (Model 3). All three modes of listening will offer important information about the patient and the therapy relationship.

How the therapist then decides to intervene will be a story about both what the therapist has come to know and how the therapist conceptualizes the ever-evolving therapeutic action – whether, in the moment, it involves primarily enhancement of knowledge *within*, provision of corrective experience *for*, or engagement in authentic relationship *with*.

So how exactly do we conceive of the process by which patients are healed? In order to understand the therapeutic process, we will think about how the therapist positions herself moment by moment in relation

to the patient. My belief is that the position she assumes will affect both what she comes to know (afference) and how she then intervenes (efference).

How the Therapist Comes to Know

With respect to how the therapist arrives at understanding of the patient, I contend that the most effective listening stance is one in which the therapist achieves an optimal balance between positioning herself as object, as selfobject, and as subject.

(1) As a neutral object, the therapist positions herself outside the therapeutic field in order to observe the patient. Her focus is on the patient's internal dynamics.

(2) As an empathic selfobject, the therapist joins alongside the patient in order to immerse herself in the patient's subjective reality. Her focus is on the patient's affective experience.

(3) As an authentic subject, the therapist remains very much centered within her own experience – using that experience (in other words, the countertransference) to deepen her understanding of the patient. Her focus is on the here-and-now engagement between them.

To this point, the therapist is simply gathering information; she has not yet done anything with what she has come to know.

How the Therapist Then Intervenes

With respect to how the therapist then intervenes, my belief is that the most effective interventive stance is one in which the therapist achieves an optimal balance between formulating interpretations, offering some form of corrective provision, and engaging interactively in relationship.

(1) The therapist formulates interpretations with an eye to advancing the patient's knowledge of her internal dynamics. The ultimate goal is resolution of the patient's structural conflicts.

(2) The therapist offers some form of corrective provision with an eye either to validating the patient's experience or, more generally, to providing the patient with a corrective experience. The ultimate goal is filling in the patient's structural deficits and consolidating the patient's self.

(3) The therapist engages the patient interactively in relationship with an eye to advancing the patient's knowledge of her relational dynamics and/or to deepening the connection between the two of them.

The ultimate goal is resolution of the patient's relational difficulties and development of her capacity to engage healthily and authentically in relationship.

With each patient, whatever her diagnosis, whatever her underlying psychodynamics, the optimal therapeutic stance is one that is continuously changing. In fact, moment-by-moment, the therapist's position shifts.

The stance the therapist assumes is sometimes spontaneous and unplanned, sometimes more deliberate and considered. In other words, there are times when the therapist finds herself unwittingly drawn in to participating with the patient in a particular way because the intersubjective field has pulled for that form of participation. But there are other times when the therapist makes a more conscious choice, based on what she intuitively senses the patient most needs in the moment in order to heal.

How the therapist decides to intervene, therefore, depends on both what she has come to understand about the patient by virtue of the listening position she has assumed and what she thinks the patient most needs – whether enhancement of knowledge, provision of experience, or engagement in relationship.

At any given point in time, the therapist is also profoundly affected by what had come before – in the moments leading up to the current moment. Past and present are always inextricably linked; no moment in time stands on its own. And so it is that how the therapist chooses to intervene in the moment depends also on what had transpired in the moments preceding.

My intent is to provide the therapist with a way to conceptualize the options available to her as she sits with her patient – with respect both to how she arrives at understanding and to what she then does or says.

I am offering not a prescription for what the therapist should do but rather a description of what the therapist already does do.

Knowledge, Experience, and Relationship

In sum, I believe that the three modes of therapeutic action (knowledge, experience, and relationship) are not mutually exclusive but mutually enhancing. The conceptual framework I am offering here is a synthetic one that integrates three perspectives:

(1) the interpretive perspective of classical psychoanalytic theory;

(2) the corrective-provision (or deficiency-compensation) perspective of self psychology and those object relations theories emphasizing the absence of good; and

(3) the relational (or interactive) perspective of contemporary psychoanalytic theory and those object relations theories emphasizing the presence of bad.

The impetus for my effort to integrate the three models stems from my belief that none of the three is sufficient, on its own, to explain our clinical data or to guide our interventions. Although there is of course some overlap, each model contains elements lacking in the other two.

Obviously, no model can begin to do justice by something this complex and multifaceted, but my hope is that the integrative model I am proposing will prompt therapists to become more aware of the choices they are continuously making about how they listen to the patient and how they then intervene.

Whereas Model 1 is a one-person psychology and Model 2 is a one-and-a-half-person psychology, Model 3 is truly a two-person psychology.

And whereas the Model 1 therapist is seen as a neutral object (whose focus is on the patient's internal process) and the Model 2

therapist is seen as an empathic selfobject or good object/good mother (whose focus is on the patient's moment-by-moment affective experience), the Model 3 therapist is seen as an authentic subject (whose focus is on the intimate edge between them).

In Model 1, although the short-term goal is enhancement of knowledge, the ultimate goal is resolution of structural conflict. In Model 2, although the immediate goal is provision of (corrective) experience, the long-range goal is filling in of structural deficit. In Model 3, although the short-term goal is engagement in relationship (and a deepening of connection between patient and therapist), the ultimate goal is development of capacity for healthy, authentic relatedness.

And, finally, whereas Model 2 is about offering the patient an opportunity to find a new good object – so that there can be restitution, Model 3 is about offering the patient an opportunity to re-find the old bad one – so that the traumatogenic early-on interactions can be worked through in the context of the patient's here-and-now engagement with the therapist.

Along these same lines, Greenberg (1986) has suggested that if the therapist does not participate as a new good object, the therapy never gets under way; and if she does not participate as the old bad one, the

therapy never ends – which captures exquisitely the delicate balance between the therapist's participation as a new good object (so that there can be a new beginning) and the therapist's participation as the old bad object (so that there can be an opportunity to achieve belated mastery of the internalized traumas).

Indeed, psychoanalysis has come a long way since the early days when Freud was emphasizing the importance of sex and aggression. No longer is the spotlight on the patient's drives (and their vicissitudes); now the spotlight is on the patient's relationships (and *their* vicissitudes).

And where once psychoanalysis focused on the relationship that exists between structures within the psyche of the patient, contemporary psychoanalysis focuses more on the relationship that exists between the patient and her objects – or, more accurately, the intersubjective relationship that exists between the patient and her subjects. In Benjamin's (1988) words: "...where objects were, subjects must be" (p. 44).

Conclusion

I am proposing that the repertoire of the contemporary therapist includes formulating interpretations, offering some form of corrective provision, and engaging interactively in a relationship that is reciprocally

mutual.

I think that the most therapeutically effective stance is one in which the therapist is able to achieve an optimal balance between (a) positioning herself outside the therapeutic field (in order to formulate interpretations about the patient and her internal process so as to facilitate resolution of the patient's structural conflict), (b) decentering from her own experience (in order to offer the patient some form of corrective provision so as to facilitate the filling in of the patient's structural deficit), and (c) remaining very much centered within her own experience (in order to engage authentically with the patient in a real relationship so as to facilitate resolution of the patient's relational difficulties).

Casement (1985), in speaking to how the therapist positions himself optimally in relation to the patient, suggests the following: The therapist must "learn how to remain close enough to what the patient is experiencing" to be able to be affected by the patient – “while preserving a sufficient distance" to function as therapist. "But that professional distance should not leave him beyond the reach of what the patient may need him to feel. A therapist has to discover how to be psychologically intimate with a patient and yet separate, separate and still intimate" (p. 30).

In the language we have been using here, the therapist must empathically join the patient where she is even as the therapist preserves her distance so that she can still function interpretively. But the therapist should never be so far away that the patient cannot find her and engage her authentically. Intimate without losing the self, separate without losing the other.

It will be a challenge for any therapist to attempt to hold in mind, simultaneously, the three different perspectives without pulling for premature closure – closure that may ease the therapist's anxiety but will probably limit the realm of therapeutic possibilities. The most effective therapists will be those who (a) manage somehow to tolerate – perhaps, even, for extended periods of time – the experience of not knowing or, in Bollas's (1989) words, the experience of necessary uncertainty; (b) are open to being shaped by the patient's need and by whatever else might arise within the context of their intersubjective relationship; and, more generally, (c) are willing to bring the best of themselves, the worst of themselves, and the most of themselves into the room with the patient – so that each will have the opportunity to find the other.

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Part 2

Module 1

THE HEALING PROCESS

AND

TRANSFORMATION OF DEFENSE INTO ADAPTATION

OVERVIEW

THE THERAPEUTIC PROCESS

FROM CURSING THE DARKNESS TO LIGHTING A CANDLE
FROM DEFENSE TO ADAPTATION

DEFENSES

DYSFUNCTIONAL / PRIMITIVE / REFLEXIVE / UNHEALTHY
RIGID / LOW – LEVEL / UNEVOLVED

ARE NEEDED FOR THE SYSTEM TO SURVIVE
BUT ARE VERY COSTLY
IN TERMS OF THE SYSTEM'S FUNCTIONALITY

ADAPTATIONS

MORE FUNCTIONAL / MORE COMPLEX / REFLECTIVE / HEALTHIER
MORE FLEXIBLE / HIGHER – LEVEL / MORE EVOLVED

ENABLE THE SYSTEM TO THRIVE
BUT ARE ULTIMATELY COSTLY
IN TERMS OF THE SYSTEM'S RESERVES

ALTHOUGH DEFENSES ARE GENERALLY
LESS HEALTHY AND LESS EVOLVED
AND ADAPTATIONS
MORE HEALTHY AND MORE EVOLVED,

BOTH ARE SELF – PROTECTIVE MECHANISMS THAT SPEAK
TO THE LENGTHS TO WHICH A SYSTEM WILL GO
IN ORDER TO PRESERVE ITS HOMEOSTATIC BALANCE
IN THE FACE OF ENVIRONMENTAL CHALLENGE

BE THAT CHALLENGE
EXTERNALLY OR INTERNALLY DERIVED
PSYCHOLOGICAL, PHYSIOLOGICAL, OR ENERGETIC

IN TRUTH

DEFENSES AND ADAPTATIONS ARE
FLIP SIDES OF THE SAME COIN

DEFENSES ALWAYS HAVE AN ADAPTIVE FUNCTION
JUST AS ADAPTATIONS DO ALSO SERVE TO DEFEND

IN OTHER WORDS

DEFENSES AND ADAPTATIONS HAVE A YIN AND YANG RELATIONSHIP, REPRESENTING, AS THEY DO, NOT OPPOSING BUT COMPLEMENTARY FORCES

FOR EXAMPLE, SHADOW CANNOT EXIST WITHOUT LIGHT

IN FACT

JUST AS IN QUANTUM THEORY
WHERE PARTICLES AND WAVES ARE THOUGHT TO BE DIFFERENT MANIFESTATIONS OF A SINGLE REALITY
DEPENDING UPON THE OBSERVER'S PERSPECTIVE

SO TOO DEFENSE AND ADAPTATION
ARE CONJUGATE PAIRS
DEMONSTRATING THIS SAME DUALITY

"BOTH – AND" NOT "EITHER – OR"

THE DISTINCTION IS HERE
BEING MADE BETWEEN

DEFENSIVE REACTIONS
THAT ARE MOBILIZED
IN THE IMMEDIATE AFTERMATH
OF CHALLENGE
AND ARE
AUTOMATIC, KNEE – JERK,
STEREOTYPIC, AND RIGID

AND ADAPTIVE RESPONSES
THAT UNFOLD
IN THE AFTERMATH OF CHALLENGE
ONLY OVER TIME
AND ARE THEREFORE
MORE PROCESSED, INTEGRATED,
FLEXIBLE, AND COMPLEX

THE THERAPEUTIC PROCESS WILL THEREFORE INVOLVE THE TRANSFORMATION OF

UNHEALTHY AND UNEVOLVED DEFENSE INTO HEALTHIER AND MORE EVOLVED ADAPTATION

DEFENSIVE REACTION INTO ADAPTIVE RESPONSE

DEFENSIVE NEED INTO ADAPTIVE CAPACITY

BY WAY OF EXAMPLES

THE NEED FOR IMMEDIATE GRATIFICATION INTO THE CAPACITY TO TOLERATE DELAY

THE NEED FOR PERFECTION INTO THE CAPACITY TO TOLERATE IMPERFECTION

THE NEED FOR EXTERNAL REGULATION OF THE SELF INTO THE CAPACITY TO BE INTERNALLY SELF – REGULATING

THE NEED TO HOLD ON INTO THE CAPACITY TO LET GO

IN ESSENCE, FROM CURSING THE DARKNESS TO LIGHTING A CANDLE

A POEM THAT SPEAKS DIRECTLY
TO A SYSTEM'S CAPACITY
TO ADAPT TO STRESSFUL INPUT

COME TO THE EDGE.
WE MIGHT FALL.
COME TO THE EDGE.
IT'S TOO HIGH!
COME TO THE EDGE!
AND THEY CAME,
AND HE PUSHED,
AND THEY FLEW …

(LOGUE 2004)


What if I fall?
Oh, but my darling,
what if you *fly*?
-e.h.

MY GOAL HAS LONG BEEN TO CREATE

A CONCEPTUAL FRAMEWORK

THAT CAPTURES THE ESSENCE OF

THE PROCESS OF HEALING

BE IT OF THE MIND OR OF THE BODY

TO THAT END

I HAVE DEVELOPED THE TERM MindBodyMatrix

A CONCEPT THAT REFLECTS A KEEN APPRECIATION

FOR THE INTIMATE AND PRECISE RELATIONSHIP

THAT EXISTS BETWEEN THE HEALTH AND VITALITY

OF THE MIND AND THAT OF THE BODY

(STARK 2008, 2012, 2014, 2015)

AS I HAVE EVOLVED

OVER THE COURSE OF THE DECADES,

SO TOO MY UNDERSTANDING

OF THE HEALING PROCESS

HAS EVOLVED –

FROM ONE THAT EMPHASIZES

THE INTERNAL WORKINGS OF THE MIND

TO ONE THAT IS MORE HOLISTIC

AND RECOGNIZES THE COMPLEX

INTERDEPENDENCE OF MIND AND BODY

LONG INTRIGUING TO ME HAS BEEN THE IDEA
THAT SUPERIMPOSING AN ACUTE PHYSICAL INJURY
ON TOP OF A CHRONIC ONE
IS SOMETIMES EXACTLY WHAT THE BODY
NEEDS IN ORDER TO HEAL

OVER TIME I HAVE COME TO BELIEVE THAT
SO TOO SUPPLEMENTING AN EMPATHICALLY ATTUNED
AND AUTHENTICALLY ENGAGED THERAPY RELATIONSHIP
WITH "OPTIMALLY STRESSFUL"
PSYCHOTHERAPEUTIC INTERVENTIONS
SPECIFICALLY DESIGNED
"TO PRECIPITATE DISRUPTION IN ORDER TO TRIGGER REPAIR"

WILL SOMETIMES BE THE MAGIC INGREDIENT NEEDED
TO OVERCOME THE INHERENT RESISTANCE TO CHANGE
SO FREQUENTLY ENCOUNTERED IN OUR PATIENTS
WITH LONGSTANDING EMOTIONAL INJURIES AND SCARS

FOR EXAMPLE

THE PRACTICE OF WOUND DEBRIDEMENT TO ACCELERATE HEALING SPEAKS DIRECTLY TO THIS CONCEPT OF CONTROLLED DAMAGE

NOT ONLY DOES DEBRIDEMENT PREVENT INFECTION BY REMOVING FOREIGN MATERIAL AND DAMAGED TISSUE FROM THE SITE OF THE WOUND BUT ALSO IT PROMOTES HEALING BY MILDLY AGGRAVATING THE AREA, WHICH WILL IN TURN JUMPSTART THE BODY'S INNATE ABILITY TO SELF – HEAL IN THE FACE OF CHALLENGE

ANOTHER EXAMPLE OF CAUSING PHYSICAL IRRITATION OR INJURY TO PROVOKE RECOVERY IS THE PRACTICE OF PROLOTHERAPY

THIS TECHNIQUE IS A HIGHLY EFFECTIVE TREATMENT FOR CHRONIC WEAKNESS AND PAIN IN SUCH VULNERABLE AREAS AS THE LOWER BACK, SHOULDER, HIP, AND KNEE

IN ORDER TO ACTIVATE THE BODY'S HEALING CASCADE, A MILDLY IRRITATING AQUEOUS SOLUTION

FOR EXAMPLE, A RELATIVELY INNOCUOUS SUBSTANCE LIKE DEXTROSE, A LOCAL ANESTHETIC LIKE LIDOCAINE, AND WATER

IS INJECTED INTO THE AFFECTED LIGAMENT OR TENDON, RESULTING ULTIMATELY IN OVERALL STRENGTHENING OF THE DAMAGED CONNECTIVE TISSUE AND ALLEVIATION OF THE PAIN

PROLOTHERAPY IS BELIEVED BY FORWARD – THINKING PRACTITIONERS TO BE SIGNIFICANTLY MORE EFFECTIVE THAN CORTISONE INJECTIONS

BECAUSE THESE LATTER TREATMENTS
ALTHOUGH SOMETIMES ABLE TO PROVIDE IMMEDIATE SHORT – TERM RELIEF OF PAIN

WILL CAUSE DESTRUCTION OF TISSUE AND EXACREBATION OF PAIN OVER THE LONG HAUL BECAUSE OF THEIR CATABOLIC
OR BREAKDOWN
EFFECT

ALONG THESE SAME LINES
BUT NOW SHIFTING FROM BODY TO MIND

IT TOOK ME YEARS TO APPRECIATE SOMETHING
ABOUT THE PSYCHOTHERAPEUTIC PROCESS
THAT IS AT ONCE
BOTH COMPLETELY OBVIOUS
AND QUITE PROFOUND

NAMELY
THAT IT WILL BE
INPUT FROM THE OUTSIDE
AND THE PATIENT'S CAPACITY
TO PROCESS, INTEGRATE,
AND ADAPT TO THIS INPUT
THAT WILL ULTIMATELY
ENABLE THE PATIENT TO CHANGE

ONLY MORE RECENTLY, HOWEVER, HAVE
I HAVE COME TO UNDERSTAND THAT

THE PATIENT MAY NEED
SOMETHING MORE THAN SIMPLY
INPUT FROM THE OUTSIDE
IN ORDER TO CHANGE

INDEED

IT MAY WELL BE ONLY
STRESSFUL INPUT FROM THE OUTSIDE

AND THE PATIENT'S CAPACITY
TO PROCESS, INTEGRATE,
AND ADAPT TO THE IMPACT
OF THIS STRESSFUL INPUT

THAT WILL PROMPT THE PATIENT TO CHANGE

IN OTHER WORDS

IT IS NOT SO MUCH GRATIFICATION AS FRUSTRATION
AGAINST A BACKDROP OF GRATIFICATION
OPTIMAL FRUSTRATION

NOT SO MUCH SUPPORT AS CHALLENGE
AGAINST A BACKDROP OF SUPPORT

NOT SO MUCH EMPATHY AS EMPATHIC FAILURE
AGAINST A BACKDROP OF EMPATHY

THAT WILL PROVIDE THE THERAPEUTIC
LEVERAGE NEEDED TO PROVOKE
AFTER INITIAL DESTABILIZATION

EVENTUAL RESTABILIZATION
AT A HIGHER LEVEL OF
FUNCTIONALITY AND ADAPTIVE CAPACITY

MORE SPECIFICALLY

IF THERE IS NO THWARTING OF DESIRE

THAT IS, NO OBSTACLE TO BE OVERCOME

THEN THERE WILL BE NOTHING

THAT NEEDS TO BE MASTERED

AND THEREFORE NO REAL IMPETUS

FOR TRANSFORMATION AND GROWTH

BEHIND THIS "NO PAIN / NO GAIN"

APPROACH IS MY FIRM BELIEF

IN THE UNDERLYING RESILIENCE

THAT PATIENTS WILL INEVITABLY

DISCOVER WITHIN THEMSELVES

ONCE THEY ARE FORCED TO TAP INTO

THEIR INBORN ABILITY TO SELF – CORRECT

IN THE FACE OF ENVIRONMENTAL CHALLENGE

WHICH SPEAKS TO THE WISDOM OF THE BODY (CANNON 1932)

AN INNATE CAPACITY THAT WILL ULTIMATELY ENABLE THEM TO ADVANCE FROM LESS – EVOLVED DEFENSIVE REACTION TO MORE – EVOLVED ADAPTIVE RESPONSE

Module 2

CHAOS THEORY

AND

PSYCHIC INERTIA

WHY IS IT THAT PEOPLE
KEEP PLAYING OUT THE SAME SCENARIOS
IN THEIR LIVES OVER AND OVER AGAIN
EVEN WHEN THEY KNOW
THAT THE OUTCOME WILL BE JUST
AS DISAPPOINTING THIS TIME
AS IT WAS THE TIME BEFORE?

ALBERT EINSTEIN CAPTURES BEAUTIFULLY
THE ESSENCE OF THESE
UNCONSCIOUS RE – ENACTMENTS –

“INSANITY IS DOING THE SAME THING
OVER AND OVER AGAIN
AND EXPECTING DIFFERENT RESULTS.”

INDEED

PERHAPS PART OF BEING HUMAN IS THAT
WE WILL SO OFTEN FIND OURSELVES
DOING THAT WHICH WE KNOW
WE OUGHT NOT TO BE DOING
AND NOT DOING THAT WHICH WE KNOW
WE OUGHT TO BE DOING

AUTOBIOGRAPHY IN 5 SHORT CHAPTERS by Portia Nelson

CHAPTER 1

I WALK DOWN THE STREET
THERE IS A DEEP HOLE IN THE SIDEWALK
I FALL IN
I AM LOST … I AM HELPLESS
IT ISN'T MY FAULT
IT TAKES FOREVER TO FIND A WAY OUT

CHAPTER 2

I WALK DOWN THE SAME STREET
THERE IS A DEEP HOLE IN THE SIDEWALK
I PRETEND I DON'T SEE IT
I FALL IN AGAIN
I CAN'T BELIEVE I AM IN THE SAME PLACE
BUT IT ISN'T MY FAULT
IT STILL TAKES A LONG TIME TO GET OUT

AUTOBIOGRAPHY IN 5 SHORT CHAPTERS by Portia Nelson

CHAPTER 3

I WALK DOWN THE SAME STREET
THERE IS A DEEP HOLE IN THE SIDEWALK
I SEE IT IS THERE
I STILL FALL IN … IT'S A HABIT
MY EYES ARE OPEN
I KNOW WHERE I AM
IT IS MY FAULT
I GET OUT IMMEDIATELY

CHAPTER 4

I WALK DOWN THE SAME STREET
THERE IS A DEEP HOLE IN THE SIDEWALK
I WALK AROUND IT

CHAPTER 5

I WALK DOWN ANOTHER STREET

I AM HERE REMINDED OF

A SATURDAY NIGHT LIVE SKIT IN WHICH TWO MEN ARE SITTING AROUND A FIRE CHATTING AND ONE SAYS TO THE OTHER –

“YOU KNOW HOW WHEN YOU STICK A POKER IN THE FIRE AND LEAVE IT IN FOR A LONG TIME, IT GETS REALLY, REALLY HOT?

AND THEN YOU STICK IT IN YOUR EYE, AND IT REALLY, REALLY HURTS?

I HATE IT WHEN THAT HAPPENS! I JUST HATE IT WHEN THAT HAPPENS!”

A POPULAR SONG
THAT SPEAKS TO THE NEED
SO MANY OF US HAVE
TO RECREATE THAT WITH WHICH
WE ARE MOST FAMILIAR
AND THEREFORE MOST COMFORTABLE
IS A ROCK SONG
BY THE LATE WARREN ZEVON (1996)
ENTITLED

“IF YOU WON’T LEAVE ME
I’LL FIND SOMEBODY WHO WILL”

THE REPETITION COMPULSION SPEAKS TO
THE TENDENCY TO RE – ENACT
THE SAME DYSFUNCTIONAL SCENARIOS
AGAIN AND AGAIN
ON THE STAGE OF ONE'S LIFE

SCENARIOS THAT ARE BOTH SELF – INDULGENT AND SELF – DESTRUCTIVE

THIS CONCEPT SPEAKS TO THE HOPE
THAT SPRINGS ETERNAL IN ALL OF US –
THE HOPE THAT PERHAPS, THIS NEXT TIME,
THERE WILL BE A DIFFERENT OUTCOME,
A BETTER RESOLUTION

"RELENTLESS HOPE" (STARK 1994)
THE REFUSAL TO CONFRONT – AND GRIEVE – INTOLERABLY PAINFUL REALITIES
ESPECIALLY WITH RESPECT TO THE OBJECTS OF OUR DESIRE

WE TURN NOW TO CHAOS THEORY TO INFORM OUR UNDERSTANDING OF WHAT FUELS PSYCHIC INERTIA AND THE RESISTANCE TO CHANGE

IN CERTAIN SCIENTIFIC CIRCLES

PEOPLE ARE NOW BEING DESCRIBED AS COMPLEX ADAPTIVE, SELF – ORGANIZING CHAOTIC SYSTEMS

COMPLEX – THE INTRICATE INTERDEPENDENCE OF THE SYSTEM'S COMPONENTS

ADAPTIVE – THE CAPACITY TO LEARN FROM EXPERIENCE BY ADAPTING AND NOT JUST BY DEFENDING

SELF – ORGANIZING – THE SPONTANEOUS EMERGENCE OF SYSTEM – WIDE PATTERNS ARISING FROM THE INTERPLAY OF THE SYSTEM'S COMPONENTS

CHAOTIC – AN UNDERLYING ROBUST ORDEREDNESS THAT WILL EMERGE OVER TIME AS THE SYSTEM EVOLVES DESPITE THE SYSTEM'S APPARENT RANDOMNESS

AS I WILL SOON HOPE TO DEMONSTRATE

IT IS ALSO USEFUL TO CONCEIVE OF

THE THERAPEUTIC PROCESS ITSELF

AS A SELF – ORGANIZING (CHAOTIC) SYSTEM

CHARACTERIZED BY

THE EMERGENCE OF PATTERNS

NAMELY, HEALING CYCLES OF
DISRUPTION FOLLOWED BY REPAIR
AT EVER – HIGHER LEVELS
OF AWARENESS, ACCEPTANCE,
AND ACCOUNTABILITY

AS THE TREATMENT EVOLVES

EXAMPLES OF SELF – ORGANIZING (CHAOTIC) SYSTEMS
WHEREBY ORDER EMERGES FROM CHAOS AS THE SYSTEM EVOLVES

CRYSTALLIZATION – THE SPONTANEOUS EMERGENCE OF BEAUTIFULLY PATTERNED CRYSTALS FROM SOLUTIONS OF RANDOMLY MOVING MOLECULES

THE ASSEMBLAGE OF RIPPLED DUNES FROM GRAINS OF SAND

THE GENERATION OF SWIRLING SPIRAL PATTERNS IN HURRICANES

THE PHENOMENON WHEREBY THOUSANDS OF FIREFLIES GATHERED IN TREES AT NIGHT AND FLASHING ON AND OFF RANDOMLY WILL BEGIN TO FLASH IN UNISON

A DRAMATIC ILLUSTRATION OF THE PHASE – LOCKING OF BIORHYTHMS

THE PHENOMENON WHEREBY FEMALE ROOMMATES WILL BEGIN TO MENSTRUATE ON THE SAME CYCLE

THE PHENOMENON WHEREBY A NUMBER OF GRANDFATHER CLOCKS WITH THEIR PENDULUMS INITIALLY SWINGING RANDOMLY WILL EVENTUALLY ENTRAIN, SUCH THAT ALL THE PENDULUMS WILL BE SWINGING IN PRECISE SYNCHRONY (BENTOV 1988)

NEURAL NETWORKS, FASHION TRENDS, THE STOCK MARKET, TRAFFIC JAMS

CHAOS THEORY CONCEIVES OF

SELF – ORGANIZATION

AS INVOLVING ISLANDS OF

PREDICTABILITY

AMIDST A SEA OF

CHAOTIC UNPREDICTABILITY

NO MATTER HOW DYSFUNCTIONAL THEY MIGHT BE

SELF – ORGANIZING SYSTEMS

FUELED AS THEY ARE BY THEIR HOMEOSTATIC TENDENCY TO REMAIN CONSTANT OVER TIME

RESIST PERTURBATION (KREBS 2013)

HOW IS THIS RELEVANT FOR THE WORK WE DO?

PATIENTS MUST BE SUFFICIENTLY "STRESSED"

BY INPUT FROM THE OUTSIDE

THAT IS, BY OPTIMALLY STRESSFUL INTERVENTIONS THAT ARE ANXIETY – PROVOKING BUT ULTIMATELY GROWTH – PROMOTING

THAT THERE WILL BE IMPETUS

THAT IS, FORCE NEEDED TO BRING ABOUT CHANGE

FOR THE (DYSFUNCTIONAL) STATUS QUO TO BE DESTABILIZED

TO EXPEDITE ADVANCEMENT OF THE PATIENT

FROM IMPAIRED CAPACITY TO MORE ROBUST CAPACITY
FROM COMPROMISED HEALTH TO A STATE OF WELL – BEING

THE THERAPIST MUST
ALTERNATELY AND REPEATEDLY

CHALLENGE THE PATIENT
TO PRECIPITATE DISRUPTION

AND THEN SUPPORT THE PATIENT
TO CREATE OPPORTUNITY FOR REPAIR

ALL WITH AN EYE TO TAPPING INTO

THE PATIENT'S INNATE STRIVING TOWARDS HEALTH

AND INTRINSIC ABILITY TO SELF – CORRECT

IN THE FACE OF OPTIMAL STRESS

THE NET RESULT OF WHICH WILL BE
THE THERAPEUTIC INDUCTION
OVER TIME
OF HEALING CYCLES OF
DISRUPTION AND REPAIR

DESTABILIZATION AND RESTABILIZATION
DEFENSIVE COLLAPSE AND ADAPTIVE RECONSTITUTION

AT EVER – HIGHER LEVELS
OF RESILIENCE AND VITALITY

INDEED
THE PATIENT'S JOURNEY FROM ILLNESS TO WELLNESS
WILL INVOLVE PROGRESSION
THROUGH THESE ITERATIVE CYCLES
AS THE PATIENT EVOLVES
FROM CHAOS AND DYSFUNCTION
TO COHERENCE AND FUNCTIONALITY

**“THE WORLD BREAKS EVERYONE,
AND AFTERWARD,
MANY ARE STRONG
AT THE BROKEN PLACES.”**

(HEMINGWAY 1929)

**“THAT WHICH DOES NOT KILL US
MAKES US STRONGER.”**

(NIETZSCHE 1899)

STRESS IS WHEN
YOU WAKE UP SCREAMING

AND THEN YOU REALIZE
YOU HAVEN'T FALLEN
ASLEEP YET

ANONYMOUS

Module 3

THE GOLDILOCKS PRINCIPLE

AND

CONTROLLED DAMAGE

STRESSFUL STUFF HAPPENS

BUT IT WILL BE HOW WELL THE PATIENT

IS ABLE TO PROCESS, INTEGRATE,

AND ULTIMATELY ADAPT TO ITS IMPACT

PSYCHOLOGICALLY, PHYSIOLOGICALLY, AND ENERGETICALLY

THAT WILL MAKE OF IT EITHER

A GROWTH – DISRUPTING EVENT

THAT OVERWHELMS BECAUSE IT IS "TOO MUCH"

OR

A GROWTH – PROMOTING OPPORTUNITY

THAT TRIGGERS TRANSFORMATION AND RENEWAL

STRESSFUL STUFF HAPPENS ALL THE TIME

BUT IT WILL BE HOW WELL THE PATIENT
IS ULTIMATELY ABLE TO MANAGE ITS IMPACT
THAT WILL MAKE ALL THE DIFFERENCE

IN OTHER WORDS
IT WILL BE HOW WELL THE PATIENT
IS ULTIMATELY ABLE TO COPE
WITH THE IMPACT OF STRESS IN HER LIFE

THAT WILL EITHER
DISRUPT HER GROWTH
BY COMPROMISING HER FUNCTIONALITY

OR TRIGGER HER GROWTH
BY FORCING HER TO EVOLVE
TO A HIGHER LEVEL OF ADAPTIVE CAPACITY

THE GOLDILOCKS PRINCIPLE

THE PATIENT WILL FIND HERSELF REACTING / RESPONDING IN ANY ONE OF THREE WAYS TO THE THERAPIST'S STRESSFUL INPUT

TOO MUCH STRESS / CHALLENGE / ANXIETY WILL BE TOO OVERWHELMING FOR THE PATIENT TO PROCESS AND INTEGRATE,
TRIGGERING INSTEAD DEFENSIVE COLLAPSE AND AT LEAST TEMPORARY DERAILMENT OF THE THERAPEUTIC PROCESS

TRAUMATIC STRESS

TOO LITTLE STRESS / CHALLENGE / ANXIETY WILL PROVIDE TOO LITTLE IMPETUS FOR TRANSFORMATION AND GROWTH
BECAUSE THERE WILL BE NOTHING THAT NEEDS TO BE MASTERED

TOO LITTLE STRESS WILL SERVE SIMPLY TO REINFORCE THE (DYSFUNCTIONAL) STATUS QUO

THE GOLDILOCKS PRINCIPLE AND OPTIMAL STRESS

BUT JUST THE RIGHT AMOUNT OF STRESS / CHALLENGE / ANXIETY

**TO WHICH THE FATHER OF STRESS,
HANS SELYE (1974, 1978), REFERRED AS EUSTRESS
AND TO WHICH I (2008, 2012, 2014, 2015) REFER AS**

"OPTIMAL STRESS"

WILL OFFER JUST THE RIGHT COMBINATION OF CHALLENGE AND SUPPORT NEEDED TO OPTIMIZE THE POTENTIAL FOR TRANSFORMATION AND GROWTH

**LIKE THE THREE BOWLS OF PORRIDGE SAMPLED BY GOLDILOCKS,
SO TOO THE DOSE OF STRESS PROVIDED BY THE THERAPIST
WILL BE EITHER TOO MUCH, TOO LITTLE, OR JUST RIGHT**

OUR FOCUS HERE WILL BE

THE THERAPEUTIC USE

OF OPTIMAL STRESS

TO PROVOKE RECOVERY

BY ACTIVATING

THE LIVING SYSTEM'S

INNATE ABILITY

TO HEAL ITSELF

PARENTHETICALLY

OPTIMAL STRESS CAN ALSO BE USED TO FINE – TUNE THE FUNCTIONALITY OF AN ALREADY WELL – FUNCTIONING SYSTEM AND TO SLOW THE PROGRESSION OF AGE – RELATED DECLINE IN FUNCTIONALITY

INDEED

OPTIMAL CHALLENGE OF THE BRAIN WILL SERVE TO SHARPEN MENTAL ACUITY, TO DECELERATE COGNITIVE DECLINE, AND TO COMBAT THE EFFECTS OF AGING ON THE BRAIN

JUST AS ATHLETES CAN IMPROVE THEIR PHYSICAL FITNESS BY OPTIMALLY CHALLENGING THEIR BODIES WITH PHYSICAL EXERCISE
FOR EXAMPLE, HIGH – INTENSITY INTERVAL TRAINING (HIIT)

SO TOO ALL OF US CAN IMPROVE OUR BRAIN FITNESS BY OPTIMALLY CHALLENGING OUR MINDS WITH BRAIN TEASERS
FOR EXAMPLE, MATHEMATICAL PUZZLES, WORD GAMES, CROSSWORD PUZZLES, LOGIC PROBLEMS, AND MEMORY CHALLENGES

ANY MENTAL EXERCISE REQUIRING DELIBERATE AND CONCENTRATED EFFORT
FOR EXAMPLE, ACTIVE REPETITION, FOCUSED ATTENTION, LEARNING A NEW SKILL OR A NEW LANGUAGE, REFLECTION, OR MEDITATION

WILL PROMOTE MENTAL AGILITY AND DELAY THE DECLINE IN MENTAL CAPACITY AS WE AGE

IN ADDITION TO PUZZLES AND GAMES, OUR BRAINS WILL BE STIMULATED WHEN WE ARE EXPOSED TO SITUATIONS THAT ARE NEW, UNUSUAL, DIFFERENT, NOVEL, OR UNEXPECTED

WHEN OUR DAILY ROUTINES ARE DISRUPTED

OR WHEN WE COMBINE TWO SENSES
LIKE LISTENING TO MUSIC AND SMELLING FLOWERS
OR WATCHING A SUNSET AND TAPPING OUR FINGERS

EXERCISING MORE THAN ONE SENSE AT A TIME IS A FORM OF CROSS – TRAINING FOR THE BRAIN
BECAUSE IT TAPS INTO THE BRAIN'S INHERENT TENDENCY TO FORM ASSOCIATIONS BETWEEN DIFFERENT TYPES OF INFORMATION

WHEREAS ROUTINE ACTIVITY CAN DEADEN THE BRAIN
FOR EXAMPLE, DOING THE SAME THING DAY IN AND DAY OUT

SPICING THINGS UP BY INTRODUCING VARIETY INTO ONE'S DAILY ROUTINES CAN PROVIDE THE OPTIMALLY STRESSFUL CHALLENGE NEEDED TO ACTIVATE UNDERUSED NEURAL PATHWAYS AND CONNECTIONS, THEREBY MAKING THE BRAIN MORE FIT AND FLEXIBLE

IN ESSENCE

OPTIMAL CHALLENGE OF THE MIND PROMOTES NEUROPLASTICITY

THE BRAIN'S AMAZING ABILITY TO ADAPT BY REORGANIZING, REPAIRING, AND RESTRUCTURING ITSELF

IN SUM

THE THERAPEUTIC VALUE OF CONTROLLED DAMAGE

WHETHER PHYSICAL OR MENTAL

AN APPROACH SPECIFICALLY GEARED TOWARDS
MOBILIZING THE BODY'S INTRINSIC ABILITY TO RENEW ITSELF

A CONDITION MIGHT NOT HEAL
UNTIL IT IS MADE ACUTE

THUS THE BENEFIT OF SUPERIMPOSING
AN ACUTE INJURY ON TOP OF A CHRONIC ONE

MILD AGGRAVATIONS CAN STIMULATE
THE HEALING CASCADE

MODERATE AMOUNTS OF STRESS CAN PROVOKE
MODEST OVERCOMPENSATION

INTERMITTENT EXPOSURES CAN PROMPT
ADAPTATION

OPTIMAL STRESSORS

DEPRIVING ONESELF OF HALF A NIGHT'S SLEEP ONCE A WEEK
PREFERABLY THE SECOND HALF OF THE NIGHT (FOR EXAMPLE, 3 – 7 AM)
CAN PRODUCE A RAPID, EVEN IF SHORT – LIVED,
RESTABILIZATION OF MOOD
AND RECOVERY FROM DEPRESSION

THE "STRESS" OF INTERRUPTING NORMAL SLEEP PATTERNS
MAY "RESYNCHRONIZE DISTURBED CIRCADIAN RHYTHMS"
(LEIBENLUFT & WEHR 1992)

INTERMITTENT FASTING
FOR EXAMPLE, A 36 – HOUR WATER FAST ONCE A WEEK
FROM AFTER DINNER, SAY, ON MONDAY TO BEFORE BREAKFAST ON WEDNESDAY
CAN SO SIGNIFICANTLY REDUCE THE TOTAL BODY BURDEN
THAT MENTAL CLARITY AND FOCUS
CAN BE IMPROVED DRAMATICALLY
AND A SENSE OF OVERALL WELL – BEING RESTORED

IT IS ALSO ASSOCIATED WITH HIGHER LEVELS OF
BRAIN – DERIVED NEUROTROPHIC FACTOR (BDNF)
A PROTEIN THAT PREVENTS STRESSED NEURONS FROM DYING
(MATTSON 2015)

OPTIMAL STRESSORS (CONTINUED)

MODERATE AEROBIC EXERCISE

A TEAM OF RESEARCHERS AT DUKE UNIVERSITY MEDICAL CENTER DEMONSTRATED THAT AEROBIC EXERCISE IS AT LEAST AS EFFECTIVE AS MEDICATION IN TREATING MAJOR DEPRESSION

IT ALSO IMPROVES COGNITIVE ABILITY, PARTICULARLY IN THE FRONTAL AND PREFRONTAL REGIONS OF THE BRAIN

THEY DISCOVERED THAT IF YOU DO 40 MINUTES OF AEROBIC EXERCISE DURING THE DAY, THEN YOU WILL NEED 40 MINUTES LESS OF SLEEP THAT NEXT NIGHT (BLUMENTHAL et al. 1999)

EVERY – OTHER – DAY WORKOUTS ARE PARTICULARLY EFFECTIVE

WORKOUTS CREATE MICROTEARS THAT THE BODY CAN THEN REPAIR ON THOSE DAYS WHEN THE BODY IS AT REST

MOST EFFECTIVE IS HIGH – INTENSITY INTERVAL TRAINING

AN EXERCISE STRATEGY THAT ALTERNATES PERIODS OF SHORT INTENSE ANAEROBIC EXERCISE WITH LESS INTENSE RECOVERY PERIODS

THE CYCLES OF FIRST CHALLENGE (WITH ANAEROBIC ACTIVITY) AND THEN SUPPORT (WITH AEROBIC ACTIVITY) ARE THOUGHT TO FINE – TUNE THE MindBodyMatrix AND OPTIMIZE ITS FUNCTIONALITY

OPTIMAL STRESSORS (CONTINUED)

"PIN FIRING" PARTIALLY HEALED TENDONS IN INJURED RACEHORSES TO ACCELERATE HEALING

INSERTION OF SMALL, RED – HOT PROBES INTO, SAY, AN 80% HEALED TENDON IN ORDER TO CAUSE AGGRAVATIONS THAT WILL THEN TRIGGER THE HORSE'S SELF – HEALING MECHANISMS

IN OTHER WORDS, BY SUPERIMPOSING AN ACUTE INJURY ON TOP OF A CHRONIC ONE, PIN FIRING CONVERTS A CHRONIC INFLAMMATORY PROCESS INTO AN ACUTE ONE

SINCE 2006 IT HAS BEEN APPROVED FOR VETERINARIANS AS AN ACCEPTABLE FORM OF THERAPY IN CASES REFRACTORY TO CONVENTIONAL TREATMENT

ACUPUNCTURE

A KEY COMPONENT OF TRADITIONAL CHINESE MEDICINE

INSERTION OF THIN NEEDLES INTO SPECIFIC POINTS ON THE BODY IN ORDER TO RESTORE THE FLOW OF ENERGY AND RELIEVE PAIN

BY SIMULATING AN INJURY WITHOUT ACTUALLY DAMAGING THE TISSUE, THE MILD STIMULUS IS THOUGHT TO TUNE UP THE REPAIR CHANNELS

FRAXEL LASER TREATMENTS

TO STIMULATE REGENERATION OF FACIAL COLLAGEN

DERMABRASION

INFLICT CONTROLLED DAMAGE TO PRODUCE YOUNGER, SMOOTHER, SOFTER, HEALTHIER SKIN

OPTIMAL STRESSORS (CONTINUED)

HOMEOPATHIC REMEDIES

TO ACTIVATE THE BODY'S ABILITY TO HEAL ITSELF

LIKE CURES LIKE – THE LAW OF SIMILARS

(HAHNEMANN 2008)

TREATMENT OF A RATTLESNAKE BITE WITH A DILUTED SOLUTION OF SNAKE VENOM
OR HIGH FEVERS AND THROBBING HEADACHES WITH A DILUTED SOLUTION OF BELLADONNA

ALLOPATHY – THE MAINSTREAM METHOD OF TREATING DISEASES
WITH SUBSTANCES THAT PRODUCE EFFECTS
OPPOSITE TO THOSE PRODUCED BY THE DISEASE

ANTIPYRETICS TO TREAT FEVERS / ANTI – INFLAMMATORIES TO REDUCE INFLAMMATION
ANTITUSSIVES TO SUPPRESS COUGHS / ANTIEMETICS FOR NAUSEA AND VOMITING

HOMEOPATHY – AN ALTERNATIVE METHOD OF TREATING DISEASES
WITH SUBSTANCES THAT PRODUCE EFFECTS
SIMILAR TO THOSE PRODUCED BY THE DISEASE
BUT IN DOSES SO SMALL THAT THE BODY'S
NATURAL HEALING PROCESSES WILL BE ACTIVATED

THE KEY TO THE EFFECTIVENESS OF A "DYNAMIZED" HOMEOPATHIC REMEDY –
THE ADMINISTRATION OF MINUTE DOSES OF A POTENTIZED SUBSTANCE,
WHICH MEANS THAT THE SUBSTANCE HAS BEEN SERIALLY DILUTED
AND SUCCUSSED IN ORDER TO RELEASE ITS FULL ENERGETIC POTENTIAL

THE SOLUTION CONTAINS A MEMORY (ENERGETIC SIGNATURE) OF THE SUBSTANCE,
WHICH THEN PROMPTS THE BODY TO MOBILIZE ITS DEFENSES / RESOURCES

OPTIMAL STRESSORS (CONTINUED)

VACCINATION / IMMUNOTHERAPY

ADMINISTERING EITHER A SINGLE RELATIVELY SMALL DOSE OF ALLERGEN
OR A SERIES OF VERY SMALL DOSES OVER A PERIOD OF TIME
WILL STIMULATE THE BODY'S IMMUNE SYSTEM
AND PROMOTE THE BODY'S RESISTANCE TO SUBSEQUENT EXPOSURES

THE VARIOUS FORMS OF IMMUNOTHERAPY (INCLUDING VACCINATIONS)
PREPARE THE BODY FOR FUTURE CHALLENGES
BY INDUCING TOLERANCE (aka ACQUIRED TOLERANCE OR ADAPTIVE IMMUNITY)

AND INCLUDE SUCH IMMUNE – STRENGTHENING TECHNIQUES AS

PROVOCATION – NEUTRALIZATION TESTING
ENZYME POTENTIATED DESENSITIZATION (EPD)
LOW – DOSE ANTIGEN THERAPY (LDA)
NAMBUDRIPAD'S ALLERGY ELIMINATION TECHNIQUE (NAET)

THE THEORY BEHIND SUCH TREATMENTS IS THAT
SINGLE OR INTERMITTENT EXPOSURES TO DOSES
THAT DO NOT OVERWHELM THE BODY
WILL INSTEAD PROMPT THE BODY TO ADAPT,
THEREBY PROMOTING RESISTANCE TO SUBSEQUENT EXPOSURES

CLASSICAL (PAVLOVIAN) CONDITIONING

IS A LEARNING PROCESS WHEREBY

A NEUTRAL STIMULUS (FOR EXAMPLE, THE SOUND OF A BELL)

WILL OVER TIME BECOME ASSOCIATED

WITH A POTENT STIMULUS (FOR EXAMPLE, THE SMELL OF MEAT)

THAT TRIGGERS AN INNATE REFLEX (FOR EXAMPLE, SALIVATION)

THIS ASSOCIATIVE LINK IS ACHIEVED

BY WAY OF REPEATED PAIRINGS

OF THE NEUTRAL STIMULUS WITH THE POTENT STIMULUS,

SUCH THAT THE PREVIOUSLY NEUTRAL STIMULUS

WILL ITSELF EVENTUALLY ELICIT THE INNATE REFLEX

OR RESPONDENT BEHAVIOR

SYSTEMATIC DESENSITIZATION

ALSO KNOWN AS GRADUATED EXPOSURE THERAPY

IS A FORM OF COUNTERCONDITIONING

DEVELOPED BY JOSEPH WOLPE,
IT IS A BEHAVIORAL TECHNIQUE BASED ON THE PRINCIPLE OF CLASSICAL CONDITIONING AND USED TO TREAT FEARS, PHOBIAS, AND OTHER ANXIETY DISORDERS

THE PATIENT IS TAUGHT TO ENGAGE IN SOME TYPE OF RELAXATION EXERCISE (FOR EXAMPLE, BREATH WORK) AND IS GRADUALLY EXPOSED (IN EVER – INCREASING DOSES) TO AN ANXIETY – PROVOKING STIMULUS (FOR EXAMPLE, FEAR OF HEIGHTS)

THE PATIENT WORKS HER WAY UP THE ANXIETY HIERARCHY,
FROM THE LEAST STRESSFUL TO THE MOST STRESSFUL
WHILE PRACTICING HER RELAXATION TECHNIQUE

THE GOAL OF THIS OPTIMALLY STRESSFUL PROCESS IS TO BECOME GRADUALLY DESENSITIZED TO THE TRIGGER THAT IS CAUSING THE DISTRESS

Module 4

THE SANDPILE MODEL

AND

THE PARADOXICAL IMPACT OF STRESS

THE NOTED 16TH CENTURY SWISS PHYSICIAN PARACELSUS (2004)
IS CREDITED WITH HAVING WRITTEN THAT

THE DIFFERENCE BETWEEN A POISON
AND A MEDICATION IS THE DOSAGE THEREOF

ONE MIGHT ADD, HOWEVER, THAT IT IS THE SYSTEM'S CAPACITY TO PROCESS, INTEGRATE, AND ULTIMATELY ADAPT TO THE IMPACT OF THE STRESSOR THAT WILL ULTIMATELY MAKE THE DIFFERENCE

SO A POISON IS NOT ALWAYS TOXIC,
AND NOR IS A MEDICINE ALWAYS THERAPEUTIC

FOR EXAMPLE, IF A DEPRESSED PATIENT IS RESPONDING TO 20 MG OF FLUOXETINE, BUT ONLY SUBOPTIMALLY, PERHAPS 10 MG WILL BE THE "MORE" OPTIMAL DOSE AND NOT EVER – HIGHER DOSES OF THIS SELECTIVE SEROTONIN REUPTAKE INHIBITOR

AND WHEREAS MILD TO MODERATE EXERCISE WILL USUALLY ENERGIZE THE BODY, EXCESSIVE OR PROLONGED EXERCISE MAY ULTIMATELY DEPLETE THE BODY OF ITS ADAPTATION RESERVES

THEREFORE STRESSFUL INPUT
IS INHERENTLY NEITHER BAD (POISON)
NOR GOOD (MEDICATION)

RATHER, THE DOSAGE OF THE STRESSOR,
THE UNDERLYING RESILIENCE OF THE SYSTEM,
AND THE INTERFACE BETWEEN STRESSOR
AND SYSTEM WILL DETERMINE IF THE
PATIENT DEFENDS AND DEVOLVES
TO EVER – GREATER DISORGANIZATION
OR ADAPTS AND EVOLVES
BY WAY OF A SERIES OF HEALING CYCLES
TO EVER MORE COMPLEX LEVELS OF
ORGANIZATION AND DYNAMIC BALANCE

IN OTHER WORDS

IF THE INTERFACE BETWEEN STRESSOR AND SYSTEM IS SUCH THAT THE STRESSOR IS ABLE TO PROVOKE RECOVERY WITHIN THE SYSTEM, THEN

WHAT WOULD HAVE BEEN THOUGHT TO BE A POISON WILL BECOME MEDICATION

WHAT WOULD HAVE CONSTITUTED TOXIC INPUT WILL BECOME THERAPEUTIC INPUT

WHAT WOULD HAVE OVERWHELMED WILL BECOME TRANSFORMATIVE

WHAT WOULD HAVE BEEN DEEMED TRAUMATIC STRESS WILL BECOME OPTIMAL STRESS

HISTORICALLY

THE TOXICOLOGICAL LITERATURE HAS EMBRACED
A LINEAR "NO – THRESHOLD" DOSE – RESPONSE MODEL
WHEREBY TOXINS ARE THOUGHT TO BE "TOXIC"
AT WHATEVER THEIR DOSE

BUT THE CONCEPT OF HORMESIS
LONG MARGINALIZED IN THE TOXICOLOGICAL LITERATURE
IS NOW SLOWLY GAINING ACCEPTANCE
THROUGH THE EXTRAORDINARY RESEARCH EFFORTS OF
THE AVANT – GARDE TOXICOLOGIST EDWARD CALABRESE (2008)

WHEREBY AN AGENT (A STRESSOR) GENERALLY THOUGHT
TO BE TOXIC OR INHIBITORY
AT A HIGH DOSE
WILL OFTEN BE THERAPEUTIC OR STIMULATORY
AT A LOWER DOSE

CALABRESE HYPOTHESIZES THAT THIS EXCITATORY RESPONSE
IS A MANIFESTATION OF THE SYSTEM'S ADAPTIVE RESPONSE
TO LOW – LEVEL STRESS

MORE SPECIFICALLY

LOW – LEVEL STRESS IS THOUGHT TO PROVOKE
A SYSTEM'S "MODEST OVERCOMPENSATION"
IN THE FACE OF THREATENED DISRUPTION
TO ITS HOMEOSTASIS

CALABRESE HYPOTHESIZES THAT HORMESIS
IS AN ALMOST UNIVERSAL BIOLOGICAL PHENOMENON

IN SUM

IN CONTRADISTINCTION TO A LINEAR NO – THRESHOLD DOSE – RESPONSE CURVE
A HORMETIC DOSE – RESPONSE CURVE WILL BE "BIPHASIC"

THAT IS, WHEREAS HIGH DOSES WILL INHIBIT
AND THEREFORE BE HARMFUL
LOW DOSES WILL STIMULATE
AND THEREFORE BE BENEFICIAL

HIGH – DOSE STRESS "BAD" / LOW – DOSE STRESS "GOOD"
HIGH – DOSE STRESS "TOXIC" / LOW – DOSE STRESS "THERAPEUTIC"

HIGH – DOSE STRESS "TRAUMATIC" / LOW – DOSE STRESS "OPTIMAL"

SHIFTING NOW FROM THE REALM OF THE ANIMATE TO THE REALM OF THE INANIMATE

THE SANDPILE MODEL AND THE PARADOXICAL IMPACT OF STRESS

LONG INTRIGUING TO CHAOS THEORISTS HAS BEEN THE SANDPILE MODEL (BAK 1996)

WHICH IS A PRIME EXAMPLE OF AN
OPEN, COMPLEX ADAPTIVE, SELF – ORGANIZING (CHAOTIC) SYSTEM

THIS SIMULATION MODEL IS USED TO DEMONSTRATE THE CUMULATIVE IMPACT

OVER TIME

OF ENVIRONMENTAL STRESSORS ON OPEN (CHAOTIC) SYSTEMS

EVOLUTION OF THE SANDPILE IS GOVERNED
BY SOME COMPLEX MATHEMATICAL FORMULAS
AND IS WELL KNOWN IN MANY SCIENTIFIC CIRCLES …

… BUT THE MODEL IS RARELY APPLIED TO LIVING SYSTEMS AND IS NEVER USED TO DEMONSTRATE EITHER THE REGULATORY CAPACITY OF THE LIVING SYSTEM OR THE PARADOXICAL IMPACT OF STRESS ON IT

I BELIEVE, HOWEVER, THAT THE SANDPILE MODEL PROVIDES AN ELEGANT VISUAL METAPHOR FOR HOW THE LIVING SYSTEM IS CONTINUOUSLY REFASHIONING ITSELF AT EVER – HIGHER LEVELS OF COMPLEXITY AND INTEGRATION

NOT JUST "IN SPITE OF" STRESSFUL INPUT FROM THE OUTSIDE BUT "BY WAY OF" THAT INPUT

THE SANDPILE MODEL
AND THE PARADOXICAL IMPACT OF STRESS

AMAZINGLY ENOUGH, THE GRAINS OF SAND BEING STEADILY ADDED TO THE GRADUALLY EVOLVING SANDPILE ARE THE OCCASION FOR BOTH ITS DISRUPTION AND ITS REPAIR

NOT ONLY DO THE GRAINS OF SAND BEING ADDED PRECIPITATE PARTIAL COLLAPSE OF THE SANDPILE BUT ALSO THEY BECOME THE MEANS BY WHICH THE SANDPILE WILL BE ABLE TO BUILD ITSELF BACK UP – EACH TIME AT A NEW LEVEL OF HOMEOSTASIS

THE SYSTEM WILL THEREFORE HAVE BEEN ABLE NOT ONLY TO MANAGE THE IMPACT OF THE STRESSFUL INPUT BUT ALSO TO BENEFIT FROM THAT IMPACT

THE SANDPILE MODEL
AND THE PARADOXICAL IMPACT OF STRESS

AS THE SANDPILE EVOLVES

AN UNDERLYING PATTERN WILL BEGIN TO EMERGE

CHARACTERIZED BY RECURSIVE CYCLES

OF FIRST DESTABILIZATION
A DEFENSIVE REACTION TO THE STRESSFUL IMPACT OF THE GRAINS OF SAND

AND THEN RESTABILIZATION

AT EVER – HIGHER LEVELS OF

COMPLEX ORGANIZATION AND DYNAMIC BALANCE
AN ADAPTIVE RESPONSE TO THAT IMPACT

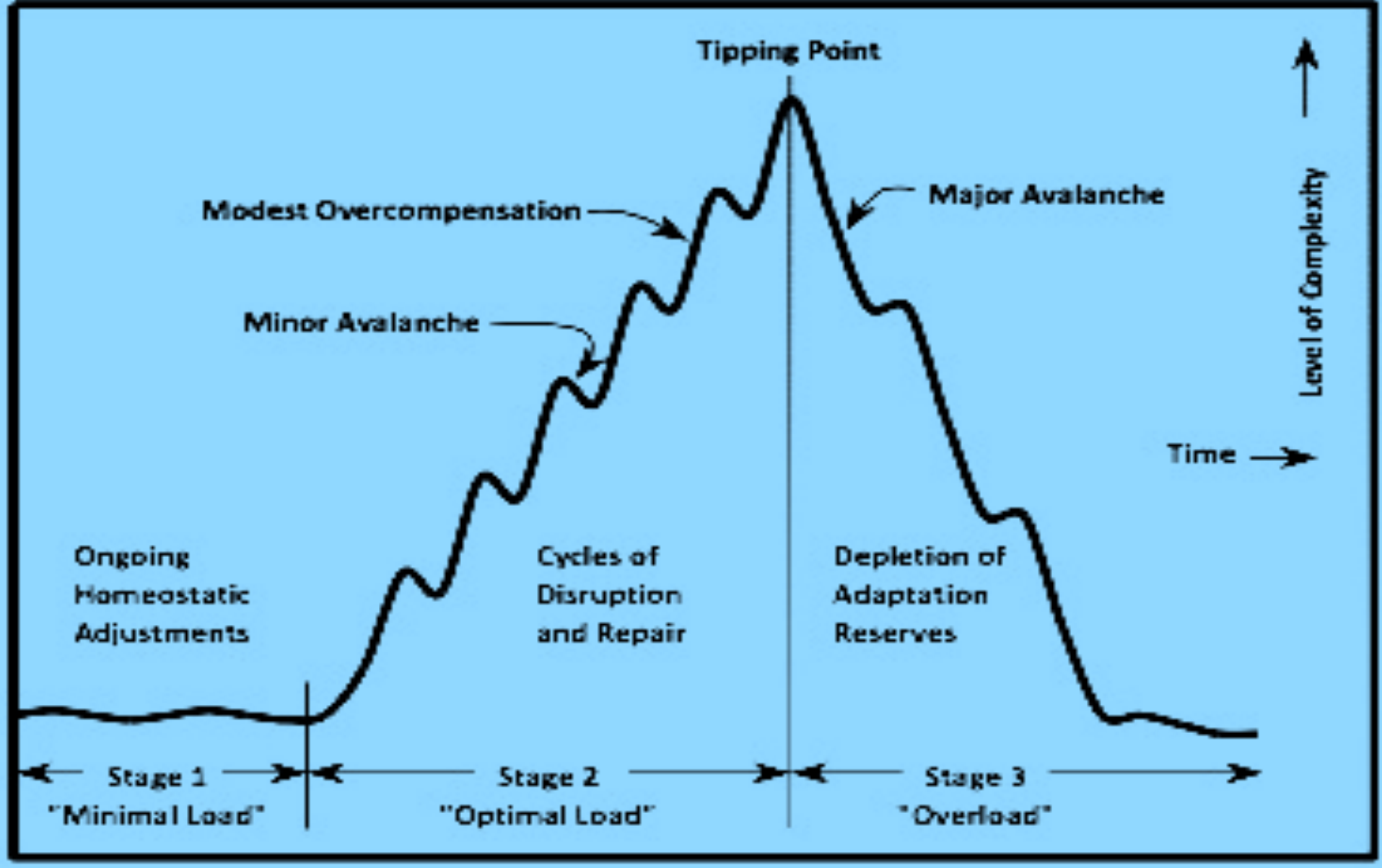
I HAVE CREATED A GRAPH THAT DEPICTS
THREE STAGES IN THE EVOLUTION OF A SANDPILE OVER TIME

STAGE 1 (MINIMAL LOAD)
IN RESPONSE TO "MINIMALLY STRESSFUL" INPUT
ONGOING HOMEOSTATIC ADJUSTMENTS

STAGE 2 (OPTIMAL LOAD)
IN RESPONSE TO "OPTIMALLY STRESSFUL" INPUT
ITERATIVE CYCLES OF DISRUPTION (MINOR AVALANCHE)
FOLLOWED BY REPAIR (MODEST OVERCOMPENSATION)

STAGE 3 (OVERLOAD)
ONCE THE SYSTEM'S ADAPTATION (NUTRIENT AND ENERGETIC)
RESERVES HAVE BECOME DEPLETED,
A TIPPING POINT WILL BE REACHED AND
AS A REACTION TO ANY ADDITIONAL,
NOW "TRAUMATICALLY STRESSFUL" INPUT
THERE WILL BE TOTAL COLLAPSE
OF THE SYSTEM (MAJOR AVALANCHE)

(STARK 2015)



Nonlinear Evolution of the Sandpile Over Time

THE HEALTH OF A SYSTEM

IS THEREFORE A STORY

ABOUT ITS CAPACITY TO ADAPT

THAT IS, ITS ABILITY TO SELF – REGULATE

AND TO RESTORE

ITS HOMEOSTATIC BALANCE

IN THE FACE OF CHALLENGE

CONTINUOUS ADJUSTMENT TO INSTABILITY

IMPLICIT IN THIS CONCEPTUALIZATION OF SELF – REGULATION
IS THE COMPELLING IDEA THAT A LIVING SYSTEM
WILL BE ABLE TO PRESERVE ITS STABILITY
ONLY BY WAY OF CONTINUOUS ADJUSTMENT TO INSTABILITY

"THE ABILITY TO SURVIVE CHANGE BY CHANGING" (MEADOWS 1997)

IN 1965, TWO OBSTETRICIANS MADE AN INTRIGUING DISCOVERY
ABOUT THE PARADOXICAL RELATIONSHIP BETWEEN
REGULARITY OF FETAL HEART RATE AND FETAL MORTALITY

THEY FOUND THAT THE MORE METRONOME – LIKE THE HEARTBEAT,
THE LESS LIKELY THE FETUS WOULD BE TO SURVIVE

WHEREAS THE GREATER THE HEART RATE VARIABILITY,
THAT IS, THE MORE VARIABLE THE HEART'S BEAT – TO – BEAT INTERVALS,
THE MORE LIKELY THE FETUS WOULD BE TO THRIVE (HON 1965)

RESILIENCE SPEAKS TO THIS ABILITY
CONTINUOUSLY TO ADJUST TO ONGOING ENVIRONMENTAL
PERTURBATION AND ADAPTIVELY TO REORGANIZE
AT EVER – NEWER HOMEOSTATIC SET POINTS

IN SUM

HEALTH SPEAKS TO

THE CAPACITY CONTINUOUSLY

TO ADJUST TO ONGOING

ENVIRONMENTAL PERTURBATION

THAT IS, TO THE STRESS OF THOSE GRAINS OF SAND

AND ADAPTIVELY TO

RECONSTITUTE AT

EVER – NEWER HOMEOSTATIC

SET POINTS

Module 5

THE WEB OF LIFE

AND

RESILIENCE

WHETHER DESCRIBED AS

THE EXTRACELLULAR MATRIX (REA & PATEL 2010)

THE GROUND REGULATION SYSTEM
(PISCHINGER & HEINE 2007)

THE CONNECTIVE TISSUE MATRIX

THE WEB OF LIFE (CAPRA 1997)

THE LIVING MATRIX (OSCHMAN 2000)

THE DIVINE MATRIX (BRADEN 2008)

OR THE MindBodyMatrix (STARK 2008)

THE LIVING SYSTEM IS

A NETWORK OF RELATIONSHIPS

AN INTRICATE WEB OF INTERDEPENDENT LIVING TISSUE
THAT EXTENDS FROM THE SURFACE OF THE BODY
TO ITS INNERMOST RECESSES
ULTIMATELY PENETRATING EVERY SINGLE CELL IN THE BODY

THE GROUND REGULATION SYSTEM

ALBERT SZENT – GYORGYI, HARTMUT HEINE,
ALFRED PISCHINGER, ROBERT BECKER,
FRITZ – ALBERT POPP, AND JAMES OSCHMAN

ARE ALL RESEARCH SCIENTISTS DEDICATED TO UNDERSTANDING
ON BOTH MOLECULAR AND SUBMOLECULAR LEVELS
THE COMPLEX WORKINGS OF THE HIGH – SPEED, BODY – WIDE
INFORMATION AND ENERGY DISSEMINATION SYSTEM
RESPONSIBLE FOR THE MAINTENANCE OF HOMEOSTASIS

A VAST NETWORK OF INTERLOCKING COMPONENTS,
REGULATORY PROCESSES, AND NEGATIVE / POSITIVE FEEDBACK LOOPS
THROUGH WHICH THE FLOW OF LIFE TAKES PLACE

THIS LIVING MATRIX CONSTITUTES A BODY CONSCIOUSNESS
WORKING IN TANDEM WITH THE BRAIN CONSCIOUSNESS
OF THE NERVOUS SYSTEM

MORE SPECIFICALLY

THIS WEB OF LIFE

IS A CONTINUOUS MESHWORK OF CONNECTIVE TISSUE FIBERS

MADE UP OF STRUCTURAL GLYCOPROTEINS (COLLAGEN AND ELASTIN)
AND CROSS – LINKING GLYCOPROTEINS (FIBRONECTIN AND LAMININ)

DISPERSED THROUGHOUT AN AMORPHOUS GROUND SUBSTANCE

A COLLOIDAL GEL CONSISTING PRIMARILY OF
LARGE SUGAR – PROTEIN (PG / GAG) MACROMOLECULES,
EACH CONTAINING A (POSITIVELY CHARGED) CORE PROTEIN BACKBONE
TO WHICH (NEGATIVELY CHARGED) HIGHLY POLYMERIZED
GLYCAN SIDE CHAINS ARE ATTACHED
LIKE THE BRISTLES ON A BRUSH

THESE SIDE CHAINS ARE TIGHTLY BOUND TO POLARIZED WATER MOLECULES

IN THE LANGUAGE OF SOLID – STATE PHYSICS

THIS GROUND REGULATION SYSTEM IS A LIQUID CRYSTAL

MORE SPECIFICALLY
BECAUSE THE LIVING MATRIX IS
A HIGHLY ORDERED ARRAY OF MOLECULES
CLOSELY PACKED AND TIGHTLY ORGANIZED
IN A CRYSTAL – LIKE LATTICE STRUCTURE,

IT HAS THE SEMICONDUCTING PROPERTIES OF A CRYSTAL

AND, AS SUCH, ALLOWS FOR THE
NEAR – INSTANTANEOUS FLOW OF
REGULATORY INFORMATION AND VIBRATORY ENERGY
THROUGHOUT THE ENTIRE FABRIC OF THE BODY

THIS CRYSTALLINITY ENABLES
THE LIVING MATRIX

WITH ITS STRUCTURAL AND CROSS – LINKING GLYCOPROTEINS,
ITS LONG – CHAIN, SUGAR – PROTEIN COMPLEXES,
AND ITS TIGHTLY BOUND LAYERS OF POLARIZED WATER

TO CONDUCT BIOPHOTONS

(UNITS OF INFORMATION AND ENERGY)

AT ABOUT THE SPEED OF LIGHT

TRANSMITTING BOTH

INFORMATION

(LIKE THE WIRE TO A LAND – LINE TELEPHONE)

AND ENERGY

(LIKE THE WIRE TO A TOASTER)

AN ASTOUNDINGLY COMPLEX GLOBAL COMMUNICATION SYSTEM

THE DIRECT CURRENTS GENERATED IN THE MATRIX ARE NOT A RESULT OF THE RELATIVELY SLOW MOVEMENT OF CUMBERSOME IONS (SODIUM AND POTASSIUM) ACROSS THE MEMBRANE OF A NERVE CELL

THAT BECOMES FIRST DEPOLARIZED AND THEN REPOLARIZED AS AN ELECTRIC IMPULSE IS CONDUCTED DOWN THE LENGTH OF THE AXON AT SPEEDS RANGING FROM 1.5 TO 400 FEET PER SECOND

RATHER, THE SPEED OF PROPAGATION OF A DIRECT CURRENT THROUGH THE LIVING MATRIX IS CLOSER TO THE SPEED OF LIGHT – 186,000 MILES PER SECOND

"THE DIRECT CURRENTS MAKING UP THE BODY FIELD ARE NOT DUE TO CHARGED IONS BUT INSTEAD DEPEND ON A MODE OF SEMICONDUCTION CHARACTERISTIC OF SOLID – STATE SYSTEMS."

(BECKER 1998)

WHETHER THE UNITS OF INFORMATION AND ENERGY ARE DESCRIBED AS

ELECTRONS, BIOPHOTONS, LIFE PARTICLES,
EXCITATIONS OF A QUANTUM FIELD, OR ENERGY QUANTA

WHETHER THE FLOW IS OF

DISCONTINUOUS PARTICLES OR CONTINUOUS WAVES

THE WAVE – PARTICLE DUALITY OF QUANTUM PHYSICS

WHETHER THE TRANSPORT SYSTEM INVOLVES

COLLAGEN FIBRILS OUTSIDE THE CELLS,
MICROTUBULES INSIDE THE CELLS,
OR SUGAR – PROTEIN MACROMOLECULES
IN THE INTERSTITIAL GROUND SUBSTANCE

WHETHER THE PROPAGATION IS BY WAY OF

LAYERS OF ELECTRICALLY CHARGED WATER,
THE PERINEURAL DC SYSTEM,
ACUPUNCTURE MERIDIANS, OR ENERGY CHANNELS

AND WHETHER THE SPEED OF TRANSMISSION IS

THE SPEED OF SEMICONDUCTIVITY, THE SPEED OF LIGHT,
OR SIMPLY INSTANTANEOUS …

THE TEAM OF INTERDISCIPLINARY RESEARCH SCIENTISTS

WHO HAVE DEVOTED THEIR CAREERS

TO THE STUDY OF THESE ESOTERIC CONCEPTS

WHATEVER THEIR SPECIFIC FIELD OF STUDY
AND WHATEVER THEIR LEXICON

SHARE A COMMON DREAM

NAMELY

TO UNRAVEL THE SECRET OF LIFE

BY STUDYING THE INNER WORKINGS

ON THE MOST ELEMENTAL LEVEL

OF THE LIVING SYSTEM

THE TAKE – HOME HERE

THE HALLMARK OF A HEALTHY SYSTEM

IS ITS CAPACITY TO COPE WITH STRESS

WHICH WILL IN TURN BE A STORY ABOUT
ITS ABILITY TO PROCESS
AND INTEGRATE THE IMPACT OF
ENVIRONMENTAL PERTURBATION

WHICH WILL IN TURN BE A REFLECTION OF
THE UNDERLYING ORDEREDNESS OF THE SYSTEM
AND THE RESULTANT EASE WITH WHICH
INFORMATION AND ENERGY CAN BE
TRANSMITTED THROUGHOUT ITS EXPANSE

“LACK OF ORDER”

MANIFESTING AS

PSYCHIATRIC / MEDICAL “DIS – ORDER”

AND

“DISRUPTED EASE OF FLOW”

MANIFESTING AS

PSYCHIATRIC / MEDICAL “DIS – EASE”

TO REVERSE THE DYSFUNCTION CAUSED BY THE CUMULATIVE IMPACT OF ENVIRONMENTAL TOXICITIES AND DEFICIENCIES

THE ORDEREDNESS AND FLUIDITY OF THE SYSTEM'S INFRASTRUCTURE MUST BE RESTORED WITH TARGETED THERAPIES

THAT "LIGHTEN THE LOAD" TO CORRECT FOR TOXICITIES

AND "REPLENISH THE RESERVES" TO CORRECT FOR DEFICIENCIES

ALL WITH AN EYE TO "FACILITATING THE FLOW" OF INFORMATION AND ENERGY THROUGHOUT THE SYSTEM

THEREBY REVITALIZING ITS RESILIENCE AND CAPACITY TO COPE WITH THE STRESS OF LIFE

(STARK 2012, 2014, 2015)

AT THE END OF THE DAY

THE GOAL OF ANY HOLISTIC TREATMENT

BE ITS FOCUS PSYCHOLOGICAL OR PHYSICAL

MUST THEREFORE BE TO RESTORE

THE INTRINSIC ORDEREDNESS

AND FLUIDITY OF THE MindBodyMatrix

SO THAT STRESSFUL CHALLENGES

CAN BE MORE EFFECTIVELY MASTERED

Module 6

A HOLISTIC CONCEPTUAL FRAMEWORK

AND

THE IMPACT OF PSYCHOLOGICAL AND PHYSIOLOGICAL STRESSORS

MY HOPE IS THAT WHAT FOLLOWS

WILL BE RELEVANT IN THE WORK

THAT YOU DO WITH YOUR PATIENTS …

WHATEVER YOUR ORIENTATION

WHATEVER THE PATIENT'S DIAGNOSIS

WHATEVER HER UNDERLYING PSYCHODYNAMICS

HOWEVER SHORT OR LONG THE TREATMENT

AT WHATEVER MOMENT IN TIME

WHETHER AT THE BEGINNING, IN THE MIDDLE,
OR AT THE END OF A TREATMENT

“ONE OF SCIENCE’S GREATEST CHALLENGES IS TO DISCOVER CERTAIN PRINCIPLES THAT WILL EXPLAIN, INTEGRATE, AND PREDICT LARGE NUMBERS OF SEEMINGLY UNRELATED PHENOMENA.”

(SCHWARTZ 1999)

DRAWING UPON CONCEPTS FROM FIELDS
AS DIVERSE AS SYSTEMS THEORY, CHAOS THEORY,
QUANTUM MECHANICS, SOLID – STATE PHYSICS,
TOXICOLOGY, AND PSYCHOANALYSIS

I WILL BE OFFERING

WHAT I HOPE WILL PROVE TO BE

A CLINICALLY USEFUL

CONCEPTUAL FRAMEWORK

FOR UNDERSTANDING

THE PROCESS OF HEALING

BE IT OF CHRONIC PSYCHIATRIC OR MEDICAL CONDITIONS

PREVIEW

THE THERAPEUTIC USE OF OPTIMAL STRESS
TO PROVOKE RECOVERY

THE TASK OF THE CHILD (GROWING UP)
THE TASK OF THE PATIENT (GETTING BETTER)

TRANSFORMATION OF DYSFUNCTIONAL DEFENSE
INTO MORE FUNCTIONAL ADAPTATION

WHERE ID WAS, THERE SHALL EGO BE
WHERE DEFENSE WAS, THERE SHALL ADAPTATION BE

AN ONGOING PROCESS INVOLVING
HEALING CYCLES OF DISRUPTION AND REPAIR

THE THERAPIST WILL PRECIPITATE DISRUPTION
IN ORDER TO TRIGGER REPAIR
BY WAY OF OPTIMALLY STRESSFUL THERAPEUTIC INTERVENTIONS THAT ALTERNATELY CHALLENGE AND THEN SUPPORT THE DEFENSE

PREVIEW

ITERATIVE CYCLES OF DESTABILIZATION

IN REACTION TO CHALLENGE

AND

IN RESPONSE TO SUPPORT

AND BY TAPPING INTO THE PATIENT'S UNDERLYING RESILIENCE

RESTABILIZATION AT EVER – HIGHER LEVELS OF FUNCTIONALITY AND ADAPTIVE CAPACITY

IN ESSENCE

BY CHALLENGING DEFENSES TO WHICH THE PATIENT HAS LONG CLUNG, PSYCHODYNAMIC PSYCHOTHERAPY OFFERS THE PATIENT A BELATED OPPORTUNITY TO PROCESS, INTEGRATE, AND ADAPT TO PREVIOUSLY UNMASTERED AND THEREFORE DEFENDED AGAINST EARLY – ON EXPERIENCE

PREVIEW

THREE MODES OF THERAPEUTIC ACTION

THREE APPROACHES TO TRANSFORMING DEFENSE INTO ADAPTATION
THREE OPTIMAL STRESSORS THAT FACILITATE THIS ACTION

TRANSFORMATION OF RESISTANCE INTO AWARENESS AND ACTUALIZATION OF POTENTIAL
BY WORKING THROUGH THE STRESS OF COGNITIVE DISSONANCE
(THE EXPERIENCE OF GAIN – BECOME – PAIN)

TRANSFORMATION OF RELENTLESSNESS INTO ACCEPTANCE
BY WORKING THROUGH THE STRESS OF AFFECTIVE DISILLUSIONMENT
(THE EXPERIENCE OF GOOD – BECOME – BAD)

TRANSFORMATION OF RE – ENACTMENT INTO ACCOUNTABILITY
BY WORKING THROUGH THE STRESS OF RELATIONAL DETOXIFICATION
(THE EXPERIENCE OF BAD – BECOME – GOOD)

AGAIN

STRESSFUL STUFF HAPPENS

BUT IT WILL BE HOW WELL

WE ARE ULTIMATELY ABLE

TO MANAGE THE IMPACT

OF STRESS IN OUR LIVES

THAT WILL EITHER DERAIL OUR DEVELOPMENT

WHEN ALL WE KNOW HOW TO DO IS TO REACT DEFENSIVELY

OR TRIGGER OUR GROWTH

ONCE WE HAVE BECOME ABLE TO RESPOND ADAPTIVELY
TO THE MYRIAD OF DISAPPOINTMENTS, FRUSTRATIONS, AND LOSSES
WITH WHICH LIFE WILL INEVITABLY CONFRONT US

IN MY OWN WRITINGS

I HAVE FOUND IT CLINICALLY USEFUL TO CONCEIVE OF PSYCHOLOGICAL STRESSORS

ESPECIALLY RELEVANT IN THE EARLY – ON PARENT – CHILD RELATIONSHIP

AS INVOLVING BOTH "TOO MUCH THAT WAS BAD" AND "NOT ENOUGH THAT WAS GOOD"

MORE SPECIFICALLY

THE "PRESENCE OF BAD"

PARENTAL ERRORS OF COMMISSION

TRAUMA AND ABUSE / TOXICITIES

AND THE "ABSENCE OF GOOD"

PARENTAL ERRORS OF OMISSION

DEPRIVATION AND NEGLECT / DEFICIENCIES

SO TOO PHYSIOLOGICAL STRESSORS INVOLVE BOTH TOXICITIES AND DEFICIENCIES

WHETHER THE PRIMARY TARGET IS MIND OR BODY
AND THE CLINICAL MANIFESTATION THEREFORE PSYCHIATRIC OR MEDICAL

THE CRITICAL ISSUE WILL BE
THE ABILITY OF THE MindBodyMatrix
TO HANDLE STRESS THROUGH ADAPTATION

IN THE PSYCHOLOGICAL REALM
AN EXAMPLE OF ADAPTATION –
HANDLING THE STRESS OF THE LOSS OF A LOVED ONE
BY CONFRONTING – AND GRIEVING – THE PAIN OF ONE'S
HEARTBREAK AND ULTIMATELY EVOLVING FROM ANGER, UPSET,
AND FEELINGS OF HELPLESSNESS TO SERENE ACCEPTANCE

IN THE PHYSIOLOGICAL REALM
AN EXAMPLE OF ADAPTATION –
HANDLING THE STRESS OF BLOCKED CORONARY ARTERIES
BY DEVELOPING NEW (COLLATERAL) ONES
TO SUPPLY THE HEART WITH THE NUTRIENTS AND OXYGEN IT NEEDS,
THEREBY AVERTING A POTENTIAL HEART ATTACK

IN THE PSYCHOLOGICAL REALM

ANOTHER EXAMPLE OF DEFENSE

WHEN THE IMPACT ON A CHILD
OF HER PARENT'S ABUSIVENESS
IS SIMPLY TOO MUCH FOR THE CHILD
TO PROCESS, INTEGRATE, AND ADAPT TO

THE CHILD MAY FIND HERSELF
DEFENSIVELY REACTING
BY DISSOCIATING

OVER TIME, DISSOCIATION MAY EMERGE
AS HER CHARACTERISTIC DEFENSIVE
STANCE IN LIFE WHENEVER
SHE FEELS THREATENED

IN THE PSYCHOLOGICAL REALM

ANOTHER EXAMPLE OF ADAPTATION

BUT WHEN THE IMPACT ON A CHILD
OF HER PARENT'S ABUSIVENESS
IS ULTIMATELY ABLE TO BE MASTERED
THAT IS, PROCESSED AND INTEGRATED

THE CHILD MAY ADAPTIVELY
RESPOND BY BECOMING
AN ADVOCATE FOR THE RIGHTS
OF HER LITTLE SISTER AND
OF OTHERS WHOM SHE SENSES
MIGHT BE AT RISK

IN THE PHYSIOLOGICAL REALM

HYPOTHYROIDISM

IN ITS INFINITE WISDOM, THE BODY WILL KNOW TO ADAPT
BY REDISTRIBUTING ITS BLOOD FLOW FROM
LESS ESSENTIAL TO MORE ESSENTIAL ORGAN SYSTEMS

THUS THE THIN FRAGILE SKIN, DRY BRITTLE HAIR,
AND TELLTALE LOSS OF THE OUTER THIRD OF
THE EYEBROWS SO CHARACTERISTIC OF HYPOTHYROIDISM

ACIDIC INTERNAL ENVIRONMENT

IN ITS INFINITE WISDOM, THE BODY WILL KNOW TO ADAPT
BY LEACHING CALCIUM FROM
ITS BONES IN AN EFFORT TO BUFFER THE ACIDITY

THE GOOD NEWS WILL BE THE RESTORATION
OF ACID – BASE BALANCE

THE BAD NEWS WILL BE THE POTENTIAL FOR
DEMINERALIZATION OF THE BONES AND
DEVELOPMENT OF OSTEOPENIA / OSTEOPOROSIS

Module 7

THE ULTIMATE GOAL OF PSYCHODYNAMIC PSYCHOTHERAPY

AND

BELATED MASTERY

TO REPEAT

PSYCHODYNAMIC PSYCHOTHERAPY

AFFORDS THE PATIENT AN OPPORTUNITY

ALBEIT A BELATED ONE

TO MASTER EXPERIENCES

THAT HAD ONCE BEEN OVERWHELMING

AND THEREFORE DEFENDED AGAINST

BUT THAT CAN NOW

WITH ENOUGH SUPPORT FROM THE THERAPIST

AND BY TAPPING INTO THE PATIENT'S UNDERLYING RESILIENCE

AND CAPACITY TO COPE WITH STRESS

BE PROCESSED AND INTEGRATED

AND ULTIMATELY ADAPTED TO

THE OPPORTUNITY AFFORDED BY

PSYCHODYNAMIC PSYCHOTHERAPY

FOR BELATED MASTERY OF TRAUMATIC EXPERIENCES

AND TRANSFORMATION

OF DEFENSE INTO ADAPTATION

SPEAKS TO THE POWER OF THE TRANSFERENCE

WHEREBY

"THE HERE – AND – NOW IS IMBUED

WITH THE PRIMAL SIGNIFICANCE OF

THE THERE – AND – THEN" (STARK 2015)

WHICH IS WHAT MAKES THE SUCCESSFUL WORKING THROUGH OF BOTH "POSITIVE TRANSFERENCE DISRUPTED" AND "NEGATIVE TRANSFERENCE" SO POWERFULLY HEALING

FROM DEFENSE TO ADAPTATION

THE EVER – EVOLVING PSYCHODYNAMIC PROCESS

AS ALREADY NOTED, DEFENSES AND ADAPTATIONS
ARE SELF – PROTECTIVE MECHANISMS
DESIGNED TO PRESERVE HOMEOSTATIC BALANCE

BUT THE THERAPEUTIC GOAL IS
TO TRANSFORM THE LESS – EVOLVED DEFENSES
INTO MORE – EVOLVED ADAPTATIONS

INITIALLY THE TRANSFORMATION
CAN BE COMPARED TO A COMPUTER'S "SAVE AS" COMMAND,
WHICH WILL CAUSE THE NEW DOCUMENT
TO BE SAVED ALONGSIDE THE OLD DOCUMENT

ULTIMATELY THE TRANSFORMATION
CAN BE COMPARED TO A COMPUTER'S "SAVE" COMMAND,
WHEREBY THE NEW DOCUMENT
WILL BE SUPERIMPOSED UPON THE OLD DOCUMENT,
THEREBY DELETING THE OLD DOCUMENT

THE DEVELOPMENTAL PROCESS AND THE THERAPEUTIC PROCESS

WHERE ID WAS, THERE SHALL EGO BE
WHERE DEFENSE WAS, THERE SHALL ADAPTATION BE

FROM ID TO EGO

FROM ID DRIVE TO EGO STRUCTURE
DRIVES GIVE RISE TO NEEDS
AND STRUCTURES PERFORM FUNCTIONS THAT ENABLE CAPACITY

FROM ID NEED TO EGO CAPACITY

FROM NEED TO CAPACITY

FROM INFANTILE NEED TO ADULT CAPACITY

FROM DEFENSIVE NEED TO ADAPTIVE CAPACITY

FROM DEFENSIVE REACTION TO ADAPTIVE RESPONSE

FROM DEFENSE TO ADAPTATION

INDEED

EGO PSYCHOLOGY IS

FOUNDED ON THE PREMISE

THAT THE EGO DEVELOPS OUT OF NECESSITY

THAT IT EVOLVES AS AN ADAPTATION

TO THE EXIGENCIES OF THE ID,

THE IMPERATIVES OF THE SUPEREGO,

AND THE DEMANDS OF EXTERNAL REALITY

ALL OF WHICH ARE ENVIRONMENTAL STRESSORS
(WHETHER INTERNAL OR EXTERNAL)
THAT WILL EXACT THEIR TOLL UNLESS THEIR IMPACT
CAN BE PROCESSED, INTEGRATED, AND ADAPTED TO

IN ESSENCE

ADAPTATION

IS A STORY ABOUT

MAKING A VIRTUE

OUT OF NECESSITY ☺

SUCH THAT

THE EGO WILL BECOME
MORE "AWARE" AND ULTIMATELY MORE "ACTUALIZED" (MODEL 1)

THE SELF
MORE "ACCEPTING" (MODEL 2)

AND THE SELF – IN – RELATION
MORE "ACCOUNTABLE" (MODEL 3)

THE ULTIMATE GOAL OF PSYCHODYNAMIC PSYCHOTHERAPY
IS TO FACILITATE THE PROCESSING AND INTEGRATING
OF STRESSFUL EXPERIENCES
IN BOTH THE THERE – AND – THEN AND THE HERE – AND – NOW

FROM DEFENSIVE REACTION
TO ADAPTIVE RESPONSE

FROM DEFENSE
TO ADAPTATION

FROM DYSFUNCTIONAL DEFENSE
TO MORE FUNCTIONAL ADAPTATION

FROM DYSFUNCTIONAL ACTIONS,
REACTIONS, AND INTERACTIONS
TO MORE FUNCTIONAL WAYS OF BEING AND DOING

FROM DYSFUNCTION
TO FUNCTIONALITY

FROM UNHEALTHY NEED
TO HEALTHY CAPACITY

FROM EXTERNALIZING BLAME
TO TAKING OWNERSHIP

FROM WHINING AND COMPLAINING
TO BECOMING PROACTIVE

FROM CURSING THE DARKNESS
TO LIGHTING A CANDLE

FROM DISSOCIATING
TO BECOMING MORE PRESENT

FROM FEELING VICTIMIZED
TO BECOMING EMPOWERED

FROM BEING JAMMED UP
TO HARNESSING ONE'S ENERGIES SO THAT THEY CAN BE CHANNELED INTO THE PURSUIT OF ONE'S DREAMS

FROM DENIAL
TO CONFRONTING HEAD – ON

FROM BEING EVER CRITICAL
TO BECOMING MORE COMPASSIONATE

TO REPEAT

GROWING UP (THE TASK OF THE CHILD)
AND GETTING BETTER (THE TASK OF THE PATIENT)

ARE THEREFORE A STORY ABOUT

TRANSFORMING NEED INTO CAPACITY

THE NEED FOR IMMEDIATE GRATIFICATION
INTO THE CAPACITY TO TOLERATE DELAY

THE NEED FOR PERFECTION
INTO THE CAPACITY
TO TOLERATE IMPERFECTION

THE NEED FOR EXTERNAL REGULATION OF THE SELF
INTO THE CAPACITY FOR
INTERNAL SELF – REGULATION

THE NEED TO HOLD ON
INTO THE CAPACITY TO LET GO

Module 8

OPTIMAL STRESS

AND

PRECIPITATING DISRUPTION TO TRIGGER REPAIR

THE OPERATIVE CONCEPT HERE IS OPTIMAL STRESS

THE THERAPEUTIC USE OF STRESS TO PROVOKE RECOVERY AND GROWTH

WE PRECIPITATE DISRUPTION

IN ORDER TO

TRIGGER REPAIR

AGAINST A BACKDROP OF EMPATHIC ATTUNEMENT AND AUTHENTIC ENGAGEMENT

WE ARE CONTINUOUSLY STRIVING

TO FORMULATE INTERVENTIONS

THAT WILL EITHER CHALLENGE

THEREBY PROVIDING IMPETUS FOR DESTABILIZATION OF THE DYSFUNCTIONAL DEFENSES

OR SUPPORT

THEREBY PROVIDING OPPORTUNITY FOR RESTABILIZATION OF THOSE SELF – PROTECTIVE MECHANISMS AT A HIGHER LEVEL OF FUNCTIONALITY AND ADAPTIVE CAPACITY

DESCRIPTION BY CLARE BOOTHE LUCE

OF ELEANOR ROOSEVELT

AS SOMEONE WHO

“COMFORTED THE DISTRESSED”

BUT “DISTRESSED THE COMFORTABLE”

(FREEDMAN 1967)

AS SOMEONE WHO SUPPORTED THOSE WHO NEEDED COMFORT BUT CHALLENGED THOSE WHO DID NOT

WITH THE THERAPIST'S FINGER EVER ON THE PULSE OF THE PATIENT'S LEVEL OF ANXIETY AND CAPACITY TO TOLERATE FURTHER CHALLENGE

THE THERAPIST WILL THEREFORE

CHALLENGE WHEN POSSIBLE

BY DIRECTING THE PATIENT'S ATTENTION TO WHERE THE PATIENT IS NOT

AND

SUPPORT WHEN NECESSARY

BY RESONATING WITH WHERE THE PATIENT IS

CHALLENGE

BY WAY OF ANXIETY – PROVOKING
INTERPRETIVE STATEMENTS
THAT CALL INTO QUESTION DEFENSES
TO WHICH THE PATIENT HAS LONG CLUNG
IN ORDER TO PRESERVE HER PSYCHOLOGICAL EQUILIBRIUM

THEREBY INCREASING HER ANXIETY

SUPPORT

BY WAY OF ANXIETY – ASSUAGING
EMPATHIC STATEMENTS
THAT HONOR THOSE SELF – PROTECTIVE DEFENSES

THEREBY DECREASING HER ANXIETY

WHEN DO WE CHALLENGE?

WHEN WE SENSE THAT WE HAVE A WINDOW OF OPPORTUNITY TO CONFRONT THE PATIENT ABOUT SOMETHING THAT WE KNOW WILL MAKE HER ANXIOUS BUT THAT WE HOPE WILL ULTIMATELY PROVIDE THE IMPETUS FOR HER RECOVERY

WHEN DO WE SUPPORT?

WHEN WE SENSE
THAT THE PATIENT NEEDS
US TO BACK OFF A LITTLE
BECAUSE WE HAVE MADE HER
TOO ANXIOUS

AS AN EXAMPLE

WE MIGHT FIRST CHALLENGE

BY HIGHLIGHTING WHAT THE PATIENT IS COMING
TO RECOGNIZE AS A DISILLUSIONING TRUTH
ABOUT THE OBJECT OF HER DESIRE

BUT THEN WE WOULD SUPPORT

BY RESONATING EMPATHICALLY WITH
HER INVESTMENT IN HOLDING ON TO HER HOPE
THAT PERHAPS SOMEDAY, SOMEHOW, SOMEWAY,
WERE SHE TO BE GOOD ENOUGH, TRY HARD ENOUGH,
BE PERSUASIVE ENOUGH, PERSIST LONG ENOUGH,
OR SUFFER DEEPLY ENOUGH,
SHE MIGHT YET BE ABLE TO MAKE
HER BOYFRIEND FALL IN LOVE WITH HER

AGAIN

OPTIMALLY STRESSFUL INTERVENTIONS

THAT BOTH CHALLENGE AND SUPPORT

ARE SPECIFICALLY DESIGNED
TO PROVOKE JUST THE RIGHT LEVEL
OF ANXIETY AND
DESTABILIZING / INCENTIVIZING STRESS

THAT IS, OPTIMAL STRESS

SUCH THAT THE POTENTIAL FOR
TRANSFORMATION AND GROWTH
WILL BE OPTIMIZED

REVIEW

IN REACTION / RESPONSE
TO OPTIMALLY STRESSFUL INPUT

THE PATIENT

HERE VIEWED AS A SELF – ORGANIZING (CHAOTIC) SYSTEM

WILL EVOLVE THROUGH

HEALING CYCLES OF DESTABILIZATION

IN REACTION TO THE THERAPIST'S CHALLENGE

AND THEN

IN RESPONSE TO THE THERAPIST'S SUPPORT

RESTABILIZATION

AT EVER – HIGHER LEVELS OF

FUNCTIONALITY AND ADAPTIVE CAPACITY

Module 9

THREE MODES OF THERAPEUTIC ACTION

AND

THREE OPTIMAL STRESSORS

BOTH REVIEW AND PREVIEW

THREE MODES OF THERAPEUTIC ACTION

THREE APPROACHES TO TRANSFORMING DEFENSE INTO ADAPTATION
THREE OPTIMAL STRESSORS THAT WILL FACILITATE THIS "ACTION"

MODEL 1 – TRANSFORMATION OF

RESISTANCE INTO AWARENESS
AND ACTUALIZATION OF POTENTIAL

BY WORKING THROUGH THE STRESS OF COGNITIVE DISSONANCE
RESULTING FROM THE EXPERIENCE OF GAIN – BECOME – PAIN

MODEL 2 – TRANSFORMATION OF

RELENTLESSNESS INTO ACCEPTANCE

BY WORKING THROUGH THE STRESS OF AFFECTIVE DISILLUSIONMENT
RESULTING FROM THE EXPERIENCE OF GOOD – BECOME – BAD

MODEL 3 – TRANSFORMATION OF

RE – ENACTMENT INTO ACCOUNTABILITY

BY WORKING THROUGH THE STRESS OF RELATIONAL DETOXIFICATION
RESULTING FROM THE EXPERIENCE OF BAD – BECOME – GOOD

MUTUALLY ENHANCING NOT MUTUALLY EXCLUSIVE

THREE MODES OF THERAPEUTIC ACTION

MODEL 1

THE INTERPRETIVE PERSPECTIVE

OF CLASSICAL PSYCHOANALYSIS

THE BEST EXEMPLAR OF WHICH IS FREUD

MODEL 2

THE CORRECTIVE – PROVISION PERSPECTIVE

OF SELF PSYCHOLOGY

AND THOSE OBJECT RELATIONS THEORIES

EMPHASIZING INTERNAL ABSENCE OF GOOD

THE BEST EXEMPLARS OF WHICH ARE KOHUT AND BALINT

MODEL 3

THE INTERSUBJECTIVE PERSPECTIVE

OF CONTEMPORARY RELATIONAL THEORY

AND THOSE OBJECT RELATIONS THEORIES

EMPHASIZING INTERNAL PRESENCE OF BAD

THE BEST EXEMPLARS OF WHICH ARE FAIRBAIRN AND MITCHELL

MODEL 1 – KNOWLEDGE

1 – PERSON PSYCHOLOGY

FOCUS ON PATIENT'S INTERNAL DYNAMICS (1)

THERAPIST AS NEUTRAL OBJECT (0)

MODEL 2 – EXPERIENCE

1½ – PERSON PSYCHOLOGY

FOCUS ON PATIENT'S AFFECTIVE EXPERIENCE (1)

THERAPIST AS EMPATHIC SELFOBJECT OR GOOD OBJECT (½)

MODEL 3 – RELATIONSHIP

2 – PERSON PSYCHOLOGY

FOCUS ON PATIENT'S RELATIONAL DYNAMICS (1)

THERAPIST AS AUTHENTIC SUBJECT (1)

MODEL 1 – COGNITIVE

ENHANCEMENT OF KNOWLEDGE "WITHIN"

ULTIMATELY, A STRONGER, WISER, AND MORE EMPOWERED EGO

MODEL 2 – AFFECTIVE

PROVISION OF CORRECTIVE EXPERIENCE "FOR"

ULTIMATELY, A MORE CONSOLIDATED, ACCEPTING, AND COMPASSIONATE SELF

MODEL 3 – RELATIONAL

ENGAGEMENT IN AUTHENTIC RELATIONSHIP "WITH"

ULTIMATELY, A MORE PRESENT AND MORE ACCOUNTABLE SELF – IN – RELATION

AS WE SHALL SOON SEE

THE THERAPEUTIC ACTION IN ALL THREE MODES INVOLVES TRANSFORMATION OF DEFENSE INTO ADAPTATION BY FACILITATING THE PATIENT'S PROCESSING AND INTEGRATING OF STRESSFUL LIFE EXPERIENCES PAST AND PRESENT INCLUDING SOME OF THE THERAPIST'S INTERVENTIONS

MODEL 1

WHERE RESISTANCE WAS,
THERE SHALL AWARENESS
AND ACTUALIZATION OF POTENTIAL BE

MODEL 2

WHERE RELENTLESSNESS WAS,
THERE SHALL ACCEPTANCE BE

MODEL 3

WHERE RE – ENACTMENT WAS,
THERE SHALL ACCOUNTABILITY BE

AND AS WE SHALL SOON SEE

THE THERAPEUTIC ACTION IN ALL THREE MODES
WILL INVOLVE WORKING THROUGH
THE OPTIMAL STRESS CREATED BY INTERVENTIONS
THAT ALTERNATELY CHALLENGE AND THEN SUPPORT

INTERVENTIONS STRATEGICALLY DESIGNED
TO TARGET AND HIGHLIGHT

MODEL 1 – COGNITIVE DISSONANCE
MODEL 2 – AFFECTIVE DISILLUSIONMENT
MODEL 3 – RELATIONAL DETOXIFICATION

THE WORKING THROUGH OF WHICH
WILL RESULT ULTIMATELY
IN RECONSTITUTION AT EVER – HIGHER LEVELS
OF AWARENESS / ACTUALIZATION OF POTENTIAL,
ACCEPTANCE, AND ACCOUNTABILITY

MATURITY INVOLVES DEVELOPING THE CAPACITY …

MODEL 1

TO KNOW AND ACCEPT THE SELF,
INCLUDING ITS PSYCHIC SCARS

MODEL 2

TO KNOW AND ACCEPT THE OBJECT,
INCLUDING ITS PSYCHIC SCARS

MODEL 3

TO TAKE RESPONSIBILITY FOR WHAT
ONE DELIVERS OF ONESELF INTO RELATIONSHIP
AND, MORE GENERALLY, INTO ONE'S LIFE

THE RESULT – WISER BUT PERHAPS SOBERED,
MORE ACCEPTING BUT PERHAPS SADDER
MORE ACCOUNTABLE BUT PERHAPS MORE BURDENED

Module 10

TRAUMATIC FRUSTRATION

AND

1 – PERSON vs.
2 – PERSON DEFENSES

THE VILLAIN IN OUR PIECE
TRAUMATIC FRUSTRATION

**BY THE PARENT AS DRIVE OBJECT (MODEL 1),
BY THE PARENT AS EMPATHIC SELFOBJECT
OR GOOD OBJECT (MODEL 2),
AND BY THE PARENT AS AUTHENTIC SUBJECT
OR RELATIONAL OBJECT (MODEL 3)**

THE HEROINE IN OUR PIECE
OPTIMAL (NONTRAUMATIC) FRUSTRATION

NAMELY, OPTIMAL STRESS

ALTHOUGH THE FOCUS IN EACH IS DIFFERENT

ALL THREE OF MY MODELS INVOLVE

AS THEIR STARTING POINT

THE INTERNAL PRICE PAID BY THE CHILD BECAUSE OF TRAUMATIC FRUSTRATION

BY THE PARENT

MODEL 1

REINFORCEMENT OF INFANTILE NEED

IN THE FACE OF ITS TRAUMATIC FRUSTRATION

MODEL 2

FAILURE TO INTERNALIZE GOOD

IN THE FACE OF TRAUMATIC DISILLUSIONMENT

MODEL 3

INTROJECTION OF BAD

IN THE FACE OF TRAUMATIC INSULT AND INJURY

THE STARTING POINT IN MODEL 1

DEFENSIVELY REINFORCED INFANTILE (LIBIDINAL AND AGGRESSIVE) DRIVES RESULTING FROM THE DRIVE OBJECT PARENT'S EARLY – ON TRAUMATIC FRUSTRATION OF THE CHILD'S AGE – APPROPRIATE (ID) DRIVES

THE THERAPEUTIC ACTION WILL INVOLVE

WORKING THROUGH OPTIMAL FRUSTRATION OF THE PATIENT'S INTENSIFIED (AND DEFENDED AGAINST) DRIVES AS THEY ARISE IN THE CONTEXT OF THE TREATMENT

WHICH WILL ULTIMATELY RESULT IN
ADAPTIVE INTEGRATION OF THOSE (ID) DRIVES
NOW TAMED AND MODIFIED
INTO HEALTHY PSYCHIC (EGO) STRUCTURE

WHICH WILL THEN ALLOW FOR THE REDIRECTING OF THEIR NOW BETTER REGULATED ENERGY INTO MORE CONSTRUCTIVE PURSUITS AND ACTUALIZATION OF POTENTIAL BY A NOW MORE SKILLED EGO

DRIVE (HORSE) AND DEFENSE (RIDER)
NO LONGER WORKING IN CONFLICT BUT IN COLLABORATION

THE STARTING POINT IN MODEL 2

STRUCTURAL DEFICIT AND IMPAIRED CAPACITY RESULTING FROM THE SELFOBJECT PARENT'S EARLY – ON TRAUMATIC FRUSTRATION OF THE CHILD'S AGE – APPROPRIATE (NARCISSISTIC) NEED TO HAVE A PERFECT PARENT

THE THERAPEUTIC ACTION WILL INVOLVE

WORKING THROUGH OPTIMAL FRUSTRATION OF THE PATIENT'S INTENSIFIED (AND DEFENDED AGAINST) NARCISSISTIC NEED TO FIND THE PERFECT PARENT AS IT ARISES IN THE CONTEXT OF THE RELATIONSHIP WITH THE SELFOBJECT THERAPIST

WHICH WILL ULTIMATELY RESULT IN ADAPTIVE TRANSMUTING (STRUCTURE – BUILDING) INTERNALIZATIONS

WHICH WILL THEN ALLOW FOR THE FILLING IN OF STRUCTURAL DEFICIT, DEVELOPMENT OF A MORE ROBUST CAPACITY TO BE A GOOD PARENT UNTO ONESELF, ACCRETION OF HEALTHY PSYCHIC STRUCTURE, AND CONSOLIDATION OF A MORE COHESIVE SELF

GRIEVING OPTIMAL DISILLUSIONMENT WILL TRANSFORM THE DEFENSIVE NEED FOR EXTERNAL REGULATION OF THE SELF INTO THE ADAPTIVE CAPACITY TO BE INTERNALLY SELF – REGULATING

THE STARTING POINT IN MODEL 3

INTERNAL DEMONS AND A SENSE OF INNER BADNESS RESULTING FROM INTROJECTION OF THE DYSFUNCTIONAL RELATIONAL DYNAMIC CHARACTERIZING THE CHILD'S EARLY – ON RELATIONSHIP WITH THE TRAUMATICALLY ABUSIVE PARENT

INTERNAL BAD OBJECTS / PATHOGENIC INTROJECTS

THE THERAPEUTIC ACTION WILL INVOLVE

WORKING THROUGH THE TURBULENCE THAT WILL INEVITABLY ARISE AT THE "INTIMATE EDGE" (EHRENBERG 1992) OF AUTHENTIC RELATEDNESS ONCE THE PATIENT DELIVERS HER PATHOGENIC INTROJECTS INTO THE RELATIONSHIP WITH HER THERAPIST

WHICH WILL ULTIMATELY RESULT IN GRADUAL MODIFICATION OF THEIR TOXICITY BY WAY OF SERIAL DILUTIONS

WHICH WILL THEN ALLOW FOR TRANSFORMATION OF THE DEFENSIVE NEED TO RE – ENACT UNMASTERED EARLY – ON RELATIONAL TRAUMAS INTO THE ADAPTIVE CAPACITY TO HOLD ONESELF ACCOUNTABLE AND TO ENGAGE IN HEALTHY, AUTHENTIC RELATEDNESS

IN THOSE MOMENTS WHEN
THE SPOTLIGHT IS ON THE PATIENT
AS CONFLICTED, JAMMED UP,
OR NEUROTIC

BECAUSE OF INTERNAL / STRUCTURAL / INTRAPSYCHIC
CONFLICT BETWEEN
GROWTH – PROMOTING BUT ANXIETY – PROVOKING
FORCES PRESSING "YES"
AND ANXIETY – ASSUAGING BUT GROWTH – IMPEDING
DEFENSIVE COUNTERFORCES PROTESTING "NO"

THE INTERPRETIVE PERSPECTIVE
OF MODEL 1
WILL BE A USEFUL WAY
TO CONCEPTUALIZE
THE THERAPEUTIC ACTION

IN THOSE MOMENTS
WHEN THE SPOTLIGHT IS ON THE PATIENT
AS NEEDY, NARCISSISTICALLY VULNERABLE,
OR ALWAYS LOOKING TO THE OUTSIDE
FOR EXTERNAL PROVISION AND REINFORCEMENT

BECAUSE OF AN IMPAIRED CAPACITY
TO BE A GOOD PARENT UNTO HERSELF

THE CORRECTIVE – PROVISION
DEFICIENCY – COMPENSATION
PERSPECTIVE OF MODEL 2
WILL BE A USEFUL WAY
TO CONCEPTUALIZE
THE THERAPEUTIC ACTION

IN THOSE MOMENTS
WHEN THE SPOTLIGHT IS ON THE PATIENT
AS REPLAYING WITH EACH NEW OBJECT
THE ONLY KIND OF (DYSFUNCTIONAL)
RELATIONSHIP SHE HAS EVER KNOWN
AND / OR AS DISAVOWING (TOXIC) ASPECTS
OF HER "SELF" AND PROJECTING THEM
ONTO HER "OBJECTS"

THE CONTEMPORARY RELATIONAL
PERSPECTIVE OF MODEL 3
WILL BE A USEFUL WAY
TO CONCEPTUALIZE
THE THERAPEUTIC ACTION

1 – PERSON vs. 2 – PERSON DEFENSES

MODEL 1

FOCUSES ON INTRAPSYCHIC (1 – PERSON) DEFENSES MOBILIZED BY THE EGO IN AN EFFORT TO PROTECT ITSELF AGAINST THREATENED BREAKTHROUGH OF DYSREGULATED AND ANXIETY – PROVOKING ID FORCES

THE IMPORTANT RELATIONSHIP IS THE ONE BETWEEN EGO AND ID

MODEL 2

FOCUSES ON INTERPERSONAL (2 – PERSON) DEFENSES MOBILIZED BY THE SELF IN AN EFFORT TO PROTECT ITSELF AGAINST BEING DISAPPOINTED BY ITS SELFOBJECTS

THE IMPORTANT RELATIONSHIP IS THE ONE BETWEEN SELF AND SELFOBJECT

MODEL 3

FOCUSES ON INTERPERSONAL (2 – PERSON) DEFENSES MOBILIZED BY THE SELF – IN – RELATION IN AN EFFORT TO PROTECT ITSELF AGAINST BEING ABUSED BY ITS OBJECTS

THE IMPORTANT RELATIONSHIP IS THE ONE BETWEEN SELF – IN – RELATION AND RELATIONAL OBJECT

MODEL 1

THE INTERPRETIVE PERSPECTIVE OF CLASSICAL PSYCHOANALYSIS

A 1 – PERSON PSYCHOLOGY

THAT FOCUSES ON THE PATIENT'S INTERNAL DYNAMICS AND POSITS INSIGHT, WISDOM, AWARENESS, EMPOWERMENT, AND ACTUALIZATION OF INHERITED POTENTIAL AS THE ULTIMATE THERAPEUTIC GOAL

MODEL 2

THE CORRECTIVE – PROVISION PERSPECTIVE OF SELF PSYCHOLOGY AND OTHER DEFICIT THEORIES

A 1½ – PERSON PSYCHOLOGY

THAT FOCUSES ON THE PATIENT'S AFFECTIVE EXPERIENCE AND POSITS ACCEPTANCE OF THE OBJECT'S LIMITATIONS, SEPARATENESS, AND IMMUTABILITY AS THE ULTIMATE THERAPEUTIC GOAL

MODEL 3

THE CONTEMPORARY RELATIONAL PERSPECTIVE

A 2 – PERSON PSYCHOLOGY

THAT FOCUSES ON THE PATIENT'S RELATIONAL DYNAMICS AND POSITS ACCOUNTABILITY AS THE ULTIMATE THERAPEUTIC GOAL

THE TRIUNE BRAIN (MacLean 1990)

THREE EVOLUTIONARILY DISTINCT STRUCTURES
BUT INTERDEPENDENT AND INTERACTIVE WITH ONE ANOTHER

NEOCORTEX (NEW BRAIN)

COGNITIVE
THE TOP LAYER OF THE CEREBRAL HEMISPHERES
CORRESPONDS TO MODEL 1

LIMBIC SYSTEM (MAMMALIAN BRAIN)

EMOTIONAL
HIPPOCAMPI – AMYGDALAE – HYPOTHALAMUS
CORRESPONDS TO MODEL 2

REPTILIAN COMPLEX (OLD BRAIN)

VISCERAL / INSTINCTUAL
BRAINSTEM – CEREBELLUM
CORRESPONDS TO MODEL 3

TOP – DOWN vs. BOTTOM – UP PROCESSING
OF INFORMATION AND ENERGY

Module 11

THERAPEUTIC INDUCTION OF HEALING CYCLES OF DISRUPTION AND REPAIR

ALTHOUGH EACH OF THESE THREE

MODES OF THERAPEUTIC ACTION PRIVILEGES

A DIFFERENT FACET OF THE HEALING PROCESS,

WHAT ALL THREE INTERDEPENDENT MODES HAVE IN

COMMON IS THEIR USE OF OPTIMALLY STRESSFUL

(ANXIETY – PROVOKING BUT ULTIMATELY GROWTH – PROMOTING)

INTERVENTIONS,

THE WORKING THROUGH AND MASTERY OF WHICH

WILL PROVOKE GRADUATED TRANSFORMATION

OF UNHEALTHY, LESS – EVOLVED DEFENSE

INTO HEALTHIER, MORE – EVOLVED ADAPTATION

MODEL 1

A DRIVE – DEFENSE MODEL THAT FOCUSES ON THE PATIENT'S UNMODULATED DRIVES AND SELF – PROTECTIVE DEFENSES

A MODEL THAT OFFERS THE NEUROTICALLY CONFLICTED PATIENT AN OPPORTUNITY TO GAIN GREATER SELF – AWARENESS AND INSIGHT INTO HER INNER WORKINGS SO THAT SHE CAN MAKE MORE INFORMED DECISIONS ABOUT HER LIFE, BECOME MORE MASTER OF HER DESTINY, AND CHANNEL HER NOW MORE MODULATED ENERGIES INTO ACTUALIZED POTENTIAL

MODEL 2

A MORE CONTEMPORARY PERSPECTIVE THAT FOCUSES ON THE PATIENT'S PSYCHOLOGICAL DEFICIENCIES, THESE PSYCHIC SCARS THE RESULT OF EARLY – ON ABSENCE OF GOOD IN THE FORM OF PARENTAL DEPRIVATION AND NEGLECT

THIS MODEL OFFERS THE NARCISSISTICALLY VULNERABLE PATIENT AN OPPORTUNITY

IN THE CONTEXT OF THE HERE – AND – NOW RELATIONSHIP WITH HER THERAPIST

BOTH TO GRIEVE THE EARLY – ON PARENTAL FAILURES AND TO EXPERIENCE SYMBOLIC RESTITUTION

MODEL 2 (CONTINUED)

**AS THE PATIENT MAKES HER PEACE
WITH THE REALITY
THAT THE PEOPLE IN HER WORLD
WERE NOT, AND WILL NEVER BE,
ALL THAT SHE
WOULD HAVE WANTED THEM TO BE,
SHE WILL EVOLVE TO A PLACE
OF GREATER ACCEPTANCE
AND INNER SERENITY**

SADDER PERHAPS, BUT MORE AT PEACE

MODEL 3

ANOTHER CONTEMPORARY PERSPECTIVE THAT FOCUSES ON THE PATIENT'S PSYCHOLOGICAL TOXICITIES, THESE PSYCHIC SCARS THE RESULT OF EARLY – ON PRESENCE OF BAD IN THE FORM OF PARENTAL TRAUMA AND ABUSE

THIS MODEL OFFERS THE RELATIONALLY CONFLICTED PATIENT AN OPPORTUNITY

IN THE CONTEXT OF THE HERE – AND – NOW RELATIONSHIP WITH HER THERAPIST

SYMBOLICALLY TO PLAY OUT HER UNRESOLVED CHILDHOOD DRAMAS BUT ULTIMATELY TO ENCOUNTER A DIFFERENT RESPONSE THIS TIME

MODEL 3 (CONTINUED)

THE OUTCOME WILL INDEED BE A BETTER ONE BECAUSE THE THERAPIST WILL BE ABLE TO FACILITATE RESOLUTION BY BRINGING TO BEAR HER OWN, MORE – EVOLVED CAPACITY TO PROCESS AND INTEGRATE ON BEHALF OF A PATIENT WHO TRULY DOES NOT KNOW HOW

AS THE PATIENT IS CONFRONTED WITH THE SOBERING REALITY OF WHAT SHE HAS BEEN UNCONSCIOUSLY RE – ENACTING IN HER RELATIONSHIPS, SHE WILL EVOLVE TO A PLACE OF GREATER ACCOUNTABILITY FOR HER ACTIONS, REACTIONS, AND INTERACTIONS

WHEN THE THERAPIST

WHETHER FUNCTIONING AS NEUTRAL OBJECT,
EMPATHIC SELFOBJECT, OR AUTHENTIC SUBJECT

OFFERS OPTIMALLY STRESSFUL INTERVENTIONS
THAT PROVIDE JUST THE RIGHT COMBINATION
OF CHALLENGE

TO PROVIDE IMPETUS

AND SUPPORT

TO PROVIDE OPPORTUNITY,

HEALING CYCLES OF DISRUPTION

IN REACTION TO THE CHALLENGE

AND REPAIR

IN RESPONSE TO THE SUPPORT
AND BY TAPPING INTO THE PATIENT'S INNATE "WILL TO RECOVER"

WILL BE INDUCED

AND ORDER WILL ULTIMATELY EMERGE FROM CHAOS

AS DYSFUNCTIONAL DEFENSE IS GRADUALLY REPLACED
BY MORE FUNCTIONAL ADAPTATION

THE THERAPEUTIC ACTION IN ALL THREE PARADIGMS
WILL INVOLVE THE THERAPEUTIC INDUCTION OF

HEALING CYCLES

OF DISRUPTION AND REPAIR

WITH RECONSTITUTION

AT EVER – HIGHER LEVELS

OF AWARENESS / ACTUALIZATION,

ACCEPTANCE, AND ACCOUNTABILITY

AS THE PATIENT PROGRESSES NONLINEARLY
FROM DISORDEREDNESS TO ORDEREDNESS

FROM DYSFUNCTION TO FUNCTIONALITY
FROM DEFENSE TO ADAPTATION

TO REPEAT

THE THERAPEUTIC ACTION OF

PSYCHODYNAMIC PSYCHOTHERAPY

OFFERS THE PATIENT

AN OPPORTUNITY

ALBEIT A BELATED ONE

TO PROCESS, INTEGRATE,

AND ADAPT TO IMPINGEMENTS

THAT HAD ONCE BEEN OVERWHELMING

AND THEREFORE DEFENDED AGAINST …

… BUT THAT CAN NOW

WITHIN THE CONTEXT OF SAFETY
PROVIDED BY THE PATIENT'S RELATIONSHIP
WITH HER THERAPIST

BE PROCESSED, INTEGRATED,
AND ADAPTED TO

THEREBY ENABLING THE PATIENT
TO EXTRICATE HERSELF
FROM THE BONDS OF HER INFANTILE ATTACHMENTS
AND HER AMBIVALENTLY CATHECTED DYSFUNCTION

SUCH THAT **DYSFUNCTIONAL DEFENSE**
CAN BE REPLACED BY **MORE FUNCTIONAL ADAPTATION**

MODEL 1

RESISTANCE TO ACKNOWLEDGING
UNCOMFORTABLE TRUTHS ABOUT ONE'S INNER WORKINGS
WILL BE REPLACED BY AWARENESS OF THOSE TRUTHS,
ULTIMATELY ENABLING ACTUALIZATION OF POTENTIAL

MODEL 2

RELENTLESS HOPE AND REFUSAL TO CONFRONT
AND GRIEVE PAINFUL TRUTHS ABOUT THE OBJECT
WILL BE REPLACED BY ACCEPTANCE OF THOSE TRUTHS

MODEL 3

COMPULSIVE AND UNWITTING RE – ENACTMENT
OF UNRESOLVED CHILDHOOD DRAMAS
WILL BE REPLACED BY ACCOUNTABILITY FOR ONE'S
ACTIONS, REACTIONS, AND INTERACTIONS

Module 12

AMBIVALENT ATTACHMENT TO DYSFUNCTIONAL DEFENSE

AND

NEUROTICALLY CONFLICTED ABOUT HEALTHY DESIRE

MODEL 1

THE INTERPRETIVE, INSIGHT – ORIENTED PERSPECTIVE OF CLASSICAL PSYCHOANALYSIS

A 1 – PERSON PSYCHOLOGY

FOCUS ON THE PATIENT AND HER INTERNAL WORKINGS

THE TRUTH WILL SET THE PATIENT FREE

JACQUES LACAN'S PITHY STATEMENT
THAT THE PATIENT GETS BETTER
ONCE THE PATIENT
COMES TO KNOW
ALL THAT THE ANALYST KNOWS,

WHICH IS WHAT THE PATIENT
HAD UNCONSCIOUSLY KNOWN
ALL ALONG

(LACAN 2007)

WHEREAS CLASSICAL PSYCHOANALYSTS TEND TO FOCUS ON INTERNAL CONFLICT BETWEEN ANXIETY – PROVOKING ID DRIVES AND ANXIETY – ASSUAGING EGO DEFENSES

I BELIEVE THAT IT IS A LITTLE MORE CLINICALLY USEFUL TO CONCEIVE OF NEUROTIC CONFLICT AS ENCOMPASSING, MORE GENERALLY, GROWTH – IMPEDING TENSION BETWEEN

EMPOWERING BUT ANXIETY – PROVOKING FORCES PRESSING YES

AND ANXIETY – ASSUAGING (DEFENSIVE) COUNTERFORCES INSISTING NO

BY THE SAME TOKEN

WHEREAS CLASSICAL PSYCHOANALYSTS CONCEIVE OF THE GOAL OF THE WORKING THROUGH PROCESS

AS TAMING THE ID

AND STRENGTHENING THE EGO

SO THAT DEFENSES
WILL NO LONGER BE NECESSARY
AND CAN BE RELINQUISHED

AND ID – EGO CONFLICTS
WILL THEREBY BE RESOLVED

I BELIEVE THAT IT IS A LITTLE MORE CLINICALLY USEFUL TO CONCEIVE OF THE GOAL OF THE WORKING THROUGH PROCESS IN MODEL 1

AS TAMING, MODIFYING, AND INTEGRATING DYSREGULATED BUT ULTIMATELY GROWTH – PROMOTING ID ENERGIES

AND EXPOSING TO THE LIGHT OF DAY EGO DEFENSES TO WHICH THE PATIENT IS INTENSELY AND AMBIVALENTLY ATTACHED

"INTENSELY" BECAUSE THEY ARE FUELED BY THE "ADHESIVENESS OF THE ID" AND "AMBIVALENTLY" BECAUSE THEY BOTH SERVE HER AND COST HER

SUCH THAT NOW BETTER REGULATED ID ENERGIES CAN BE APPROPRIATED BY A NOW MORE CAPABLE EGO TO FUEL HEALTHIER ENDEAVORS / AMBITIONS

THEREBY FACILITATING ACTUALIZATION OF POTENTIAL

AS LESS HEALTHY (AMBIVALENTLY CATHECTED) DEFENSES BECOME TRANSFORMED INTO HEALTHIER (MORE INTEGRATED) ADAPTATIONS

IN ESSENCE

THE DYSFUNCTIONAL DEFENSES TO WHICH
THE PATIENT IS AMBIVALENTLY ATTACHED
LIBIDINALLY BECAUSE THEY SERVE HER
AGGRESSIVELY BECAUSE THEY COST HER

WILL UNDERLIE HER
PSYCHIC INERTIA AND RESISTANCE TO CHANGE
AND INTERFERE WITH HER
CAPACITY TO DERIVE PLEASURE AND FULFILLMENT
FROM HER LOVE, WORK, AND PLAY

BUT BEFORE THESE RESISTIVE COUNTERFORCES
CAN BE SURRENDERED,
THE PATIENT MUST BECOME AWARE
FIRST OF THEIR EXISTENCE
AND THEN OF WHAT EXACTLY FUELS
THE TENACITY WITH WHICH SHE
IS UNWITTINGLY CLINGING TO THEM

AT THE END OF THE DAY

MY PERSPECTIVE IS NOT SO VERY DIFFERENT FROM THE WAY IN WHICH FREUD CONCEIVES OF THE INTRAPSYCHIC SITUATION

EXCEPT THAT MY FOCUS IN MODEL 1 IS ON

NOT ONLY HARNESSING THE ID'S EMPOWERING ENERGIES

SO THAT THOSE ENERGIES CAN BE INTEGRATED INTO HEALTHY PSYCHIC STRUCTURE

BUT ALSO WORKING THROUGH THE ID'S AMBIVALENT (LIBIDINAL AND AGGRESSIVE) ATTACHMENT TO THE DYSFUNCTIONAL EGO DEFENSES

SO THAT THOSE DEFENSES CAN BE RELINQUISHED AND REPLACED BY MORE FUNCTIONAL ADAPTATIONS

WHERE ONCE ID AND EGO WERE IN CONFLICT, NOW THE PATIENT WILL BE BETTER ABLE TO HARNESS THE EMPOWERING ID ENERGIES TO FUEL FORWARD MOMENTUM AND ACTUALIZATION OF POTENTIAL

MODEL 1

IN WRITING ABOUT THE CONFLICTUAL RELATIONSHIP
THAT EXISTS BETWEEN ID AND EGO,
FREUD LIKENS IT TO THE TENSION – FILLED RELATIONSHIP
THAT EXISTS BETWEEN A HORSE (ID) AND ITS RIDER (EGO)

BUT AS A RESULT OF THE WORKING THROUGH PROCESS
WHICH TAMES THE ID AND STRENGTHENS THE EGO
THE HORSE WILL INDEED BECOME TAMER
AND THEREFORE MORE MANAGEABLE
AND ITS RIDER STRONGER
AND THEREFORE MORE ADEPT AT MANAGING

HORSE AND RIDER WILL NOW BE BETTER ABLE
TO COORDINATE THEIR EFFORTS
TO CREATE A SYNERGISTIC RELATIONSHIP
THAT IS NO LONGER CONFLICTUAL BUT COLLABORATIVE

AND THE DEFENSIVE NEED TO REIN THE HORSE IN
WILL HAVE BECOME TRANSFORMED INTO
THE ADAPTIVE CAPACITY TO GIVE THE HORSE FREE REIN

CLINICAL VIGNETTE

"NEUROTICALLY CONFLICTED ABOUT HEALTHY DESIRE"

CONSIDER THE SITUATION OF M.S. WHO WANTS, MORE THAN ANYTHING ELSE IN THE WORLD, TO BE ABLE TO PUT TOGETHER AN ACTION – PACKED POWERPOINT SLIDE SHOW THAT WILL CAPTURE THE ESSENCE OF HER MOST EVOLVED THINKING, TO DATE, ABOUT THE THERAPEUTIC PROCESS

BUT SHE IS ALL JAMMED UP ABOUT IT ("NEUROTICALLY CONFLICTED") AND HAVING A LOT OF TROUBLE GETTING HERSELF TO SIT DOWN TO DO IT

AND SO IT IS THAT SHE FINDS HERSELF, WEEKEND AFTER WEEKEND, WATCHING LOTS OF TV AND TAKING LOTS OF NAPS JUST TO AVOID WORKING ON IT

HOW MIGHT WE CONCEIVE OF HER INTERNAL DYNAMICS?

ON THE ONE HAND

ARE THE ANXIETY – PROVOKING BUT ULTIMATELY HEALTH – PROMOTING FORCES WITHIN HER THAT ARE CLAMORING FOR EXPRESSION AND RELEASE

DYSREGULATED ENERGIES THAT WOULD PROVIDE THE PROPULSIVE FUEL FOR HER FORWARD MOMENTUM WERE SHE BUT ABLE TO HARNESS THEM

ENERGIES THAT ARE LITERALLY "CHOMPING AT THE BIT"

ON THE OTHER HAND

ARE THE ANXIETY – ASSUAGING BUT GROWTH – IMPEDING DEFENSIVE COUNTERFORCES MOBILIZED BY AN EGO CLEARLY MADE ANXIOUS

AND FEELING THE NEED TO REIN IN THE AFOREMENTIONED EMPOWERING ENERGIES

THE DEFENSIVE COUNTERFORCES ARE FUELING M.S.'s PROCRASTINATION

BUT AS SHE CONFRONTS HER NEUROTIC CONFLICT ABOUT MOVING FORWARD, SHE COMES TO UNDERSTAND BOTH HOW HER AVOIDANCE IS SERVING HER AND HOW HER AVOIDANCE IS COSTING HER

VERY CLEAR TO HER, AT LEAST ON A SUPERFICIAL LEVEL, IS THE PRICE SHE PAYS FOR HER DELAYING

BUT IT IS ONLY OVER TIME, AND AS M.S. BEGINS TO EXPLORE MORE DEEPLY THE REAL REASONS FOR HER PROCRASTINATION, THAT SHE COMES TO THE SOBERING REALIZATION THAT A PIECE OF WHAT IS FUELING HER AVOIDANCE IS THE ENTIRELY UNREALISTIC AND GRANDIOSELY INFANTILE DESIRE TO HAVE HER SLIDE SHOW ENCOMPASS EVERY SINGLE "GOOD IDEA" ABOUT THE THERAPEUTIC ACTION THAT SHE HAS EVER CONCEIVED OVER THE COURSE OF HER CAREER!

IT BECOMES CLEAR THAT THE PRIMARY ISSUE UNDERLYING HER PROCRASTINATION, FUELING HER RESISTANCE, AND GETTING HER JAMMED UP IS HER RELUCTANCE TO LET GO OF HER IMPOSSIBLE – TO – ACHIEVE DREAM

SO M.S. CONTINUES TO EXPLORE THE DEFENSIVE COUNTERFORCES LURKING DEEP WITHIN THAT ARE INTERFERING WITH HER ABILITY TO MOBILIZE HER ENERGIES SO THAT SHE CAN CHANNEL HER RESOURCES INTO COMPLETING HER SLIDES

IT IS ONLY ONCE M.S. BECOMES AWARE OF
JUST HOW ABSURD IT IS FOR
HER TO BE STILL HOLDING ON
TO HER DEFENSIVE NEED FOR PERFECTION,
A NEED THAT IS AT ONCE
BOTH SELF – INDULGENT AND SELF – DEFEATING,

THAT THE COGNITIVE DISSONANCE
CREATED BY THE TENSION WITHIN HER
BETWEEN HER INTENSE DESIRE TO REALIZE HER DREAM
AND HER NEW – FOUND APPRECIATION FOR
JUST HOW IMPOSSIBLE THAT DREAM REALLY IS
FORCES HER TO RELINQUISH HER RELENTLESS PURSUIT
A SURRENDER THAT IS ACCOMPANIED BY GRIEVING

AS A RESULT OF CONFRONTING – AND MOURNING – THE LOSS OF THAT DREAM, HOWEVER, M.S.'s NEED FOR PERFECTION BECOMES GRADUALLY TEMPERED INTO A MORE – EVOLVED CAPACITY TO DERIVE PLEASURE AND JOY FROM LOVINGLY CRAFTING A SET OF SLIDES THAT WILL BE AT LEAST "GOOD ENOUGH"

M.S. ALSO COMES TO THE LIBERATING REALIZATION THAT NOT EVERY "INSPIRED" IDEA SHE HAS EVER HAD NEEDS TO BE INCLUDED BUT RATHER THAT EVERYTHING INCLUDED NEEDS TO BE AS "INSPIRED" AS POSSIBLE (AND, HOPEFULLY, "INSPIRING") ☺

AS HER DIFFICULT – TO – GRATIFY NEED FOR PERFECTION IS GRADUALLY TAMED, MODIFIED, AND INTEGRATED INTO A MORE MANAGEABLE CAPACITY TO TOLERATE IMPERFECTION, M.S. FINDS HERSELF BETTER ABLE TO DIRECT HER NOW MORE MODULATED ENERGIES TOWARDS THE PURSUIT OF NOW MORE REALIZABLE GOALS

INTERESTINGLY AND PROBABLY NOT SURPRISINGLY, ALTHOUGH M.S.'s SLIDES DO NOT ULTIMATELY INCLUDE ALL THAT SHE MIGHT ORIGINALLY HAVE WANTED THEM TO, THE NET RESULT OF RELINQUISHING HER COMPULSION TO INCLUDE EVERY "GOOD IDEA" SHE HAS EVER HAD, SO FREES UP HER CREATIVITY THAT SHE FINDS HERSELF ENERGIZED AND NOW ABLE TO GENERATE A LOT OF EXCITING, NEW IDEAS GOING FORWARD!

ALL OF WHICH SHE, NO LONGER JAMMED UP, MAKES SURE TO INCLUDE IN HER BOOK OF SLIDES ☺

AS STRUCTURAL CONFLICT IS TRANSFORMED INTO STRUCTURAL COLLABORATION, THE SYNERGY OF HORSE AND RIDER BECOMES SUCH THAT NOW THEIR EFFORTS CAN BE COORDINATED

AND M.S.'s ERSTWHILE DEFENSIVE NEED TO REIN THE HORSE IN MORPHS INTO THE ADAPTIVE CAPACITY TO GIVE THE HORSE FREE REIN

Module 13

GROWTH – PROMOTING

BUT

ANXIETY – PROVOKING CONFLICT STATEMENTS

PROTOTYPICAL OPTIMALLY STRESSFUL ANXIETY – PROVOKING BUT ULTIMATELY GROWTH – PROMOTING INTERVENTIONS

MODEL 1 CONFLICT STATEMENTS ARE DESIGNED TO ENCOURAGE THE "RESISTANT" PATIENT TO STEP BACK FROM THE IMMEDIACY OF THE MOMENT IN ORDER TO TAKE STOCK OF BOTH HER INVESTMENT IN MAINTAINING THINGS AS THEY ARE AND THE PRICE SHE PAYS FOR DOING SO

MODEL 2 DISILLUSIONMENT STATEMENTS ARE DESIGNED TO FACILITATE THE NECESSARY GRIEVING THAT THE "RELENTLESS" PATIENT MUST DO ONCE SHE BEGINS TO CONFRONT HER REFUSAL TO ACCEPT PAINFUL REALITIES ABOUT THE OBJECTS IN HER WORLD

MODEL 3 RELATIONAL INTERVENTIONS ARE DESIGNED TO ENCOURAGE THE "RE – ENACTING" PATIENT TO TAKE RESPONSIBILITY FOR THE UNMASTERED CHILDHOOD DRAMAS THAT SHE IS COMPULSIVELY REPLAYING ON THE STAGE OF HER LIFE

MODEL 1 CONFLICT STATEMENTS

THE PROCESS OF RENDERING CONSCIOUS
WHAT HAD ONCE BEEN UNCONSCIOUS
CAN BEST BE FACILITATED THROUGH THE USE OF
OPTIMALLY STRESSFUL CONFLICT STATEMENTS
THAT ALTERNATELY CHALLENGE AND THEN SUPPORT

THEY FIRST CHALLENGE BY SPEAKING
TO THE PATIENT'S ADAPTIVE CAPACITY
TO KNOW CERTAIN ANXIETY – PROVOKING REALITIES

AND THEN
WITH COMPASSION AND WITHOUT JUDGMENT
SUPPORT BY RESONATING EMPATHICALLY
WITH THE PATIENT'S DEFENSIVE NEED
TO DENY KNOWING THOSE UNCOMFORTABLE TRUTHS

THE PATIENT DOES KNOW

**BE IT SOME PAINFUL TRUTH ABOUT HER INTERNAL DYNAMICS,
THE PRICE SHE PAYS FOR MAINTAINING THE STATUS QUO,
OR THE THERAPEUTIC WORK SHE HAS YET TO DO**

BUT

WOULD RATHER NOT

AND SO,

MADE ANXIOUS,

SHE DEFENDS

MODEL 1 CONFLICT STATEMENTS

STRATEGICALLY DESIGNED TO CREATE
DESTABILIZING TENSION WITHIN THE PATIENT
BETWEEN HER KNOWLEDGE OF ANXIETY – PROVOKING
BUT ULTIMATELY GROWTH – PROMOTING (AND EMPOWERING)
REALITIES

AND THE DEFENSES SHE MOBILIZES
IN ORDER TO EASE THAT ANXIETY

THEIR FORMAT

"YOU KNOW THAT …, BUT YOU FIND YOURSELF …"

FIRST THE THERAPIST CHALLENGES
BY HIGHLIGHTING AN ANXIETY – PROVOKING REALITY

AND THEN SUPPORTS
BY SPEAKING TO THE PATIENT'S ANXIETY – ASSUAGING DEFENSE

MODEL 1 CONFLICT STATEMENTS

"YOU KNOW THAT …, BUT YOU FIND YOURSELF …"

THE THERAPIST FIRST CHALLENGES BY SPEAKING DIRECTLY TO THE PATIENT'S OBSERVING EGO AND ADAPTIVE CAPACITY TO KNOW SOME PAINFUL TRUTH

WHICH WILL INCREASE THE PATIENT'S ANXIETY

BUT THEN SUPPORTS BY RESONATING EMPATHICALLY WITH THE PATIENT'S EXPERIENCING EGO AND DEFENSIVE NEED TO DENY SUCH KNOWING

WHICH WILL DECREASE THE PATIENT'S ANXIETY

THE PATIENT DOES KNOW "BUT" WOULD RATHER NOT

AND SO IT IS THAT SHE, MADE ANXIOUS, DEFENDS

AND "FINDS HERSELF" THINKING, FEELING, OR DOING WHATEVER SHE NEEDS TO IN ORDER TO MAINTAIN THINGS AS THEY ARE

IN THE ARMAMENTARIUM OF THE MODEL 1 THERAPIST

AWARENESS – PROMOTING BUT ANXIETY – PROVOKING INTERVENTIONS

FIRST THE REALITY (THAT IS, WHAT THE PATIENT REALLY DOES KNOW) AND THEN THE DEFENSE OR RESISTANCE (AND WHAT FUELS IT)

YOU KNOW THAT ULTIMATELY YOU'LL NEED TO LET JOSE GO BECAUSE HE, LIKE YOUR DAD, REALLY ISN'T AVAILABLE IN THE WAY THAT YOU WOULD HAVE WANTED HIM TO BE; BUT, FOR NOW, ALL YOU CAN THINK ABOUT IS HOW DESPERATELY YOU WANT TO BE WITH HIM AND HOW HORRIBLE IT WOULD BE TO LOSE HIM.

YOU KNOW THAT EVENTUALLY YOU'LL NEED TO MAKE YOUR PEACE WITH THE REALITY OF JUST HOW LIMITED YOUR MOTHER IS; BUT YOUR FEAR IS THAT WERE YOU EVER TO LET YOURSELF REALLY FEEL THE PAIN OF THAT, YOU WOULD NEVER RECOVER.

YOU KNOW THAT SOMEDAY YOU'LL HAVE TO LET SOMEBODY IN IF YOU'RE EVER TO HAVE A MEANINGFUL RELATIONSHIP; BUT, IN THE MOMENT, THE THOUGHT OF MAKING YOURSELF THAT VULNERABLE IS ABSOLUTELY INTOLERABLE. THERE'S NO WAY YOU'RE WILLING TO RUN THE RISK OF BEING HURT EVER AGAIN.

MODEL 1 CONFLICT STATEMENTS

ANXIETY – PROVOKING BUT ULTIMATELY GROWTH – PROMOTING PSYCHOTHERAPEUTIC INTERVENTIONS

STRATEGICALLY FORMULATED TO PRECIPITATE DISRUPTION IN ORDER TO TRIGGER REPAIR

THESE OPTIMALLY STRESSFUL STATEMENTS CALL THE PATIENT'S ATTENTION TO THE CONFLICT THAT EXISTS WITHIN HER BETWEEN THE OBJECTIVE REALITY THAT SHE KNOWS WITH HER HEAD AND THE SUBJECTIVE EXPERIENCE THAT SHE FEELS WITH HER HEART

ULTIMATELY, AND MOST IMPORTANTLY, THESE CONFLICT STATEMENTS WILL HIGHLIGHT THE PRICE THE PATIENT IS PAYING FOR REMAINING SO DEEPLY ENTRENCHED IN HER (DYSFUNCTIONAL) STATUS QUO
EVEN AS THEY WILL ALSO RESONATE EMPATHICALLY WITH HER INVESTMENT IN MAINTAINING THAT STATUS QUO EVEN SO

OPTIMALLY STRESSFUL

MODEL 1 CONFLICT STATEMENTS

THAT ALTERNATELY CHALLENGE AND THEN SUPPORT

YOU KNOW THAT ULTIMATELY YOU WILL NEED TO CONFRONT – AND GRIEVE – THE REALITY THAT TOM IS NOT AVAILABLE IN THE WAYS THAT YOU WOULD HAVE WANTED HIM TO BE AND THAT UNTIL YOU MAKE YOUR PEACE WITH THAT PAINFUL REALITY YOU WILL CONTINUE TO BE MISERABLE; BUT, IN THE MOMENT, ALL YOU CAN THINK ABOUT IS HOW ANGRY YOU ARE THAT HE DOESN'T TELL YOU MORE OFTEN THAT HE LOVES YOU.

YOU KNOW THAT YOU WON'T FEEL TRULY FULFILLED UNTIL YOU ARE ABLE TO GET YOUR THESIS COMPLETED; BUT YOU CONTINUE TO STRUGGLE, FEARING THAT WHATEVER YOU MIGHT WRITE JUST WOULDN'T BE GOOD ENOUGH OR CAPTURE WELL ENOUGH THE ESSENCE OF WHAT YOU ARE WANTING TO SAY.

YOU KNOW THAT IF YOUR RELATIONSHIP WITH ELANA IS TO SURVIVE, YOU WILL NEED TO TAKE AT LEAST SOME RESPONSIBILITY FOR THE PART YOU'RE PLAYING IN THE INCREDIBLY ABUSIVE FIGHTS THAT YOU AND SHE ARE HAVING; BUT YOU TELL YOURSELF THAT IT ISN'T REALLY YOUR FAULT BECAUSE IF SHE WEREN'T SO PROVOCATIVE, THEN YOU WOULDN'T HAVE TO BE SO VINDICTIVE!

IN ESSENCE

MODEL 1 CONFLICT STATEMENTS

STRIVE TO CREATE INCENTIVIZING TENSION WITHIN THE PATIENT
BETWEEN HER DAWNING AWARENESS
OF JUST HOW COSTLY HER DEFENSES ARE
WITH AN EYE TO MAKING THEM MORE EGO – DYSTONIC
AND HER NEW – FOUND UNDERSTANDING
OF JUST HOW INVESTED SHE HAS BEEN
IN HOLDING ON TO THEM EVEN SO
WITH AN EYE TO HIGHLIGHTING HOW EGO – SYNTONIC THEY ARE

ULTIMATELY

THE EVER – INCREASING INTERNAL DISSONANCE
RESULTING FROM HER EVER – EVOLVING INSIGHT
INTO BOTH THE COST AND THE BENEFIT
OF MAINTAINING HER ATTACHMENT
TO HER (DYSFUNCTIONAL) DEFENSES
WILL GALVANIZE HER TO ACTION
IN ORDER TO RESOLVE THE INNER TENSION

MODEL 1 CONFLICT STATEMENTS

YOU KNOW THAT EVENTUALLY YOU WILL NEED TO FACE THE REALITY THAT YOUR MOTHER WAS NEVER REALLY THERE FOR YOU AND THAT YOU WON'T GET BETTER UNTIL YOU LET GO OF YOUR HOPE THAT MAYBE SOMEDAY YOU'LL BE ABLE TO MAKE HER CHANGE; BUT YOU'RE NOT QUITE YET READY TO DEAL WITH ALL THE PAIN AROUND THAT BECAUSE YOU ARE AFRAID THAT YOU MIGHT NEVER SURVIVE THE HEARTBREAK AND DESPAIR YOU WOULD FEEL WERE YOU TO FACE THAT DEVASTATING REALITY.

YOU KNOW THAT YOUR NEED FOR YOUR CHILDREN TO UNDERSTAND YOUR PERSPECTIVE MIGHT BE A BIT UNREALISTIC; BUT YOU TELL YOURSELF THAT YOU HAVE A RIGHT TO THEIR RESPECT – AND THEIR FORGIVENESS.

YOU'RE COMING TO UNDERSTAND THAT YOUR ANGER CAN PUT PEOPLE OFF; BUT YOU TELL YOURSELF THAT YOU HAVE A RIGHT TO BE AS ANGRY AS YOU WANT BECAUSE OF HOW MUCH YOU HAVE SUFFERED OVER THE YEARS.

YOU KNOW THAT IF YOU ARE EVER TO GET ON WITH YOUR LIFE, YOU WILL HAVE TO LET GO OF YOUR CONVICTION THAT YOUR CHILDHOOD SCARRED YOU FOR LIFE; BUT IT'S HARD NOT TO FEEL LIKE DAMAGED GOODS WHEN YOU GREW UP IN A HORRIBLY ABUSIVE HOUSEHOLD WITH A MEAN AND NASTY MOTHER WHO WAS ALWAYS CALLING YOU A LOSER.

Module 14

RECURSIVE CYCLES OF CHALLENGE AND SUPPORT

AND

LOCATING THE CONFLICT WITHIN THE PATIENT

TO REVIEW

MODEL 1 CONFLICT STATEMENTS

ENCOURAGE THE PATIENT TO STEP BACK FROM
THE IMMEDIACY OF THE MOMENT IN ORDER TO FOCUS ON
THE UNDERLYING FORCES AND COUNTERFORCES
WITHIN HER THAT ARE TYING UP HER ENERGIES
AND INTERFERING WITH HER FORWARD MOMENTUM

THEY ARE DESIGNED TO TEASE OUT
AND, ON THE PATIENT'S BEHALF, ARTICULATE
THE CONFLICT WITHIN HER
BETWEEN HER VOICE OF REALITY
WHICH WILL BE ANXIETY – PROVOKING BUT ULTIMATELY INSIGHT – PROMOTING

AND THE GROWTH – OBSTRUCTING
DEFENSIVE COUNTERFORCES
THAT SHE MOBILIZES IN AN EFFORT
TO EASE HER ANXIETY AND SILENCE THAT VOICE

YOU KNOW THAT YOU'RE PAYING A PRICE FOR CLINGING TO YOUR ANGER (A LOT OF THAT ANGER OLD, FROM WAY BACK); BUT YOU FIND YOURSELF FEELING THAT YOU REALLY DON'T HAVE MUCH OF A CHOICE.

YOU WOULD WANT TO BE ABLE TO FORGIVE ME; BUT THE PAIN AND THE HURT GO SO DEEP THAT YOU CAN'T IMAGINE EVER BEING ABLE TRULY TO TRUST ME – OR ANYONE ELSE.

YOU KNOW THAT YOU MIGHT WELL LATER REGRET IT; BUT, IN THE MOMENT, ALL YOU CAN THINK ABOUT IS HOW GOOD IT WOULD FEEL WERE YOU TO HAVE THAT ICE CREAM SUNDAE.

YOU KNOW THAT IF YOU ARE REALLY SERIOUS ABOUT FINDING YOURSELF A PARTNER, THEN YOU WILL NEED TO PUT YOURSELF OUT THERE IN A WAY THAT YOU DON'T ORDINARILY DO; BUT YOU FIND YOURSELF HOLDING BACK BECAUSE YOU HAVE AN UNDERLYING CONVICTION THAT NO MATTER HOW HARD YOU MIGHT TRY, IT WOULDN'T REALLY MAKE ANY DIFFERENCE ANYWAY.

YOU KNOW THAT EVENTUALLY, IF YOU ARE EVER TO WORK THROUGH YOUR FEARS OF INTIMACY, YOU WILL HAVE TO LET SOMEONE IN; BUT, RIGHT NOW, YOU'RE FEELING THAT YOU SIMPLY CANNOT AFFORD TO BE THAT VULNERABLE. IN THE PAST, WHEN YOU WERE VULNERABLE, ESPECIALLY IN RELATION TO YOUR MOTHER, YOU ALWAYS GOT HURT.

RECURSIVE CYCLES OF

CHALLENGE, THEN SUPPORT

ADDRESSING

COGNITIVE, THEN AFFECTIVE

HEAD, THEN HEART

KNOWLEDGE, THEN EXPERIENCE

OBJECTIVE, THEN SUBJECTIVE

OBSERVING EGO, THEN EXPERIENCING EGO

LEFT BRAIN, THEN RIGHT BRAIN

ADAPTIVE CAPACITY, THEN DEFENSIVE NEED

ADAPTATION, THEN DEFENSE

WITH THE THERAPIST'S FINGER EVER ON THE PULSE OF THE PATIENT'S LEVEL OF ANXIETY AND CAPACITY TO TOLERATE FURTHER CHALLENGE,

MOMENT BY MOMENT

THE THERAPIST WILL ALTERNATELY SUPPORT

BY RESONATING WITH WHERE THE PATIENT IS

AND THEN CHALLENGE

BY DIRECTING THE PATIENT'S ATTENTION TO ELSEWHERE

BACK AND FORTH, BACK AND FORTH
FIRST SUPPORT AND CHALLENGE, THEN CHALLENGE AND SUPPORT

MOMENT BY MOMENT

THE THERAPIST WILL ALTERNATELY CHALLENGE

BY REMINDING THE PATIENT OF AN ANXIETY – PROVOKING REALITY THAT THE PATIENT HAS THE ADAPTIVE CAPACITY TO ACKNOWLEDGE (ALBEIT RELUCTANTLY)

AND THEN SUPPORT

BY RESONATING WITH THE PATIENT'S DEFENSIVE NEED TO MAINTAIN THINGS EXACTLY AS THEY ARE

ALL WITH AN EYE TO GENERATING AN OPTIMAL LEVEL OF INCENTIVIZING AND THEREFORE GROWTH – PROMOTING STRESS

PARENTHETICALLY

AS WE SIT WITH OUR PATIENTS,
THERE IS ALWAYS A DIALECTICAL TENSION
WITHIN US, AS WELL, BETWEEN

ON THE ONE HAND
OUR VISION OF WHO WE
THINK THE PATIENT COULD BE
WERE SHE BUT ABLE
TO MAKE HEALTHIER CHOICES

AND

ON THE OTHER HAND
OUR RESPECT FOR THE REALITY OF WHO SHE IS
AND FOR THE CHOICES, NO MATTER HOW UNHEALTHY,
THAT SHE IS CONTINUOUSLY MAKING

WE ARE THEREFORE ALWAYS STRUGGLING TO FIND
AN OPTIMAL BALANCE WITHIN OURSELVES BETWEEN
WANTING THE PATIENT TO CHANGE
AND ACCEPTING THE REALITY OF WHO SHE IS

IMPORTANTLY

MODEL 1 CONFLICT STATEMENTS

BY LOCATING WITHIN THE PATIENT

THE CONFLICT BETWEEN

HER ANXIETY – PROVOKING KNOWLEDGE

OF A DISTRESSING REALITY AND

HER ANXIETY – ASSUAGING NEED

TO DISMISS IT,

THE THERAPIST IS DEFTLY SIDESTEPPING

THE POTENTIAL FOR CONFLICT

BETWEEN THERAPIST AND PATIENT

MODEL 1 CONFLICT STATEMENTS

THE THERAPIST WHO IS ABLE TO RESIST THE TEMPTATION

TO GET BOSSY BY OVERZEALOUSLY ADVOCATING

FOR THE PATIENT TO DO THE "RIGHT THING"

WILL BE ABLE MASTERFULLY TO AVOID GETTING

DEADLOCKED IN A POWER STRUGGLE WITH THE PATIENT

SUCH A STRUGGLE CAN EASILY ENOUGH ENSUE

WHEN THE THERAPIST TAKES IT UPON HERSELF

TO REPRESENT THE VOICE OF REALITY

A STANCE THAT THEN LEAVES THE PATIENT
NO OPTION BUT TO BECOME THE VOICE OF OPPOSITION

WHEN THE THERAPIST INTRODUCES A CONFLICT STATEMENT WITH

"YOU KNOW THAT …"

SHE WILL BE FORCING THE PATIENT TO TAKE RESPONSIBILITY FOR WHAT SHE REALLY DOES KNOW

BUT IF THE THERAPIST, IN A MISGUIDED ATTEMPT TO URGE THE PATIENT FORWARD, RESORTS SIMPLY TO TELLING THE PATIENT WHAT THE THERAPIST KNOWS, NOT ONLY DOES THE THERAPIST RUN THE RISK OF FORCING THE PATIENT TO BECOME EVER MORE ENTRENCHED IN HER DEFENSIVE STANCE OF PROTEST BUT ALSO THE THERAPIST WILL BE ROBBING THE PATIENT OF ANY INCENTIVE TO TAKE RESPONSIBILITY FOR HER OWN DESIRE TO GET BETTER

IT REALLY IS AN UNTENABLE SITUATION
FOR THE THERAPIST TO BE THE ONE REPRESENTING
THE HEALTHY (ADAPTIVE) VOICE OF YES

AND FOR THE PATIENT, MADE ANXIOUS, TO BE THEN
STUCK IN THE POSITION OF HAVING TO COUNTER WITH
THE UNHEALTHY (DEFENSIVE) VOICE OF NO

AND SO IT IS THAT IN THE FIRST PART OF THE CONFLICT STATEMENT
THE THERAPIST HIGHLIGHTS WHAT THE PATIENT,
AT LEAST ON SOME LEVEL, REALLY DOES KNOW

IN ESSENCE
BY LOCATING THE CONFLICT SQUARELY WITHIN THE PATIENT
AND NOT IN THE INTERSUBJECTIVE FIELD BETWEEN
THERAPIST AND PATIENT, CONFLICT STATEMENTS FORCE
THE PATIENT TO TAKE OWNERSHIP OF BOTH SIDES
OF HER AMBIVALENCE ABOUT GETTING BETTER
BOTH THE YES FORCES AND THE NO COUNTERFORCES
MOBILIZED IN REACTION TO THOSE YES FORCES

ALSO NOTE THE IMPLICIT MESSAGE DELIVERED BY THE THERAPIST IN THE SECOND PART OF A CONFLICT STATEMENT WHEN SHE USES SUCH TEMPORAL EXPRESSIONS AS

"FOR NOW" – "RIGHT NOW"
"AT THE MOMENT" – "IN THE MOMENT"
"AT THIS POINT IN TIME"

WHICH SHE WILL DO WHEN SHE IS ADDRESSING THE PATIENT'S "INVESTMENT IN" THE DYSFUNCTIONAL DEFENSE

YOU KNOW YOU'RE PAYING A STEEP PRICE FOR YOUR REFUSAL TO STOP SMOKING, OF PARTICULAR CONCERN BECAUSE OF YOUR RECURRENT LUNG INFECTIONS; BUT, IN THE MOMENT, YOU FIND YOURSELF FEELING THAT YOU SIMPLY MUST HAVE THE CIGARETTES IN ORDER TO RELIEVE THE MASSIVE ANXIETY THAT YOU'RE FEELING BECAUSE OF THE LAWSUIT.

THE THERAPIST IS ATTEMPTING TO HIGHLIGHT THE FACT THAT EVEN IF, FOR NOW, THE PATIENT WOULD SEEM TO BE INVESTED IN PROTESTING HER RIGHT TO MAINTAIN THINGS AS THEY ARE, AT ANOTHER POINT IN TIME THAT COULD CHANGE

IN SUM

OPTIMALLY STRESSFUL CONFLICT STATEMENTS
ARE DESIGNED TO PROVOKE THE RELINQUISHMENT
OF DYSFUNCTIONAL DEFENSES
BY GENERATING COGNITIVE AND AFFECTIVE DISSONANCE

IMPORTANTLY

THE WISDOM OF THE BODY IS SUCH THAT IT CANNOT TOLERATE
THE DISTRESS OF DISEQUILIBRIUM FOR EXTENDED PERIODS OF TIME
AND WILL THEREFORE BE PROMPTED TO TAKE ACTION
IN ORDER TO RESOLVE THE TENSION AND RESTORE THE ORDER

ULTIMATELY

IT WILL BE THE PATIENT'S EVER – EVOLVING
ADAPTIVE CAPACITY TO RECOGNIZE THE FUNDAMENTAL CONFLICT
BETWEEN COST AND BENEFIT
THAT WILL SIMPLY FORCE HER TO LET GO OF HER DYSFUNCTION

THAT IS, TO SURRENDER HER UNHEALTHY DEFENSES
DESPITE THEIR ERSTWHILE ROBUSTNESS
IN FAVOR OF HEALTHIER ADAPTATIONS

AS SHE EVOLVES FROM
CURSING THE DARKNESS TO LIGHTING A CANDLE

Module 15

COGNITIVE DISSONANCE

AND

FROM STRUCTURAL CONFLICT TO STRUCTURAL COLLABORATION

TO SUMMARIZE

IN ORDER TO INCREASE THE PATIENT'S AWARENESS OF HER AMBIVALENT ATTACHMENT TO HER DYSFUNCTIONAL DEFENSES

THE MODEL 1 INTERPRETIVE THERAPIST

ALTERNATELY CHALLENGES BY HIGHLIGHTING
WHAT THE PATIENT IS COMING TO UNDERSTAND
AS THE PRICE SHE PAYS FOR CLINGING
TO HER DYSFUNCTIONAL DEFENSES

A PRICE THAT FUELS HER AGGRESSIVE CATHEXIS OF THOSE DEFENSES

AND THEN SUPPORTS BY RESONATING WITH
WHAT THE THERAPIST IS COMING TO UNDERSTAND
AS THE INVESTMENT THE PATIENT HAS IN HOLDING ON
TO HER DYSFUNCTIONAL DEFENSES EVEN SO

AN INVESTMENT THAT FUELS HER LIBIDINAL CATHEXIS OF THOSE DEFENSES

BACK AND FORTH – BACK AND FORTH

IN AN EFFORT TO MAKE THE AMBIVALENTLY HELD DEFENSE
EVER LESS EGO – SYNTONIC AND EVER MORE EGO – DYSTONIC

EVER – INCREASING AWARENESS OF INTERNAL CONFLICT

THE GOAL OF THESE OPTIMALLY STRESSFUL INTERVENTIONS IS NOT ONLY TO GIVE THE PATIENT SUFFICIENT SPACE TO EXPERIENCE WHATEVER SHE MIGHT FIND HERSELF FEELING AS A REACTION TO BEING CONFRONTED WITH ANXIETY – PROVOKING REALITIES THAT SHE CAN NO LONGER DENY

BUT ALSO TO PROMOTE ENOUGH DETACHMENT THAT SHE WILL BE ABLE TO BRING TO BEAR HER SELF – REFLECTIVE CAPACITY

ALL WITH AN EYE TO MAKING HER EVER MORE ACUTELY AWARE OF THE STRUGGLE BEING WAGED WITHIN HER BETWEEN WHAT HER HEAD – ALBEIT BEGRUDGINGLY – KNOWS AND WHAT HER HEART – IN DESPERATE PROTEST – FEELS

BY REPEATEDLY FORMULATING CONFLICT STATEMENTS
THAT STRATEGICALLY JUXTAPOSE
THE PATIENT'S DAWNING AWARENESS OF
JUST HOW STEEP A PRICE SHE IS PAYING
FOR HOLDING ON TO HER DEFENSES

THAT IS, THE PAIN

AND HER NEW – FOUND APPRECIATION FOR
HOW THEY HAVE SERVED HER

THAT IS, THE GAIN

THE THERAPIST WILL BE ABLE TO CREATE
GALVANIZING TENSION WITHIN THE PATIENT

GROWTH – PROMOTING DISSONANCE
THAT WILL ULTIMATELY BECOME
THE FULCRUM FOR THERAPEUTIC CHANGE

AND SO IT IS THAT THE THERAPIST
WILL REPEATEDLY JUXTAPOSE BOTH

THE "PRICE PAID" (PAIN)
AND THE "INVESTMENT IN" (GAIN)

IN ORDER INCREMENTALLY
TO MAKE THE PATIENT'S
AMBIVALENTLY HELD
DYSFUNCTIONAL DEFENSES
EVER LESS EGO – SYNTONIC

THAT IS, EVER LESS CONSONANT WITH
WHO SHE WOULD WANT TO BE

AND EVER MORE EGO – DYSTONIC OR EGO ALIEN

THAT IS, EVER MORE DISSONANT WITH
WHO SHE WOULD WANT TO BE

AS LONG AS THE GAIN IS GREATER THAN THE PAIN,

THE PATIENT WILL MAINTAIN THE DEFENSE AND REMAIN ENTRENCHED

BUT ONCE THE PAIN BECOMES GREATER THAN THE GAIN,

THE STRESS AND STRAIN THEREBY CREATED AS A RESULT OF THE COGNITIVE AND AFFECTIVE DISSONANCE BETWEEN THE PAIN AND THE GAIN WILL PROVIDE THE IMPETUS NEEDED …

… FOR THE PATIENT GRADUALLY TO
RELINQUISH HER ATTACHMENT TO THE DEFENSE
IN ORDER TO RESTORE HER PSYCHOLOGICAL EQUILIBRIUM

THEREBY

RESOLVING STRUCTURAL CONFLICT

BETWEEN ID DRIVE AND EGO DEFENSE

THE NOW STRONGER EGO
WILL BE BETTER ABLE TO REGULATE
THE NOW TAMER FORCES OF THE ID
BY REDIRECTING THOSE ENERGIES
INTO MORE CONSTRUCTIVE CHANNELS

IN SUM
AS THE EGO BECOMES EMPOWERED
AND THE ID ENERGIES ARE HARNESSED,
THE PATIENT'S NEUROTIC CONFLICTEDNESS
AND RESULTANT OBSTRUCTED PROGRESSION THROUGH LIFE
WILL BECOME GRADUALLY TRANSFORMED INTO
ACTUALIZATION OF POTENTIAL

IN ESSENCE

A WEAK EGO'S NEED TO DEFEND
AGAINST THE UNTAMED ENERGIES OF AN ID
WILL HAVE BECOME GRADUALLY TRANSFORMED
INTO A STRONGER EGO'S CAPACITY TO CHANNEL
THOSE NOW TAMER ENERGIES
INTO MORE CONSTRUCTIVE PURSUITS

IN LANGUAGE PERHAPS MORE FAMILIAR

THE DEFENSIVE NEED TO

"PUT A LID ON THE ID"

WILL HAVE BECOME

GRADUALLY TRANSFORMED INTO

THE ADAPTIVE CAPACITY TO

"SUBLIMATE"

AS CONFLICT IS REPLACED BY COLLABORATION

MODEL 1 HIGHLIGHTS

ENHANCED KNOWLEDGE / INSIGHT / WISDOM

INCREASED SELF – AWARENESS

RENDERING CONSCIOUS THE UNCONSCIOUS

INCREASED AWARENESS OF INTERNAL CONFLICT BETWEEN EMPOWERING FORCES AND GROWTH – IMPEDING DEFENSIVE COUNTERFORCES

DEEP APPRECIATION FOR THE AMBIVALENCE OF THE PATIENT'S ATTACHMENT TO THESE RESISTANT COUNTERFORCES

MORE SPECIFICALLY, UNDERSTANDING THAT THESE DEFENSES BOTH BENEFIT HER

THUS HER LIBIDINAL CATHEXIS OF THEM

(AND THE IMPORTANCE OF ADDRESSING HER INVESTMENT IN HAVING THEM)

AND COST HER

THUS HER AGGRESSIVE CATHEXIS OF THEM

(AND THE IMPORTANCE OF ADDRESSING THE PRICE SHE IS PAYING FOR HAVING THEM)

AN INTENSELY AMBIVALENT ATTACHMENT THAT SPEAKS TO THE ADHESIVENESS OF THE ID AND MUST BE WORKED THROUGH BEFORE THESE DEFENSES CAN BE RELINQUISHED

MODEL 1 HIGHLIGHTS (CONTINUED)

THE WORKING THROUGH PROCESS
WILL TAME THE ID AND STRENGTHEN THE EGO
AND WILL INVOLVE HIGHLIGHTING THE COGNITIVE DISSONANCE
BETWEEN THE BENEFIT (GAIN) AND THE COST (PAIN)

THEREBY RENDERING THE DEFENSES
INCREASINGLY EGO – DYSTONIC AND EVER LESS EGO – SYNTONIC

THE OPTIMAL STRESS AND STRAIN OF THIS COGNITIVE
DISSONANCE WILL CREATE INCENTIVIZING TENSION THAT WILL
ULTIMATELY FORCE SURRENDER OF THE UNHEALTHY DEFENSES
IN FAVOR OF HEALTHIER ADAPTATIONS
AND RESOLUTION OF THE STRUCTURAL CONFLICT
IN FAVOR OF STRUCTURAL COLLABORATION
A TAMER HORSE (ID) AND A STRONGER RIDER (EGO) NOW OPERATING SYNERGISTICALLY

WITH THE FREEING UP OF ENERGIES THAT HAD ONCE BEEN HELD IN CHECK,
THE EMPOWERING (ID) ENERGIES CAN NOW BE ADAPTIVELY HARNESSED
AND CHANNELED (BY THE EGO) INTO MORE CONSTRUCTIVE PURSUITS,
THEREBY FUELING ACTUALIZATION OF POTENTIAL

FROM STRUCTURAL CONFLICT TO STRUCTURAL COLLABORATION
FROM "DEFENSE AGAINST" TO "ADAPTING TO"

Module 16

NATURE vs. NURTURE

AND

I – IT vs. I – THOU RELATIONSHIPS

WHEREAS THE THERAPEUTIC ACTION IN MODEL 1
INVOLVES WORKING THROUGH
THE STRESS OF GAIN – BECOME – PAIN
AS DEFENSES ONCE EGO – SYNTONIC
ARE MADE INCREASINGLY EGO – DYSTONIC

THE THERAPEUTIC ACTION IN MODEL 2
INVOLVES WORKING THROUGH
THE STRESS OF GOOD – BECOME – BAD
AS THE PATIENT'S DEFENSIVE NEED TO CLING TO ILLUSION
IS CHALLENGED AND GRADUALLY REPLACED BY
MORE ACCURATE (AND SOBERING) PERCEPTIONS OF REALITY

AND THE THERAPEUTIC ACTION IN MODEL 3
INVOLVES WORKING THROUGH
THE STRESS OF BAD – BECOME – GOOD
AS THE PATIENT'S DEFENSIVE NEED TO CLING TO DISTORTION
BECAUSE THAT IS ALL SHE HAS EVER KNOWN
IS CHALLENGED AND GRADUALLY REPLACED BY
MORE ACCURATE (AND LESS TOXIC) PERCEPTIONS OF REALITY

AS HAD BEEN NOTED EARLIER

CLASSICAL PSYCHOANALYSTS CONCEIVE OF PSYCHOPATHOLOGY AS DERIVING FROM THE PATIENT

IN WHOM THERE IS THOUGHT TO BE
INTERNAL CONFLICT
BETWEEN AN UNTAMED ID AND A WEAK EGO

BUT SELF PSYCHOLOGISTS AND OBJECT RELATIONS THEORISTS CONCEIVE OF PSYCHOPATHOLOGY AS DERIVING FROM THE PARENT

AND THE PARENT'S TRAUMATIC FAILURE
OF THE CHILD

OVERVIEW

WHEREAS CLASSICAL PSYCHOANALYSTS FOCUS ON
DEFENSIVE REINFORCEMENT OF INFANTILE DRIVES
WHICH THEN GIVES RISE TO INTERNAL CONFLICT BETWEEN
INTENSIFIED ID DRIVES AND AN UNDEVELOPED EGO MADE ANXIOUS

SELF PSYCHOLOGISTS FOCUS ON
TRAUMATIC PARENTAL ERRORS OF OMISSION
THAT CREATE INTERNAL DEFICITS
WHICH THEN GIVE RISE TO AN INTENSIFIED NEED TO FIND
IN THE HERE – AND – NOW RELATIONSHIP WITH THE THERAPIST
THE GOOD PARENT THE PATIENT NEVER HAD
CONSISTENTLY AND RELIABLY EARLY – ON

AND OBJECT RELATIONS THEORISTS FOCUS ON
TRAUMATIC PARENTAL ERRORS OF COMMISSION
THAT CREATE INTERNAL BAD OBJECTS
WHICH THEN GIVE RISE TO COMPULSIVE AND UNWITTING RE – ENACTMENTS
IN THE HERE – AND – NOW RELATIONSHIP WITH THE THERAPIST
OF THE TOXIC RELATIONAL DYNAMICS
THAT HAD CHARACTERIZED THE PATIENT'S
EARLY – ON RELATIONSHIP WITH HER ABUSIVE PARENT

IN OTHER WORDS
SELF PSYCHOLOGISTS AND
OBJECT RELATIONS THEORISTS FOCUS

NOT SO MUCH ON NATURE

THE PROVINCE OF MODEL 1

AS ON NURTURE

THE PROVINCE OF MODELS 2 AND 3

WHETHER

THE QUALITY OF PARENTAL CARE

MODEL 2

OR THE MUTUALITY OF FIT BETWEEN PARENT AND CHILD

MODEL 3

NATURE

WHAT DERIVES FROM WITHIN THE CHILD

MODEL 1

NURTURE

WHAT DERIVES FROM WITHIN THE RELATIONSHIP BETWEEN PARENT AND CHILD

MODEL 2 AND MODEL 3

BUT PLEASE NOTE
THE CRITICAL DISTINCTION
BETWEEN

QUALITY OF PARENTAL CARE
A STORY ABOUT "GIVE"
WHICH MAKES OF MODEL 2
A 1½ – PERSON PSYCHOLOGY

AND MUTUALITY OF FIT
A STORY ABOUT "GIVE – AND – TAKE"
WHICH MAKES OF MODEL 3
A 2 – PERSON PSYCHOLOGY

AS THE ETIOLOGY HAS SHIFTED FROM NATURE TO NURTURE,

SO TOO THE LOCUS OF THE THERAPEUTIC ACTION HAS SHIFTED

FROM "INSIGHT BY WAY OF INTERPRETATION"

TO "A CORRECTIVE EXPERIENCE BY WAY OF THE REAL RELATIONSHIP"

THAT IS, FROM WITHIN THE PATIENT TO WITHIN THE RELATIONSHIP BETWEEN THERAPIST AND PATIENT

MODEL 2

AN "I – IT" RELATIONSHIP

A 1 – WAY RELATIONSHIP BETWEEN SOMEONE WHO GIVES AND SOMEONE WHO TAKES

MODEL 3

AN "I – THOU" RELATIONSHIP

A 2 – WAY RELATIONSHIP INVOLVING GIVE – AND – TAKE, MUTUALITY, RECIPROCITY, AND COLLABORATION

(BUBER 1923)

THE EMPHASIS IN MODEL 2

IS NOT SO MUCH ON THE RELATIONSHIP PER SE
AS IT IS ON THE FILLING IN OF DEFICIT
BY WAY OF THE THERAPIST'S CORRECTIVE PROVISION

MORE ACCURATELY
BY WAY OF THE PATIENT'S WORKING THROUGH
DISRUPTIONS TO THAT CORRECTIVE PROVISION
OCCASIONED BY THE THERAPIST'S INEVITABLE EMPATHIC FAILURES

IN OTHER WORDS
THE THERAPEUTIC ACTION IN MODEL 2
INVOLVES CONFRONTING AND GRIEVING
DISAPPOINTMENT THE PATIENT EXPERIENCES
IN THE FACE OF FAILURES
IN THE THERAPIST'S CORRECTIVE PROVISION

OPTIMAL DISILLUSIONMENT AND
THE RESULTANT TRANSMUTING INTERNALIZATIONS

AND THE RELATIONSHIP THAT EXISTS
BETWEEN A PERSON WHO PROVIDES
AND A PERSON WHO IS
THE RECIPIENT OF SUCH PROVISION
MODEL 2

IS A FAR CRY FROM THE RELATIONSHIP
THAT EXISTS BETWEEN TWO REAL PEOPLE
MODEL 3

THIS LATTER
AN INTERSUBJECTIVE RELATIONSHIP
INVOLVING "RECIPROCALLY MUTUAL INTERACTION"
BETWEEN TWO SUBJECTS

BOTH OF WHOM ARE THOUGHT
TO CONTRIBUTE TO WHAT TRANSPIRES
AT THE INTIMATE EDGE BETWEEN THEM

Module 17

CORRECTIVE PROVISION

vs.

AUTHENTIC ENGAGEMENT

AND SO IT IS THAT IN THE PAST 30 YEARS OR SO CONTEMPORARY THEORISTS HAVE BEGUN TO HIGHLIGHT THE CRITICAL DISTINCTION BETWEEN

MODEL 2

THE THERAPIST'S PROVISION OF A CORRECTIVE EXPERIENCE

AS A NEW GOOD OBJECT

FOR THE PATIENT

MODEL 3

THE THERAPIST'S PARTICIPATION IN A REAL RELATIONSHIP

AS AN AUTHENTIC SUBJECT

WITH THE PATIENT

MORE SPECIFICALLY, NOTE THE DISTINCTION BETWEEN

THE THERAPIST'S PARTICIPATION AS A NEW GOOD OBJECT

MODEL 2

AND

THE THERAPIST'S PARTICIPATION AS AN AUTHENTIC SUBJECT

MODEL 3

WHICH WILL ALMOST INEVITABLY END UP INVOLVING
THE THERAPIST'S PARTICIPATION AS THE OLD BAD OBJECT
BECAUSE OF THE PATIENT'S EVER – PRESENT NEED
TO RECREATE THE EARLY – ON TRAUMATIC FAILURE SITUATION
IN THE HERE – AND – NOW RELATIONSHIP WITH HER THERAPIST
IN AN EFFORT TO ACHIEVE BELATED MASTERY

AGAIN

WE ARE SPEAKING HERE

TO THE DISTINCTION BETWEEN

A MODEL OF THERAPEUTIC ACTION

THAT CONCEIVES OF

THE THERAPY RELATIONSHIP

AS INVOLVING GIVE

THE THERAPIST GIVING, THE PATIENT TAKING

MODEL 2

AND A MODEL THAT CONCEIVES OF

THE THERAPY RELATIONSHIP

AS INVOLVING GIVE – AND – TAKE

BOTH PARTICIPANTS GIVING AND TAKING

MODEL 3

MICHAEL BALINT

AN ADVOCATE FOR THE
MODEL 2 CORRECTIVE – PROVISION APPROACH

WRITES ABOUT THE "AREA OF THE BASIC FAULT,"
WHICH MUST BE "PUT RIGHT"

"IT IS DEFINITELY
A TWO – PERSON RELATIONSHIP
IN WHICH, HOWEVER,
ONLY ONE OF
THE PARTNERS MATTERS …"

(BALINT 1968)

ALTHOUGH THERE ARE STILL SOME WHO WRITE ABOUT
"A CORRECTIVE EXPERIENCE
BY WAY OF THE REAL RELATIONSHIP,"

THIS TELESCOPES TWO DIFFERENT CONCEPTS
AND OBFUSCATES THE CRITICAL CLINICAL DISTINCTION
BETWEEN A THERAPY RELATIONSHIP
THAT INVOLVES GIVE
DISPLACEMENT OF NEED TO FIND NEW GOOD AND THEN
WORKING THROUGH POSITIVE TRANSFERENCE DISRUPTED

AND A THERAPY RELATIONSHIP
THAT INVOLVES GIVE – AND – TAKE
PROJECTION OF NEED TO REFIND OLD BAD AND THEN
WORKING THROUGH NEGATIVE TRANSFERENCE

A "CORRECTIVE EXPERIENCE" IN THE FIRST INSTANCE (MODEL 2)
A "REAL RELATIONSHIP" IN THE SECOND (MODEL 3)

AGAIN

MODEL 2 THEORISTS FOCUS ON THE PRICE THE CHILD PAYS BECAUSE OF WHAT THE PARENT DID NOT DO

DEPRIVATION AND NEGLECT

ABSENCE OF GOOD

DEFICIENCY

INTERNALLY RECORDED IN THE FORM OF STRUCTURAL DEFICIT AND IMPAIRED CAPACITY

TO BE A GOOD PARENT UNTO ONESELF

A DEFICIT THAT THEN GIVES RISE TO THE SEARCH FOR A NEW GOOD PARENT

TO COMPENSATE FOR THE EARLY – ON ERRORS OF OMISSION

IN ESSENCE

THE DEFICIT CREATES THE NEED TO FIND NEW GOOD

TO FILL IN FOR MISSING PSYCHIC STRUCTURE AND FUNCTIONAL CAPACITY

ONCE THAT NEED FOR NEW GOOD

GETS DELIVERED

BY WAY OF DISPLACEMENT

INTO THE THERAPY RELATIONSHIP,

A POSITIVE TRANSFERENCE WILL EMERGE

WHETHER A MIRROR OR AN IDEALIZING TRANSFERENCE

WORKING THROUGH DISRUPTIONS OF WHICH

WILL CONSTITUTE THE THERAPEUTIC ACTION

TO BE DISTINGUISHED FROM THE NEGATIVE TRANSFERENCE

OF MODEL 3 THAT WILL EMERGE WHEN

PATHOGENIC INTROJECTS GET DELIVERED

BY WAY OF PROJECTION OR PROJECTIVE IDENTIFICATION

INTO THE THERAPY RELATIONSHIP

AGAIN

MODEL 3 THEORISTS FOCUS ON THE PRICE THE CHILD PAYS BECAUSE OF WHAT THE PARENT DID DO

TRAUMA AND ABUSE

PRESENCE OF BAD

TOXICITY

INTERNALLY RECORDED AND STRUCTURALIZED IN THE FORM OF PATHOGENIC INTROJECTS

MORE SPECIFICALLY, PAIRS OF INTERNAL BAD OBJECTS
VICTIMIZER – VICTIM / CRITICIZER – CRITICIZEE / ABANDONER – ABANDONEE

THAT BECOME FILTERS THROUGH WHICH THE PATIENT THEN EXPERIENCES HER WORLD

EITHER DISTORTEDLY (BECAUSE OF PROJECTION)
OR IN ACTUALITY (BECAUSE OF PROJECTIVE IDENTIFICATION)

MODEL 3

WHEN

UNDER THE SWAY OF THE REPETITION COMPULSION

THESE PATHOGENIC INTROJECTS AND DYSFUNCTIONAL "PATTERNS OF RELATIONAL EXPECTATION" (HEDGES 1983) ARE COMPULSIVELY AND UNWITTINGLY RE – PLAYED IN THE THERAPY RELATIONSHIP,

A NEGATIVE TRANSFERENCE WILL EMERGE

WHETHER THE RESULT OF PROJECTION OR PROJECTIVE IDENTIFICATION

AND THE PATIENT WILL END UP RE – EXPERIENCING THE EARLY – ON TRAUMATIC FAILURE SITUATION

AGAIN AND AGAIN

UNTIL SOMETHING DIFFERENT HAPPENS AND THERE CAN BE RESOLUTION OF THE DYSFUNCTIONAL RELATIONAL DYNAMIC, ACCOMPANIED BY STRUCTURAL MODIFICATION

ABSENCE OF GOOD

AND

PRESENCE OF BAD

GENERALLY GO HAND IN HAND

FOR EXAMPLE, THE CHILD WHO WAS RARELY PRAISED
WAS PROBABLY ALSO OFTEN CRITICIZED

THE CHILD WHO WAS NOT ADMIRED
WAS PROBABLY ALSO OFTEN DEVALUED

DEPRIVATION / NEGLECT (DEFICIENCY)

AND TRAUMA / ABUSE (TOXICITY)

DEMONSTRATE THE SAME YIN AND YANG COMPLEMENTARITY

THAT CHARACTERIZES DEFENSE AND ADAPTATION

Module 18

POSITIVE TRANSFERENCE DISRUPTED

vs.

NEGATIVE TRANSFERENCE

IN SUM

DISPLACEMENT OF NEED

"TO FIND NEW GOOD"

GIVES RISE TO ILLUSION

AND POSITIVE TRANSFERENCE

MODEL 2

PROJECTION OF NEED

"TO REFIND OLD BAD"

GIVES RISE TO DISTORTION

AND NEGATIVE TRANSFERENCE

MODEL 3

MODEL 3

WHEN THE PATIENT IS SIMPLY IMAGINING THAT THE THERAPIST EITHER IS OR MIGHT BECOME THE OLD BAD PARENT,

WE SPEAK OF PROJECTION, DISTORTION, AND NEGATIVE TRANSFERENCE

BUT WHEN THE THERAPIST IS IMPACTED BY THE PATIENT'S FORCE FIELD SUCH THAT SHE ACTUALLY BECOMES THE OLD BAD PARENT,

THEN WE SPEAK OF PROJECTIVE IDENTIFICATION, REALITY – BASED PERCEPTION, AND ACTUALIZED NEGATIVE TRANSFERENCE

WHEN THIS LATTER SITUATION EMERGES, ITS RESOLUTION WILL BE ONE OF THE MOST CHALLENGING – ALBEIT ULTIMATELY REWARDING – THINGS WE WILL EVER BE CALLED UPON TO FACILITATE

MODEL 2

**WHEN THE PATIENT IS SIMPLY IMAGINING
THAT THE THERAPIST EITHER IS
OR MIGHT BECOME A NEW GOOD PARENT,**

WE SPEAK OF DISPLACEMENT, ILLUSION, AND POSITIVE TRANSFERENCE

**BUT WHEN THE THERAPIST IS IMPACTED
BY THE PATIENT'S FORCE FIELD SUCH THAT
SHE ACTUALLY BECOMES THE NEW GOOD PARENT,**

THEN WE SPEAK OF "DISPLACIVE IDENTIFICATION" (STARK 1999), REALITY – BASED PERCEPTION, AND ACTUALIZED POSITIVE TRANSFERENCE

ACTUALIZED POSITIVE TRANSFERENCE

IN THE PSYCHOANALYTIC LITERATURE, THIS LATTER SITUATION TENDS TO BE VIEWED AS A "NO – NO" BECAUSE IT IS THOUGHT TO BE FRAUGHT WITH THE POTENTIAL FOR TOO MUCH GRATIFICATION OF THE PATIENT AND AS BEING THEREFORE PRONE TO ESCALATING OUT OF CONTROL

BUT JUST AS WE HAVE ALL HAD THE UNCANNY EXPERIENCE OF BEING DRAWN IN BY THE PATIENT'S FORCE FIELD TO DOING "BAD" THINGS THAT HORRIFY US ONCE WE HAVE BECOME AWARE OF HAVING PARTICIPATED COUNTERTRANSFERENTIALLY IN THE PATIENT'S TRANSFERENTIAL RE – ENACTMENT (PROJECTIVE IDENTIFICATION BECAUSE PROJECTION IS INVOLVED),

SO TOO MOST OF US HAVE PROBABLY HAD THE UNCANNY EXPERIENCE OF FINDING OURSELVES ABLE TO BE MORE ARTICULATE, MORE LOVING, AND WISER THAN WE COULD EVER HAVE IMAGINED POSSIBLE, IN WHICH CASE WE MIGHT WELL BE RESPONDING TO THE FORCE FIELD CREATED BY A PATIENT DESPERATELY INTENT UPON FINDING A NEW GOOD PARENT

AND SO WE ARE NOW UNCONSCIOUSLY "IN COLLUSION WITH HER ILLUSION" THAT WE WILL INDEED BE ABLE TO MAKE UP THE DIFFERENCE TO HER ("DISPLACIVE IDENTIFICATION" BECAUSE DISPLACEMENT IS INVOLVED)

(STARK 1994)

AS WITH WORKING THROUGH PROJECTIVE IDENTIFICATION,

SO TOO WORKING THROUGH DISPLACIVE IDENTIFICATION CAN BE ONE OF THE MOST POWERFULLY EFFECTIVE

EVEN AS IT IS CHALLENGING

TOOLS THAT WE HAVE IN OUR ARMAMENTARIUM

NOTE THAT WHEREAS PROJECTIVE IDENTIFICATION FALLS SQUARELY IN THE DOMAIN OF MODEL 3, DISPLACIVE IDENTIFICATION HAS ELEMENTS OF BOTH MODEL 2

BECAUSE IT IS A STORY ABOUT NEW GOOD

AND MODEL 3

BECAUSE IT INVOLVES MUTUALITY OF IMPACT AND TRANSFERENCE / COUNTERTRANSFERENCE ENACTMENT

MODEL 2

ABSENCE OF GOOD
WILL REQUIRE "ADDITION"
STRUCTURAL GROWTH

WHEREAS

MODEL 3

PRESENCE OF BAD
WILL REQUIRE "SUBTRACTION"
STRUCTURAL CHANGE / MODIFICATION

AS NOTED EARLIER

TO CORRECT FOR DEFICIENCY
REPLENISH THE RESERVES BY ADDING NEW GOOD

TO CORRECT FOR TOXICITY
LIGHTEN THE LOAD BY CHANGING OLD BAD

MODEL 2

WORKING THROUGH
DISRUPTED POSITIVE TRANSFERENCE

WORKING THROUGH THE STRESSFUL EXPERIENCE
OF GOOD – BECOME – BAD

THE EXPERIENCE OF PERFECTION FOLLOWED BY EMPATHIC FAILURE
THE EXPERIENCE OF ILLUSION FOLLOWED BY DISILLUSIONMENT

INEVITABLY THIS DYNAMIC WILL HAPPEN REPEATEDLY
THE NET RESULT OF WHICH WILL BE
GRADUAL ACCRETION OF PSYCHIC STRUCTURE,
CONSOLIDATION OF THE SELF,
AND TAMING OF THE NEED FOR THE OBJECT
TO BE SOMETHING IT IS NOT

A STORY ABOUT CONFRONTING
AND GRIEVING HEARTBREAK
AND EVOLVING ULTIMATELY TO A PLACE
OF SERENE – ALBEIT SOBER – ACCEPTANCE

MODEL 3

WORKING THROUGH NEGATIVE TRANSFERENCE

WORKING THROUGH THE STRESSFUL EXPERIENCE OF BAD – BECOME – GOOD

TWO PHASES OF A PROJECTIVE IDENTIFICATION

THE INDUCTION PHASE

WILL BE INITIATED WHEN A PATIENT
UNDER THE SWAY OF HER REPETITION COMPULSION
DRAWS THE THERAPIST IN TO PARTICIPATING AS THE OLD BAD OBJECT

THE RESOLUTION PHASE

WILL BE USHERED IN ONCE THE BAD THERAPIST BECOMES ABLE
TO PROVIDE CONTAINMENT BY RELENTING, STEPPING BACK,
RECOVERING HER PERSPECTIVE, AND TAKING OWNERSHIP OF THE PART
SHE HAS BEEN PLAYING IN THE DRAMA BEING
MUTUALLY ENACTED BETWEEN THEM

MODEL 3

WORKING THROUGH NEGATIVE TRANSFERENCE

BY NEGOTIATING THE VICISSITUDES
THAT WILL INEVITABLY ARISE
AT THE INTIMATE EDGE

AND EVOLVING ULTIMATELY
TO A PLACE OF ACCOUNTABILITY
AND HEALTHY, AUTHENTIC RELATEDNESS

THE NET RESULT OF WHICH WILL BE
RELATIONAL DETOXIFICATION
OF TOXIC EXPECTATION

Module 19

SYMBOLIC CORRECTIVE

FOR

EARLY – ON DEPRIVATION AND NEGLECT

WHEREAS MODEL 1 IS ABOUT CONFLICT

THAT MUST ULTIMATELY BE RESOLVED

CONFLICT THAT ARISES IN THE CONTEXT OF AN ID THAT NEEDS TO BE TAMED AND AN EGO THAT NEEDS TO BE STRENGTHENED

MODEL 2 IS ABOUT DEFICIT THAT

MUST ULTIMATELY BE CORRECTED FOR

DEFICIT THAT ARISES IN THE CONTEXT OF FAILURE IN THE EARLY – ON ENVIRONMENTAL PROVISION

MODEL 2 IS ULTIMATELY ABOUT

PROVISION OF CORRECTIVE EXPERIENCE

RESONATING EMPATHICALLY WITH THE PATIENT'S AFFECTIVE ("FELT") EXPERIENCE

CONFRONTING THE PATIENT WITH DISILLUSIONING REALITIES

FACILITATING ACCESS TO HER UNDERLYING GRIEF

TRANSMUTING (STRUCTURE – BUILDING) INTERNALIZATIONS

FILLING IN STRUCTURAL DEFICIT

DEVELOPING THE CAPACITY TO BE A GOOD PARENT UNTO HERSELF

CONSOLIDATING A MORE COHESIVE SELF

EVOLVING TO A PLACE OF SERENE ACCEPTANCE AND INNER CALM

IN ESSENCE

MODEL 2

POSITS RESTITUTIVE PROVISION AS THE PRIMARY THERAPEUTIC AGENT

MORE ACCURATELY, WORKING THROUGH
FAILURES IN THE THERAPIST'S RESTITUTIVE PROVISION

THE ESSENCE OF WHAT IS HEALING IS NO LONGER THOUGHT TO BE SIMPLY "THE TRUTH" (MODEL 1) BUT RATHER "MAKING GOOD A DEFICIENCY" (MODEL 2)
THE LIBIDINAL AND AGGRESSIVE DRIVES
NOW TAKING A BACK SEAT TO MORE RELATIONAL NEEDS

FOR EXAMPLE, THE NEED FOR EMPATHIC RECOGNITION, THE NEED FOR VALIDATION, THE NEED TO BE ADMIRED, THE NEED FOR SOOTHING, AND THE NEED TO BE HELD

THE MODEL 2 THERAPIST IS THOUGHT TO SERVE NO LONGER AS A DRIVE OBJECT BUT RATHER EITHER AS

AN EMPATHIC SELFOBJECT

USED TO COMPLETE THE SELF BY PERFORMING THOSE FUNCTIONS THAT THE PATIENT IS UNABLE TO PERFORM ON HER OWN

OR A GOOD OBJECT / A GOOD MOTHER

OPERATING IN LOCO PARENTIS

THIS CORRECTIVE – PROVISION MODEL FOCUSES ON THE PATIENT'S AFFECTIVE EXPERIENCE

HER FELT EXPERIENCE / WHAT IS EXPERIENCE – NEAR

ESPECIALLY, THE PAIN OF HER GRIEF

THE PAIN OF HER DISAPPOINTMENT / THE PAIN OF HER DISILLUSIONMENT

IN ESSENCE, THE MODEL 2 THERAPIST IS EVER EMPATHICALLY ATTUNED TO THE "POINT OF EMOTIONAL URGENCY" IN THE PATIENT

(MODELL 1996)

IT IS FOR THE MODEL 2 THERAPIST
TO FOCUS ON UNDERSTANDING
EXCLUSIVELY FROM THE PATIENT'S PERSPECTIVE

AND WHEN THE THERAPIST'S SUBJECTIVITY
INTERFERES WITH HER ABILITY
TO IMMERSE HERSELF EMPATHICALLY
IN THE PATIENT'S SUBJECTIVE EXPERIENCE,
IT IS PEJORATIVELY REFERRED TO AS
COUNTERTRANSFERENCE

AND IS NOT THOUGHT TO ADVANCE THE THERAPEUTIC ENDEAVOR

EVELYNE SCHWABER'S 1992 ARTICLE ENTITLED
"COUNTERTRANSFERENCE: THE ANALYST'S RETREAT
FROM THE PATIENT'S VANTAGE POINT"

SPEAKS TO HOW COUNTERTRANSFERENCE IS CONCEPTUALIZED IN MODEL 2
IN MARKED CONTRAST TO ITS CRITICALLY INFORMATIVE ROLE IN MODEL 3

THE MODEL 2 THERAPIST MATTERS – BUT ONLY TO THE EXTENT THAT SHE CAN PROVIDE FOR THE PATIENT AND NOT BECAUSE OF WHO SHE IS …

RATHER, THE MODEL 2 THERAPIST IS EXPECTED TO FUNCTION AS A SELFOBJECT THAT PROVIDES EITHER MIRRORING CONFIRMATION OF THE PATIENT'S GRANDIOSE SELF

OR AN OPPORTUNITY FOR THE PATIENT TO FUSE IN FANTASY WITH AN IDEALIZED PARENT IMAGO, THEREBY ENABLING THE PATIENT TO PARTAKE OF THE THERAPIST'S IMAGINED PERFECTION

MORE GENERALLY, THE MODEL 2 SELFOBJECT THERAPIST OFFERS THE HOLDING, THE BEING MET, AND THE VALIDATION THAT WERE NOT PROVIDED CONSISTENTLY AND RELIABLY BY THE PARENT DURING THE CHILD'S FORMATIVE YEARS

THIS REPARATION FUNCTIONS AS A SYMBOLIC CORRECTIVE FOR THE EARLY – ON DEPRIVATION AND NEGLECT

IT IS THEN IN THE CONTEXT OF THIS NEW RELATIONSHIP THAT THERE WILL BE OPPORTUNITY FOR REPARATION

A "NEW BEGINNING"

(BALINT 1968)

AS PREVIOUSLY NOTED

ALTHOUGH SOME MODEL 2 THEORISTS
BELIEVE THAT IT IS THE EXPERIENCE
OF GRATIFICATION ITSELF THAT IS
COMPENSATORY AND ULTIMATELY HEALING,

MOST BELIEVE THAT IT IS THE OPTIMAL STRESS
CREATED BY THE EXPERIENCE OF FRUSTRATION
AGAINST A BACKDROP OF GRATIFICATION

FRUSTRATION (DISILLUSIONMENT) PROPERLY GRIEVED
THAT IS, OPTIMAL DISILLUSIONMENT

THAT WILL MOST EFFECTIVELY
PROMOTE STRUCTURAL GROWTH
AND DEVELOPMENT OF CAPACITY

AGAIN

IF THERE IS NO THWARTING OF DESIRE BY THE THERAPIST, THEN THERE WILL BE NOTHING THAT NEEDS TO BE MASTERED AND THEREFORE NO IMPETUS FOR ADAPTIVE TRANSMUTING INTERNALIZATION AND ACCRETION OF SELF STRUCTURE

AND THERE WILL BE NO OPPORTUNITY FOR THE PATIENT, BY WAY OF GRIEVING, TO MAKE HER PEACE WITH THE REALITY THAT SHE WILL NEVER BE ABLE TO HAVE ALL THAT SHE SHOULD HAVE HAD AS A CHILD AND FOR WHICH SHE HAS SPENT A LIFETIME SEARCHING

Module 20

GRIEVING, RELENTING,

AND

FORGIVENESS

MODEL 2

WITHIN THE CONTEXT OF SAFETY PROVIDED BY THE RELATIONSHIP WITH HER THERAPIST, THE PATIENT WILL BE GIVEN AN OPPORTUNITY TO GRIEVE THE EARLY – ON PARENTAL FAILURES

IN ESSENCE

BY VIRTUE OF THE PATIENT'S TRANSFERENCE TO THE THERAPIST

WHEREBY THE PRESENT IS IMBUED WITH THE PRIMAL SIGNIFICANCE OF THE PAST,

MASTERY IN THE HERE – AND – NOW OF NONTRAUMATIC (OPTIMALLY DISILLUSIONING) EXPERIENCES AT THE HANDS OF THE THERAPIST WILL BE TANTAMOUNT TO MASTERY IN THE THERE – AND – THEN OF TRAUMATIC EXPERIENCES SUSTAINED AT THE HANDS OF THE INFANTILE OBJECT

MODEL 2

BUT IN ADDITION TO THIS DIRECT BENEFIT OF WORKING THROUGH TRANSFERENTIAL RUPTURES

THEREBY ENABLING EXTRICATION
FROM THE BONDS OF INFANTILE ATTACHMENTS,

MASTERY IN THE HERE – AND – NOW OF OPTIMALLY STRESSFUL EXPERIENCES IN RELATION TO THE THERAPIST WILL HELP TO RESTORE THE PATIENT'S RESILIENCE,

SUCH THAT SHE WILL BECOME EVER BETTER EQUIPPED TO PROCESS AND INTEGRATE THE IMPACT OF THE MULTITUDE OF DISAPPOINTMENTS, FRUSTRATIONS, AND LOSSES WITH WHICH SHE WILL CONTINUE TO BE CONFRONTED AS SHE MOVES FORWARD BOTH IN THE THERAPY AND, MORE GENERALLY, IN HER LIFE

IN ESSENCE, WITH EVERY SUCCESSIVE AND SUCCESSFUL NEGOTIATION OF FIRST RUPTURE AND THEN REPAIR, THE PATIENT WILL EVOLVE TO EVER – HIGHER LEVELS OF FUNCTIONALITY AND ADAPTIVE CAPACITY, THEREBY PROGRESSIVELY INCREASING HER ABILITY TO COPE WITH STRESS
AN IMPORTANT HALLMARK OF MENTAL (AND PHYSICAL) HEALTH

ULTIMATELY

THE THERAPEUTIC ACTION

IN MODEL 2

INVOLVES THE PATIENT'S GRIEVING

FEELING TO THE DEPTHS OF HER SOUL

ALL THE ANGUISH, ANGER, FRUSTRATION,

DESPAIR, HEARTBREAK, SADNESS,

LONELINESS, AND REGRET THAT COME WITH

CONFRONTING CERTAIN INTOLERABLY

DISILLUSIONING REALITIES ABOUT HER OBJECTS

GRIEVING

GRIEVING IS A PROTRACTED PROCESS THAT TRANSFORMS THE PATIENT'S REFUSAL TO CONFRONT THE PAIN OF HER GRIEF ABOUT THE OBJECT'S LIMITATIONS, SEPARATENESS, AND IMMUTABILITY INTO THE CAPACITY TO TOLERATE THOSE INESCAPABLE REALITIES

IN THE CONTEXT OF THE TREATMENT, IT INVOLVES
WORKING THROUGH OPTIMAL DISILLUSIONMENT
THAT IS, DISRUPTED POSITIVE TRANSFERENCE

BY CONFRONTING THE PAIN OF HER GRIEF,

ADAPTIVELY INTERNALIZING THE GOOD THAT HAD BEEN THERE PRIOR TO THE DISRUPTION
IF YOU CANNOT ALWAYS COUNT ON EXTERNAL PROVISION, BEST THAT YOU INTERNALIZE WHATEVER GOOD YOU CAN SO THAT IT WILL ALWAYS BE THERE FOR YOU

AND ARRIVING ULTIMATELY AT A PLACE OF SERENE ACCEPTANCE, FORGIVENESS, AND INNER PEACE

GRIEVING

ONLY MORE RECENTLY HAVE I COME TO APPRECIATE THAT GENUINE GRIEVING REQUIRES OF US THAT, AT LEAST FOR PERIODS OF TIME, WE BE FULLY PRESENT WITH THE ANGUISH OF OUR GRIEF, THE PAIN OF OUR REGRET, AND THE INTENSITY OF THE RAGE WE WILL EXPERIENCE WHEN WE ARE CONFRONTED WITH SOBERING AND SHOCKING REALITIES ABOUT OURSELVES, OUR RELATIONSHIPS, AND OUR WORLD

WE MUST NOT ABSENT OURSELVES FROM OUR GRIEF; WE MUST ENTER INTO AND EMBRACE IT, WITHOUT TURNING AWAY

WE CANNOT EFFECTIVELY GRIEVE WHEN WE ARE DISSOCIATED, MISSING IN ACTION, OR FLEEING THE SCENE

WE NEED TO BE PRESENT, ENGAGED, IN THE MOMENT, MINDFUL OF ALL THAT IS GOING ON INSIDE OF US, GROUNDED, FOCUSED, AND IN THE HERE – AND – NOW

IF, INSTEAD, WE ARE IN DENIAL, UNWILLING TO CONFRONT, CLOSED, SHUT DOWN, NUMB, RETREATING, REFUSING TO FEEL, PROTESTING, OR REFUSING TO ACCEPT, THEN NO REAL GRIEVING CAN BE DONE

GRIEVING

GENUINE GRIEVING – USUALLY ACCOMPLISHED ONLY INCREMENTALLY AND OVER TIME – IS THEREFORE AN ONGOING TORTUROUS AND TORTUOUS PROCESS OF ALTERNATELY FALLING INTO THE DEPTHS OF DEVASTATION AND HEARTBREAK AND THEN RAGING AGAINST THE WORLD AND RAILING AGAINST OUR FATE

BUT ULTIMATELY IT INVOLVES FORGIVING, RELENTING, SURRENDERING, RELINQUISHING, SEPARATING, AND MOVING ON

IT IS WHAT IT IS; IT WAS WHAT IT WAS; AND, AT THE END OF THE DAY, AS THE SERENITY PRAYER REMINDS US, WE MUST ACCEPT THE THINGS THAT WE CANNOT CHANGE, MUST HAVE THE COURAGE TO CHANGE THE THINGS THAT WE CAN, AND MUST HAVE THE WISDOM TO KNOW THE DIFFERENCE

(SIFTON 2005)

ALL CHANGE, OF COURSE, INVOLVES LOSS AND A LETTING GO AS WE GRIEVE

GRIEVING

ACCORDING TO ELISABETH KUBLER – ROSS (2014), WHEN WE ARE DEALING WITH DEATH OR SOME OTHER CATASTROPHIC LOSS, WE MOVE THROUGH FIVE DISTINCT STAGES OF GRIEF – FIRST WE GO INTO DENIAL BECAUSE THE LOSS IS SO UNTHINKABLE THAT WE CANNOT IMAGINE IT IS TRUE – THEN WE BECOME ANGRY WITH EVERYONE, ANGRY WITH SURVIVORS, ANGRY WITH OURSELVES – AND THEN WE BARGAIN – WE BEG, WE PLEAD, AND WE PROMISE TO RELINQUISH EVERYTHING WE HAVE – WE OFFER UP OUR SOULS IN EXCHANGE FOR JUST ONE MORE DAY – BUT WHEN WE HAVE EXHAUSTED OURSELVES FROM THE EFFORT OF BEING ANGRY AND THE BARGAINING HAS FAILED, WE FALL INTO DEPRESSION, DESPAIR, AND A SENSE OF HELPLESS DEFEAT – UNTIL, EVENTUALLY, WE HAVE TO ACCEPT THAT WE HAVE DONE EVERYTHING THAT WE COULD POSSIBLY HAVE DONE – BUT TO NO AVAIL – AND WE FINALLY SURRENDER – WE LET GO AND MOVE, AT LAST, INTO SOBER ACCEPTANCE OF THE HEARTBREAKING REALITY

"He's just doing that to get attention."

“GRIEF IS

NATURE’S WAY

OF HEALING

A BROKEN HEART.”

(BECKMAN 1990)

“WHEN A DEEP INJURY

IS DONE US,

WE NEVER RECOVER

UNTIL WE FORGIVE.”

(PATON 2003)

ALTHOUGH IT MIGHT NOT BE ABSOLUTELY NECESSARY, FORGIVENESS DOES PROBABLY ACCELERATE THE RECOVERY PROCESS CONSIDERABLY

WHAT DOESN’T BEND, ULTIMATELY BREAKS

Module 21

RELENTLESS HOPE

AND

THE ILLUSION OF OMNIPOTENT CONTROL

RELENTLESS HOPE

PATIENTS WHO ARE NOT ABLE TO STAY PRESENT WITH THE PAIN OF THEIR GRIEF AND THEREFORE ABSENT THEMSELVES FROM THAT PAIN

WHO ARE NOT ABLE TO BE MINDFUL OR IN THE MOMENT AND INSTEAD HAVE THE NEED TO DISSOCIATE

MAY NOT BE ABLE EFFECTIVELY TO GRIEVE THEIR LOSSES

INSTEAD THEY MAY FIND THEMSELVES CLINGING TENACIOUSLY TO WHAT I (AS NOTED EARLIER) DESCRIBE AS RELENTLESS HOPE (STARK 1994)

THE HOPE A DEFENSE ULTIMATELY AGAINST GRIEVING

RELENTLESS HOPE

A PATIENT'S REFUSAL TO DEAL WITH
THE PAIN OF HER GRIEF ABOUT
THE OBJECT OF HER DESIRE
WILL FUEL THE RELENTLESSNESS
WITH WHICH SHE PURSUES IT

BOTH THE RELENTLESSNESS OF HER HOPE
THAT SHE MIGHT YET BE ABLE TO
MAKE THE OBJECT OVER INTO WHAT SHE
WOULD WANT IT TO BE
AND THE RELENTLESSNESS OF THE OUTRAGE
SHE EXPERIENCES IN THOSE MOMENTS
OF DAWNING RECOGNITION THAT,
DESPITE HER BEST EFFORTS AND MOST FERVENT DESIRE,
SHE MIGHT NEVER BE ABLE
TO MAKE THAT ACTUALLY HAPPEN

RELENTLESS HOPE

BUT, EVEN MORE FUNDAMENTALLY,
WHAT FUELS THE RELENTLESSNESS
OF THE PATIENT'S PURSUIT
IS THE FACT OF THE OBJECT'S EXISTENCE
AS SEPARATE FROM HERS,
AS OUTSIDE THE SPHERE
OF HER OMNIPOTENCE,
AND AS THEREFORE UNABLE
TO BE EITHER POSSESSED OR CONTROLLED

IN TRUTH, IT IS THIS VERY IMMUTABILITY
OF THE OBJECT
THE FACT THAT IT CANNOT BE FORCED TO CHANGE

THAT PROVIDES THE PROPULSIVE
FUEL FOR THE PATIENT'S RELENTLESS PURSUIT

RELENTLESS HOPE

EVEN IN THE FACE OF INCONTROVERTIBLE
EVIDENCE TO THE CONTRARY,
THE PATIENT WILL PURSUE
THE OBJECT OF HER DESIRE
WITH A VENGEANCE,

THE INTENSITY OF HER ENTITLED PURSUIT
FUELED BY HER CONVICTION
THAT THE OBJECT

COULD GIVE IT
WHERE THE OBJECT BUT WILLING

SHOULD GIVE IT
BECAUSE THAT IS HER DUE

AND WOULD GIVE IT
WERE SHE BUT ABLE TO GET IT RIGHT

THE FACT THAT THE PATIENT CLINGS SO TENACIOUSLY TO HER BELIEF THAT THE OBJECT WOULD GIVE IT WERE SHE, THE PATIENT, BUT ABLE TO GET IT RIGHT SPEAKS TO THE PATIENT'S DEFENSIVE NEED TO SEE HERSELF AS HAVING THE POWER TO MAKE THINGS CHANGE, AS HAVING THE LOCUS OF CONTROL

IN OTHER WORDS

IT SPEAKS TO THE PATIENT'S ILLUSIONS OF GRANDIOSE OMNIPOTENCE

HAD THE PATIENT, AS AN INFANT, HAD THE EXPERIENCE
AT LEAST FOR A WHILE
OF A "GOOD ENOUGH MOTHER" WHO WAS ABLE
TO "MEET THE OMNIPOTENCE OF HER INFANT"
BY RECOGNIZING AND RESPONDING
TO THE INFANT'S EVERY NEED,

THEN THE PATIENT, PROPELLED BY HER "INBORN MATURATIONAL THRUST," WOULD HAVE BEEN ABLE GRADUALLY TO "ABROGATE HER NEED FOR OMNIPOTENT CONTROL OF HER OBJECTS" (WINNICOTT 1965)

BUT WHEN THE PATIENT, AS AN INFANT, HAS HAD NO SUCH EXPERIENCE, THEN HER ILLUSIONS OF GRANDIOSE OMNIPOTENCE WILL HAVE BECOME DEFENSIVELY REINFORCED OVER TIME, MANIFESTING ULTIMATELY AS A RELENTLESS PURSUIT OF THE UNATTAINABLE

THIS PURSUIT FUELED BY HER WISHFUL FANTASY
THAT SURELY SHE SHOULD BE ABLE TO MAKE
THE OBJECTS OF HER DESIRE RELENT

RELENTLESS HOPE

IN THE POIGNANT WORDS OF ELVIN SEMRAD (2003)

"PRETENDING THAT IT CAN BE

WHEN IT CAN'T IS HOW

PEOPLE BREAK THEIR HEARTS."

Module 22

RELATIONAL vs. INTERNAL SADOMASOCHISTIC PSYCHODYNAMICS

THE PATIENT'S RELENTLESS PURSUIT HAS BOTH MASOCHISTIC AND SADISTIC COMPONENTS

HER RELENTLESS HOPE
WHICH FUELS HER MASOCHISM
IS THE STANCE TO WHICH SHE DESPERATELY CLINGS
IN ORDER TO AVOID CONFRONTING
CERTAIN INTOLERABLY PAINFUL REALITIES
ABOUT THE OBJECT AND ITS SEPARATENESS

HER RELENTLESS OUTRAGE
WHICH FUELS HER SADISM
IS THE STANCE TO WHICH SHE RESORTS
IN THOSE MOMENTS OF DAWNING RECOGNITION
THAT THE OBJECT IS SEPARATE AND UNYIELDING

I DO NOT LIMIT SADOMASOCHISM
TO THE SEXUAL ARENA

RATHER, I CONCEIVE OF IT AS
A DYSFUNCTIONAL RELATIONAL DYNAMIC
THAT GETS PLAYED OUT
TO A GREATER OR LESSER EXTENT
IN MANY OF A PERSON'S RELATIONSHIPS

ESPECIALLY IF THAT PERSON HAS NOT YET
COME TO TERMS WITH THE REALITY
THAT THE WORLD WILL NEVER BE
ALL THAT SHE WOULD HAVE
WANTED IT TO BE

MASOCHISM AND SADISM ALWAYS GO HAND IN HAND

IN OTHER WORDS

THE MASOCHISTIC DEFENSE OF RELENTLESS HOPE AND THE SADISTIC DEFENSE OF RELENTLESS OUTRAGE ARE FLIP SIDES OF THE SAME COIN

THEY ARE BOTH DEFENSES AND SPEAK TO THE PATIENT'S REFUSAL TO CONFRONT THE PAIN OF HER GRIEF ABOUT THE OBJECT'S LIMITATIONS, SEPARATENESS, AND IMMUTABILITY

IN ESSENCE

THEY SPEAK TO THE PATIENT'S REFUSAL TO CONFRONT THE PAIN OF HER GRIEF ABOUT THE OBJECT'S REFUSAL TO BE POSSESSED AND CONTROLLED

MASOCHISM IS A STORY ABOUT THE PATIENT'S HOPE

HER RELENTLESS HOPE
HER HOPING AGAINST HOPE THAT PERHAPS
SOMEDAY, SOMEHOW, SOMEWAY,
WERE SHE TO BE BUT GOOD ENOUGH,
TRY HARD ENOUGH, BE PERSUASIVE ENOUGH,
PERSIST LONG ENOUGH, SUFFER DEEPLY ENOUGH,
OR BE "MASOCHISTIC" ENOUGH,

SHE MIGHT YET BE ABLE TO EXTRACT FROM THE OBJECT
SOMETIMES THE PARENT HERSELF
SOMETIMES A STAND – IN FOR THE PARENT
THE RECOGNITION AND LOVE DENIED HER AS A CHILD

IN OTHER WORDS
SHE MIGHT YET BE ABLE TO COMPEL
THE IMMUTABLE OBJECT TO RELENT

NOTE THAT THE INVESTMENT IS NOT SO MUCH IN THE
SUFFERING PER SE AS IT IS IN THE
PASSIONATE HOPE THAT PERHAPS THIS TIME …

SADISM IS A STORY ABOUT THE RELENTLESS PATIENT'S REACTION TO THE LOSS OF HOPE

EXPERIENCED IN THOSE MOMENTS OF DAWNING RECOGNITION THAT SHE IS NOT GOING TO GET, AFTER ALL, WHAT SHE HAD SO DESPERATELY WANTED AND FELT SHE NEEDED TO HAVE IN ORDER TO GO ON

ORDINARILY A PERSON WHO HAS BEEN TOLD NO
MUST CONFRONT THE PAIN OF HER DISAPPOINTMENT
AND COME TO TERMS WITH IT
THAT IS, SHE MUST GRIEVE

THE PATIENT MUST ULTIMATELY MAKE HER PEACE
WITH THE SOBERING REALITY THAT
BECAUSE OF EARLY – ON PARENTAL FAILURES
IN THE FORM OF BOTH ABSENCE OF GOOD (DEPRIVATION AND NEGLECT)
AND PRESENCE OF BAD (TRAUMA AND ABUSE)

SHE NOW HAS PSYCHIC SCARS THAT MAY NEVER ENTIRELY HEAL AND WILL MOST CERTAINLY MAKE HER JOURNEY THROUGH LIFE RATHER MORE DIFFICULT THAN IT MIGHT OTHERWISE HAVE BEEN

BUT A PERSON WHO IS UNABLE TO ADAPT TO THE REALITY THAT HER OBJECTS WILL NEVER BE ALL THAT SHE WOULD HAVE WANTED THEM TO BE MUST DEFEND HERSELF AGAINST THE KNOWLEDGE OF THAT INTOLERABLY PAINFUL REALITY

AND SO, INSTEAD OF CONFRONTING THE PAIN OF HER DISAPPOINTMENT, GRIEVING THE LOSS OF HER ILLUSIONS, ADAPTIVELY INTERNALIZING WHATEVER GOOD THERE WAS, AND RELINQUISHING HER PURSUIT, THE RELENTLESS PATIENT DOES SOMETHING ELSE

AS THE PATIENT COMES TO UNDERSTAND THAT SHE IS NOT IN FACT GOING TO BE REWARDED FOR HER UNSTINTING EFFORTS, SHE REACTS WITH THE SADISTIC UNLEASHING OF A TORRENT OF ABUSE DIRECTED EITHER TOWARDS HERSELF FOR HAVING FAILED TO GET WHAT SHE HAD SO DESPERATELY WANTED

OR TOWARDS THE DISAPPOINTING OBJECT FOR HAVING FAILED TO PROVIDE IT

MORE ACCURATELY

THE PATIENT MAY ALTERNATE BETWEEN
ENRAGED PROTESTS AT HER OWN INADEQUACY
AND SCATHING REPROACHES AGAINST THE OBJECT
FOR HAVING FRUSTRATED HER DESIRE

SADISM, THEN, IS A STORY ABOUT THE PATIENT'S RELENTLESS OUTRAGE IN THE FACE OF BEING THWARTED

AND THEREBY CONFRONTED WITH THE LIMITS
OF HER POWER TO FORCE THE OBJECT TO CHANGE

IN OTHER WORDS

WHEN THE PATIENT'S NEED TO POSSESS AND CONTROL THE OBJECT IS FRUSTRATED, WHAT COMES TO THE FORE WILL BE THE PATIENT'S NEED TO PUNISH THE OBJECT BY ATTEMPTING TO DESTROY IT

SO IF A PATIENT IN THE MIDDLE OF A THERAPY SESSION SUDDENLY BECOMES ABUSIVE, WHAT QUESTION MIGHT THE THERAPIST THINK TO POSE?

IF THE THERAPIST ASKS "HOW DO YOU FEEL THAT I HAVE FAILED YOU?" AT LEAST SHE KNOWS ENOUGH TO ASK THE QUESTION, BUT SHE IS ALSO INDIRECTLY SUGGESTING THAT THE ANSWER WILL BE PRIMARILY A STORY ABOUT THE PATIENT AND THE PATIENT'S PERCEPTION OF HAVING BEEN FAILED

THEREFORE BETTER TO ASK "HOW HAVE I FAILED YOU?"

HERE THE THERAPIST IS SIGNALING HER RECOGNITION OF THE FACT THAT SHE HERSELF MIGHT WELL HAVE CONTRIBUTED TO THE PATIENT'S EXPERIENCE OF DISILLUSIONMENT AND HEARTACHE

THE THERAPIST MUST HAVE BOTH THE WISDOM TO RECOGNIZE AND THE INTEGRITY TO ACKNOWLEDGE THE PART SHE MIGHT HAVE PLAYED BY FIRST STOKING THE FLAMES OF THE PATIENT'S DESIRE AND THEN DEVASTATING THROUGH HER FAILURE, ULTIMATELY, TO DELIVER

IN ANY EVENT
THE SADOMASOCHISTIC CYCLE IS REPEATED
ONCE THE (SEDUCTIVE) OBJECT
THROWS THE PATIENT A FEW CRUMBS

THE SADOMASOCHIST
EVER HUNGRY FOR SUCH MORSELS
WILL BECOME ONCE AGAIN HOOKED
AND REVERT TO HER ORIGINAL STANCE
OF SUFFERING, SACRIFICE, AND SURRENDER
IN A REPEAT ATTEMPT
TO GET WHAT SHE SO DESPERATELY WANTS
AND FEELS SHE MUST HAVE

RELATIONAL vs. INTERNAL SADOMASOCHISTIC DEFENSES

SADOMASOCHISM CAN BE PLAYED OUT

EITHER RELATIONALLY

IN THE FORM OF ALTERNATING CYCLES
OF RELENTLESS HOPE AND RELENTLESS OUTRAGE

OR INTERNALLY

IN THE FORM OF ALTERNATING CYCLES
OF SELF – INDULGENCE AND SELF – DESTRUCTIVENESS

IN OTHER WORDS

THE SADOMASOCHISTIC PATIENT
WHO HAS A LIBIDINAL (RELENTLESSLY HOPEFUL)
AND AN AGGRESSIVE (RELENTLESSLY OUTRAGED)
ATTACHMENT TO THE BAD OBJECT
MAY WELL ALSO HAVE
A LIBIDINAL (RELENTLESSLY SELF – INDULGENT)
AND AN AGGRESSIVE (RELENTLESSLY SELF – DESTRUCTIVE)
ATTACHMENT TO THE BAD SELF

FOR EXAMPLE, CONSIDER A PATIENT WITH A SEEMINGLY INTRACTABLE EATING DISORDER, ONE THAT COMPELS HER SOMETIMES TO BINGE
THEREBY AFFORDING LIBIDINAL RELEASE
AND SOMETIMES TO FAST
THEREBY AFFORDING AGGRESSIVE RELEASE

THE VICIOUSLY SELF – SABOTAGING CYCLE MIGHT GO AS FOLLOWS –
A CALORIE – RESTRICTING PATIENT, FEELING DEPRIVED, BECOMES RESENTFUL AND THEN FEELS ENTITLED TO GRATIFY HERSELF BY INDULGING IN COMPULSIVE EATING, WHICH THEN MAKES HER FEEL GUILTY AND PROMPTS HER TO PUNISH HERSELF BY SEVERELY RESTRICTING HER CALORIC INTAKE (ONCE AGAIN), WHICH THEN MAKES HER FEEL DEPRIVED, ANGRY, AND ENTITLED TO INDULGE IN YET ANOTHER EATING BINGE, AND SO ON AND SO FORTH

CYCLES OF DEPRIVATION, SELF – INDULGENCE, GUILT, SELF – DESTRUCTIVENESS

AND SO IT IS THAT WE SPEAK OF
THE MASOCHISTIC DEFENSE OF SELF – INDULGENCE
AND THE SADISTIC DEFENSE OF SELF – DESTRUCTIVENESS
IN RELATION TO THE "BAD SELF"

JUST AS WE SPEAK OF
THE MASOCHISTIC DEFENSE OF RELENTLESS HOPE
AND THE SADISTIC DEFENSE OF RELENTLESS OUTRAGE
IN RELATION TO THE "BAD OBJECT"

ACCEPTING THE REALITY OF THE OBJECT AS SEPARATE

IF THE PATIENT IS EVER TO RELINQUISH HER COMPULSIVE RE – ENACTMENTS, HER RELENTLESS PURSUITS, HER INFANTILE NEED TO POSSESS AND CONTROL, AND HER SELF – INDULGENT / SELF – DESTRUCTIVE BEHAVIORS, THE REALITY OF THE OBJECT AS SEPARATE FROM THE SELF AND AS HAVING ITS OWN CENTER OF INITIATIVE MUST ULTIMATELY BE CONFRONTED AND GRIEVED

BUT IF THE PATIENT IS UNABLE TO MAKE HER PEACE WITH THE REALITY THAT HER OBJECTS ARE SEPARATE AND THEREFORE IMMUTABLE, THEN SHE WILL BE CONSIGNING HERSELF TO A LIFETIME OF CHRONIC FRUSTRATION, UNRELENTING HEARTBREAK, IMPOTENT RAGE, PROFOUND DESPAIR, AND TORMENTING FEELINGS OF HELPLESSNESS AND POWERLESSNESS EVERY TIME SHE IS CONFRONTED WITH THE INESCAPABLE REALITY THAT HER OBJECTS CANNOT BE POSSESSED, CONTROLLED, OR MADE OVER INTO WHOM SHE WOULD HAVE WANTED THEM TO BE

THE SCHIZOID DEFENSE OF RELENTLESS DESPAIR AND PROFOUND HOPELESSNESS (STARK 2015)

BECAUSE OF INTOLERABLY PAINFUL EARLY – ON DISAPPOINTMENTS AND HEARTACHE, THE INNERMOST SELF OF THE SCHIZOID PATIENT HAS SECRETLY WITHDRAWN

THE NEED IS TO PROTECT THE INTEGRITY OF A PRECARIOUSLY ESTABLISHED SELF FROM BEING SHATTERED (OR "FRACTURED") BY A HEARTBREAKING RESPONSE FROM THE OBJECT (MODELL 1996)

THUS THE PSYCHIC RETREAT (SCHIZOID WITHDRAWAL) AND DENIAL OF OBJECT NEED SUPPORTED BY ILLUSIONS OF GRANDIOSE SELF – SUFFICIENCY

ON THE ONE HAND

THE SCHIZOID PATIENT YEARNS TO BE IN RELATIONSHIP BUT FEARS CATASTROPHIC REJECTION

ON THE OTHER HAND

LACK OF CONNECTION IS ACCOMPANIED BY FEAR OF EGO DISSOLUTION AND FRAGMENTATION AND TERRIFYING AWARENESS OF HER ULTIMATE SEPARATENESS AND ALONENESS

TO REVIEW

THE SCHIZOID DEFENSE OF RELENTLESS DESPAIR AND PROFOUND HOPELESSNESS

THE DILEMMA OF THE SCHIZOID
IS THAT SHE HAS AN UNDERLYING
INTENSE LONGING TO BE CLOSE
BUT A TERROR OF BEING FOUND

AND SO IT IS THAT
SHE DETACHES HERSELF
COMPLETELY FROM OBJECTS
AND RENOUNCES ALL HOPE

THE GOAL IS
TO CANCEL RELATIONSHIPS,
TO MAKE NO DEMANDS,
AND TO WANT NO ONE

“HUMANKIND

CANNOT BEAR

VERY MUCH REALITY.”

(ELIOT 1943)

Module 23

DISILLUSIONMENT STATEMENTS

AND

ADAPTIVE TRANSMUTING INTERNALIZATION

SO HOW DO WE HELP OUR PATIENTS GRIEVE?

MODEL 1

CONFLICT STATEMENTS STRIVE TO HIGHLIGHT THE PATIENT'S INTERNAL CONFLICT BY FIRST SPEAKING TO THE PATIENT'S ADAPTIVE CAPACITY TO ACKNOWLEDGE CERTAIN PAINFUL TRUTHS AND THEN RESONATING EMPATHICALLY WITH THE PATIENT'S DEFENSIVE NEED TO PROTEST

MODEL 2

DISILLUSIONMENT STATEMENTS STRIVE TO FACILITATE THE PATIENT'S GRIEVING BY FIRST SPEAKING TO THE PATIENT'S ADAPTIVE CAPACITY TO ACKNOWLEDGE CERTAIN PAINFUL TRUTHS AND THEN RESONATING EMPATHICALLY WITH THE PAIN OF THE PATIENT'S GRIEF AS SHE BEGINS TO FACE THOSE TRUTHS

BOTH INTERVENTIONS ARE ANXIETY – PROVOKING BUT ULTIMATELY GROWTH – PROMOTING

AWARENESS – PROMOTING INTERVENTION

MODEL 1 CONFLICT STATEMENT (BUT)

**YOU KNOW THAT ULTIMATELY YOU WILL
NEED TO LET JOSE GO BECAUSE HE, LIKE YOUR DAD,
REALLY ISN'T AVAILABLE IN THE WAY
THAT YOU WOULD HAVE WANTED HIM TO BE;
BUT, FOR NOW, ALL YOU CAN THINK ABOUT IS HOW
DESPERATELY YOU WANT TO BE WITH HIM.**

ACCEPTANCE – PROMOTING INTERVENTION

MODEL 2 DISILLUSIONMENT STATEMENT (AND)

**YOU KNOW THAT ULTIMATELY YOU WILL
NEED TO LET JOSE GO BECAUSE HE, LIKE YOUR DAD,
REALLY ISN'T AVAILABLE IN THE WAY
THAT YOU WOULD HAVE WANTED HIM TO BE;
AND IT BREAKS YOUR HEART.**

MODEL 1 CONFLICT STATEMENT

"YOU KNOW THAT …, BUT YOU (MADE ANXIOUS) FIND YOURSELF THINKING, FEELING, OR DOING IN ORDER NOT TO HAVE TO KNOW …"

AT LEAST ON SOME LEVEL THE PATIENT DOES KNOW "BUT" IS MADE INTOLERABLY ANXIOUS

MODEL 2 DISILLUSIONMENT STATEMENT

"YOU KNOW THAT …, AND IT BREAKS YOUR HEART …"

AT LEAST ON SOME LEVEL THE PATIENT DOES KNOW "AND" IS BEGINNING TO CONFRONT IT

THE PATIENT DOES KNOW "AND" IS NOW BETTER ABLE TO TOLERATE THE PAIN OF IT

AND SO THE THERAPIST USES A DISILLUSIONMENT STATEMENT TO HELP THE PATIENT ACCESS HER GRIEF

MORE SPECIFICALLY

MODEL 2 DISILLUSIONMENT STATEMENTS

ARE DESIGNED TO FACILITATE THE GRIEVING
OF A PATIENT WHO IS BEGINNING TO ACKNOWLEDGE
THE PAIN OF HER GRIEF

FIRST THE THERAPIST CHALLENGES
BY HIGHLIGHTING THE DISILLUSIONING REALITY THAT
THE PATIENT IS GRADUALLY COMING TO RECOGNIZE

AND THEN
IF THE THERAPIST SENSES THAT THE PATIENT IS READY
SUPPORTS BY RESONATING EMPATHICALLY WITH
THE PATIENT'S EXPERIENCE OF HEARTBREAK

"YOU KNOW THAT …,
AND IT BREAKS YOUR HEART …"

THESE STATEMENTS ARE USED IN THOSE MOMENTS
WHEN THE PATIENT IS NO LONGER AS DEFENDED
AND IS NOW BETTER ABLE TO CONFRONT – AND GRIEVE –
THE PAIN OF HER DISAPPOINTMENT

WITH RESPECT TO THE SECOND PART OF A DISILLUSIONMENT STATEMENT

THE MODEL 2 THERAPIST

MIGHT OFFER THE HEARTBROKEN PATIENT
ANY OF THE FOLLOWING

I WONDER IF IT BREAKS YOUR HEART …

IT SOUNDS AS IF IT BREAKS YOUR HEART …

IT SEEMS AS IF IT BREAKS YOUR HEART …

IT MUST BREAK YOUR HEART …

BUT MORE TO THE POINT IS THE FOLLOWING

IT BREAKS YOUR HEART …

THERE IS NO NEED FOR THOSE EXTRA WORDS
AT THE BEGINNING

WHETHER THE THERAPIST USES
A CONFLICT STATEMENT
OR A DISILLUSIONMENT STATEMENT
OR CONSTRUCTS SOME OTHER
INTERVENTION THAT ALTERNATELY
INCREASES THE PATIENT'S ANXIETY
BY DIRECTING HER ATTENTION
TO WHERE SHE WOULD RATHER NOT BE

AND THEN DECREASES HER ANXIETY
BY VALIDATING WHERE SHE IS

THE UNDERLYING PRINCIPLE WILL BE
THE THERAPEUTIC USE OF STRESS
TO PROVOKE RECOVERY

TO FACILITATE THE GRIEVING PROCESS

THE THERAPIST REPEATEDLY DIRECTS THE PATIENT'S ATTENTION

BACK AND FORTH

BETWEEN CONFRONTING HER WITH UNCOMFORTABLE REALITIES

THAT, AT LEAST ON SOME LEVEL, SHE REALLY DOES KNOW TO BE TRUE

AND THEN RESONATING EMPATHICALLY WITH HOW THE PATIENT IS DEALING WITH THEM

IF DEFENSIVELY (BECAUSE THE PAIN IS SIMPLY TOO MUCH),
A CONFLICT STATEMENT

IF ADAPTIVELY (BECAUSE THE PAIN IS MORE TOLERABLE),
A DISILLUSIONMENT STATEMENT

IF THE EXPERIENCE OF
DISILLUSIONING HEARTBREAK
THE STRESSFUL EXPERIENCE OF GOOD – BECOME – BAD
CAN ULTIMATELY BE ADEQUATELY
PROCESSED AND INTEGRATED
THAT IS, GRIEVED

THE PATIENT WILL ADAPTIVELY INTERNALIZE
THOSE SELFOBJECT FUNCTIONS
THAT THE OBJECT HAD BEEN PERFORMING
PRIOR TO ITS DISAPPOINTMENT OF HER
TRANSMUTING (STRUCTURE – BUILDING) INTERNALIZATIONS

THEREBY FILLING IN DEFICIT
AND CONSOLIDATING THE SELF
FROM "SOME HOLES" TO "WHOLESOME"
THE THERAPEUTIC ACTION IN MODEL 2

THESE STRUCTURE – BUILDING

INTERNALIZATIONS

WILL ENABLE THE PATIENT

TO PRESERVE INTERNALLY

A PIECE OF

THE ORIGINAL EXPERIENCE

OF EXTERNAL GOODNESS

(THUS THEIR ADAPTIVE VALUE)

AT THE END OF THE DAY

MODEL 2 IS ABOUT THE PATIENT'S CONFRONTING AND GRIEVING THE REALITY OF THE OBJECT'S LIMITATIONS, SEPARATENESS, AND IMMUTABILITY

AND

BY WAY OF RELENTING, FORGIVING, INTERNALIZING, SEPARATING, LETTING GO, AND MOVING ON

ARRIVING ULTIMATELY AT A PLACE OF SERENE ACCEPTANCE

IN THE PROCESS,
ALSO MAKING HER PEACE WITH THE REALITY
OF THE LIMITS OF HER POWER
TO FORCE THE OBJECT TO CHANGE

MODEL 2 – WORKING THROUGH DISAPPOINTMENT

AS THE RELENTLESS PATIENT BEGINS TO GRIEVE

AND GRADUALLY TO LET GO OF HER

NEED TO POSSESS AND CONTROL THE OBJECT

AND, WHEN THWARTED, HER NEED TO ATTEMPT

ITS DESTRUCTION THROUGH RETALIATION,

SHE WILL SLOWLY BUT SURELY RELINQUISH

HER RELENTLESS PURSUIT OF THE UNATTAINABLE

IN FAVOR OF REFOCUSING HER ENERGIES

ON THE PURSUIT OF MORE APPROPRIATE,

AND MORE ATTAINABLE, OBJECTS

THE THERAPEUTIC ACTION IN MODEL 2 IS THEREFORE SEEN AS BEING A STORY ABOUT WORKING THROUGH THE PATIENT'S EXPERIENCE OF BEING DISAPPOINTED

THAT IS, OPTIMALLY DISILLUSIONED

AT THE HANDS OF A THERAPIST

OFTEN A STAND – IN FOR THE PARENT

WHO TURNS OUT TO BE NOT ALL THAT THE PATIENT WOULD HAVE HOPED SHE COULD BE

PROMPTING EVENTUAL RELINQUISHMENT OF THE PATIENT'S RELENTLESS HOPE AND DECATHEXIS OF THE AMBIVALENTLY HELD (AND TORMENTING) OBJECT OF HER DESIRE

ONLY ONCE THE PATIENT
HAS BEEN ABLE TO MASTER AND INTEGRATE
HER DISSOCIATED GRIEF
WILL SHE BE ABLE TO RELINQUISH
HER RELENTLESS AND INFANTILE
PURSUIT OF THE UNATTAINABLE

SHE WILL HAVE TRANSFORMED
DYSFUNCTIONAL DEFENSE
THE NEED TO HOLD ON

INTO MORE FUNCTIONAL ADAPTATION
THE CAPACITY TO LET GO

ONCE SHE HAS GRIEVED AND, IN THE PROCESS,
DEVELOPED A MORE REFINED AWARENESS
OF THE LIMITATIONS INHERENT IN RELATIONSHIP
AND A MORE EVOLVED CAPACITY
TO ACCEPT THAT WHICH SHE CANNOT CHANGE

IN SUM

THE THERAPEUTIC ACTION IN MODEL 2

INVOLVES WORKING THROUGH

DISRUPTED POSITIVE TRANSFERENCE

THAT IS, GRIEVING DISILLUSIONMENT

THE EXPERIENCE OF GOOD – BECOME – BAD

THEREBY TRANSFORMING

RELENTLESS HOPE

INTO MATURE ACCEPTANCE

I AM HERE REMINDED
OF THE NEW YORKER CARTOON
IN WHICH A GENTLEMAN,
SEATED IN A RESTAURANT
NAMED THE DISILLUSIONMENT CAFÉ,
IS AWAITING THE ARRIVAL OF HIS ORDER

THE WAITER RETURNS TO HIS TABLE
AND ANNOUNCES,
“YOUR ORDER IS NOT READY,
AND NOR WILL IT EVER BE”

Module 24

OBJECTIVE NEUTRALITY

vs.

EMPATHIC ATTUNEMENT

vs.

AUTHENTIC ENGAGEMENT

REVIEW

WHEREAS THE THERAPEUTIC ACTION
IN MODEL 2 INVOLVES WORKING THROUGH

POSITIVE TRANSFERENCE DISRUPTED
THE EXPERIENCE OF GOOD – BECOME – BAD
DISILLUSIONMENT

THEREBY TRANSFORMING RELENTLESSNESS
INTO SERENE ACCEPTANCE

THE THERAPEUTIC ACTION
IN MODEL 3 INVOLVES WORKING THROUGH

NEGATIVE TRANSFERENCE
THE EXPERIENCE OF BAD – BECOME – GOOD
DETOXIFICATION

THEREBY TRANSFORMING RE – ENACTMENT
INTO ACCOUNTABILITY

MODEL 2

IS ABOUT DISILLUSIONMENT

AND STRUCTURAL GROWTH

ADDING NEW GOOD TO CORRECT FOR DEFICIENCY

MODEL 3

IS ABOUT DETOXIFICATION

AND STRUCTURAL MODIFICATION

CHANGING OLD BAD TO CORRECT FOR TOXICITY

MODEL 3

THE INTERSUBJECTIVE PERSPECTIVE OF CONTEMPORARY RELATIONAL THEORY

A 2 – PERSON PSYCHOLOGY

FOCUSES ON THERAPISTS AND PATIENTS WHO RELATE TO EACH OTHER AS REAL PEOPLE

BOTH OF WHOM BRING THEIR AUTHENTIC SELVES INTO THE ROOM

MODEL 3

RECIPROCITY

MUTUALITY OF INFLUENCE / IMPACT

HERE – AND – NOW ENGAGEMENT

CO – CREATION OF EXPERIENCE

TRANSFERENCE / COUNTERTRANSFERENCE ENTANGLEMENT

USE OF THE THERAPIST'S SELF TO FIND, AND BE FOUND BY, THE PATIENT

CONTRIBUTIONS OF BOTH PARTICIPANTS TO THE TURBULENCE THAT WILL INEVITABLY ARISE BETWEEN THEM

KOHUT WRITES ABOUT THE "INEVITABLE EMPATHIC FAILURE"
(KOHUT 1966)

HOW MIGHT WE UNDERSTAND THE INEVITABILITY OF SUCH FAILURE?

IS IT PRIMARILY A STORY ABOUT THE THERAPIST AND HER LACK OF PERFECTION?

OR IS IT PRIMARILY A STORY ABOUT THE PATIENT AND HER EXERTING OF INTERPERSONAL PRESSURE ON THE THERAPIST TO PARTICIPATE AS THE OLD BAD OBJECT?

MODEL 2

SELF PSYCHOLOGY CONTENDS THAT THE THERAPIST WILL INEVITABLY FAIL THE PATIENT BECAUSE THE THERAPIST IS NOT PERFECT

AND CANNOT BE EXPECTED TO BE PERFECT

MODEL 3

BUT MANY RELATIONAL THEORISTS BELIEVE THAT A THERAPIST'S FAILURES OF HER PATIENT ARE NOT JUST A STORY ABOUT THE THERAPIST
AND THE THERAPIST'S LACK OF PERFECTION

BUT ALSO A STORY ABOUT THE PATIENT
AND THE PATIENT'S EXERTING OF INTERPERSONAL PRESSURE ON THE THERAPIST TO PARTICIPATE IN WAYS BOTH "FAMILIAL AND THEREFORE FAMILIAR" (MITCHELL 1988)

IN OTHER WORDS
THE CONTEMPORARY RELATIONAL PERSPECTIVE CONCEIVES OF THE THERAPIST'S FAILURES AS SPEAKING TO HER OPENNESS TO BECOMING A PARTICIPANT IN THE PATIENT'S COMPULSIVE AND UNWITTING RE – ENACTMENTS

MORE SPECIFICALLY

RELATIONAL THEORY HAS IT THAT THE THERAPIST'S FAILURES DO NOT SIMPLY HAPPEN IN A VACUUM

RATHER, THEY OCCUR IN THE CONTEXT OF AN ONGOING, CONTINUOUSLY EVOLVING RELATIONSHIP BETWEEN TWO REAL PEOPLE

AND SPEAK TO THE THERAPIST'S RECEPTIVITY TO THE PATIENT'S UNCONSCIOUS NEED TO BE FAILED IN WAYS SPECIFICALLY DETERMINED BY HER EARLY – ON DEVELOPMENTAL HISTORY (CASEMENT 1992) AND INTERNALLY RECORDED AND STRUCTURALIZED IN THE FORM OF INTERNAL BAD OBJECTS AND DYSFUNCTIONAL RELATIONAL DYNAMICS

THE MODEL 3 THERAPIST'S FAILURES OF HER PATIENT ARE THEREFORE THOUGHT TO BE CO – CONSTRUCTED – BOTH A STORY ABOUT THE THERAPIST (AND WHAT SHE GIVES / BRINGS TO THE THERAPEUTIC INTERACTION) AND A STORY ABOUT THE PATIENT (AND WHAT SHE GIVES / BRINGS TO THE THERAPEUTIC INTERACTION)

AS NOTED EARLIER

WHEN THE MODEL 3
RELATIONAL THERAPIST
PARTICIPATES AS
AN AUTHENTIC SUBJECT,
THIS USUALLY BECOMES A STORY
ABOUT ALLOWING HERSELF
TO BE DRAWN IN
TO PARTICIPATING
AS THE OLD BAD OBJECT

THE LOCUS OF THE THERAPEUTIC ACTION IN MODEL 3 ALWAYS INVOLVES THIS MUTUALITY OF IMPACT,

BOTH THERAPIST AND PATIENT
AS AUTHENTIC SUBJECTS
CONTINUOUSLY CHANGING
SOMETIMES FOR THE BETTER, SOMETIMES FOR THE WORSE
BY VIRTUE OF BEING
IN RELATIONSHIP WITH EACH OTHER

THIS IS IN MARKED CONTRAST TO THE EMPATHIC MODEL 2 THERAPIST, WHOSE AUTHENTICITY AND SUBJECTIVITY ARE THOUGHT TO BE IMPEDIMENTS TO HER ABILITY TO BE EVER EMPATHICALLY ATTUNED TO THE PATIENT'S VANTAGE POINT AND ARE THEREFORE TO BE KEPT OUT OF THE ROOM

THE AUTHENTIC ENGAGEMENT OF THE MODEL 3 THERAPIST vs. THE EMPATHIC ATTUNEMENT OF THE MODEL 2 THERAPIST

AS AN AUTHENTIC SUBJECT,

THE MODEL 3 THERAPIST REMAINS

VERY MUCH CENTERED

WITHIN HER OWN EXPERIENCE,

ALLOWS THE PATIENT'S

EXPERIENCE TO ENTER INTO HER,

AND TAKES IT ON "AS" HER OWN

THEREBY LETTING HERSELF BE CHANGED BY IT

THE AUTHENTIC ENGAGEMENT OF THE MODEL 3 THERAPIST vs. THE EMPATHIC ATTUNEMENT OF THE MODEL 2 THERAPIST

AS AN EMPATHIC SELFOBJECT,

THE MODEL 2 THERAPIST DECENTERS

FROM HER OWN EXPERIENCE,

JOINS ALONGSIDE THE PATIENT,

AND ENTERS INTO THE PATIENT'S EXPERIENCE

BUT SHE TAKES IT ON ONLY "AS IF"

IT WERE HER OWN BECAUSE

IT NEVER ACTUALLY BECOMES HER OWN

TO REVIEW

SO THERE ARE THREE DISTINCTLY DIFFERENT POSITIONS THAT THE THERAPIST WILL ASSUME, MOMENT BY MOMENT, WITH RESPECT TO HOW SHE LISTENS AND HOW SHE THEN REACTS / RESPONDS

THE OBJECTIVE NEUTRALITY OF THE MODEL 1 THERAPIST

HEAD

THE EMPATHIC ATTUNEMENT OF THE MODEL 2 THERAPIST

HEART

THE AUTHENTIC ENGAGEMENT OF THE MODEL 3 THERAPIST

GUT

MORE GENERALLY

HOW THE THERAPIST POSITIONS HERSELF

MOMENT BY MOMENT

THE OPTIMAL THERAPEUTIC STANCE
WILL BE ONE THAT IS CONTINUOUSLY SHIFTING

SOMETIMES SPONTANEOUS
AND UNPLANNED,
SOMETIMES MORE CONSIDERED
AND DELIBERATE

SOMETIMES THE THERAPIST WILL FIND HERSELF
UNWITTINGLY DRAWN IN TO PARTICIPATING
IN A CERTAIN WAY

BUT AT OTHER TIMES THE THERAPIST WILL MAKE
A MORE CONSCIOUS CHOICE
BASED ON WHAT SHE SENSES THE PATIENT
MOST NEEDS IN THE MOMENT IN ORDER TO HEAL

Module 25

ENACTMENT

AND

THE PATIENT AS INTENTIONED

IN SUM

WHEREAS MODEL 2 CONCEIVES OF THE PATIENT AS HAVING THE NEED TO FIND A NEW GOOD OBJECT,

MODEL 3 CONCEIVES OF THE PATIENT AS HAVING THE NEED TO REFIND THE OLD BAD OBJECT

(BOLLAS'S "CREATED ENVIRONMENT" 1989)

SO THAT THE PATIENT CAN HAVE AN OPPORTUNITY TO REVISIT THE EARLY – ON TRAUMATIC FAILURE SITUATION AND ACHIEVE MASTERY THIS TIME

REPETITION COMPULSION

BOTH UNHEALTHY AND HEALTHY ASPECTS

THE UNHEALTHY PIECE HAS TO DO WITH
THE PATIENT'S NEED TO HAVE MORE OF SAME
NO MATTER HOW PATHOLOGICAL
BECAUSE THAT IS ALL THE PATIENT HAS EVER KNOWN

HAVING SOMETHING DIFFERENT
WOULD CREATE ANXIETY
BECAUSE IT WOULD HIGHLIGHT THE FACT
THAT THINGS COULD BE
AND COULD THEREFORE HAVE BEEN
DIFFERENT

IN ESSENCE, HAVING SOMETHING DIFFERENT
WOULD CHALLENGE THE PATIENT'S ATTACHMENT
TO THE INFANTILE (PARENTAL) OBJECT

REPETITION COMPULSION (CONTINUED)

BOTH UNHEALTHY AND HEALTHY ASPECTS

BUT THE HEALTHY PIECE
OF THE PATIENT'S NEED
TO BE NOW FAILED
AS SHE WAS ONCE FAILED
HAS TO DO WITH HER NEED
TO HAVE THE OPPORTUNITY
TO ACHIEVE BELATED MASTERY
OF THE EARLY – ON PARENTAL FAILURES

THE HOPE BEING THAT PERHAPS
THIS TIME THERE WILL BE
A DIFFERENT OUTCOME

CLASSICAL PSYCHOANALYSTS SPEAK OF SUPEREGO INTROJECTS

FOR EXAMPLE, A CRITICAL SUPEREGO INTROJECT
A HARSHLY PUNITIVE SUPEREGO INTROJECT

WHERE ONCE THE ABUSIVE PARENT HAD RAILED AGAINST THE CHILD,
NOW THAT DYNAMIC GETS PLAYED OUT BETWEEN SUPEREGO AND EGO
(WITH THE SUPEREGO NOW RAILING AGAINST THE EGO)

BUT I THINK IT IS MORE CLINICALLY USEFUL TO CONCEIVE OF SUCH PATHOGENIC INTROJECTS AS EXISTING IN PAIRS

FOR EXAMPLE, CRITICIZER AND CRITICIZEE / VICTIMIZER AND VICTIM

AND OF THE THERAPEUTIC ACTION AS THEREFORE A STORY ABOUT NEGOTIATING THE TREACHEROUS VICISSITUDES THAT WILL INEVITABLY EMERGE AT THE INTIMATE EDGE OF AUTHENTIC ENGAGEMENT BETWEEN THERAPIST AND PATIENT ONCE A PATIENT DELIVERS HER DYSFUNCTIONAL RELATIONAL DYNAMIC OF HER THERE – AND – THEN INTO THE HERE – AND – NOW OF THE TRANSFERENCE

WHERE ONCE THE ABUSIVE PARENT HAD RAILED AGAINST THE CHILD,
NOW THAT DYNAMIC GETS PLAYED OUT BETWEEN THERAPIST AND PATIENT
(WITH ULTIMATELY BOTH RAILING AGAINST EACH OTHER)

ONCE WE APPRECIATE THAT INTERNAL BAD OBJECTS ALWAYS EXIST IN PAIRS, WE MUST RECOGNIZE THAT THE PATIENT CAN IDENTIFY WITH EITHER POLE OF THE INTROJECTIVE CONSTELLATION AND THEN PROJECT THE OTHER POLE ONTO THE THERAPIST

THE ACTIVE POLE

WILL GENERALLY BE THE ROLE OF THE PARENT IN RELATION TO THE CHILD

THE PASSIVE POLE

WILL GENERALLY BE THE ROLE OF THE CHILD IN RELATION TO THE PARENT

WHEN THE PATIENT IDENTIFIES WITH THE PASSIVE POLE, PROJECTS THE ACTIVE POLE ONTO THE THERAPIST, AND THEN GETS HER THERAPIST TO DO UNTO HER THE BAD THAT HAD BEEN DONE UNTO HER AS A CHILD, WE SPEAK OF A "DIRECT" NEGATIVE TRANSFERENCE

WHEN THE PATIENT IDENTIFIES WITH THE ACTIVE POLE, PROJECTS THE PASSIVE POLE ONTO THE THERAPIST, AND THEN DOES UNTO HER THERAPIST THE BAD THAT HAD BEEN DONE UNTO HER AS A CHILD, WE SPEAK OF AN "INVERTED" NEGATIVE TRANSFERENCE

(STARK 1994)

UNLIKE MODEL 2
WHICH PAYS RELATIVELY LITTLE ATTENTION
TO THE PATIENT'S PROACTIVITY
IN RELATION TO THE THERAPIST

MODEL 3 ADDRESSES ITSELF SPECIFICALLY TO THE FORCE FIELD CREATED BY THE PATIENT WHO UNDER THE SWAY OF HER REPETITION COMPULSION

IS THOUGHT TO BE EVER INTENT UPON RECREATING THROUGH PROJECTIVE IDENTIFICATION

THE EARLY – ON TRAUMATIC FAILURE SITUATION
BY DRAWING THE THERAPIST IN TO PARTICIPATING
AS THE OLD BAD OBJECT

WHICH IS WHAT MUST HAPPEN IF THE PATIENT IS EVER TO CONQUER HER INTERNAL DEMONS STRUCTURAL MODIFICATION

IN OTHER WORDS

THE RELATIONAL MODEL CONCEIVES OF THE PATIENT AS AN AGENT, AS PROACTIVE, AS INTENTIONED IN HER ACTIVITIES, AND AS ACCOUNTABLE

WHETHER SHE LIKES IT OR NOT

THE MODEL 3 THERAPIST THEREFORE ATTENDS CLOSELY
TO WHAT THE PATIENT DELIVERS OF HERSELF
INTO THE THERAPY RELATIONSHIP AND
TO HER OWN COUNTERTRANSFERENTIAL REACTION / RESPONSE
TO THE PATIENT'S TRANSFERENTIAL ENACTMENTS

IN FACT

THE PATIENT'S ACTIVITY IN RELATION TO THE THERAPIST IS SEEN AS AN

ENACTMENT

THE UNCONSCIOUS INTENT OF WHICH IS TO ENGAGE THE THERAPIST IN SOME FASHION

EITHER

BY ELICITING (PROVOKING) FROM THE THERAPIST A "FAMILIAL AND THEREFORE FAMILIAR" REACTION

(MITCHELL 1988)

OR

BY COMMUNICATING TO THE THERAPIST SOMETHING DEEPLY IMPORTANT AND UNMASTERED ABOUT THE PATIENT'S INTERNAL WORLD

ACTUALLY

THE PATIENT MAY KNOW OF NO OTHER WAY TO GET SOME UNRESOLVED PIECE OF HER SUBJECTIVE EXPERIENCE UNDERSTOOD

USUALLY AN UNPROCESSED AND UNINTEGRATED RELATIONAL TRAUMA FROM EARLY – ON

THAN BY UNWITTINGLY ENACTING IT IN THE RELATIONSHIP WITH HER THERAPIST

THEREBY CREATING EITHER
A DIRECT NEGATIVE TRANSFERENCE OR
AN INVERTED NEGATIVE TRANSFERENCE

THE COMPLEX VICISSITUDES OF WHICH WILL NEED TO BE NEGOTIATED AT THE INTIMATE EDGE OF AUTHENTIC RELATEDNESS FOR THERE TO BE STRUCTURAL RESOLUTION

Module 26

RELATIONAL INTERVENTIONS

AND

ACCOUNTABILITY STATEMENTS

CLINICAL VIGNETTE – "GREAT TAN, BITCH!"

THE THERAPIST'S USE OF SELF
TO INFORM HER UNDERSTANDING OF THE PATIENT

THE PATIENT, JANET, IS A 31 – YEAR – OLD MARRIED WOMAN WHO HAS A HISTORY OF DIFFICULT RELATIONSHIPS WITH ALMOST EVERYONE IN HER LIFE

SHE IS PARTICULARLY TROUBLED BY HER LACK OF CLOSE WOMEN FRIENDS

OVER THE COURSE OF THE PREVIOUS THREE YEARS, JANET HAS BEEN WORKING HARD IN THE TREATMENT, HAS MADE SUBSTANTIAL GAINS IN HER PROFESSIONAL LIFE, AND HAS VERY MUCH IMPROVED THE QUALITY OF HER RELATIONSHIP WITH HER HUSBAND

JANET AND HER THERAPIST (A WOMAN) HAVE HAD A GOOD, RELATIVELY UNCONFLICTED RELATIONSHIP

JANET CLEARLY LIKES, AND IS RESPECTFUL OF, HER THERAPIST

BUT UPON THE THERAPIST'S RETURN FROM A WEEK – LONG VACATION IN FLORIDA, JANET, AT THE END OF A SESSION, JUST AS SHE IS LEAVING, TURNS BACK TO HER THERAPIST AND, AS A PARTING SHOT, BLURTS OUT "GREAT TAN, BITCH!"

THE THERAPIST, AWARE OF FEELING TAKEN ABACK, SAYS NOTHING, SMILES WANLY, AND NODS GOOD – BYE

CLINICAL VIGNETTE – "GREAT TAN, BITCH!"

AFTER DISCUSSING THE SITUATION WITH A COLLEAGUE,
THE THERAPIST OPENS THE NEXT SESSION WITH THE FOLLOWING

"WE HAVE TALKED A LOT ABOUT HOW UPSETTING IT IS FOR YOU TO HAVE SO FEW WOMEN FRIENDS. I THINK THAT NOW, IN LIGHT OF WHAT HAPPENED AT THE END OF OUR LAST SESSION, I AM COMING TO UNDERSTAND SOMETHING THAT I HAD NEVER BEFORE ENTIRELY UNDERSTOOD. WHEN YOU LEFT LAST TIME, YOUR PARTING WORDS WERE 'GREAT TAN, BITCH!' I WONDER IF YOU, BY SAYING THAT, WEREN'T TRYING TO SHOW ME WHAT SOMETIMES HAPPENS FOR YOU WHEN YOU FEEL CLOSE TO A WOMAN AND THEN FIND YOURSELF BECOMING COMPETITIVE."

THE THERAPIST'S AWARENESS OF
HER OWN COUNTERTRANSFERENTIAL REACTION
OF FEELING TAKEN ABACK AND PUT OFF BY THE PATIENT'S DOOR HANDLE REMARK
TO THE PATIENT'S PROVOCATIVE ENACTMENT
ENABLES THE THERAPIST TO OFFER THE PATIENT
AN ACCOUNTABILITY STATEMENT THAT CHALLENGES THE PATIENT
TO TAKE OWNERSHIP OF HER HOSTILE COMPETITIVENESS

CLINICAL VIGNETTE – "GREAT TAN, BITCH!"

THEN THERAPIST AND PATIENT, TOGETHER,
MUST WEND THEIR WAY OUT OF
WHAT HAS BECOME A MUTUAL ENACTMENT

IN THE PROCESS, FINDING THAT BOTH SURVIVE,
DISCOVERING, IN ESSENCE, THE INDESTRUCTIBILITY OF EACH

ALTHOUGH THE THERAPIST SHOULD ALWAYS ATTEMPT TO WITHSTAND
THE PATIENT'S EFFORTS TO DRAW HER IN TO PARTICIPATING
IN THE PATIENT'S DRAMATIC RE – ENACTMENTS,
RELATIONAL THEORIES OF THERAPEUTIC ACTION POSTULATE THAT
IT IS NOT ONLY INEVITABLE BUT ALSO NECESSARY
AND THEREFORE DESIRABLE
THAT ULTIMATELY THE THERAPIST WILL FAIL THE PATIENT

AND IN THE VERY WAYS THAT THE PATIENT MOST NEEDS TO BE
FAILED IF SHE IS EVER TO DETOXIFY HER INTERNAL BADNESS,
REWORK HER INTERNALIZED TRAUMAS,
AND OVERCOME HER INTERNAL DEMONS
IN OTHER WORDS, IF THERE IS EVER TO BE STRUCTURAL CHANGE

MODEL 3 IS ABOUT ACCOUNTABILITY

WHENEVER A PATIENT SAYS OR DOES SOMETHING
THAT THE THERAPIST EXPERIENCES AS PROVOCATIVE,
I DESCRIBE IT AS A "PROVOCATIVE ENACTMENT"

IN ORDER TO GET THE PATIENT TO TAKE OWNERSHIP
OF WHAT SHE IS IMPLICITLY ATTEMPTING TO COMMUNICATE
THE THERAPIST HAS THE OPTION OF ASKING
THE PATIENT ANY OF THE FOLLOWING

"HOW ARE YOU HOPING THAT I WILL RESPOND?"
WHICH ADDRESSES THE ID

"HOW ARE YOU FEARING THAT I MIGHT RESPOND?"
WHICH ADDRESSES THE SUPEREGO

"HOW ARE YOU IMAGINING THAT I WILL RESPOND?"
WHICH ADDRESSES THE EGO

ALL THREE RELATIONAL INTERVENTIONS DEMAND OF THE PATIENT
THAT SHE MAKE HER INTERPERSONAL INTENTIONS MORE EXPLICIT
THAT SHE TAKE RESPONSIBILITY FOR HER PROVOCATIVE ENACTMENT

MORE GENERALLY

MODEL 1 USES CONFLICT STATEMENTS TO INCREASE THE PATIENT'S AWARENESS OF HER INTERNAL CONFLICTS AND TO PROMPT EVENTUAL TRANSFORMATION OF STRUCTURAL CONFLICT INTO STRUCTURAL COLLABORATION AND ACTUALIZATION OF POTENTIAL

MODEL 2 USES DISILLUSIONMENT STATEMENTS TO FACILITATE THE PATIENT'S GRIEVING OF INTOLERABLY PAINFUL DISAPPOINTMENTS AND TO PROMPT EVENTUAL TRANSFORMATION OF RELENTLESS HOPE INTO ACCEPTANCE

MODEL 3 USES ACCOUNTABILITY STATEMENTS TO INCREASE THE PATIENT'S AWARENESS OF HER TENDENCY TO PLAY OUT UNMASTERED CHILDHOOD DRAMAS ON THE STAGE OF HER LIFE AND TO PROMPT EVENTUAL TRANSFORMATION OF THOSE COMPULSIVE AND UNWITTING RE – ENACTMENTS INTO ACCOUNTABILITY

MORE SPECIFICALLY

MODEL 3 ACCOUNTABILITY STATEMENTS

INVOLVE INTERPRETING THE PATIENT'S ENACTMENTS AS AN EFFORT

EITHER TO DRAW THE THERAPIST IN TO PARTICIPATING AS THE ABUSIVE PARENT BY WAY OF BEHAVIOR ON THE PATIENT'S PART THAT IS UNCONSCIOUSLY DESIGNED TO ELICIT AN ABUSIVE REACTION FROM THE THERAPIST

A DIRECT NEGATIVE TRANSFERENCE IN WHICH THE THERAPIST IS MADE INTO THE ABUSIVE PARENT AND THE PATIENT ONCE AGAIN ASSUMES THE ROLE OF THE ABUSED CHILD

OR TO GET THE THERAPIST TO UNDERSTAND FIRSTHAND WHAT IT WAS LIKE FOR THE PATIENT GROWING UP BY WAY OF THE PATIENT'S DOING UNTO THE THERAPIST WHAT WAS ONCE DONE UNTO HER BY THE ABUSIVE PARENT

AN INVERTED NEGATIVE TRANSFERENCE IN WHICH THE PATIENT ASSUMES THE ROLE OF THE ABUSIVE PARENT AND BEHAVES AS SUCH IN RELATION TO THE THERAPIST IN ORDER TO MAKE THE THERAPIST UNDERSTAND

ON THE ONE HAND

IT IS CERTAINLY DAUNTING TO IMAGINE THAT A THERAPIST MIGHT EVER BECOME EVEN A LITTLE ABUSIVE IN RELATION TO HER PATIENT

ON THE OTHER HAND

IF THE PATIENT HAD AN ABUSIVE PARENT

AND THEREFORE INTROJECTED THE VICTIMIZER – VICTIM RELATIONAL DYNAMIC

BUT THE THERAPIST DOES NOT ALLOW HERSELF TO BE DRAWN IN TO PARTICIPATING COUNTERTRANSFERENTIALLY IN WHATEVER WAY THE PATIENT MIGHT NEED HER TO,

THEN THE THERAPIST WILL BE ROBBING THE PATIENT OF A PRIME OPPORTUNITY TO REWORK HER SENSE OF HERSELF AS BAD AND OF THE WORLD AS BAD BY PLAYING OUT THE DYSFUNCTIONAL DYNAMIC OF SELF – SABOTAGE AND VICTIMIZATION ON THE STAGE OF HER LIFE

INDEED IT MAY WELL BE ONLY BY WAY OF RECREATING WITH HER THERAPIST THE ONLY KIND OF RELATIONSHIP SHE HAS EVER KNOWN, THAT THE PATIENT WILL BE AT LAST ABLE TO NEGOTIATE WITH HER THERAPIST A DIFFERENT ENDING

MODEL 3 ACCOUNTABILITY STATEMENTS ADDRESS THE ISSUE OF OWNERSHIP

BE IT ON THE PART OF THE PATIENT OR THE THERAPIST AND WHETHER IT INVOLVES A DIRECT NEGATIVE TRANSFERENCE OR AN INVERTED NEGATIVE TRANSFERENCE

**"IT OCCURS TO ME THAT YOU,
BY WAY OF YOUR BEHAVIOR IN HERE WITH ME,
ARE HELPING ME TO UNDERSTAND SOMETHING
THAT I HAD NEVER BEFORE ENTIRELY UNDERSTOOD …"**

**"I THINK THAT YOU HAVE BEEN TRYING TO
COMMUNICATE SOMETHING IMPORTANT TO ME
THAT I HAD BEEN REFUSING TO RECOGNIZE …"**

**"I WONDER IF MY DIFFICULTY APPRECIATING JUST
HOW DESPERATE YOU WERE MADE YOU FEEL THAT
YOU HAD TO DO SOMETHING DRAMATIC
IN ORDER TO GET MY ATTENTION …"**

IN ESSENCE

THE THERAPIST IS HERE HOLDING HERSELF ACCOUNTABLE FOR HER CONTRIBUTION TO THE PATIENT'S ENACTMENT

FURTHERMORE FRAMING THE PATIENT'S PROVOCATIVE TRANSFERENTIAL ACTIVITY IN THIS WAY

THAT IS, AS AN UNDERSTANDABLE REACTION TO THE THERAPIST'S INABILITY / REFUSAL TO UNDERSTAND SOMETHING IMPORTANT ABOUT THE PATIENT'S INTERNAL EXPERIENCE

MAY THEN MAKE IT A LITTLE EASIER FOR THE PATIENT HERSELF TO TOLERATE BEING HELD ACCOUNTABLE

IN OTHER WORDS

WHEN THE THERAPIST ACKNOWLEDGES HER PART, THE PATIENT MAY THEN BE ABLE TO ACKNOWLEDGE HER PART WITHOUT LOSING FACE

Module 27

CONTAINMENT

AND

THE CAPACITY TO RELENT

TO REVIEW

PROJECTIVE IDENTIFICATION

BE IT A DIRECT OR AN INVERTED NEGATIVE TRANSFERENCE

THE INDUCTION PHASE

BY DELIVERING HER PATHOGENIC INTROJECTS
INTO THE RELATIONSHIP WITH HER THERAPIST,
THE PATIENT DRAWS THE THERAPIST IN TO
PARTICIPATING COUNTERTRANSFERENTIALLY
IN THE PATIENT'S TRANSFERENTIAL ENACTMENT

THE RESOLUTION PHASE

RESOLUTION IS ACHIEVED ONCE THE THERAPIST BRINGS TO BEAR
HER OWN, MORE – EVOLVED CAPACITY TO PROCESS AND INTEGRATE
THAT IS, TO DETOXIFY PATHOGENICITY
ON BEHALF OF A PATIENT WHO TRULY DOES NOT KNOW HOW

THEREBY RETURNING TO THE PATIENT
FOR RE – INTROJECTION A SLIGHTLY DETOXIFIED
VERSION OF THE ORIGINAL TOXIC BOLUS

IN ESSENCE

A SYMBOLIC REPETITION OF THE ORIGINAL RELATIONAL TRAUMA BUT WITH A MUCH HEALTHIER RESOLUTION THIS TIME

THE EXPERIENCE OF BAD – BECOME – GOOD

INDEED, THE HALLMARK OF A SUCCESSFUL

PROJECTIVE IDENTIFICATION

IS THE THERAPIST'S CAPACITY

TO TOLERATE

WHAT THE PATIENT

FINDS INTOLERABLE

PROVISION OF CONTAINMENT

THE MODEL 3 THERAPIST MUST BE ABLE NOT ONLY TO TOLERATE BEING MADE INTO THE PATIENT'S OLD BAD OBJECT

BUT ALSO

ONCE THE THERAPIST HAS ALLOWED HERSELF TO BE DRAWN IN TO WHAT HAS BECOME A MUTUAL ENACTMENT

TO EXTRICATE HERSELF BY STEPPING BACK

THEREBY RECOVERING HER OBJECTIVITY AND HER THERAPEUTIC EFFECTIVENESS

MOST IMPORTANTLY

THE THERAPIST MUST HAVE THE CAPACITY TO RELENT

THE THERAPIST MUST HAVE
BOTH THE WISDOM TO RECOGNIZE
AND THE INTEGRITY TO ACKNOWLEDGE
CERTAINLY TO HERSELF, PERHAPS TO THE PATIENT AS WELL
HER OWN PARTICIPATION IN THE DRAMA
THAT IS BEING PLAYED OUT BETWEEN THEM
ON THE STAGE OF THE TREATMENT

IN ESSENCE, THE THERAPIST MUST BE ABLE BOTH TO RELENT AND TO HOLD HERSELF ACCOUNTABLE FOR HER OWN ENACTMENTS

IF THE THERAPIST NEVER ALLOWS HERSELF TO BE DRAWN IN TO PARTICIPATING WITH THE PATIENT IN HER ENACTMENTS

FAILURE OF ENGAGEMENT AND LOST OPPORTUNITY

IF, HOWEVER, THE THERAPIST ALLOWS HERSELF TO BE DRAWN IN TO THE PATIENT'S INTERNAL DRAMAS BUT THEN GETS LOST

FAILURE OF CONTAINMENT AND THE POTENTIAL FOR RETRAUMATIZATION

ALTHOUGH INITIALLY THE THERAPIST
MIGHT INDEED FAIL THE PATIENT
IN MUCH THE SAME WAYS
THAT HER PARENT HAD FAILED HER

THE INDUCTION PHASE

ULTIMATELY THE THERAPIST
WILL CHALLENGE THE PATIENT'S
PROJECTIONS BY LENDING ASPECTS
OF HER "OTHERNESS" TO THE INTERACTION
OR, AS WINNICOTT (1965) WOULD HAVE SAID, HER "EXTERNALITY"

SUCH THAT THE PATIENT WILL HAVE
THE EXPERIENCE OF SOMETHING
THAT IS "OTHER – THAN – ME"
AND CAN TAKE THAT IN

THE RESOLUTION PHASE

WHAT THE PATIENT THEN INTROJECTS

WILL BE AN AMALGAM,

PART CONTRIBUTED BY THE THERAPIST

SOMETHING MORE PROCESSED, INTEGRATED, AND DETOXIFIED

AND PART CONTRIBUTED BY THE PATIENT

THE ORIGINAL PROJECTION

PARENTHETICALLY

IN THE PSYCHOANALYTIC LITERATURE,

“INTERNALIZE” TENDS TO IMPLY “POSITIVE”

AS IN “TRANSMUTING INTERNALIZATION”

WHEREAS “INTROJECT” TENDS TO IMPLY “NEGATIVE”

AS IN “PATHOGENIC INTROJECT”

AND BECAUSE THE THERAPIST IS NOT, IN FACT, AS BAD AS THE PARENT HAD BEEN, THERE CAN BE A HEALTHIER RESOLUTION THIS TIME

THERE WILL BE REPETITION OF THE ORIGINAL TRAUMA BUT EVENTUAL INCREMENTAL DETOXIFICATION OF THE PATIENT'S INTERNAL WORLD AND INTEGRATION AT A HIGHER LEVEL OF ACCOUNTABILITY

SERIAL DILUTIONS

GRADUATED DETOXIFICATION

THE ITERATIVE CYCLES OF INDUCTION AND RESOLUTION

"MORE OF SAME" AND THEN "SOMETHING NEW"

WILL HAPPEN REPEATEDLY RESULTING ULTIMATELY IN STRUCTURAL MODIFICATION

NOTE THAT IT IS THE SECOND (RESOLUTION) PHASE OF THE PROJECTIVE IDENTIFICATION THAT CONSTITUTES THE CHALLENGE AND THE FIRST (INDUCTION) PHASE THAT REINFORCES AND SUPPORTS THE DYSFUNCTIONAL STATUS QUO

AGAIN

IT IS NOT ONLY INEVITABLE
BUT ALSO NECESSARY
AND THEREFORE DESIRABLE
THAT ULTIMATELY THE THERAPIST
WILL FAIL THE PATIENT

AND IN THE VERY WAYS THAT
THE PATIENT MOST NEEDS
TO BE FAILED
IF SHE IS EVER TO HAVE
AN OPPORTUNITY TO
REWORK HER INTERNAL BADNESS

THE THERAPIST'S CAPACITY TO TOLERATE "BEING BAD"
(CONTINUED)

IF THE MODEL 2 THERAPIST CANNOT TOLERATE
"BREAKING THE PATIENT'S HEART"
EVERY NOW AND AGAIN,

THE THERAPIST WILL BE ROBBING THE PATIENT
OF THE OPPORTUNITY ADAPTIVELY TO INTERNALIZE
MISSING PSYCHOLOGICAL FUNCTIONS
VIA OPTIMAL DISILLUSIONMENT AND TRANSMUTING INTERNALIZATION

SO TOO IF THE MODEL 3 THERAPIST REFUSES TO PARTICIPATE
AT LEAST EVERY NOW AND AGAIN
AS SOMEONE WHO
"INITIALLY RETRAUMATIZES BUT ULTIMATELY RELENTS,"

THE THERAPIST WILL BE ROBBING THE PATIENT
OF THE OPPORTUNITY TO REWORK
VIA SERIAL DILUTIONS
HER INTROJECTED BOLUSES OF TOXICITY

THE THERAPIST'S CAPACITY TO TOLERATE "BEING BAD"

BECAUSE THE ORIGINAL
"HEARTBREAK" (MODEL 2) AND "ABUSE" (MODEL 3)
OCCURRED IN THE
CONTEXT OF THE THERE – AND – THEN
ENGAGEMENT BETWEEN PARENT AND CHILD,

IT STANDS TO REASON THAT
THE REWORKING OF THOSE
EARLY – ON RELATIONAL TRAUMAS
WILL NEED TO OCCUR IN THE
CONTEXT OF THE HERE – AND – NOW
ENGAGEMENT BETWEEN THERAPIST AND PATIENT

IN OTHER WORDS
BECAUSE THE ETIOLOGY INVOLVED FAILURES AT
THE INTIMATE EDGE BETWEEN PARENT AND CHILD,
THE THERAPEUTIC ACTION SHOULD INVOLVE RENEGOTIATING
AT LEAST SOME VERSION OF THOSE RELATIONAL FAILURES AT
THE INTIMATE EDGE BETWEEN THERAPIST AND PATIENT

“IF THE THERAPIST DOES NOT PARTICIPATE AS A NEW GOOD OBJECT, THE THERAPY MAY NEVER GET UNDER WAY.

BUT IF SHE DOES NOT PARTICIPATE AS THE OLD BAD ONE, IT MAY NEVER END.”

(GREENBERG 1986)

WHICH CAPTURES EXQUISITELY THE DELICATE BALANCE BETWEEN THE THERAPIST’S PARTICIPATION AS A NEW GOOD OBJECT SO THAT THERE CAN BE A STARTING OVER

AND THE THERAPIST’S PARTICIPATION AS THE OLD BAD ONE SO THAT THERE CAN BE AN OPPORTUNITY TO ACHIEVE BELATED MASTERY OF THE INTROJECTED TRAUMAS AND ABUSE

BY THE SAME TOKEN, IF THE THERAPIST DOES NOT PARTICIPATE AS THE OLD BAD OBJECT, THE THERAPY MAY NEVER GET UNDER WAY

BUT IF SHE DOES NOT PARTICIPATE AS A NEW GOOD ONE, IT MAY NEVER END

IN SUM

OVER THE COURSE OF A TREATMENT
THE PATIENT SHOULD THEREFORE HAVE AN
OPPORTUNITY TO EXPERIENCE HER THERAPIST
AS BOTH A NEW GOOD OBJECT
AND THE OLD BAD ONE

MODEL 2 – STRUCTURAL GROWTH
BY WORKING THROUGH
THE EXPERIENCE OF GOOD – BECOME – BAD
DISILLUSIONMENT / POSITIVE TRANSFERENCE DISRUPTED

MODEL 3 – STRUCTURAL MODIFICATION
BY WORKING THROUGH
THE EXPERIENCE OF BAD – BECOME – GOOD
NEGATIVE TRANSFERENCE

Module 28

INTROJECTIVE IDENTIFICATION

AND

A CERTAIN BEAUTY IN BROKENNESS

MODEL 3

AS WE KNOW

IF EARLY – ON TRAUMA AND ABUSE EXPERIENCED
BY THE CHILD AT THE HANDS OF HER PARENT
CANNOT BE PROCESSED AND INTEGRATED
INTO HEALTHY PSYCHIC STRUCTURE,

THEN THE UNMASTERED EXPERIENCE
WILL BECOME STRUCTURALIZED IN THE MIND
OF THE DEVELOPING CHILD AS INTERNAL BADNESS

THE CLINICAL CHALLENGE WILL THEN BE –

ONCE TRAUMATIZING EXPERIENCE HAS BECOME
INTERNALLY RECORDED AS BADNESS,
HOW CAN IT LATER BE ACCESSED
IN THE TREATMENT AND DETOXIFIED?

PROJECTIVE IDENTIFICATION
AND INTROJECTIVE IDENTIFICATION

PROJECTIVE IDENTIFICATION

"RELATIONAL DISCONFIRMATION OF TOXIC EXPECTATION"

THE INDUCTION PHASE COMMENCES ONCE THE PATIENT PROJECTS ONTO THE THERAPIST SOME ASPECT OF THE PATIENT'S EXPERIENCE THAT HAS BEEN TOO TOXIC FOR THE PATIENT TO PROCESS AND INTEGRATE AND THEN EXERTS PRESSURE ON THE THERAPIST TO ACCEPT THAT PROJECTION, THEREBY INDUCTING THE THERAPIST INTO THE PATIENT'S ENACTMENT

THE RESOLUTION PHASE IS USHERED IN ONCE THE THERAPIST STEPS BACK FROM HER PARTICIPATION IN WHAT HAS BECOME A MUTUAL ENACTMENT AND BRINGS TO BEAR HER OWN, MORE – EVOLVED CAPACITY TO PROCESS AND INTEGRATE ON BEHALF OF A PATIENT WHO TRULY DOES NOT KNOW HOW – SUCH THAT WHAT IS THEN REINTROJECTED BY THE PATIENT CAN BE MORE EASILY ASSIMILATED INTO HEALTHY PSYCHIC STRUCTURE

AND, IF ALL GOES WELL, THESE CYCLES WILL HAPPEN REPEATEDLY, THE NET RESULT OF WHICH WILL BE GRADUAL DETOXIFICATION OF THE PATIENT'S INTERNAL TOXICITY

INTROJECTIVE IDENTIFICATION (STARK 2015)

"RELATIONAL DILUTION OF TOXIC EXPERIENCE"

THIS CONCEPT DESCRIBES WHAT HAPPENS NOT WHEN THE PATIENT INITIATES THE THERAPEUTIC ACTION BY EXERTING PRESSURE ON THE THERAPIST TO TAKE ON, AS THE THERAPIST'S OWN, SOME ASPECT OF THE PATIENT'S UNMASTERED EXPERIENCE BUT RATHER WHEN THE THERAPIST INITIATES THE THERAPEUTIC ACTION BY INTUITIVELY AND NOT ALTOGETHER UNCONSCIOUSLY ENTERING INTO THE PATIENT'S INTERNAL WORLD AND TAKING ON, AS THE THERAPIST'S OWN, SOME ASPECT OF THE PATIENT'S UNMASTERED EXPERIENCE

THIS TAKES PLACE IN NOT ONLY THE THERAPIST – PATIENT RELATIONSHIP BUT ALSO THE PARENT – INFANT RELATIONSHIP

CERTAINLY A GOOD MOTHER WHO IS ATTUNED TO HER INFANT'S MOMENT – BY – MOMENT EXPERIENCE WILL USE INTROJECTIVE IDENTIFICATION AS A MATTER OF COURSE

INTROJECTIVE IDENTIFICATION

"RELATIONAL DILUTION OF TOXIC EXPERIENCE"

MORE SPECIFICALLY

AN AUTHENTICALLY ENGAGED MOTHER, SENSING HER INFANT'S DISTRESS, WILL ENTER INTO THE INFANT'S DYSREGULATED AFFECTIVE STATE AND TAKE IT ON AS HER OWN, LENDING ASPECTS OF HER OWN, MORE – EVOLVED CAPACITY TO A PROCESSING AND INTEGRATING OF HER CHILD'S UNMASTERED EXPERIENCE

THE MOTHER WILL DO THIS INTUITIVELY AND REPEATEDLY, THE NET RESULT OF WHICH WILL BE DILUTION AND MODULATION OF HER CHILD'S EXPERIENCE OF DISTRESS – AND EVENTUAL DEVELOPMENT OF THE CHILD'S CAPACITY TO MANAGE OVERWHELMING AFFECT ON HER OWN

AS THIS PROCESS CONTINUES, THE CHILD'S NEED FOR EXTERNAL REGULATION OF THE SELF WILL BECOME TRANSFORMED, OVER TIME, INTO THE CAPACITY TO BE INTERNALLY SELF – REGULATING

WHETHER RELATIONAL DISCONFIRMATION OF TOXIC EXPECTATION OR RELATIONAL DILUTION OF TOXIC EXPERIENCE

THE NET RESULT WILL BE STRUCTURAL MODIFICATION OF THE INTROJECTED BADNESS

WITH PROJECTIVE IDENTIFICATION,
IT WILL BE THE PATIENT
WHO INITIATES THE THERAPEUTIC ACTION

WHEREAS WITH INTROJECTIVE IDENTIFICATION,
IT WILL BE THE THERAPIST

BUT WHETHER
RELATIONAL DISCONFIRMATION
OF TOXIC EXPECTATION
OR RELATIONAL DILUTION
OF TOXIC EXPERIENCE,

THE NET RESULT WILL BE
STRUCTURAL MODIFICATION
OF DYSFUNCTIONAL RELATIONAL DYNAMICS
AND INTROJECTED BOLUSES OF TOXICITY

BY WAY OF NEGOTIATING THE VICISSITUDES THAT WILL INEVITABLY ARISE
AT THE INTIMATE EDGE OF AUTHENTIC ENGAGEMENT
BETWEEN TWO RELATIONAL OBJECTS
WHO ARE EVER BUSY "MUTUALLY IMPROVISING" (HARTMAN 2016)
AS THEY CHOREOGRAPH THEIR INTERACTIVE STEPS

WORKING THROUGH PROJECTIVE IDENTIFICATION
REQUIRES OF THE MODEL 3 THERAPIST
THAT SHE BE ABLE TO TOLERATE
BEING MADE AS BAD AS THE PATIENT
MIGHT NEED HER TO BE
WITHOUT LOSING HER OWN SELF FOR TOO LONG

WORKING THROUGH INTROJECTIVE IDENTIFICATION
REQUIRES OF THE MODEL 3 THERAPIST
THAT SHE BE ABLE TO TOLERATE
BEING OVERWHELMED BY THE INTENSITY
OF THE PATIENT'S DYSREGULATED AFFECT
WITHOUT LOSING HER OWN SELF FOR TOO LONG

IN OTHER WORDS
IT IS IMPORTANT THAT THE THERAPIST BE ABLE TO
LOSE HER SELF EVERY NOW AND AGAIN (INDUCTION PHASE)
BUT THAT SHE NOT GET SO LOST THAT SHE
CANNOT THEN REFIND HER SELF (RESOLUTION PHASE)

CONTAINMENT AND ACCOUNTABILITY

WHETHER BY WAY OF
DISCONFIRMATION OF TOXIC EXPECTATION (PROJECTIVE IDENTIFICATION)
OR DILUTION OF TOXIC EXPERIENCE (INTROJECTIVE IDENTIFICATION)

THE RELATIONAL PERSPECTIVE IS
ULTIMATELY A STORY ABOUT
THE THERAPIST'S USE OF SELF
TO FACILITATE MODIFICATION OF
THE PATIENT'S SENSE OF SELF AS BAD

THEREBY DEFUSING
THE PATIENT'S NEED
TO PLAY OUT HER BADNESS
ON THE STAGE OF HER LIFE

AS IRRESPONSIBLE RE – ENACTMENT
IS GRADUALLY REPLACED
BY RESPONSIBLE ACCOUNTABILITY

IN CONCLUSION ☺

THANK YOU SO MUCH
FOR TAKING THIS JOURNEY WITH ME
AND FOR SEEING IT THROUGH TO THE END

MOST IMPORTANTLY
I HOPE YOU HAVE ENJOYED YOURSELVES
AND NOW HAVE ADDITIONAL WAYS
TO CONCEPTUALIZE AND FRAME
THE WORK THAT YOU DO
WITH SUCH PASSION AND COMMITMENT

IN CLOSING

I WOULD LIKE TO BORROW FROM STEPHEN MITCHELL A WONDERFUL ANECDOTE THAT CAPTURES THE ESSENCE OF THE QUINTESSENTIAL STRUGGLE IN WHICH ALL OF US THERAPISTS ARE ENGAGED AS WE ATTEMPT TO MASTER OUR ART

MITCHELL (1988) WRITES –

"<STRAVINSKY> HAD WRITTEN A NEW PIECE WITH A DIFFICULT VIOLIN PASSAGE. AFTER IT HAD BEEN IN REHEARSAL FOR SEVERAL WEEKS, THE SOLO VIOLINIST CAME TO STRAVINSKY AND SAID HE WAS SORRY, HE HAD TRIED HIS BEST, <BUT> THE PASSAGE WAS TOO DIFFICULT; NO VIOLINIST COULD PLAY IT. STRAVINSKY SAID, 'I UNDERSTAND THAT. WHAT I AM AFTER IS THE SOUND OF SOMEONE TRYING TO PLAY IT.'"

AS THERAPISTS, OUR WORK IS EXQUISITELY DIFFICULT AND FINELY TUNED – AND OFTEN WE WILL NOT BE ABLE TO GET IT JUST RIGHT – PERHAPS, HOWEVER, WE CAN CONSOLE OURSELVES WITH THE THOUGHT THAT IT IS THE EFFORT WE MAKE TO GET IT JUST RIGHT THAT WILL ULTIMATELY COUNT


she took
THE LEAP
and built
HER WINGS
on the way down

OPTIMAL STRESS

STRONGER AT THE BROKEN PLACES

**IS THERE NOT A CERTAIN BEAUTY IN BROKENNESS,
A BEAUTY NEVER ACHIEVED BY THINGS UNBROKEN?**

**IF A BONE IS FRACTURED AND THEN HEALS,
THE AREA OF THE BREAK WILL BE STRONGER THAN
THE SURROUNDING BONE
AND WILL NOT AGAIN EASILY FRACTURE**

ARE WE TOO NOT STRONGER AT OUR BROKEN PLACES?

**IS THERE NOT A CERTAIN BEAUTY IN BROKENNESS,
A QUIET STRENGTH WE ACQUIRE
FROM SURVIVING ADVERSITY AND HARDSHIP
AND MASTERING THE EXPERIENCE OF
DISAPPOINTMENT, HEARTBREAK, AND DEVASTATION?**

**AND, THEN, WHEN WE FINALLY RISE ABOVE IT,
DON'T WE RISE UP IN QUIET TRIUMPH,
EVEN IF ONLY WE NOTICE …**

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