



**Martha Stark, MD**

an existential-humanistic  
approach to relentless despair

**A Heart Shattered,  
The Private Self,  
and A Life Unlived**

# **A Heart Shattered, The Private Self, and A Life Unlived**

**An Existential-Humanistic Approach to Relentless Despair**

**by Martha Stark, MD**

I gave you a part of me that I knew you could break—but you  
didn't.

Anonymous

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## Model 4: Relentless Despair

Patients who have never fully confronted—and grieved—the pain of their early-on heartbreak will often cling tenaciously to their hope that perhaps someday the object of their desire will be forthcoming. But there are others who, in the aftermath of their early-on heartbreak, will find themselves withdrawing completely from the world of objects—their heart shattered...

To protect themselves against being once again devastated, this latter group of patients will retreat, withdraw, detach themselves from relationships—psychic retreat, schizoid withdrawal, emotional detachment from the world of people, from life itself—only then to find themselves overwhelmed by intense feelings of isolation, alienation, and emptiness—the competent, accomplished, cheerful, compliant *false (public) self* they present to the world belying the truth that lies hidden within, namely, not only their private turmoil, tormented heartbreak, harrowing loneliness, and annihilating terror but also their stymied creativity and desperate (albeit conflicted) longing for meaningful connectedness with the world.

Instead of *relentless hope*, which figures prominently in my Model 2 (an *absence of good* model that focuses on the patient's *relentless pursuit of new good*), and its cousin *relentless outrage*, which figures prominently in my Model 3 (a *presence of bad* model that focuses on the patient's *compulsive re-enactment of old bad* in the face of *frustrated desire*), the experience of being-in-the-world for these latter (Model 4) patients will be

one of *relentless despair*—a profound hopelessness that they keep hidden behind the *false self* they present to the world, a self-protective armor that masks the deeply entrenched brokenness and thwarted potential of the *true self* (Stark 2017).

Whereas the relentless hope of the Model 2 patient and the relentless outrage of the Model 3 patient speak to the patient's intense (albeit maladaptive) engagement with the world of objects, the relentless despair of the Model 4 patient speaks to the patient's utter lack of any real engagement with the world of objects.

### **Whether Momentary State or More Sustained Trait**

Whereas my Model 1 (the interpretive perspective of classical psychoanalysis) is a story about neurotic conflictedness, my Model 2 (the corrective-provision perspective of self psychology and other deficit theories) is a story about narcissistic vulnerability, and my Model 3 (the intersubjective perspective of contemporary relational theory) is a story about noxious relatedness, my Model 4 (an existential-humanistic perspective) is a story about nonrelatedness, that is, psychic deadness and emotional shutdown as the patient's defensive reaction to intolerably painful responses from the object — be the patient's self-protective retreat simply a momentary defensive maneuver or *state* (because the object's response has really hurt the patient's heart) or a more sustained characterological stance or *trait* (because the patient has been hurt so many times in the past that she has let go of the world of objects and given up all hope for meaningful, authentic engagement with them).

More specifically, whereas Model 1 features neurotic defenses, it is also relevant when, in the moment, a patient is resistant and not aware; whereas Model 2 features narcissistic defenses, it is also relevant when, in the moment, a patient is relentless and not accepting; whereas Model 3 features character disordered defenses, it is also relevant when, in the moment, a patient is re-enacting and not accountable; and whereas Model 4



features schizoid defenses, it is also relevant when, in the moment, a patient is retreating and not accessible.

In other words, Model 4 speaks not only to patients who are fundamentally schizoid (and conceal their true self behind a self-protective facade) but also to patients who, in the moment, have psychically retreated because their heart has been so badly hurt.

## Existential Contributions to Model 4

### Viktor Frankl's Existential Despair

Relevant here are the writings of Viktor Frankl, an Austrian existential psychiatrist and author of the well-known *Man's Search for Meaning* (1997). Frankl offers the following pithy formulation:  $D \text{ equals } S \text{ minus } M$ —(D) existential despair equals (S) suffering minus (M) meaning—despair equals suffering without meaning.

My slight paraphrase would be as follows: (D) relentless despair equals (S) solitary suffering minus (M) meaningful moments of meeting—relentless despair equals solitary suffering without meaningful moments of meeting. In fact, I will be proposing that *moments of authentic meeting* with others are what give life its meaning, especially germane for the Model 4 patient who has closed herself off from the world for fear of being devastatingly disappointed—only then to find herself lost, without any real purpose, direction, anchor, or goals—privately in pain, heartbreaking lonely, and desperately struggling to make sense of a world that seems so desolate and barren and an existence that feels so absurd.

### Martin Heidegger's Inauthentic Existence

Relevant as well is Martin Heidegger (1962), a German existential philosopher who writes about the importance of authenticity as giving meaning, purpose, worthwhileness, and direction to life.

Authentic being-in-the world, Heidegger suggests, refers to the attempt to live one's life according to the needs of one's inner being, rather than the demands of one's early conditioning or of society. Authentic being-in-the-world always involves this element of

freedom and choice. Inauthenticity, however, refers to living one's life as determined by outside forces, expectations, pressures, demands, and influences.

As we shall see, an authentic existence is equivalent to Winnicott's (1960) concept of the true self and a life that is real; but an inauthentic existence is equivalent to Winnicott's concept of the false self and a life that is not real—in essence, an unlived life (Model 4).

## Psychoanalytic Contributions to Model 4

### Donald Winnicott's False Self

Winnicott's concept of the false self—a self-protective defensive armor mobilized early on in life to protect the privacy of the true self from impingement by a maternal environment perceived as intrusive and potentially dangerous is particularly relevant to Model 4.

Winnicott (1965) postulates that the person who eventually develops a false self never had the experience of a good-enough mother able to provide a protective envelope—a facilitating or holding environment—within which her young child's inherited potential could become actualized.

More specifically, at a time when it is age-appropriate for the infant to have a mother upon whom she can be absolutely dependent—an unfalteringly reliable mother able to recognize and respond to the infant's every need—the mother's inability to meet the omnipotence of her young child will be absolutely annihilating.

As a result, the nascent true self of the infant—the potential source of spontaneity and creativity—will go into hiding, avoiding at all costs the possibility of exposing itself without being seen or responded to. Its essence will remain incommunicado, its core unrecognized, unacknowledged, undeveloped. ...desperate to be known but terrified of being found.

What then crystallizes out over time will be a false self—a public (or social) self that will gradually become ever more adept at accommodating itself, chameleon-like, to whatever it senses is expected of it, all the while keeping hidden its underlying anguish and broken-hearted despair.

The person will live, but the existence will be empty, hollow, shallow, false, and terrifyingly lonely. It will be a lie—one based on compliance and conformity, not one based on authenticity or truth.

The person will make a show of being real, but it will only be a semblance of the truth—it will be only "as if" she is alive—because her life will be a sham, a charade, a part she is playing, a borrowed identity assumed for the occasion. ...a life unlived—because she is living a lie.

Secrets, lies, pretensions, and concealments will characterize her existence.

Buried deep within will be her shattered heart and her profound sense of disconnection from the world—an inner void, overwhelming dread, and existential angst—and, in the words of the poet Mark Slaughter (2009), “the terror and depression of cold isolation—that black hole of raw solitude.”

### *Kelly Clarkson*

Kelly Clarkson’s emotionally raw, vulnerable, and hauntingly beautiful songs speak of the heartbreak (and subsequent shutdown) that she experienced because of her father’s traumatic abandonment of her and her family when she was six years old—the essence of which she captures in her well-known 2004 song entitled “Because of You,” in which she makes reference to the false self that she now presents to the world in order to cover the pain of that early-on heartbreak at the hands of her father—

Because of you I never stray too far from the sidewalk  
Because of you I learned to play on the safe side so I don’t get hurt  
Because of you I find it hard to trust not only me, but everyone around me  
Because of you I am afraid

I lose my way and it's not too long before you point it out  
I cannot cry because I know that's weakness in your eyes  
I'm forced to fake a smile, a laugh everyday of my life  
My heart can't possibly break when it wasn't even whole to start with.

Because of you I never stray too far from the sidewalk  
Because of you I learned to play on the safe side so I don't get hurt  
Because of you I try my hardest just to forget everything  
Because of you I don't know how to let anyone else in  
Because of you I'm ashamed of my life because it's empty  
Because of you I am afraid.

### *Richard Cory*

The narrative poem “Richard Cory” by Edwin Arlington Robinson (2010) also captures poignantly the great divide that can exist between the public (or false) self and the private (or true) self.

Whenever Richard Cory went down town,  
We people on the pavement looked at him:  
He was a gentleman from sole to crown,  
Clean favored, and imperially slim.

And he was always quietly arrayed,  
And he was always human when he talked;  
But still he fluttered pulses when he said,  
“Good-morning,” and he glittered when he walked.

And he was rich—yes, richer than a king—  
And admirably schooled in every grace:  
In fine, we thought that he was everything  
To make us wish that we were in his place.

So on we worked <till dawn, waiting> for the light,  
And went without the meat, and cursed the bread;  
And Richard Cory, one calm summer night,  
Went home and put a bullet through his head.

On the surface of things, Richard Cory appears to have it all: riches, grace, impeccable good manners, charm, glitter, imperial good looks—

but, despite his regal bearing and enviable wealth, his life is empty and internally impoverished and “one calm summer night” he simply goes home and “puts a bullet through his head” to end it all.

### Primary Aloneness

Also relevant for the Model 4 patient are Winnicott’s (1988) formulations about primary aloneness. Winnicott posits this state of being alone as an inevitable and ever-present aspect of a person’s existence.

Winnicott hypothesizes that the absolutely dependent infant will be able to relax into, and even enjoy, this fundamental aloneness—but only if she is being subliminally bathed in the boundless support provided by a good-enough mother’s holding (Eigen 2009). But if this environmental provision is not reliably present, then for the infant—and, later, for the Model 4 adult—the experience of being alone will be absolutely terrifying.

This, of course, is Winnicott’s (1960) elegant concept of *being alone in the presence of*. In essence, if the infant is lucky enough to be alone in the presence of a mother upon whom the infant can be absolutely dependent, then later on in life that person will be able more easily to tolerate the experience of being alone.

### Kohut vs. Winnicott

With respect to the young child’s developmental progression from one stage to the next, there is a critically important distinction to be made here between how Heinz Kohut conceptualizes the impetus for that advancement and how Donald Winnicott conceptualizes it.

For Kohut (1966), the child progresses from the less evolved stage of using the other as a selfobject to complete the self to the more evolved stage of relating to the other as a person in her own right. This progression is accomplished by way of working through—

and grieving—optimal frustration by the disillusioning selfobject and subsequent transmuting (or structure-building) internalizations, such that structural deficit will be filled in and adaptive capacity (to be a good parent unto oneself) will develop—which makes this developmental progression more a story about nurture than nature, more a story about environmental impact than genetic blueprint.

But for Winnicott (1960), the child's progression from the less evolved stage of absolute dependence through the somewhat more evolved stage of relative dependence (or transitional object relatedness) to the most evolved stage of towards independence (or towards autonomy) will take place regardless, that is, whether there is gratification or frustration by the facilitating environment. For Winnicott, therefore, advancement from one stage to the next is the result of an inborn maturational thrust—which makes this developmental progression more a story about nature than nurture.

What this means is that if the mother is indeed good enough, then the young child's need for omnipotent control will become tamed, modified, and integrated and her true self—one that is grounded, centered, focused, empowered, spontaneous, heartfelt, and creative—will begin to blossom. But if the mother is not good enough, then the young child will still progress through the maturational stages, but the young child's self-protective need for omnipotent control will remain untamed. More specifically, the advancement will proceed but at the expense of the birthing of a robust and well-defined true self.

Although this defensively reinforced need to be the center of someone's world might well be masked by the compliance of a false self, it will nonetheless be lurking beneath the surface, interfering with the person's ability to find genuine, mutually satisfying connection with the world of objects and to experience the precious shared moments of authentic meeting that make life so much more meaningful and so much less lonely.



## The Need for Omnipotent Control

In order to understand the therapeutic action in working with Model 4 patients, we will draw upon Winnicott's (1988) depiction of the young child's maturational progression from *absolute dependence* to *relative dependence*. Successful advancement from one stage to the next is a result of the facilitating (or holding) environment provided by a good-enough mother able to meet the omnipotence of her young child; that is, an affectively attuned mother able to recognize and respond to each and every one of her young child's needs, having even anticipated most of them prior to the child's signaling of her desire.

Winnicott writes that, during the stage of absolute dependence, the infant's healthy need to possess and control the objects within her sphere of omnipotent control is an age-appropriate need that the mother must be willing, and able, to gratify if the infant is ever to advance successfully beyond this early stage in its maturational development.

If the mother is unable to meet her infant's need for omnipotent control, the child will still advance but at the expense of developing a robust true self.

More specifically, according to Winnicott, during the stage of absolute dependence, the primary maternal preoccupation of the ordinary devoted mother will enable her to be so exquisitely attuned to her infant's every gesture that she will be able, again and again, to meet its omnipotence by bringing the world to her infant, thereby

reinforcing its sense of personal agency, affirming its continuity of being, and facilitating the emergence of its true self.

Relevant here is the critical distinction that Winnicott makes between id (or instinctual) needs, which seek discharge, and ego (or self) needs, which seek objects.

Winnicott postulates that although id needs must be frustrated, ego needs must be satisfied and, further, that during the stage of absolute dependence the infant's need for omnipotent control of her environment is an age-appropriate ego need that must indeed be gratified.

I myself make the following distinction: If you give the person an inch and she (having then become hungry for even more) takes a mile, then it is an id need. But if you give the person an inch and she (having then become at least temporarily satisfied) lets it go, then it is an ego need.

With respect to the absolutely dependent infant, if the good-enough mother is able, consistently and reliably enough, to gratify her infant's need to be seen, heard, recognized, known, and understood, then the infant will ultimately be able to relinquish her need to be in control, described by Winnicott as a graduated abrogation of the need to be in control.

Winnicott notes that the absolutely dependent infant will simply outgrow her insistence that she be in total control of her surrounds, letting go of that ego need in much the way that later, as a relatively

dependent young child, she will simply let go of her ego need for the comfort and security of her transitional object—be that object a tattered blanket, a shabby teddy bear, a soiled piece of cloth, or some other item imbued with her mother's soothing and reassuring essence.

But a mother who is not good enough will be unable to satisfy her infant's need to be in complete and utter control of the world around her, unable to recognize and respond to the infant's needs, demanding instead that the infant recognize and respond to her own needs.

In essence, if maternal care is not good enough, then the infant will not come into existence.

Winnicott (1960) writes, "With 'the care that it receives from its mother' each infant is able to have a personal existence, and so begins to build up what might be called a continuity of being. On the basis of this continuity of being the inherited potential gradually develops into an individual infant. If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement."

Winnicott suggests that the young child of a good-enough mother ought to be able to look into her mother's eyes and see a reflection of her burgeoning self in her mother's devoted gaze, a reflection of the unique and cherished person the young child is becoming. But the young child of a mother who is not good enough and not able to provide mirroring confirmation of her young child's true and beloved identity will see nothing.

The alternative to being is reacting, but reacting interrupts being and annihilates. Winnicott (1960) goes on to write, “The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being.”

What is the fate of needs that are traumatically frustrated? Traumatically thwarted needs, whether id or ego, become intensified. As a result, the very young child whose mother was not good enough will never outgrow her defensively reinforced need to be the center of someone’s world, although that traumatically frustrated ego need will fester inside—untamed and unintegrated. And even when the child grows up, she will find herself unable, and unwilling, to relinquish her self-protective illusions of control, control that she unconsciously experiences as necessary in order to preserve the integrity of her tenuously consolidated self.

As we shall soon see, this striving to be in control in an effort to protect the cohesiveness of a precariously established self is the hallmark of a Model 4 patient.

### **Amy and Her Need for Omnipotent Control ~ A Clinical Vignette**

I present now a clinical vignette that demonstrates the powerfully healing impact of a therapist’s willingness to honor her patient’s need for omnipotent control of her objects when that ego need has been traumatically thwarted early on—even if inadvertently—by an impinging and annihilating maternal environment.

More specifically, this case speaks to the transformative power of revisiting—playfully—the maturational stage of absolute dependence in order to correct for early-on traumatic frustration of the child’s defensively reinforced ego need to be met.

I worked with Amy, weekly, for two years (from ages 7 to 9). Mother had originally brought her in because Amy had become a behavior problem in school and was now also getting bad grades.

Mother reported that Amy had always been a very sad little girl but had never been willing, or able, to talk to anybody about what was really going on inside her.

Amy did not have any friends and mostly played by herself in her room.

Mother had taken Amy to see a number of different therapists over the course of the previous three years, but Amy had refused to talk to any of them.

Mother, who was admittedly a bit over-controlling, was nonetheless very well-intentioned and in a tremendous amount of pain because she was feeling so completely shut out of her daughter’s world. In the face of Amy’s depression, her problematic behaviors in school, and her bad grades, mother was feeling absolutely overwhelmed and helpless.

A colleague of mine saw mother; I saw Amy.

Every week in our therapy sessions, Amy would have us play school. She was the teacher, and I was her student.

Actually, it seemed to me that she was a rather strict teacher, but then she seemed to feel that I was a rather naughty student.

In truth, Amy was quite a stern taskmaster, quite a tough disciplinarian—and, I might add, not always very nice about it.

Believe me, I did everything that I could to be very good, to respond as best I could to each and every one of her many commands, but she was relentless and quite punitive.

Sometimes Amy would demand that I sit at the little school desk that I had in my office, a tiny little thing into which I could barely fit at all.

But whenever I would complain that the desk was too small, she would tell me that it only seemed that way because I was so fat and that I should be quiet.

Periodically, she would tell me to stand up and, as soon as I had struggled out of the little desk to my feet, she would insist that I be promptly seated. ...up and down, up and down, again and again and again.

Amy would tell me that my posture needed improvement and that I needed to stand up straighter so that I could look taller.

If I did not react quickly enough, Amy would send me to the corner of the room, where I was to stand by myself, face to the wall, so that I could think about how bad I had been.

Or if she were mad at me because she thought that I had been misbehaving and needed to be punished, she would get particular pleasure from making me go to the blackboard, where I was to write, over and over again, *I have been very bad, I have been very bad*. And then I was to sign it.

I would indeed write that, again and again, on the doggone blackboard, although I kept telling her that I did not like the chalk or the blackboard—but she would tell me that this did not matter and that I was to keep doing it anyway.

So, I would make a face while I was doing it, which I know she saw.

Amy would give me homework assignments that I was to do between sessions.

Naturally, I would do them. But she would always give me a bad grade on them, even when I had gotten all the answers right!

When I would complain and ask her why my grade was so bad, she would tell me that it was because I was so dumb.

Oh, Amy was a tough little tyrant.

Believe me, I never once challenged her authority, and I always did the very best that I could to accommodate myself to every single one of her imperious commands.

Amy just loved bossing me around; and, as it happens, I did not really mind either, except for the part about the chalk and the blackboard.

Interestingly, she never once asked me to do something that I really would not be able to do. In other words, she never once put me in the untenable position of having to say no to her.

So, over the course of our two years together, I did basically everything she asked—I offered her no resistance; nor did I interpret her need to be in control.

I did not, for example, suggest that perhaps her need to have omnipotent control of me was compensatory for underlying feelings of powerlessness and inadequacy in relation to her somewhat domineering mother.

Indeed, I wanted Amy to have the experience of being able to exercise complete control of her surrounds—an experience that I sensed she had been denied as an infant and was now being denied as a latency age child in the relationship with her well-intentioned but anxiously over-controlling mother.

Meanwhile, I was beginning to hear from mother's therapist that Amy was behaving much better in school and was no longer engaging in the negative attention-getting

behaviors that had originally brought her to treatment.

Amy was beginning to talk to her mother—and now had a few friends.

And mother reported that Amy did not seem to be so sad anymore.

Simultaneously, there came a time in our own work when my little friend appeared to need less and less for me to accommodate myself to her every need.

As she developed confidence in her ability to control her surrounds, she no longer had the same need to be constantly demonstrating this power in relation to me. She was indeed gradually abrogating some of her defensive omnipotence.

In our sessions, Amy became less tyrannical, less bossy, less controlling—more vulnerable, more accessible, softer, gentler, more tender.

And sometimes, to reward me when she thought that I had been particularly obedient or when she was especially pleased with my *progress* (as she called it), she would give me a little pat on my back.

One time, she even told me that something I had done was very good.

Amy also started to give me As on my homework assignments. And sometimes she would even give me a little star for my homework because I had done it so neatly—lovely shiny gold stars that she would bring in from home for me.

And then one day, Amy brought in her own report card for me to see—without a word but with a big happy smile, she proudly presented it to me—and it had all As on it!

My little friend and I, we certainly did other things over the course of our two years together (including a little bit of interpretive work), but I believe that what was most healing for her was my non-demanding, non-intrusive, non-controlling stance and my



willingness to provide her with consistent gratification of her need for omnipotent control of her environment, a need that had been traumatically thwarted early on, thereby prompting her psychic retreat and schizoid withdrawal from the world.

At the end of the day, I believe that what was transformative for Amy was my ability to create a safe space into which she could deliver what most needed to be delivered, namely, her need to be able to feel in control so that she would be able to risk becoming absolutely dependent on me (a stand-in for her mother) without having to fear a catastrophically annihilating response that would shatter her heart.

### **I Gave You a Part of Me That I Knew You Could Break—But You Didn't**

I am here reminded of the anonymous quote with which I began—*I gave you a part of me that I knew you could break—but you didn't*.

It is only recently that I have come truly to appreciate how powerfully healing it can be for a patient whose heart was fragmented early on by an impinging maternal environment to be given an opportunity in the here-and-now engagement with her therapist to be in control as much as is possible—an opportunity to become absolutely dependent on someone whose stalwart reliability and unconditional predictability the patient is coming, over time, to trust.

If all goes well, patient and therapist may even begin to experience occasional moments of pleasurable and joyful connectedness, precious moments of meeting that will give meaning and authenticity to the patient's existence—an existence that might otherwise have remained desolate, barren, impoverished, and desperately lonely.

Indeed, I conceptualize the therapeutic action in Model 4 as involving this co-creation of a transitional space between patient and therapist (created in part by the patient and her defensive need to be in control and in part by the therapist and her

adaptive capacity to delight in being controlled)—a co-created potential space into which the patient, who has emotionally shut down as a result of having had her heart destroyed early on, can begin to deliver the parts of her *self* that are most vulnerable, most fragile, most prone to breakage—and can then gradually discover, to her surprise and delight, that her therapist will be so intuitively sensitive, gently attuned, lovingly present, and tenderly devoted to her care that she need no longer worry quite so much about having her heart, once again, shattered.

In essence, the therapeutic action involves the provision of an opportunity for the patient to regress to the stage of absolute dependence—but with a different, much better outcome this time. ...regress to redo.

Relevant here is Fabrice Correia's (2014) philosophical concept of *existential (or ontological) dependence*, that is, absolute reliance upon another for one's very existence, one's very identity. This existential construct poignantly captures the essence of Winnicott's concept of absolute dependence.

Also along these same lines, in *Drama of the Gifted Child*, Alice Miller (1982) writes, "True autonomy is preceded by the experience of being dependent." Miller goes on to write, "True liberation can be found only beyond the deep ambivalence of infantile dependence," about which I will later be saying more—when I speak to our need to understand, and respect, the Model 4 patient's intense ambivalence about being found vs. remaining hidden and the importance of eventually reconciling this dialectical tension that exists within the patient between her longing for connectedness and her terror of being found.

To sum up Winnicott's contributions to my understanding of what is involved in working with patients who were deprived of the early-on and entirely age-appropriate experience of being the center of someone's universe, it is critically important that we be

able, and willing, to adapt ourselves to their need to control us and that we be able, and willing, to do this—with pleasure and delight—for as long as they might need us to do so.

And, as we shall later see, this will require of us that we be able to devote ourselves, often with infinite patience, to the tender and devoted care of our patient—that we be able, and willing, to be unfalteringly present, unflinchingly reliable, absolutely dependable, expertly accommodating, boundlessly supportive, ever malleable, non-possessive, non-intrusive, non-impinging, non-demanding, non-interpretive, totally dedicated, loving, tender, gentle, humane, compassionate, and kind.

This, of course, is the primary maternal preoccupation of Winnicott's ordinary devoted mother to which I earlier referred—something the patient, as a very young child, should have been able to experience during the stage of absolute dependence but was denied.

### **Michael Balint's Benign Regression to Dependence**

Relevant here is the distinction Michael Balint (1959) makes between malignant regression and benign regression.

In essence, when defensively reinforced id needs are gratified, it is usually disastrous for both patient and therapist and can pose a real threat to the ongoing treatment, especially when it occasions the patient's malignant regression to insatiable hunger for ever more.

But when defensively reinforced ego needs are gratified, there is opportunity for the patient's benign regression in the service of the ego, that is, benign regression in the service of the treatment, to a stage in her development that was not properly negotiated at

the time but that can now be renegotiated in the hope of achieving a better outcome this time.

More specifically, Balint writes about the therapeutic value of benign regression to dependence for those patients who have developed a basic fault because of failure in the early-on environmental provision. With respect to what then becomes part of the therapeutic action, Balint speaks to the importance of allowing for a harmonious interpenetrating mix-up between patient and therapist, such that—at least for a while—the patient can have the self- and life-affirming experience of being peacefully merged with another—an experience needed to correct for what was missed early on.

Whereas Winnicott's interest is in the false self and the clinical importance of providing a holding environment to facilitate access to the true self and Balint's interest is in the area of the basic fault and the clinical importance of fostering a benign regression to make possible a new beginning, both Winnicott and Balint are addressing the toxic impact of unmastered early-on relational failures and the therapeutic impact of environmental provision in the here-and-now to correct for what was not consistently and reliably provided in the there-and-then.

Along these same lines, Christopher Bollas (1989) has written about ordinary regression to dependence—a regression that, he suggests, will be arrested by the therapist's interpretations but fostered by the therapist's receptivity.

In what follows, I will be drawing upon Winnicott's regression to absolute dependence, Balint's benign regression in the service of the ego, and Bollas's ordinary regression to dependence to capture the essence of what I believe is at the heart of what we must provide for our Model 4 patients, namely, an opportunity to experience therapeutic regression to dependence—an opportunity to regress in order to redo.

*Keith Urban and Carrie Underwood*

I am reminded of Keith Urban and Carrie Underwood's beautiful (2016) duet entitled "The Fighter"—in which a woman whose precious heart has been broken at an earlier time in her life (here representing the Model 4 patient) keeps asking for, and needing, reassurance that, were she to fall, were she to cry, were she to be scared, her man would be there to catch her and to hold her tight (here representing the Model 4 therapist)...

The chorus of the song goes as follows:

What if I fall (I won't let you fall)  
What if I cry (I'll never make you cry)  
And if I get scared (I'll hold you tighter)  
When they're trying to get to you, baby, I'll be the fighter

What if I fall (I won't let you fall)  
What if I cry (I promise I'll never make you cry)  
And if I get scared (I'll hold you tighter)  
When they're trying to get to you, baby, I'll be the fighter.

### **Masud Khan's Dread of Surrender to Resourceless Dependence**

Particularly relevant for Model 4 patients who have psychically retreated from authentic engagement for fear of being retraumatized is the work of Masud Khan, a British psychoanalyst whose training analyst was Winnicott and who wrote extensively about the privacy of the self.

In a brilliant 1972 paper published in the *International Journal of Psychoanalysis*, Khan writes about the importance of giving patients who have emotionally withdrawn from the world of objects an opportunity to overcome their dread of surrender to resourceless dependence on the therapist—an emotional surrender that hopefully will be experienced by the patient as transcendent, liberating, and transformative—and not simply as a defeat. It would seem that Khan's resourceless dependence is akin to Winnicott's absolute dependence.

Khan highlights that the therapist must be able to overcome her own dread of surrender to the therapeutic process, her own hesitation about bringing her authentic self into the treatment room, and her own anxieties about letting herself be controlled by the patient if there is ever to be hope that the patient, in *her* turn, will be able eventually to overcome *her* dread of surrender to resourceless dependence on another.

Khan describes this process of mutual surrender as one that allows the patient to find herself through another, that is, to discover her own authentic self by way of experiencing the therapist's capacity to deliver her own authentic self into the relationship.

### **Sara: An Unforgivable Mistake ~ A Clinical Vignette**

The following vignette speaks to numbers of issues that can arise at the *intimate edge* (Ehrenberg 1992) between patient and therapist. For our purposes here, however, I will be using it to demonstrate the powerful impact of a therapist's willingness, and ability, to expose to the patient her own raw vulnerability.

I have been seeing Sara, an exceptionally gifted 55-year-old therapist, four times a week for the past five years.

Five years ago, at the very beginning of our work together, I said something to Sara that made her feel I did not want to work with her. (I apologize for not being able to share with you the specifics of what I actually said, but Sara asked me, please, not to. She did, however, give me permission to share the rest.)

Sara considers what I said to her in our third session those five years ago to have been a mistake for which she will never be able to forgive me, although she desperately wishes that she could.

At the time, I was horrified that Sara would have so misunderstood what I was saying. But given what I have since come to know about her, I can now appreciate why what I said was indeed deeply hurtful to her.

Over the course of our years together, Sara has spent much time trying to decide whether or not she feels safe enough to continue our work. But because of the unforgivable mistake that I made those five years ago, she fears she may never be able to trust me.

Although periodically I have attempted to clarify (rather defensively, I am sure) what I had thought I was trying to say in our third session those five years ago, understandably Sara has not been all that interested in listening and has held fast to her experience of me as untrustworthy and of the therapy as a place that is not safe—certainly not safe enough to bring her pain, her tears, her anger, her loneliness.

Over time, what Sara and I have come to understand about our dynamic is that we have unwittingly recreated (between us) the mutually torturing relationship that she had had with her toxic mother. At times, Sara is her bad mother and I am Sara who, as a little girl, was tormented by her double-binding mother. At other times, I am her bad mother and Sara is tormented by me as she was once tormented by her mother.

In my work with Sara, it has been extremely important to her that I be able to confirm her experience of things, not just that I validate her perceptions as plausible constructions of reality (Hoffman 1983) but that I actually confirm them. In other words, Sara needs me to agree that her reality is the truth. Otherwise, she begins to feel crazy.

Almost without fail I have been able to confirm Sara's perceptions, most of which have seemed to me to be uncannily on target.

Unfortunately, some of her uncannily accurate perceptions have been about me. Although it is more difficult when the focus is on me and my vulnerabilities, ultimately (with the one exception noted above) I have been able, and willing, to confirm these perceptions as well.

As an example of how Sara will zero in on me: When recently she came to a session and asked to schedule a number of extra sessions, I was obviously very pleased (I actually said something to the effect of “Yes! Yes! Yes!”). Indeed, it meant a great deal to me that she would want the extra time, particularly in light of her experience of me as having failed her so unforgivably early on in our relationship.

We therefore spent some time scheduling the extra sessions and then I said, gently, "You know I am so pleased to be scheduling additional appointments, but it occurs to me that I should be asking you how you feel about having these extra sessions."

Sara did not answer for a long time. After what seemed like an eternity to me, she said finally, sadly, that she was now not sure the extra sessions were such a good idea after all; she said that she was suddenly feeling that maybe I did not really want her to be coming for the additional appointments.

Although I was initially stunned by her response, in time she helped me to understand something that I had not previously understood. By asking Sara to share with me how she felt about having the extra sessions, I was, in a way, humiliating her. Obviously, she would not have asked for this extra time if a part of her had not wanted the additional contact with me. So, my asking of her that she admit to wanting more time with me was tantamount to my forcing her to acknowledge having desire in relation to me. Indeed, had I, in advance, thought more about my somewhat formulaic question, then I would probably have known not to ask it.



What I now understood was that by asking her to tell me how she was feeling about getting the extra time, I really was more *going by the book* than *coming from my heart* (Hoffman 1983). I had been taught that it is always important to explore whatever underlying expectations, hopes, or fears the patient might have whenever she asks for something from her therapist. I really was more going by the book than by what I did know (deep inside of me), namely, that despite Sara's deep reservations about me, a part of her was beginning to trust me a little more and was wanting me to know this without her having to say it outright.

Indeed, I came to see that Sara's experience of me as having humiliated her was not just a story about her but also a story about me. I was able to understand that I really was shaming her by asking of her that she acknowledge wanting to have the extra time with me.

Sara has been a wonderful teacher—she has devoted considerable time and energy to teaching me to be a better therapist to her and, in all honesty, a better therapist period. I am so much wiser for my time with her. I am increasingly coming to see how often I will unconsciously fall back on going by the book instead of coming from my heart—not always in the big ways, but in the little ways (some of the rituals, some of the routines that I will do without really thinking them through).

This we have accomplished.

But there has been between us the ongoing issue that we have not yet been able to resolve, namely, what to do with respect to the unforgivable mistake I had made those numbers of years ago—about which I feel absolutely terrible and for which I have apologized many times over from the bottom of my soul.

Periodically, Sara will turn to me and ask, point-blank, that I confirm her perception of me as having failed her unforgivably in that third session those five years ago. And, over the years, she has made it very clear that were I to confirm this perception, she would have no choice but to terminate her treatment with me. But when I do not confirm this perception, then she feels that she has no choice but to continue to feel unsafe.

When Sara and I get into this place, as we have so many times over the course of our years together, my mind almost snaps from the pressure of how crazy-making the whole thing is. Sara puts me in an untenable position by asking of me that I confirm her perception of me as untrustworthy and of my early-on mistake as unforgivable. But I too put Sara in an untenable position by holding on to my wish that Sara will someday both trust me and forgive me. Sara asks of me something that I cannot possibly do; but then I ask of her something that she cannot possibly do.

It is indeed agony for us both, yes—but it is also telling, telling us a great deal about the toxic relationship that she had had with her mother. I believe we are doing the work that needs to be done, namely, attempting to negotiate our way through and out of this convoluted, mutually torturing, hopelessly enmeshed relationship that is, in fact, a recreation of the double-binding, no-win relationship that she had had with her mother. It is a mutual enactment—in which both of us are participating.

But by way of the drama that is being re-enacted between us, Sara is enabling me to experience, firsthand, what the experience must have been like for her in relation to her mother. We will need someday to find our way out of this Catch-22 situation—but, for now, we must both sit with the uncertainty of not knowing what will ultimately unfold.

The other day, however, something different did happen. Sara was once again begging me to admit that what I had said to her those numbers of years earlier was unforgivable. As I listened, I found myself feeling so sad, so trapped, so anguished, and

so tormented that I suddenly burst into tears. I rested my head in my hands and just sobbed. Sara sat there very still, barely breathing, watching, waiting. Eventually I stopped, and we continued our talking. This time I knew not to ask her the pat question, "How was it for you, my crying?"

But later in the session, I think she showed me what it must have been like for her. She herself began to cry—she put her head in her hands and wept. Now I sat there very still, barely breathing, watching, waiting. What made it particularly poignant for me was my knowing that she (as an adult) had never before cried in front of anyone.

Our work continues.

### **Karen Maroda's Moments of Emotional Surrender**

The evocative vignette above speaks to the importance of the therapist's willingness, and ability, to overcome her own dread of surrender to the therapeutic process if the patient is ever to do the same. In other words, the therapist must sometimes be willing, and able, to go there first before the patient will be willing, and able, to follow suit. I myself needed to feel safe enough with Sara to cry before Sara could feel safe enough with me to let herself cry.

Karen Maroda (2002), in addressing the importance of the therapist's emotional honesty and personal openness, is one of only several contemporary relational writers who write about the therapeutic impact of mutual surrender in the patient-therapist relationship. More specifically, she highlights that for patients who are afraid to reveal too much of themselves, some degree of emotional surrender on the part of the therapist is sometimes necessary if the patient is ever to be reached.

Maroda writes eloquently about these powerfully transformative moments of emotional surrender, noting that surrender (along with vulnerability and disclosure) is

one of many relational events that is mutual but not necessarily symmetrical.

### **Arnold Modell's Denial of Object Need and Illusions of Grandiose Self-Sufficiency**

Also germane for understanding Model 4 patients is Arnold Modell's beautifully fine-tuned description of patients who have psychically retreated from the world of objects in order to protect the cohesiveness of a precariously established self from being shattered by an intolerably unempathic response from the object (Modell 1996).

Modell suggests that to avoid potential dissolution of the integrity and coherence of a fragile self, such patients will assume a stance of self-protective isolation—a defensive posture supported by denial of object need and illusions of grandiose self-sufficiency. This psychic retreat is simply a means of preserving the integrity of a self that is tenuously consolidated and ever in danger of being destroyed by an impinging and potentially annihilating object.

To avoid fragmentation of the vulnerable self and to defend against the possibility of further traumatic shattering at the hands of an interpretive, impinging, and penetrating therapist, the patient will keep her authentic self out of relationship and maintain a defensive posture of affective nonrelatedness.

To capture the essence of the patient's experience of being in the world, Modell uses the apt metaphor of a cocoon—and, in the context of the transference, a cocoon attached by way of a thin gossamer filament to the person of the therapist. "Patients may feel as if they are in their own cocoon, which is in turn enveloped by the analytic setting." Modell refers to this self-protective stance on the patient's part as "a sphere within a sphere—a state of self-holding within the larger sphere" of the therapeutic setting.

Modell also highlights that it is critically important for the therapist to be exquisitely attuned to the patient's intense ambivalence about being in relationship—conflict

between being found and remaining hidden. Indeed, although a part of the patient yearns to be known and seen by the therapist, another part of the patient zealously guards the sacrosanctity of her privacy, keeping hidden what most matters to her, unwilling to let anyone in.

For the patient to be intimate is to run the risk of having her heart shattered, but for her to be separate is to run the risk of ego dissolution and fragmentation of the self.

In other words, the dilemma for such (Model 4) patients is how to be a part of the world without being destroyed, but how to be apart from the world without disappearing...

With respect to this dilemma highlighted by Modell, I am here reminded of an evocative quote from the American writer Louise Erdrich (2019): “Life will break you. Nobody can protect you from that, and living alone won’t either, for solitude will also break you with its yearning. You have to love. You have to feel. It is the reason you are here on earth. You are here to risk your heart. You are here to be swallowed up. And when it happens that you are broken, or betrayed, or left, or hurt, or death brushes near, let yourself sit by an apple tree and listen to the apples falling all around you in heaps, wasting their sweetness. Tell yourself you tasted as many as you could.”

Modell goes on to explain that because the patient often presents as grandiosely self-sufficient and as needing nothing from anybody, the therapist may well find herself reacting with sleepiness and a sense of boredom to the patient’s massive affect block—to the patient’s seeming impenetrability and lack of interest in the therapist. The temptation for the therapist will be to withdraw—a human and universal reaction to the patient’s state of affective nonrelatedness.

But the therapist's capacity to remain empathically attuned and soulfully present, even so, will be absolutely crucial if the heart of the patient is ultimately to be accessed and the patient to become genuinely engaged in treatment and, eventually, in life itself.

Also difficult for the therapist will be the extended silences into which such patients will often fall—silences to which the therapist may well react with frustration, irritation, or annoyance if she does not deeply appreciate the terror, dread, angst, and despair that underlie the patient's refusal to surrender.

Ever appreciating, however, that there is at least a part of the patient that yearns to be seen, the therapist must use her intuition to decide whether, in the moment, the patient is wanting to be found or needing, at least for the time being, to remain hidden, not known, not seen.

Relevant here is Winnicott's (2005) poignant: "It is a joy to be hidden and a disaster not to be found."

With respect to the therapeutic action, Modell suggests that the therapist, by remaining non-impinging, non-probing, non-demanding, and non-interpretive, will be providing the patient an opportunity to feel tenderly and lovingly held, which will then serve to foster the illusion of safety and protection from dangers both external and internal—critically important if the patient is ever to be accessed. In short, the patient must be able to experience the therapist as a "non-intrusive, muse-like presence lending support to the integrity, coherence, and cohesiveness of the nascent self."

And if indeed the therapist has the capacity to wait and can rein in her therapeutic zeal, then over time the patient's defensive self-reliance will incrementally evolve from the dark despair of raw solitude to the comfort and solace of companionable solitude

(Modell 1996)—and the patient’s cocoon-like self, which had long been lying dormant, waiting for the right moment, will begin to emerge.

### **R. D. Laing’s Divided Self**

Along these same lines, R. D. Laing (1990), a student of existentialism and long interested in the experience of being-in-the-world, writes about the divided self as speaking to the *defensive split in the self* that develops as a reaction to ontological insecurity. Ontological insecurity, Laing suggests, speaks to the lack of meaning, order, and continuity in one’s life and consequent insecurity about one’s existence; splitting of the self is then an attempt to manage the deep anxiety and dread that arise from this uncertainty about the human condition and the state of the world in general.

More specifically, Laing (1990) writes, “If a position of primary ontological security has been reached, the ordinary circumstances of life do not afford a perpetual threat to one’s own existence. If such a basis for living has not been reached, the ordinary circumstances of everyday life constitute a continual and deadly threat.” Laing goes on to write that if an individual cannot take the realness, aliveness, autonomy, and identity of himself and others for granted, then he will be forced to devise strategies to preserve his identity and avoid losing his self.

Laing’s divided self speaks, then, to the inherent tension that exists between, on the one hand, the patient’s authentic (or private) identity and, on the other hand, the inauthentic (or public) persona that is presented to the world. Laing’s two split selves are akin to Winnicott’s true self and false self.

Laing’s ontologically insecure patients, whose defensive strategies are used to protect the integrity of a vulnerable self, are of course Model 4 patients.

### **Donald Burnham's Need-Fear Dilemma**

Also relevant here are the formulations of Donald Burnham (1969), an American psychiatrist who, some fifty years ago, was observing that many of the inpatients with whom he was working at Chestnut Lodge in Maryland were struggling with something to which he referred as the need-fear dilemma, also an apt concept for the internal dividedness that characterizes Model 4 patients. Burnham's schizo-dynamics speak to both the patient's desperate need to find connection and merger with others and her equally intense fear of being destroyed and lost in the process.



## **Stark's Model 4 vs. Stark's Models 2 and 3**

### **Relentless Hope (Model 2) and Relentless Outrage (Model 3) vs. Relentless Despair (Model 4)**

Let me shift now to highlighting a major distinction between, on the one hand, the relentless despair of those patients who were so shattered by their early-on relational traumas that, to protect themselves from being completely destroyed, they have basically let go of relationships altogether and sometimes of life itself and, on the other hand, the relentless hope and relentless outrage of those patients who are still holding on despite their early-on relational traumas—these latter patients still in relentless pursuit of the unattainable.

For years, I have been writing about relentless hope and relentless outrage—both of which are defenses to which patients will cling in order to avoid having to confront—and grieve—intolerably painful realities about the object of their desire. Their refusal to deal with the pain of their grief will fuel the relentlessness with which they pursue the object—both the relentlessness of their hope that they might yet be able to make it over into what they would want it to be and the relentlessness of the outrage they experience in those moments of dawning recognition that, despite their best efforts and most fervent desire, they might never be able to make that actually happen—in those moments of anguished heartbreak when they are confronted head-on with the inescapable reality of the object's refusal to relent.

And so it is that patients persist in their relentless pursuits—desperate with desire to compel the object to change and outraged when confronted with the reality of its limitations, separateness, and immutability.

## **Mark: Empathic Grunts**

### **~ A Clinical Vignette**

This vignette is about a patient who was relentless in his pursuit of that which, at least on some level, he knew he could never have but to which he nonetheless felt entitled—a man who had not yet confronted the pain of his early-on heartache in relation to his father.

The patient, Mark, is a man who sought me out for a consultation several years ago.

Mark is a psychiatrist, had been in analysis for some eight years with a well-known and highly respected local training analyst, and was feeling very stuck in his treatment. He explained to me that he was becoming increasingly dissatisfied with his analyst because he was not getting the kind of support he wanted and felt he deserved.

By way of illustration, Mark cited a time when he had gone to his analyst's office, had lain down on the couch, and had told his analyst in some detail about the very difficult day he had been having—he had had three admissions to write up, he had had to skip lunch, he had been reprimanded by the attending, and when it had come time to leave for his analytic hour he had found that his car had been blocked in by other cars so that he had had to take a taxi in order to be on time. In the confusion, he had lost his wallet and had therefore been forced to beg the cab driver to accept a check, and so on and so forth.

In his consultation with me, Mark expressed his outrage and his bitterness, protesting that all he had wanted from his analyst was an empathic grunt, some acknowledgment by the analyst of how frustrated and angry he (the patient) must be feeling because of the horrid day he had been having. The patient demanded, "Was that too much to ask? All I wanted was a little kindness, a little compassion!"

Mark went on to talk about how his colleagues had confirmed his belief that if his analyst could not give him even this, then he (the patient) had no business remaining in such a disappointing relationship, that it was masochistic for him to stay.

But as Mark's story unfolded, I came to see things in a somewhat different light.

Admittedly, it does not seem unreasonable to be asking for a bit of support, understanding, and comfort at a time when you are feeling overwhelmed and agitated. But for the patient to be looking for such support from someone whom he knew did not give that kind of support (although the analyst did offer many other good things), for the patient to be looking still, even after these eight years, for support from someone whom he knew had never given that kind of support—this is what caught my attention! This is what seemed to me to be masochistic.

So whereas Mark was thinking that it was masochistic for him to be staying in a relationship with someone who was not giving him what he so desperately wanted, I was beginning to think that it was masochistic for the patient to be wanting still that which he was clearly never going to be getting—and that the solution lay not necessarily in severing the relationship with his analyst but, first, in facing the reality that he was never going to get exactly what he would have wanted and, then, in grieving that. The patient would get other good things from his analyst (and, in fact, over the course of the previous eight years, had gotten all sorts of good things from his analyst)—but never the empathic grunts.

Admittedly, I did also wonder a bit about the analyst's seeming refusal to relent, refusal to allow himself to be influenced even a little by the patient's impassioned entreaties; but, in this particular instance, I decided not to focus on what I suspected was the analyst's contribution to the stalemated situation between them. My fear was that were I to speak too much to the part I sensed his analyst might be playing, the patient

might use this to reinforce his own rather entrenched position, which would then obscure the more important issue of the patient's accountability for his own relentlessness, fueled by his refusal to confront the reality of his analyst's limitations.

I therefore said that, at this point, I believed the work of the analysis would involve Mark's confronting, head-on, the excruciatingly painful reality that his analyst was never going to give him exactly what he wanted. I also said I suspected that the analyst was a stand-in for one or both of his parents and that his experience of thwarted longing in relation to his analyst was the recapitulation of an early-on—and never grieved—heartbreakingly disappointing and painful relationship with a parent.

Although Mark, in the first of his three consultation sessions with me, had said that (as a result of the work he had done over the course of the previous eight years) he felt he had pretty much made his peace with his parents' very real limitations, when I now framed the stalemated situation in his analysis as speaking perhaps to frustrated desire and unrequited longing with respect to a parent, he began to resonate with this.

Somewhat shaken, Mark now, in the third and final session of our consultation, finally acknowledged that, indeed, he had always been frustrated in his desire to get recognition from his father, a narcissistic man who was chronically depressed and totally unavailable for support or comfort. As the patient now talked about his father, he began to express what he said he had always known, on some level, but had never really been able to let himself think or feel, namely, that his heart had been broken by his father's failure of him, by his father's inability to respond to his desperate pleas for attention and love. This is a beautiful example of the unthought known to which Bollas (1989) refers.

As our session continued, it became very clear that although Mark had given lip service during the eight years of his analysis to acknowledging how devastated he had

been by his father's emotional remoteness, he had never really let himself feel just how traumatizing his father's inaccessibility had actually been for him.

Furthermore, Mark's refusal to grieve that early-on failure was forcing him to relive it in the here-and-now of the transference and was intensifying that early pain—but now in relation to his analyst.

As we explored other areas of Mark's life, we came to see that it was a recurring theme for him to be ever wanting from his objects the one thing they would never be able to give, a recurring pattern for him to be ever in a state of frustrated longing and thwarted desire in relation to the significant people in his life.

I suggested to Mark that before he made a decision about whether or not to continue with his analyst, he should use the analysis to make his peace with just how disappointed he was in his analyst. I told him I thought that in the process he would also be doing some important—even if belated—grief work around the emotional unavailability of his father.

So, I proposed that instead of immediately rushing off to another analyst in order to pursue elsewhere his relentless search for gratification, Mark should stay in the relationship with his current analyst at least long enough to gain insight into why he was always in the position of trying to extract the right thing from the wrong person (Menninger 1956), that is, why he was ever in relentless pursuit of the unattainable.

In essence, I told Mark I thought that he would need to take some responsibility for the part he was playing in the unfolding of his life's drama, that he would need to take some ownership of his relentless hoping against hope that his analyst might someday turn out to be someone whom the patient knew, in his heart of hearts, the analyst would

never—and could never—be, and that the patient would eventually need to confront the pain of his grief about his father and those he had chosen to be parent substitutes.

More generally, I hypothesize that the patient's relentless pursuit of the right things from the wrong people is the hallmark of a patient with relentless hope and sadomasochistic defenses.

### **The Masochistic Defense of Relentless Hope and the Sadistic Defense of Relentless Outrage**

More specifically, the patient's relentless pursuit of the bad object has both masochistic and sadistic components.

The patient's relentless hope (which fuels her masochism) is a story about her hoping against hope that perhaps someday, somehow, some way, 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.

The intensity of this pursuit is fueled by her conviction that the object could give it (were the object but willing), should give it (because that is the patient's due), and would give it (were she, the patient, but able to get it right).

Please note that the patient's investment is not so much in the suffering per se as it is in her passionate hope that, perhaps, this time...

The patient's relentless outrage (which fuels her sadism) is a story about her reaction to having been thwarted in her desire.

The healthy response of a patient to disappointment is to confront—and grieve—the pain of it, feeling to the depths of her soul all that needs to be felt in order ultimately to arrive at a place of serene acceptance, in the process adaptively internalizing the *good that had been* (Stark 1994) prior to the rupture, which is the essence of transmuting (or structure-building) internalizations.

When confronted with the reality that the object of her desire is separate, has its own center of initiative, and is not going to relent and powered by her conviction that she has been duped, conned, cheated, betrayed, or victimized, the relentless patient may react with the sadistic unleashing of a torrent of abuse directed—whether in actual fact or simply in fantasy—either towards herself (for having failed to get what she had so desperately wanted) or towards the disappointing object (for having failed to deliver it).

The sadomasochistic cycle will be repeated once the seductive object throws the patient a few crumbs. The patient, 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 in order to survive.

Despite the heartbreak that these relentlessly hopeful and relentlessly outraged patients experience, they will continue to hold on and refuse to let go.

For others, the early-on heartbreak is simply too much to bear. And these latter patients, who have simply given up and let go, I describe as having relentless despair. Although they may make a show of being authentically engaged in the world, in truth they have shut down and retreated psychically—broken, shattered, and no longer holding on to any hope at all of ever being seen, found, recognized, or known for who they really are.

## **Fairbairn's Ambivalent Attachment to the Bad Object**

In order better to appreciate what fuels the intensity with which relentlessly hopeful patients move towards their objects and relentlessly outraged patients move against their objects, we turn now to W. R. D. Fairbairn (1954), who is perhaps best known for “the libido is fundamentally object-seeking not pleasure-seeking” and his delightfully pithy “A bad object is infinitely better than no object at all”—this latter a concept that, I believe, accounts in large part for the relentlessness of the patient's infantile pursuit of her objects—both the relentlessness of her hope and the relentlessness of her outrage in the face of being denied.

Over the years, many have written about internal bad objects (or pathogenic introjects) to which the patient is attached; but few have addressed the critical issue of what exactly fuels these intense attachments.

It is to Fairbairn that we must look in order to understand the nature of the patient's attachment to her internal bad objects, an attachment that makes it difficult for her to separate from the (now-introjected) infantile object and therefore to extricate herself from her relentless pursuits (Model 2) and her compulsive repetitions (Model 3).

Let me review what Fairbairn has to say about how bad experiences at the hands of the infantile object are internally recorded and structuralized.

Writes Fairbairn, when a child's need for contact is frustrated by her mother, the child deals with her frustration by defensively introjecting the bad mother. It is as if the child finds it intolerably painful to be disappointed by her mother; the child, to protect herself against the pain of having to know just how bad her mother really is, therefore introjects her mother's badness—in the form of an internal bad object. Basically, in order not to have to feel the pain of her grief, the child takes the burden of her mother's badness upon herself.



As we know, this happens all the time in situations of abuse. The patient will recount episodes of outrageous abuse at the hands of her mother (or her father) and will then say that she feels not angry but guilty. After all, it is easier to experience herself as bad (and unlovable) than to experience the parent as bad (and unloving). It is easier to experience herself as having deserved the abuse than to confront the intolerably painful reality that the parent should never have done what she did.

More generally, a child whose heart has been broken by her parent will defend herself against the pain of her grief by taking on the parent's badness as her own, thereby enabling her to preserve the illusion of her parent as good and as ultimately forthcoming if she (the child) could but get it right.

In essence, by defensively introjecting the bad parent, the child is able to maintain an attachment to her actual parent and, as a result, is then able to hold on to her hope that perhaps someday, somehow, some way, were she to be but good enough, try hard enough, suffer long enough, she might yet be able to compel the parent to change.

And so it is that the child remains intensely attached to the (now-introjected) bad object. Again, says Fairbairn, a relationship with a bad object is infinitely better than no relationship at all—because, although the object is bad, the child can at least still hope that the object might someday be good.

But, to repeat, what does Fairbairn suggest is the actual nature of the child's attachment to the internal bad object?

As we have just seen, the child who has been failed by her mother takes the burden of the mother's badness upon herself. Introjection, therefore, is the first line of defense.

Moments ago I had suggested that, according to Fairbairn, a bad mother is a mother who frustrates her child's longing for contact. But, writes Fairbairn, a seductive mother,

who first says *yes* and then says *no*, is a very bad mother.

Fairbairn's interest is in these very bad mothers—these *seductive* mothers.

More specifically, Fairbairn posits that when the child has been failed by a mother who is seductive, the child will introject this exciting but ultimately rejecting mother.

Introjection, therefore, is the first line of defense; but splitting is the second line of defense.

Fairbairn's concept of splitting is to be distinguished from Kernberg's (1995) concept of borderline splitting, in which an object is pre-ambivalently experienced as either all good (and therefore libidinally cathected) or all bad (and therefore aggressively cathected)—splitting that goes hand in hand with the borderline's tenuously established libidinal object constancy (or evocative memory capacity) and notoriously defective capacity to internalize good.

Once Fairbairn's bad object is inside, it is split into two parts—the exciting object that offers the enticing promise of relatedness and the rejecting object that ultimately fails to deliver. Two questions—one of which is a trick question. Is the rejecting (depriving) object a good object or a bad object? Yes, a bad object. Is the exciting (enticing) object a good object or a bad object? That was the trick question—it too is a bad object!

Splitting of the ego goes hand in hand with splitting of the object. For Fairbairn, there is no id; rather, the ego is a dynamic structure, a structure with its own reservoir of id energy—its own libido and its own aggression.

The so-called libidinal ego attaches itself to the exciting object and longs for contact, hoping against hope that the object will be forthcoming. The antilibidinal ego (which is a

repository for all the hatred and destructiveness that have accumulated as a result of frustrated longing) attaches itself to the rejecting object and rages against it.

What then is the actual nature of the patient's attachment to the bad object? It is, of course, ambivalent; it is both libidinal and antilibidinal (or aggressive) in nature. The bad object is both needed because it excites (which is why it is libidinally cathected) and hated because it rejects (which is why it is aggressively cathected).

To reiterate: Kernberg's good object is an object that gratifies and is therefore libidinally cathected. But when that object frustrates, it becomes a bad object that is then aggressively cathected. The object is therefore either a good object or a bad object and is either loved or hated (pre-ambivalence).

By contrast, Fairbairn's good object is an object that gratifies and is therefore libidinally cathected. But when that object frustrates, it becomes a bad object that is both libidinally and aggressively cathected—and is both loved and hated. Fairbairn's attachment to the bad object is therefore ambivalent, which explains the patient's reluctance to relinquish her attachment to it. Although furious (relentless outrage) when frustrated by the object, she is still hopeful (relentless hope) that it might yet come through for her.

A story that Guntrip (1973) recounts is that Fairbairn had once asked a child whose mother would beat her cruelly, "Would you like me to find you a new, kind Mommy?" to which the child had immediately responded with, "No, I want my own Mommy." Fairbairn interpreted the child's response as speaking to the intensity of not only the antilibidinal (or aggressive) tie to the bad object but also the libidinal tie to the bad object—the idea being that the devil you know is better than the devil you don't know, and certainly better than no devil at all!

In any event, repression is the third line of defense, repression of the ego's attachment to the exciting/rejecting object.

According to Fairbairn, then, at the core of the repressed is not an impulse, not a trauma, not a memory; rather, at the core of the repressed is a forbidden relationship—an intensely conflicted relationship with a bad object that is both loved and hated. Such a relationship involves both longing and aversion, desire and revulsion—although because the attachment is repressed, the patient may be unaware that both sides exist.

What this means clinically is that patients who are relentless in their pursuit of the bad object must ultimately acknowledge both their intense longing for the object and their outraged disappointment in the aftermath of the (seductive) object's failure of them.

And until the patient genuinely grieves the unmastered relational failures that have brought her to this place (whether such failures involved absence of good and/or presence of bad), she will remain hostage to her internal bad objects, which she both loves and hates, and will therefore be unable to extricate herself from the bonds of her infantile attachments, her relentless pursuits, and her compulsive repetitions—ever in futile pursuit of a different outcome, a better resolution this next time.

As Albert Einstein (1995) once quipped, “The definition of insanity is doing the same thing over and over again and expecting different results.”

### **Guntrip's Schizoid Withdrawal from All Objects**

Whereas the endopsychic situation of the schizoid personalities in whom Fairbairn is interested is one of intense and ambivalent attachment to the internal bad (seductive) object to the exclusion of all external relationships, the endopsychic situation of the schizoid personalities in whom Guntrip is interested is one of psychic retreat from all relationships—both external and internal.

Guntrip (1969) describes the schizoid stance as one of emotional detachment from all objects—the heart of such patients having taken flight because engagement in relationship and in life itself simply hurts too much. The innermost self of the schizoid has secretly withdrawn and retreated to an objectless world. It is just too painful even to hope for something different.

The schizoid attempts to cancel relationships, to want no one, and to make no demands. The resolve is to live in a detached fashion, untouched, without feeling, aloof, keeping people at bay, avoiding at all cost commitment to anyone.

Of one of his patients who reported to him, “I don’t seem to come here,” Guntrip (1969) writes that it was “as if she came in body but did not bring herself with her. She found herself in the same state of mind when she asked the young man next door to go for a walk with her. He did and she became tired, dull, unable to talk; she commented: ‘It was the same as when I come here: I don’t seem to be present.’ Her reactions to food were similar. She would long for a nice meal and sit down to it and find her appetite gone, as if she had nothing to do with eating.”

Guntrip (1969) goes on to write, “External relationships seem to have been emptied by a massive withdrawal of the real libidinal self. Effective mental activity has disappeared into a hidden inner world; the patient’s conscious ego is emptied of vital feeling and action, and seems to have become unreal. You may catch glimpses of intense activity going on in the inner world through dreams and fantasies, but the patient’s conscious ego merely reports these as if it were a neutral observer not personally involved in the inner drama of which it is a detached spectator. The attitude to the outer world is the same: *non-involvement and observation at a distance without any feeling*, like that of a press reporter describing a social gathering of which he is not a part, in which he has no personal interest, and by which he is bored.”

It is the terrifying fear of being annihilated by the object that drives the patient to detach herself completely from the world of objects and to renounce all hope. But it is the terrifying fear of ego dissolution when confronted with how utterly alone she then feels that compels her to reach out once more for contact.

Much as described by Modell (1996), Laing (1990), and Burnham (1969), Guntrip's schizoid is caught in the throes of a terrible need-fear—wish-dread—dilemma. On the one hand, she desperately needs objects but is terrified that she will be destroyed by them; on the other hand, she desperately needs her solitude but is terrified that she will then disappear.

More specifically, Guntrip (1969) writes that the patient's wish to merge and to become as one with the object is in conflict with her antithetical defensive quest for an illusory self-sufficiency.

As a result, the schizoid rarely experiences moments of authentic meeting (without which life is empty and meaningless) because those moments of engagement, though precious, are fraught with so much fear. Although intensely terrifying, such moments are nonetheless desperately needed in order to give meaning to an existence that would otherwise remain desolate, barren, and impoverished.

### **Fairbairn's Relentless Hope and Relentless Outrage vs. Guntrip's Relentless Despair**

Now to compare Fairbairn (1954) and Guntrip (1969):

- (1) Fairbairn believes that for the schizoid “a bad object is infinitely better than no object at all.” Although the following are not Guntrip's actual words, Guntrip could well have said that for the schizoid “no object at all is infinitely better than running the risk of encountering a bad object that could shatter the heart into a million pieces.”

- (2) Whereas Fairbairn writes about patients for whom attachment to objects, even bad objects, is absolutely essential, Guntrip writes about patients for whom attachment to objects, even good objects, is intolerable.
- (3) Whereas Fairbairn's patients are entangled with, and compulsively attached to, their objects, Guntrip's patients have abandoned relationships with objects altogether.
- (4) For Fairbairn, the patient's regressive longings relate to a desire to remain attached to the bad object; for Guntrip, however, the patient's regressive longings relate to a desire to retreat from the world and to withdraw into total isolation.
- (5) Finally, for Fairbairn, the greatest resistance in therapy is the patient's tenacious attachment to the bad object; for Guntrip, however, the greatest resistance in therapy is the patient's impenetrability and dread of surrender to dependence upon another.

#### **Appropriation of Guntrip's Definition of Schizoid Phenomena for Model 4**

I use Fairbairn to inform my understanding of relentless hope and relentless outrage (the province of Models 2 and 3) and Guntrip to inform my understanding of relentless despair (the province of Model 4).

More specifically, I use Fairbairn's depiction of the schizoid's endopsychic situation—one that involves intense, ambivalent, and painful attachment to the internal bad object—as my conceptual framework for both the *masochistic defense of relentless hope* (masochistic in the sense that it involves ongoing suffering, sacrifice, and surrender in a desperate but futile attempt to extract from the object something that will never be forthcoming) and the *sadistic defense of relentless outrage* (sadistic in the sense that it involves the unleashing of a torrent of self-righteous indignation and abuse—in the aftermath of being disappointed—either towards the object for having failed to deliver the narcissistic supplies or towards the self for having failed in her efforts to extract them).

I am now proposing that we use Guntrip's depiction of the schizoid's endopsychic situation—one that involves a more extreme retreat from the world of objects and, even, from life itself—as our conceptual framework for Model 4 and the *schizoid defense of relentless despair and profound hopelessness* (schizoid in the sense that it involves self-protective withdrawal, psychic retreat, emotional detachment, impenetrability, solitary suffering, haunting loneliness, illusions of grandiose self-sufficiency, and denial of object need).

To review: Relentless hope is at the heart of Model 2 (self psychology and other deficit theories advancing the idea that relational failures in the there-and-then fuel the patient's desperate—albeit futile—search for restitution in the here-and-now), and relentless outrage is at the heart of Model 3 (the contemporary relational perspective advancing the idea that relational failures in the here-and-now reopen old wounds and unmastered feelings of victimization and outraged indignation).

Both relentless hope and relentless outrage speak to relentless pursuit of the unattainable and generally go hand in hand.

But whereas Model 2 is about structural deficit, narcissistic defenses, unrealistic expectations, and relentless hope and Model 3 is about relational conflict, character disordered defenses, denial of responsibility, externalization, and relentless outrage, Model 4 (a more existential-humanistic perspective) is about relational deficit—the result of a heart shattered by a devastatingly annihilating response from the object and subsequent (defensive) psychic retreat.

### **Characteristic Defensive Stances**

Before I go on, I would like to address briefly the (reassuring) dovetailing of my models with what others have observed about the various defensive stances individuals



will adopt in order to cope with the stressful impact of the environment—both external and internal—on their psyches.

I first reference the work of the pediatrician Jan Chozen Bays (2002). After examining hundreds of newborns, Bays came to the conclusion that every baby fell into one of three fundamental categories:

- (1) Some babies were born craving sensory experiences—she labeled these babies hungry and clingy (which corresponds to my Model 2);
- (2) Other babies were born angry with the world—these she labeled irritable and averse (which corresponds to my Model 3); and
- (3) Still others were born just wanting to be unconscious and, when distressed, wanting to go to sleep—and these she labeled ignoring and shunning (which corresponds to my Model 4).

And, similarly, Buddhism (Das 1998) teaches that there are three different reactions to outside stimuli: (1) passion or lust; (2) aggression or hostility; and (3) ignorance.

All three mental states are thought to act like poisons that cloud the mind. They have the power to captivate so entirely that the world cannot be perceived as it really is. These poisonous states of mind entrap us, imprison us, and make our world small—predictable and with no surprises.

Furthermore, back in the 1930s, Karen Horney (1950) was crafting her theory of neurosis, in which she described three different coping strategies that develop as ways of dealing with early-on relational failures—(1) movement towards people (or compliance); (2) movement against people (or aggression); and (3) movement away from people (or detachment).

Finally, Schoenleber and Berenbaum (2012), as a result of their research on the mechanisms of shame regulation, propose three distinct categories of maladaptive shame

regulation strategies designed to downregulate shame and believed to be fundamental to much of personality pathology: (1) dependence (or overreliance) on others in an effort to avoid being held responsible for one's decisions and actions, thereby circumventing the experience of shame; (2) aggression in an effort to redirect the shame into anger towards either the self or the other; and (3) social withdrawal (or escape) in an effort to disengage from situations in which shame is either impending or already present.

But whether Bays' tripartite classification of newborns, the Buddhist description of the three poisons, Horney's delineation of three character styles, or Schoenleber and Berenbaum's categorization of three shame regulation strategies, the differentiations made by all four dovetail nicely—and respectively—with my Model 2 concept of relentless hope, my Model 3 concept of relentless outrage, and my Model 4 concept of relentless despair.

## **Nurture (Models 2, 3, and 4) vs. Nature (Model 1)**

Of note is the fact that my Models 2, 3, and 4 are all stories about ways in which the patient reacts defensively to the impact of toxic environmental failures—whether by relentlessly pursuing the object (Models 2 and 3) or by relentlessly retreating from the object (Model 4).

In contradistinction to these models is my Model 1 (the interpretive perspective of classical psychoanalysis). This model is about relentless conflictedness, the result of tension between anxiety-provoking but ultimately growth-promoting internal propulsive forces pressing *yes* and anxiety-assuaging but growth-disrupting internal resistive counterforces defending *no*—or, in terms perhaps more familiar, untamed id needs insisting *yes* and a weak, unevolved ego, made anxious, mobilizing defenses that counter with *no* (Freud 1923).

With respect to the role of nurture vs. nature in the etiology of the four models: To what extent is the dysfunction that ultimately gives rise to what come to be embedded character styles or defensive stances a story about the noxious impact of a toxic relational environment on the psyche of the developing child and to what extent is it a story about the urgent and dysregulating impact of inborn and untamed internal forces? Environment or genes? Nurture or nature?

Whereas Models 2, 3, and 4 are more about nurture than nature—traumatic failures in the early-on environmental provision, Model 1 is more about nature than nurture—unmodulated instinctual (id) drives.

In other words, whereas Model 2 (which is about movement towards), Model 3 (which is about movement against), and Model 4 (which is a story about movement

away) are all stories about relational dynamics gone awry, Model 1 (which is a story about movement inwards) is more a story about internal dynamics gone awry.

### **One-Person vs. Two-Person Defenses**

It is to Arnold Modell (1975) that I owe my appreciation for the critical distinction between ego-protective one-person defenses (relevant for Model 1) and self-protective two-person defenses (relevant for Models 2, 3, and 4):

One-person (or intrapsychic) defenses are mobilized by an *ego*, made anxious, striving to protect itself against the threatened breakthrough of dysregulated and anxiety-provoking id forces.

These include such well-known intrapsychic mechanisms as (1) repression, (2) intellectualization, (3) rationalization, (4) compartmentalization, and (5) reaction formation—mobilization of which will give rise to internal, structural, neurotic conflict.

Here the important relationship is the one that exists between the ego and the id. Model 1 involves these one-person defenses.

Two-person (or interpersonal) defenses are mobilized by a *self*, made anxious, striving to protect itself against being failed by an object that breaks one's heart.

These include the much less well-known interpersonal defenses of (1) the narcissistic need for validation by a mirroring selfobject, (2) the narcissistic need to fuse in fantasy with an idealized selfobject, (3) the masochistic defense of relentless hope, (4) the sadistic defense of relentless outrage, (5) projective identification, (6) the need for omnipotent control of the object, (7) illusions of grandiose self-sufficiency, (8) denial of object need, (9) the defense of self-protective isolation, (10) the defense of affective nonrelatedness, and (11) the schizoid defense of relentless despair—again, all of which

are two-person defenses mobilized to protect the vulnerable self from being failed, disappointed, victimized, or annihilated by the object.

Now the important relationship is the one that exists between the self and the object. Models 2, 3, and 4 involve these two-person defenses.

## **The Marriage of Psychoanalysis and Philosophy in Model 4**

By way of review: In order better to contextualize Model 4, I draw upon the pioneering contributions both of psychoanalytic writers in the object relations tradition (most notably, Fairbairn, Guntrip, Winnicott, Balint, Khan, Bollas, and Modell) and of philosophical writers in the existential tradition (most notably, Heidegger and Frankl), from which it follows that my approach to the therapeutic action in Model 4 is best described as an existential-humanistic one.

Whether attachment insecurity resulting from unmastered early-on relational traumas (a concept that assumes center stage in object relations theory) or ontological insecurity—the price of sentience—resulting from fundamental uncertainty about one’s existence (a concept that assumes center stage in existentialism), the net result will be relentless despair, profound hopelessness, and existential angst—all of which the Model 4 patient embodies.

By the same token, whether the therapeutic action in Model 4 is described as providing gratification of the patient’s need to be in omnipotent control, which will help the patient to relinquish her illusions of grandiose self-sufficiency, her denial of object need, and her dread of surrender to resourceless dependence and will thereby create opportunity for harmonious, interpenetrating, and healing mix-up between patient and therapist (the transformative process when the focus is on object relations theory and involves a revisit to redo), or as helping the patient to overcome her existential terror of authentic being-in-the-world, to reconcile the seemingly irreducible dialectical tension within her between existence as absurd and existence as meaningful, and to reconstitute at a higher level of complex understanding, dynamic balance, and felicitous integration (the transformative process when the focus is on existentialism and the search for

meaning), the net result will be a transcendence of despair, psychic detachment, relational absence, existential dread, and ontological insecurity.

In essence, whether the therapeutic action in Model 4 is conceptualized as a story about evolving from schizoid retreat to emotional accessibility (when the approach is more psychodynamic) or as a story about evolving from nihilistic renunciation of existence to existential acceptance of its dualities and of the reality that one has the freedom—and, indeed, the responsibility—to create one's own meaning (when the approach is more philosophical), the net result will be a new beginning, rebirth of purpose, re-engagement, revitalization, and actualization of thwarted potential.

By way of clarification, nihilism speaks to the defensive need to deny existence; it contends not only that there is no intrinsic meaning in the universe but also that it is pointless even to try to find it. Existentialism speaks to the adaptive capacity to triumph over the absurdity of existence by exercising the freedom to construct one's own meaning; it contends that by way of a combination of awareness, free will, and personal responsibility, one can create something meaningful even though the world is intrinsically meaningless.

Additionally, whether the healing process is seen as involving the transformation of relentless despair into awakened hope by working through the optimal stress of surrendering to absolute dependence upon another (when the focus is on object relations theory) or as involving the transformation of inauthentic being-in-the-world into authentic being-in-the-world by working through the optimal stress of transcending the dialectical tension between the seemingly irreconcilable dualities of existence (when the focus is on existentialism), the net result will be a life lived with passion, commitment, authenticity, and joy.

And marrying the two perspectives (psychoanalytic and philosophical), the net result in Model 4 will be a reconceptualization of opposition (and dividedness) as a story about the potential for harmonious coexistence (and complementarity) of seemingly disparate entities, which represents a dovetailing of Laing's (1990) concept of the divided self, Bromberg's (1998) concept of the multiplicity of selves (and myriad self-states), and the existential concept of creating meaning despite omnipresent awareness of life's absurdity. Dividedness will become multiplicity as the dichotomization of *either/or* becomes the complementarity of *both/and*.

Additionally, the net result in Model 4 will be to facilitate, in the transitional space between patient and therapist, the emergence of moments of authentic meeting that will give meaning to a life that would otherwise have remained desolate, impoverished, directionless, and desperately lonely, thereby transforming an unlived life into a life that is being lived with authenticity and purpose—a life that still has despair but now also hope, still has pain but now also pleasure, still has moments of anguished disengagement but now also moments of precious and life-sustaining connection.

This authentic being-in-the-world, however, requires of the patient that she be able resolutely to face—and accept—the horrifying truth of one's ever-present vulnerability to loss and death and that she be able to embrace her life even with that painful awareness.

The absurdist philosopher Albert Camus (1989) contends that individuals should embrace the absurd condition of human existence, even as they hold fast to their belief in their individual freedom and continue to search for meaning.

Apropos here are the words of Edward Abbey (2005), "The fear of death follows from the fear of life. A man who lives fully is prepared to die at any time."



## **General Characteristics of Model 4 Patients**

Not surprisingly, the issue of control is particularly relevant for patients for whom the world is unreliable, disappointing, dangerous, terrifying, and potentially annihilating and who therefore resort to schizoid defenses in order to protect the integrity of the fragile self. Objects are experienced as able to retraumatize and destroy because of how little control one has over them. Self-protectively, Model 4 patients retreat psychically from the frightening world of people into the relative comfort and safety of a much more predictable—albeit desperately lonely—inner sanctum, populated by things over which they feel they can have much more control.

Predictability, reliability, consistency, dependability, and controllability are therefore of paramount importance. Routines and rituals lend a certain security and provide a certain comfort by imposing order on a world that would otherwise be experienced as intolerably unsafe, frightening, and heartbreakingly disappointing.

Although there is obviously a continuum in terms of the capacity to be engaged in the world, the Model 4 patient's experience of overwhelming helplessness and ontological terror has a lot in common, in its extreme form, with Melanie Klein's (2002) psychotic anxiety, Margaret Mahler's (1956) organismic distress, Wilfred Bion's (1984) nameless dread, Max Schur's (1956) primary anxiety, John Frosch's (1995) basic anxiety, Margaret Little's (1977) annihilation anxiety, Heinz Kohut's (1966) disintegration anxiety, and Donald Winnicott's (1965) unthinkable anxiety.

Winnicott's fear of breakdown may also be relevant here—although Winnicott postulates that the fear of breakdown is actually the fear of a breakdown that has already happened but that could not be experienced at the time.

With respect to Model 4 patients, there is sometimes a passion for the outdoors, the ocean, the mountains, nature, animals, pets, the weather, video games, television, movies, computers, the internet, trivia, science fiction, Star Wars, action heroes, comics, magic, puzzles, games, card tricks, solitaire—all of which are predictable, reliable, and non-threatening; offer no surprises; and do not involve interacting with real people.

For the patient who employs schizoid defenses, the basic danger involves a threat to psychic survival, either experienced as a present menace or anticipated as a future calamity. The fear is of being invaded, annihilated, engulfed, entrapped, fractured, demolished, broken, merged, enmeshed, penetrated, fragmented, shattered, destroyed, abandoned, mutilated, suffocated, drowned, or vaporized. The patient is overwhelmed by feelings of powerlessness in the face of dangers (both outer and inner) that threaten the very integrity of a vulnerable, fragile, and precariously established self.

To summarize the Model 4 patient's experience of being-in-the-world (or, perhaps more accurately, experience of not-being-in-the-world): raw heartbreak; harrowing loneliness; relentless despair; schizoid withdrawal; existential angst; retreat, resignation, and defeat; emotional detachment; inner emptiness; internal impoverishment; psychic deadness; solitary suffering; crippling anxiety; annihilation terror; dread; panic; attachment insecurity; ontological insecurity; a shattered soul; a fractured heart; brokenness; spiritual isolation; reclusiveness; substance abuse and other private addictions; perversions; idiosyncratic preoccupations; an active, rich, and intricately detailed fantasy life; desperation; a black hole; cold solitude; impenetrability; inaccessibility; profound hopelessness; utter desolation; a vulnerable, fragile, and tenuously established self; overwhelming helplessness; denial of object need; illusions of grandiose self-sufficiency; affective nonrelatedness; defensive quest for an illusory self-sufficiency; a divided self; a private self; a false self; a self-protective armor; lies, secrets, pretensions, and concealments; dissembling; inauthentic being-in-relationship;

inauthentic being-in-the-world; overwhelming feelings of alienation and estrangement; a life devoid of meaningful moments of authentic meeting with others; and, finally, the ongoing struggle to reconcile the dialectical tension between the need to be met and the fear of being found and between existence as meaningful and existence as absurd and pointless.

In essence—a life unlived and the haunting specter of a meaningless being-towards-death (Heidegger 1962).

### *Simon and Garfunkel's "I Am a Rock"*

Simon and Garfunkel's (1966) well-known song, "I Am a Rock," captures to perfection the essence of the Model 4 patient's experience of being-in-the-world:

A winter's day  
In a deep and dark  
December  
I am alone  
Gazing from my window to the streets below  
On a freshly fallen silent shroud of snow  
I am a rock  
I am an island

I've built walls  
A fortress deep and mighty  
That none may penetrate  
I have no need of friendship, friendship causes pain  
It's laughter and it's loving I disdain  
I am a rock  
I am an island

Don't talk of love  
But I've heard the words before  
It's sleeping in my memory  
I won't disturb the slumber of feelings that have died  
If I never loved I never would have cried

I am a rock  
I am an island  
  
I have my books  
And my poetry to protect me  
I am shielded in my armor  
Hiding in my room, safe within my womb  
I touch no one and no one touches me  
I am a rock  
I am an island  
  
And a rock feels no pain  
And an island never cries

### *Warren Zevon's "Splendid Isolation"*

Warren Zevon's (1989) song "Splendid Isolation" also speaks, exquisitely and poignantly, to the essence of the Model 4 patient's self-protective retreat from the world:

I want to live alone in the desert  
I want to be like Georgia O'Keefe  
I want to live on the Upper East Side  
And never go down in the street  
  
Splendid Isolation  
I don't need no one  
Splendid Isolation  
  
Michael Jackson in Disneyland  
Don't have to share it with nobody else  
Lock the gates, Goofy, take my hand  
And lead me through the World of Self  
  
Splendid Isolation  
I don't need no one  
Splendid Isolation  
  
Don't want to wake up with no one beside me  
Don't want to take up with nobody new  
Don't want nobody coming by without calling first  
Don't want nothing to do with you

I'm putting tinfoil up on the windows  
Lying down in the dark to dream  
I don't want to see their faces  
I don't want to hear them scream

Splendid Isolation  
I don't need no one  
Splendid Isolation

### **Patients on the Spectrum Are Not Model 4**

Let me hasten to add that Model 4 does not include people *on the spectrum*, people who would appear to be almost hardwired (constitutionally) to be awkward in their social interactions, to have limited interests (although often intense interest in one or two subjects, sometimes to the exclusion of everything else), to engage in repetitive routines or rituals, to have speech and language peculiarities, and to be satisfied with limited social contact.

Asperger's (a milder autism spectrum disorder) would seem to be much more a story about genetic anomaly than a story about the toxic impact of a noxious environment.

### *Find Someone to Love and Love Without Condition*

*Love Anthony* (2013) is a beautiful, loving, and poignant novel that Lisa Genova, a bestselling author and neuroscientist, writes about Anthony—an autistic boy who never spoke; who loved Barney, the number three, and lining up rocks; who did not like to be touched; and who did not make eye contact—but who taught his mom an incredible lesson about loving.

As the author writes the book and Anthony's autism becomes more familiar to her, however, she begins to see more and more the ways in which she and he are similar—she chews her fingernails as a form of self-soothing; she feels calm when her house is clean and all the picture frames level and centered; she cannot stand the thought of someone

else sitting in her seat at the library; she feels agitated when there is too much noise around her; and sometimes she just needs to be alone.

And as the author continues to write, she comes to see that their real similarities have nothing to do with autism. She begins to realize that the story is more about Anthony the boy than Anthony the boy with autism. Autism becomes almost irrelevant and eventually she is simply writing about Anthony, a person worthy of happiness and safety, a person worthy of feeling wanted and loved—just like her. The more she writes about Anthony, the more she realizes that she is actually writing about herself.

Anthony teaches her a lesson her heart needed to learn, which is captured in a (fictional) letter that he writes to her prior to his untimely death at age 8 from a grand mal seizure—

Dear Mom,

You already possess the answers to your questions. You already hold them in your heart. But your mind still resists. I understand that sometimes we need reassurance, to hear the words, “I love you too.” A two-way conversation.

But I wasn’t here to do the things you dreamed and even feared I’d do before I was born. I wasn’t here to play Little League, go to the prom, go to college, go to war, become a doctor or a lawyer or a mathematician (although I would’ve been great at that one). I wasn’t here to be married, to have children and grandchildren, or to grow to be an old man. All that has been done or will be done.

And I wasn’t here to help others understand immunology, gastroenterology, genetics, or neuroscience. I wasn’t here to solve the riddle of autism. Those answers are for another time.

I came here to simply be, and autism was the vehicle of my being. Although my short life was difficult at times, I found great joy in being Anthony. Autism made it difficult to connect with you and Dad and other people through things like eye contact and conversation and your activities. But I wasn’t interested in connecting in those ways, so I felt no deprivation in this. I connected in other ways, through the song of your voices, the energy of your emotions, the comfort in being near you, and, sometimes, in

moments I treasured, through sharing the experience of something I loved—the blue sky, my rocks, the Three Pigs story.

And you, Mom, I loved you. You've asked if I felt and understood that you loved me. Of course I did. And you know this. I loved your love because it kept me safe and happy and wanted, and it existed beyond words and hugs and eyes.

This brings me to the other reason I was here. I was here for you, Mom. I was here to teach you about love.

Most people love with a guarded heart, only if certain things happen or don't happen, only to a point. If the person we love hurts us, betrays us, abandons us, disappoints us, if the person becomes hard to love, we often stop loving. We protect our delicate hearts. We close off, retreat, withhold, disconnect, and withdraw. We might even hate.

Most people love conditionally. Most people are never asked to love with a whole and open heart. They only love part way. They get by.

Autism was my gift to you. My autism didn't let me hug and kiss you, it didn't allow me to look into your eyes, it didn't let me say aloud the words you so desperately wanted to hear with your ears. But you loved me anyway.

You're thinking. *Of course I did. Anyone would have.* This isn't true. Loving me with a full and accepting heart, loving all of me, required you to grow. Despite your heartache and disappointment, your fears and frustration and sorrow, despite all I couldn't show you in return, you loved me.

You loved me unconditionally.

You haven't experienced this kind of love with Dad or your parents or your sister or anyone else before. But now, you know what unconditional love is. I know my death has hurt you, and you've needed time alone to heal. You're ready now. You'll still miss me. I miss you, too. But you're ready.

Take what you've learned and love someone again. Find someone to love and love without condition.

This is why we're all here.

Love,  
Anthony

## **Robert: A Dear Man with Asperger's ~ A Clinical Vignette**

And now I wanted to share with you a story about my patient Robert, a dear man with Asperger's—and also not Model 4.

Robert was a brilliantly prolific and well-known writer. Ever gracious and polite, everybody liked him—although people did not really matter all that much to him.

Nonetheless, this dear man somehow managed to be in therapy with me for many years—but mostly because his wife Jane insisted that he keep coming. He and I therefore decided to make the most of it and soon settled into a very comfortable routine of weekly conversations (as we called them), in which we discussed things like complex adaptive, nonlinear dynamical, self-organizing chaotic systems and this our confusing world (made up of islands of predictability amidst a sea of chaotic unpredictability).

Actually, we had a great time of it. And Jane was extremely grateful because she felt that, over time, Robert was indeed becoming much more present in their relationship—and engaged.

Among other things, I would have him memorize certain socially appropriate behaviors—for example, that he needed to make a fuss over Jane's birthday and that he needed to make some effort to stay in touch with his (adult) children—every now and then anyway. He told me that I was helping him to appreciate the importance of using his intelligence to figure out what he should be doing in different situations. We decided to call it cognitive empathy—doing the right thing not from the heart, but from the head.

Jane, albeit a bit controlling, was a good woman who loved Robert dearly—and Robert was extremely attached to her and did love her, even though he had difficulty telling her that.

So, one day I found a poem that I thought captured beautifully the essence of Robert's feelings for her. He and I decided to rewrite it in order to make it a custom-fit.



He wanted to call the poem—“To Jane, From Robert” but I told him he should call it “To Jane, With Love, From Robert”—so he did.

We invited Jane to join us for one of our sessions so that Robert could read our poem to her.

You say it is hard to keep waiting,  
For me to say “I love you too,”  
But I have been telling you everyday,  
In many ways you never knew.

It pours down upon the umbrella,  
That I hold for you in the rain,  
Is captured when I kiss your bruises,  
In order to relieve your pain.

It’s in the cake I bake for you,  
And offer you the biggest slice,  
And when you tell me that you love it,  
How I then bake it for you twice.

It’s buckled into the seat belt,  
I always tell you to put on,  
And in all the ways that I miss you,  
Whenever I find that you’re gone.

Maybe I don’t say those four words (“I love you too”),  
In the routine and standard way,  
But I hope that my actions speak louder,  
Than anything that I might say.

So if you are tired of waiting,  
For those four words to leave my mouth,  
All I can say is that outside it is cold,  
So don’t forget to take your coat.

As Jane listened, she wept and said it helped her to understand him a little better—  
and then she leaned over and kissed him tenderly on the lips, a kiss he returned.

Robert, by then 58, died a little while later. He had been suddenly stricken with terminal cancer but told me matter-of-factly that he was not afraid to die. He said that his family would be better off after he died because of his generous life insurance policy.

Robert wanted to continue our work right up to the end. Interestingly, never once did he flinch in the face of his impending death—it held no fear for him. Unlike Dylan Thomas’s (1971) “Do Not Go Gentle Into That Good Night,” in which Thomas is urging his sickly father to “rage, rage against the dying of the light” and resist his demise, Robert accepted the fact that he would be dying from his cancer with grace and dignity.

Those many of us who loved Robert still grieve his passing.

## Working with Model 4 Patients

### The Model 4 Therapist's Stance

In working with Model 4 patients, of course it will be critically important that the therapist have both the ability and the willingness to be fully present and authentically engaged throughout, to be absolutely dependable, stalwartly reliable, infinitely patient, tenderly loving, devoted, accepting, yielding, malleable, accommodating, playful, non-demanding, non-intrusive, non-probing, and non-interpretive. Indeed, it will be the therapist's capacity to be ever responsive to the patient's need to be in omnipotent control that—over time and in conjunction with nonjudgmental highlighting of the patient's conflictedness about having yearnings and longings—will enable the patient to relinquish her denial of object need and overcome her dread of surrender to infantile dependence, such that she will be able to revisit the early-on maturational stage of absolute dependence and have a truly corrective relational experience this time.

Whether Balint's (1959) harmonious interpenetrating mix-up or Winnicott's (1960, 1965) in-between space, transitional area, potential space, or intermediate area of experience, these concepts speak to the co-creation of a synergistic and mystical space-between containing interlocking aspects of both patient and therapist. In the evocative words of Laura Praglin (2006), this transformative "in-between" is a "meeting-ground of potentiality and authenticity"—located neither solely within the patient nor solely within the therapist.

In order to create this powerfully healing transitional space, the Model 4 therapist must—especially during the initial stages of treatment—simply stay out of the way, allow herself to be controlled (and delight in that), offer no resistance, and foster an atmosphere of safety, reliability, and dependability. She is a soulful presence who asks

very little of the patient and, instead, invites the patient to deliver into the space-between whatever it is that the patient most needs, or wants, to deliver.

It is for the therapist to wait patiently, ever respectful of, and honoring, the patient's need to remain hidden—even when the therapist has occasional glimpses of the patient's longing to be found. It is critical that the therapist control her therapeutic zeal (Freud 2012) and that she not let herself be seduced into believing that the patient is readier to be accessed than the patient actually is.

Winnicott reminds us that often entire treatments, presumed to be effective, are merely being done on the false self and are only *as if* (Deutsch 1965) transformative.

Winnicott (1960) cautions, “If only we can wait, the patient arrives at understanding creatively and with immense joy... The principle is that it is the patient and only the patient who has the answers.”

#### **Model 4 Facilitation Statements**

Inspired by Laing's concept of the divided self, Burnham's concept of the need-fear dilemma, the psychoanalytic contributions of Fairbairn, Guntrip, Winnicott, Balint, Khan, Bollas, and Modell, and the philosophical contributions of Heidegger and Frankl, I have designed a psychotherapeutic intervention for patients who—whether simply momentarily (state) or more characterologically (trait)—have not only self-protectively retreated from engagement with the world of objects but also nihilistically retreated from life itself.

When the focus is on the patient's attachment insecurity, these Model 4 facilitation statements—informed by Burnham's need-fear dilemma—will resonate empathically with, on the one hand, the patient's desperate need to be known, to be understood, to be met, and to surrender to infantile dependence and, on the other hand, her diametrically

opposed intense fear of being found and of losing her autonomy, her self-sufficiency, her privacy, and her *self*.

By way of example: **“A part of you wants desperately to be seen, known, and understood; but another part of you is terrified of being found.”**

When the focus is on the patient’s ontological insecurity, however, these facilitation statements—here, too, informed by Burnham’s need-fear dilemma—will resonate empathically with, on the one hand, the patient’s desperate search for meaning and, on the other hand, her diametrically opposed profound despair about the futility and absurdity of being-in-the-world.

By way of example: **“A part of you desperately wishes that you could find joy in being alive; but another part of you is so overwhelmed with despair about the absurdity of it all that you cannot imagine ever being able to experience anything even remotely close to genuine happiness.”**

In speaking to the various layers of the patient’s experience of being-in-relationship (attachment insecurity) and of being-in-the-world (ontological insecurity), facilitation statements express an appreciation for the complexity, multiplicity, and richness of the patient’s experience-of-being—thereby honoring the collage of selves that constitute her whole being.

**“Your heart breaks from the loneliness of it all, which makes you long for connection; but then you find yourself holding back because it just feels too risky to hope for anything more.”**

Here the therapist is articulating, on the patient’s behalf, both the heartbreak of her loneliness (which prompts her yearning for connection) and her terror of making contact (which then prompts her retreat).

**“A part of you would want to be able to find a way to make your life feel worthwhile; but another part of you is convinced that this is simply not going to happen for you.”**

**“You feel desperately lonely and disconnected from people and would wish you could feel that you belonged somewhere; but you find yourself holding back for fear of being devastatingly disappointed and left once again with a shattered heart.”**

**“A part of you would want to be able to find something that could make your life more meaningful; but another part of you fears that it is simply not in the cards for you ever to find any real pleasure in life or in companionship.”**

**“A part of you wishes that you could simply enjoy being with people; but another part of you feels so empty and inadequate that you cannot imagine ever being able to feel comfortable in social situations.”**

**“A part of you longs to have a partner with whom you could share your life; but another part of you cringes at the thought of putting yourself out there and making yourself that vulnerable.”**

**“A part of you longs for connection with others; but you hold back for fear of being once again failed.”**

**“You yearn to be connected to friends so that you can feel more part of the world; but then you hesitate because it is just too frightening to think about putting yourself out there in that way.”**

**“You would wish that you could enjoy the love and support that you sense from me in here; but, in the moment, you are terrified that were you to allow yourself to relax into experiencing me in that way, your heart would be broken again—as it**

**was so often, those many years ago now, when you were young, so vulnerable, and completely dependent upon your mother.”**

**“You would wish that you could do something that would make your life feel more meaningful and more real; but then everything comes tumbling down around you and you find yourself feeling totally overwhelmed with the absurdity and the pointlessness of it all.”**

With her finger ever on the pulse of the patient’s level of anxiety and capacity to tolerate the highlighting of her ambivalence about being-in-relationship and being-in-the-world, the therapist—using her intuition to determine when the moment might be right to remind the patient of her state of dividedness (that is, both her need and her fear, both her desperate longing and her intense terror)—will offer these facilitation statements in an effort to encourage the Model 4 patient to become aware of, and take ownership of, both sides of her ambivalence about being engaged, being present, being connected, being authentic, having hope, and being alive.

**“Sometimes you think about trying to put yourself out there; but then it all seems so pointless.”**

**“On some level, you would wish that you could let yourself need someone; but, on another level, you find yourself feeling that you do not want to be in the position of having any needs whatsoever.”**

**“A part of you would want to be able to trust me; but another part of you holds back for fear of being betrayed—too many people have already shattered your world by promising and then not delivering.”**

**“A part of you is desperate to be able to feel that you belong in the world; but another part of you is terrified that you will always feel that you are on the outside**

**and will never really belong.”**

**“A part of you very much wants to get better and recognizes that coming in every week and sharing whatever you might be feeling probably gives you the best chance of making that happen; but another part of you is exhausted, discouraged, and not at all sure that you have it in you to keep trying.”**

**“You desperately want to get better and to feel better; but you cannot imagine what more you could possibly do to get there and are convinced that your current state might simply be your lot in life.”**

In essence, facilitation statements address the Model 4 patient’s internal dividedness between, on the one hand, those self- and life-affirming forces within her that long—albeit conflictedly—for moments of authentic meeting with, and emotional surrender to, others and, on the other hand, those self- and life-negating defensive counterforces within her that compel her to deny her need for others and to retreat from meaningful engagement with them into self-imposed solitary confinement.

In sum, facilitation statements speak to the patient’s ambivalence about being-in-relationship and being-in-the-world. More specifically, they address the patient’s internal conflictedness between, on the one hand, the adaptive forces within her that seek meaningful moments of authentic meeting despite the terror and, on the other hand, the defensive counterforces within her that prompt her to retreat; to remain autonomous and grandiosely self-sufficient; and to keep herself hidden, concealed, not exposed, not accessible, and not found. Alone but safe.

Sensitively rendered facilitation statements reflect no judgment on the therapist’s part. Rather, they speak—always with compassion—to the patient’s intense ambivalence about being-in-relationship or, more generally, being-in-the-world and offer the patient



the freedom then to elaborate upon either her desperate desire to be found or her desperate need to remain hidden.

Depending upon how emotionally accessible the patient is in the moment, resonating empathically with her desperate desire to be engaged in life will be sometimes anxiety-provoking, sometimes anxiety-assuaging. By the same token, resonating empathically with her intense fear of being engaged in life will be sometimes anxiety-assuaging, sometimes anxiety-provoking.

But facilitation statements, by highlighting both sides of the patient's ambivalence about being engaged in life, will enable the therapist both to challenge (by speaking to the side of the patient's ambivalence that is anxiety-provoking—be it her desire or her fear) and to support (by speaking to the side of the patient's ambivalence that is anxiety-assuaging—be it her desire or her fear), the net result of which will be the generation of optimal stress. Incrementally and over time, this stress will destabilize the dysfunctional status quo (of her disengagement from the world); and, in order to restore homeostatic balance, the wisdom of her body will prompt restabilization at a higher level of engagement with the world—as the patient evolves from emotional retreat to affective accessibility, from relational absence to authentic presence, from relentless despair to awakened hope.

At various points in time, almost all patients (and not just patients who are characterologically Model 4) will be driven by both adaptive forces that press for authentic connectedness and defensive counterforces that prompt psychic retreat. It will therefore be the ever-shifting dynamic balance between adaptation and defense that will be the deciding factor as to whether the patient, in the moment, is more comfortable with being accessed and engaged in relationship or with remaining shut down and allowed simply to be.

And, as Modell (1996) reminds us, it will be for therapists to use their intuition to decide whether, in the moment, the patient wants to be found or needs, for the time being, to remain hidden.

There will, of course, be those times when speaking at all the patient's state of internal dividedness will be intolerably anxiety-provoking and much too provocative, in which case it will be for the therapist to wait to address the patient's yearnings and fears until a more opportune moment arises.

In any event, optimally stressful, growth-promoting facilitation statements are strategically designed to capture the essence of the dialectical tension that exists within the patient between two seemingly irreconcilable stances, thereby creating opportunities for the patient then to take ownership of, and reflect upon, the nature of both her need to be present and her need to remain absent—her need to be found and her need to remain hidden.

Ongoing use of these optimally stressful facilitation statements will (1) prompt exploration, on ever deeper levels, of the underlying relational dynamics that had contributed, in the there-and-then, to the patient's defensive retreat from authentic presence and then (2) allow for the working through of those unmastered early-on relational traumas in the here-and-now.

### **Evolving from Either/Or to Both/And**

In my Model 1 (the interpretive perspective of classical psychoanalysis), my Model 2 (the corrective-provision perspective of self psychology and those object relations theories that emphasize internal absence of good), and my Model 3 (the intersubjective perspective of contemporary relational theory and those object relations theories that emphasize internal presence of bad) the therapeutic action involves the gradual transformation of something old (the defense) into something new (an adaptation)—as

resistance is transformed into awareness (Model 1), relentless hope into acceptance (Model 2), and re-enactment into accountability (Model 3).

But the therapeutic action in my Model 4 involves holding on to some element of the old (retreat, relentless despair, resignation, affective nonrelatedness, relational absence, and nihilistic renunciation of existence) even as elements of the new (accessibility, awakened hope, aliveness, affective relatedness, authentic presence, and existential acceptance of life's dualities) are being introduced and embraced. The existential-humanistic perspective of Model 4 appreciates the relativism of existence and the absence of absolute truths and objective realities.

Just as in quantum mechanics where particles and waves are thought to be different manifestations of a single reality (depending upon the observer's perspective), so too in Model 4 defense and adaptation are thought to be conjugate pairs demonstrating this same duality—both/and not either/or.

In the words of Albert Camus (1989), “Happiness and the absurd are <born> of the same earth. They are inseparable.”

In fact, existentialism emphasizes that every aspect of life is created from a balanced interaction of opposite and competing forces—yet forces that are not just opposites but complementary. They do not cancel each other out; they merely balance each other, like the wings of a bird.

In the same spirit, Dean Cavanagh (2006) has written, “Both precious and absurd, this tightrope of existence we walk in both directions; strung only on a rhythm of heartbeats across a void.”

Existence is not about either/or but both/and—with peaceful coexistence of multiple truths and multifaceted realities. It is not about either inauthentic being-in-the-world or

authentic being-in-the-world but acceptance of both potentialities; it is not about either ontological insecurity or ontological security but acceptance of both mental states; it is not about either remaining hidden or becoming found but acceptance of both possibilities; it is not about having either a false self or a true self but acceptance of both ways of being; and it is not about a divided self but a multiplicity of selves.

In essence, living life is about acceptance of fundamental and seemingly irreconcilable truths about one's being-in-the-world.

Relevant here is a Hasidic tale recounted by Martin Buber (1991): Everyone must have two pockets with a slip of paper in each pocket. He or she can then reach into either the one or the other depending upon the need. When feeling depressed or discouraged, one should reach into the right pocket and there find the words: "For my sake was the world created." But when feeling high and mighty, one should reach into the left pocket and there find the words: "I am but dust and ashes."

#### **Model 4 Freedom-to-Choose Statements**

Indeed, as the therapeutic process evolves, the interventions offered by the therapist will begin to focus less on the dichotomization of either/or and more on the complementarity of both/and.

No longer will the therapist simply highlight the patient's intense ambivalence about being lost vs. being found.

Rather, the therapist will speak to the freedom the patient has with respect to how she positions herself in her life going forward, no matter her circumstances.

**"We know that you struggle and find yourself despairing and tempted to retreat; but, even so and as you know, going forward you have the freedom—and the responsibility—to choose..."**

**“We know that you struggle and find yourself despairing and tempted to retreat; but, even so and as you know, going forward the choice is yours...”**

These more confrontational Model 4 interventions—felicitously named freedom-to-choose statements—take the form of first supporting the patient by resonating empathically with her experience of life as absurd, her conviction that she is irreparably damaged, and/or her regressive longing to retreat from the stress of life into splendid isolation and reclusiveness and of then challenging the patient by speaking to her adaptive capacity to recognize that—even so and as she knows—going forward the choice is hers as to how she positions herself in relation to that tormented struggle and her unremitting despair.

**“You are enraged that your sister was the favored child and you are tempted simply to give up; but, even so and as you know, it is entirely up to you—what you decide to do with your life and where you go from here.”**

**“We know that you don’t want to open your heart to anyone; but, even so, you know that as long as you keep yourself so closed off, you will remain isolated and miserable.”**

These freedom-to-choose statements acknowledge the patient’s temptation to defend against the pain of her existence by retreating into despair at the same time that they highlight the fact that her future is in her hands.

In other words, despite the patient’s inclination to renounce her existence and consign herself to defeat, she has the freedom—and the responsibility—to choose the extent to which she will be authentically present in her life and will embrace both being-in-relationship and being-in-the-world.

Along these same lines, Viktor Frankl (1997) argues that we cannot avoid suffering; but, even so, we can choose how we cope with it, find meaning in it, and move forward with renewed purpose. Frankl observes, “Between stimulus and response is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.”

In the language we are using here, in that space is our power either to react defensively (by wallowing in our despair and abnegating responsibility for our lives) or to respond adaptively (by acknowledging that, even so and despite our despair, going forward the meaning we make of our lives is entirely up to us).

**“You hold back for fear of being rejected; but, even so and as you know, unless you dare to take at least some risks, you will never get any of what you might want.”**

**“We know that you would rather have no needs at all; but, as you know, unless you let yourself get in touch with what you might someday want from somebody, your life will remain empty and desperately lonely.”**

**“You are reluctant to put yourself out there because you are so afraid; but, even so and as you know, unless you at least try, you will never have even a chance to find a life partner.”**

**“Your fear is that you will keep falling into those black holes, no matter what you do; but, as you are coming to realize, when you dare to let yourself be more vulnerable with your husband, the pain lets up a bit and you have moments of relief.”**

**“Because of everything that happened to you when you were young, you now feel so broken inside that you cannot imagine ever being able to feel good about**

**yourself or your life. But, as you know, unless you make an effort to do something different, then you will never feel better. It was ‘on them’ back then; but it is ‘on you’ now.”**

**“We know that you now feel trapped by your life circumstances. But, even so and as you know, unless you make the decision to get serious about changing the things over which you do indeed have control (no matter frightening that might be for you), then your life will remain empty and you will continue to feel desperately lonely and alienated.”**

In essence, these freedom-to-choose statements are designed to facilitate advancement of the patient from nihilistic renunciation of existence to existential acceptance of its dualities and recognition of the sobering reality that, whatever her current life circumstances, the choice is hers as to how she lives her life going forward.

In other words, the patient has the freedom—and the responsibility—to choose...

With the following, Camus (1989) addresses the simultaneity of acceptance and protest: “Accepting the absurdity of everything around us is one step, a necessary experience: it should not become a dead end. It arouses a revolt that can become fruitful.”

Against the backdrop of empathic acknowledgment of the patient’s despair, these Model 4 freedom-to-choose statements are intentionally designed to highlight the stark reality that, moving forward, it is entirely up to them to do whatever they must in order to come alive and grab ahold of life, despite its absurdity.

Christopher Logue’s (1996) poem “Come to the Edge” is a powerfully evocative poem that speaks to both the universal resistance to letting go of what is familiar (no

matter how dysfunctional) and the potential capacity within all of us not only to adapt to, but also to benefit from, being optimally challenged.

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 ...

It will be the occasional and always judicious use of optimally stressful freedom-to-choose statements that will, over time and incrementally, prompt the patient to evolve from either/or to both/and (that is, from opposition to complementarity), as seemingly irreconcilable dualities are transcended and a new level of integration is achieved—one that accepts both defeat and triumph and incentivizes forward movement.

Matthew Mather (2012) reminds us, “The existentialists did say that life was all about pulling the victory of meaning from the jaws of senseless absurdity.”

**“We know that you feel so empty and inadequate and cannot imagine that you would have anything to offer in a relationship; but, even so and as you know, as long as you cling to this idea of yourself as defective and flawed, your life will continue to feel pointless and futile.”**

**“You are lonely all the time and feel totally alienated from the rest of the world; but, even so and as you know, if things are ever to change, you will need someday to make the choice to start doing things differently.”**

Again, unlike Model 1, Model 2, and Model 3, the existential-humanistic approach of Model 4 does not specifically require the letting go of something and the grieving of its loss. Rather, Model 4 involves evolving to a higher level of integration, dynamic



balance, and complex understanding—a transcending of inherently conflictual polarities by accepting, as a given, the dialectical tension between them and going on to construct a meaningful existence even so.

In the paradoxical words of Samuel Beckett (2007), “I can’t go on, I’ll go on.”

Indeed, as the treatment advances, the therapist will strategically supplement facilitation statements with these freedom-to-choose statements, such that she will be able not only to resonate empathically with how excruciatingly conflicted the patient is about being authentically engaged in the world but also to challenge the patient by reminding her of what she really does know, namely, that despite the terror and the despair that are fueling her psychic inertia, her schizoid withdrawal, and her emotional retreat, it is ultimately up to her to grab ahold of whatever precious moments she can so that she can create a more meaningful and more fulfilling existence for herself—whatever her past traumatic experiences and whatever her current life circumstances.

*Facilitation Statement:*

**“You desperately wish that you could have moments of authentic meeting with people and you begin to have glimmerings of hope that this might actually be possible for you; but then the despair kicks in and you find yourself once again immobilized.”**

*Freedom-to-Choose Statement:*

**“Your life goes on against the backdrop of this feeling that nothing really matters, that everything in your life is so totally pointless and absurd; but, even so and as you know, if you are ever to have the kind of life that you have repeatedly said you desperately want to have, then you will need to step up to the plate and**

**start putting yourself out there and taking risks in ways that you do not ordinarily do.”**

I am here reminded of Portia Nelson’s (1994) “Autobiography in 5 Short Chapters,” which speaks both to the power of our intense attachment to the dysfunctional status quo and to our capacity ultimately to change.

#### 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

#### 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

Transitioning from the polarization of either/or to the complementarity of both/and will mark the patient's evolution from nihilistic rejection of existence to existential acceptance of responsibility for creating meaning and purpose in her life despite its fundamental absurdity—as retreat becomes accessibility and emotional availability, relational absence becomes authentic presence, relentless despair becomes awakened hope, and resignation becomes a new beginning, a heart repaired, and a life lived.

Ultimately, the therapeutic goal in Model 4 is to cultivate the patient's adaptive capacity to hold simultaneously in mind both sides of her tormented ambivalence about being-in-the-world and, despite the appeal of surrendering to defeat and succumbing to paralysis, to grab ahold of whatever precious moments of connectedness she can create for herself—moments of authentic meeting that will afford her at least some comfort, peace of mind, and, at last, a sense of belonging.

In the words of Jean-Paul Sartre (2018), “Life begins on the other side of despair.”

## **Thomas's Intense Yearning for One More Dance with His Father ~ A Clinical Vignette**

I present now an extended clinical vignette that I think captures beautifully the essence of all that we have been addressing to this point.

The words in quotation marks are the actual words my patient used.

I worked with Thomas for six years (from 2000 to 2006). By the time Thomas had terminated, he was no longer a dissociated, alienated, lonely, frightened “control freak” but a wonderfully engaged man who was living his life in an authentic and heartfelt way.

When first he came to me, Thomas was 28, a tall, lean, prematurely white-haired, handsome, bespectacled man, a college dropout who had nonetheless managed, by dint of his hard work, to become the owner of a fairly successful restaurant in Brookline. He presented with an agitated depression, reporting that his personal life had become a total “mess” because of some really bad choices that he had made along the way. Thomas said he was desperate and needed my help in figuring out what he should do to straighten out his life.

Thomas was in a painfully empty marriage to Sandra, whom he had known since high school and with whom he had had two children, Bill and Dan; he was having a passionate affair with a wonderful woman named Molly, whom he considered his soul mate; he was dating Donna on the side because he was afraid to commit to Molly; he was still sexually involved from time to time with Doris, a former girlfriend, because he could not bring himself to break things off with her; and he was the father of an illegitimate child by Jane, a one-night stand some years earlier that had produced a daughter named Autumn, whom Thomas was allowed to see only occasionally. Thomas, who loved music, was a songwriter, and played guitar, would say to me, with a slight,

self-deprecating twinkle in his eye, “There should be songs written about having four women, but, I guess, who would be interested in such songs?”

Sometimes when Thomas was feeling especially bad about his “roaming eye,” he would “practice not being attracted to other women,” but he was never able to sustain his abstinence for long because he was so terrified of being alone. In the meantime, he lived by the rule, “Never get so close that it hurts when they leave.”

Thomas was racked with guilt about everything. He “managed” his complicated life and what he called his “moral badness” and “sinful existence” by engaging in numbers of compulsive rituals and routines, by keeping himself always “at a remove” from too much involvement in life, and by maintaining “rigid robotic-like control” at all times. He was a “clean freak” who took four showers a day, carefully wiped down the engine in his car every week, and washed the outside of his house three times a year. Disciplined, structured, regimented, controlled—constructs he lived by. He loved orderedness, symmetry, balance, organization.

One of Thomas’s rituals centered around managing the delicate strings that he experienced as being attached to his back. He knew they weren’t really there, but their imagined presence, and their tendency to become entangled, troubled him deeply even so. Way in advance of his appointment time, Thomas would drive to my office, carefully get out of his car so that the strings would not get tangled, walk up my driveway using the same number of steps every time, come around to the back of my house, and enter the sun porch waiting room. Once inside, however, things would get a little more complicated. He had explained to me that it was easiest for him simply to remain standing quietly at attention inside the sun porch door instead of attempting to sit because, in turning his body to take a seat, he might create an intolerably anxiety-provoking entangling of the strings.

Upon entering my office, Thomas would carefully take a seat, knowing that, at the end of the hour, he would then need to “undo” that process by reversing the order of the actions that had brought him to that spot. Very carefully, therefore, Thomas would back out of my office, out of my waiting room, and down the driveway (the same number of steps down the driveway as steps up), and back into his car, without having messed up the strings. Thomas was a graceful man with a soft elegance, so he was able to manage all of this with such finesse that, unless you watched him closely, you might never notice.

Thomas’s goal in life, at that early stage in our treatment, was to keep his “path” as uncomplicated as possible, so that he would be able to avoid the potential for entanglement of the strings and, thereby, a shortening of his life. He recognized the irony in this—that he, whose life had been immeasurably complicated by virtue of the many “bad choices” he had made along the way, would be now so intent upon simplifying things. Thomas was desperately afraid of dying. And were the strings to become entangled and their length thereby shortened, well, the thought of that was terrifying for him and an all-too-poignant reminder of the finitude of life, the terrifying passage of time, and the inevitable end. He was tormented by thoughts of his own mortality and the knowing that nothing would last, nothing was permanent.

Thomas would tell me: “I have always thought that you should not think about things that bother you. You should pretend the problems are not there. If you need to, you can have ‘scheduled unhappiness,’ whereby you designate a certain period of time to think about how unhappy you are. But then it is important to move on.”

In a desperate attempt to ease his pain, Thomas had been drinking alcoholically for over 14 years—although, shortly into his treatment, he stopped drinking on a dime when I happened to suggest, as a throwaway comment, that the drinking might be contributing to his agitation and his depression.

Not surprisingly, Thomas, for whom “being in control” was a top priority, wanted always to be in control of our sessions and of what he talked about, which was totally fine with me. The “process” between us, therefore, unfolded gradually, organically, with Thomas always leading the way. In our sessions, he would share details about his life, speaking always in his “reporter mode”; between our sessions, he would often leave me messages on my voice mail in which he would “report in” with details about his week: “It’s Thomas, reporting in...” he would always say. Whether in session or between sessions, never the feelings, simply the facts. Again, all of this was just fine with me. Meanwhile, I was becoming very, very fond of this dear man whose vulnerable, tormented soul was so racked with guilt, sadness, and pain.

Thomas’s father had been a very successful dentist, universally liked and admired, but he was a demanding father with very high standards. He was “very exacting,” said Thomas, “good for the teeth but not for the son.” His mother, an actuary, was a good woman, but with more “head” than “heart.” Both parents were often absent, physically and emotionally. Early on in our work, Thomas said very little about them other than that he had loved them and they had loved him—and very little about his childhood.

There did come a time in our work, however, when Thomas began to talk about a dear childhood friend, Bobby, with whom he had been very close and whom he had deeply trusted. He and Bobby had lived next door to each other for many years and would play together for hours on end—make-believe games in which both would have superhuman powers and no vulnerabilities—and they would live forever.

Thomas had loved Bobby dearly and was devastated when, with neither advance notice nor explanation, Bobby and his family had suddenly left town when he and Bobby were both nine. They had never even had a chance to say good-bye. Thomas, dissociated but clearly in pain, reported to me that he had never fully recovered from his grief about

the loss of Bobby, that some part of him had died the day he found out Bobby was simply gone. As he recounted the details of their very special relationship and then Bobby's sudden, incomprehensible, and devastating departure, Thomas shed no tears; rather, it was I who began to tear up as Thomas spoke of his heartbreak.

Thomas witnessed my tears but made no mention of them, nor did I. But to the next session he came bearing a poem that he had written over the course of the previous week in honor of his deep friendship with Bobby. It was entitled "*Sometimes Sad, Forever –*"

When you and I were young,  
We were forever,  
We were in control,  
And anything, everything was possible.

Our lives were as one,  
Though not really.  
I was you,  
Though never quite.  
Always, simply, wanting to be.

But then you slipped away.  
Unscheduled. Forever.  
Leaving me behind  
With this sadness, this pain, this loneliness  
that never lets up. Ever.

My dreams came crashing down around me  
through a frightened void  
shattered...  
splinters lying, like an abandoned jigsaw  
puzzle pieces missing—like my life.

I love you, Bobby.  
Forever and for always.  
But you are gone from me.  
Where did you go?  
I am lost—and so desperately lonely without you.



Again and again, Thomas would ask rhetorically, “Why would you want to love someone if they’re going to leave you anyway?”

Thomas had been an only child until he was seven, at which time his younger sister was born. He reported, “I was mean to her because I always thought that she was smarter than I was. She was a weird eater, 5’6” and 100 pounds. I didn’t like her that much, but I was afraid she might die on me because she was so skinny.”

His sister had not died, but, when Thomas was 21, his father had—a horrific death, from cancer of the head of the pancreas.

Thomas reported, “I felt responsible for his death. When I was young, I had been my dad’s pride and joy. But, in high school, I began to live irresponsibly, drinking, drugging, lots of sex. I knew I was letting my dad down. I think he had wanted me to be a dentist, just like him. I was good with my hands and probably would have made a good dentist. But, in my late teens, I wasn’t caring much about stuff. I was just living on the edge—indulgently, destructively. And drinking a lot. I got the girl pregnant and then headed off to Europe for a year or so. I was running away from everything.”

It was only after returning from Europe that Thomas had finally told his father about his illegitimate daughter Autumn. Father had been devastated and had said that he was not yet ready to meet her. This was the first, last, and only time they had spoken of Autumn, but Thomas could not forgive himself for having given birth to this child out of wedlock in the first place and then for having burdened his father with the knowledge of it.

“My dad never asked me what was wrong with me or why my life was such a mess. We never talked about things like that. One day, however, just before my 21st birthday, totally unexpectedly, my dad invited me to have lunch with him, which wasn’t

something he had ever done before. But we never had that lunch. He suddenly got very sick and was diagnosed with bad cancer. I have always wondered what he would have wanted to talk to me about. In my life, there is Part 1: the time before my dad got sick. Then there is Part 2: the time after my dad got sick.”

Later Thomas reported, “My dad was so disappointed in me. I know I let him down terribly. I think I broke his heart. I wasn’t the son he had wanted me to be. He had the cancer, but I think he died from a broken heart.”

As Thomas talked about his unresolved grief and tormenting heartache, his pain was palpable—but never any tears. In fact, as an adult, he had never shed any tears, except during sad movies. But, as was often the case, when he (ever the reporter) would speak of his pain, his internal turmoil, his racking guilt, his sadness, his heartbreak, his anguish, his loneliness, it was I who would be crying. And it happened a lot. Seeing my tears, Thomas would reach for the box of Kleenex beside his chair and hand it to me. I kept the box of Kleenex beside the patient chair and not my own because, with most of my patients, I myself did not really need it. As I cried, Thomas would sit very still, patiently, gently, tenderly until I had composed myself and my tears had passed and then he would continue. Again, we never talked about my tears or what they might mean to him, or to me for that matter! It’s just what we did together. He would speak of his heartbreak, and I would cry. And I loved it that he, ever attuned to my face, would offer me that Kleenex.

One particularly poignant moment was when Thomas was telling me about how he would regularly visit his father’s gravesite even those many years later, where he would talk for hours and hours on end, softly, lovingly, apologetically, to his dad about his daughter Autumn and his regret and his guilt and his shame and all the things he wished he had been able to talk to his dad about “during the living years.” Thomas would leave a

special bouquet of carefully selected flowers for his dad because he knew how much his dad loved flowers and gardens, an interest they had shared.

As Thomas talked about one of the visits to his father's gravesite, I found myself crying so much—I was sobbing actually—that Thomas had to stop talking for quite a while. Once my tears began to subside, Thomas asked me, gently, if it was OK for him to continue. I said, "I need another moment, please." So, he sweetly waited. Again, Thomas and I never talked about my tears or his lack of them. It worked for us both.

Thomas was intrigued when, one day, I suggested to him that "grieving on your own is very inefficient but sharing the grief with someone else will make it so much more efficient." He responded, "OK. You know, I had never really understood how you could complete something with someone who was already dead. Once you die, you're dead. Like a rock. But maybe I could, you know, share the grief with you."

Shortly thereafter, Thomas brought me another poem, which he had just written for his dad. It was entitled "*A Song to My Dad.*"

Dad, I'm writing you this letter, pretending you'll get to know its contents  
But, when I imagine your eyes, dried like raisins left lonely in their sockets  
I feel the futility of it all, writing a letter that you will never read,  
another exercise in self-indulgence  
Just time wasted.

The last time I wrote to you, when I was 10  
or was I starting college?  
I guess it doesn't really matter.  
The mandatory letters, meaningless anyway.

Now as I prepare to let you in  
It is too late  
Twelve years or so—too late.

When we were told that you would be dying soon,  
I climbed, shaking, the stairs to visit you in the hospital,

my guts retching  
I, always so good with words,  
shrieking inside “Fuck you, God!!”  
And there you lay, rotting,  
on the Bullfinch Ward at the Mass General, a lobby for the almost dead.

I wonder, if you were to sit here with me  
If I could make you know how much I love you  
and how much I miss you—and how sorry I feel

I wonder, if I screamed it in your face,  
As I have so many times at the Linwood Cemetery,  
if you could ever know how much I ache for you

I need you to tell me you love me—in spite of it all  
I need you to lie to me if necessary  
That would be OK.

Then you could hug me like you used to when I was very small  
and not yet a disappointment  
and you weren’t dead

or like you would have if I had let you  
or like we did that time in the garden after we made it so beautiful  
and full of life,  
or as I should have when you became empty...  
your life freshly ripped from its turncoat cocoon  
by the bad cancer that would not relent

you were dead  
you were dead too soon  
you are dead forever

it feels very empty in here  
I was told that after the mourning period, things would feel better  
but my mourning period is lasting forever it seems  
a just punishment.

I have fathered some children you would love  
they would love you  
they would want to spend some of their lives with you  
you could hug them whenever you wanted

I could watch with pride, even as I was feeling envious longing  
hoping no one would witness my heartbreak and my regret

I've done a lot of disappointing since you left  
I can't seem to shake it  
I can't ever be you  
I'm sorry  
I didn't mean to kill you.

I love you,  
Thomas

One day Thomas, who had always come on time for every single one of his sessions, in fact, sometimes up to 30 minutes early, Thomas came five minutes late, having been stuck in terrible traffic, and was totally distraught. To complicate matters, he was concerned that, in his haste, the “strings” attached to his back might have become entangled. Time, of course, every single moment, was so very precious to him. Ordinarily, I would not make up the time to a late patient but, with Thomas, I wanted to and so I told him that I would like to make up those five minutes to him at the end of our session. He was able to let me know that it meant the world to him, that I would be willing to do this, and, I believe, it marked one of several turning points in the treatment. For reasons never entirely clear to either of us, after I gave him those five minutes back, Thomas found himself becoming less and less concerned about the strings and their potential entanglement. In fact, he kind of forgot about the strings altogether, much as a young child, one day, simply lets go of his tattered blankie.

Over the course of our six years together, Thomas turned his life around. As he (and I) grieved the loss of Bobby and, later, the loss of his dad, his heart began to heal and he became more engaged in life, more invested in life, less afraid, more grounded, less terrified of dying, more present, less frantic about the passage of time, more committed to living right and well and authentically, in the moment, and with passion.

Several years into our work together, Thomas had divorced his wife, had stopped seeing the other girlfriend, and had called things off with his sometime lover. Meanwhile, he and Molly were getting very serious and building a gorgeous house on a lake, the outside of which Thomas was not planning to wash! One very special day, as a thank you gift, Thomas proudly presented me with a beautiful photograph of his “family” at their new waterfront home, all of them happily relaxing on their deck overlooking the lake. The photograph included Molly, his two sons Bill and Dan (by Sandra), Autumn (who, much to Thomas and Molly’s delight, now considered their home to be her home), and Thomas, grinning from ear to ear. Thomas said that it was because of our work together that he was now able to smile. I was incredibly touched. More tears. Mine, of course. Throughout our time together, Thomas had never once shed a tear. But that was fine.

Thomas told me that one of the most comforting things I had ever told him was when I had shared with him the idea that if you were blessed enough to be in a mutually loving relationship, then inevitably either you would end up losing them (whether to death or to something else) or they would end up losing you. And that’s just the way it was, an excruciatingly painful and sobering reality with which all of us must eventually make our peace. Thomas said that my sharing this “fundamental truth” with him had been clarifying and tremendously reassuring; it had helped him to feel less frightened, more grounded, and less alone.

And then it was time for us to say good-bye and we were ready for it, sad as it was for us both. To one of our last sessions, Thomas brought his guitar and played for me Luther van Dross’s heart-wrenching song entitled “Dance with My Father,” about a young boy’s yearning to be able to dance, just one more time, with his dearly beloved but long-departed father. “I never dreamed that he would be gone from me / If I could steal one final glance, one final step, one final dance with him / I’d play a song that would

never, ever end / 'Cause I'd love, love, love / To dance with my father again / Every night I fall asleep and this is all I ever dream."

I would like now to share with you what happened in the final moments of our last session. At the very end, when Thomas stood up to leave for the last time, no longer worried at all about any strings attached, I, with access to lots of tissues, reached out my hand to take ahold of his. He immediately reached for my hand, and I then placed my second hand around his. Then, after only a moment's hesitation, he slowly raised his second hand to his face and, as I followed the movement of his arm, I could see that he was pointing to the tears that were welling up in his eyes and beginning to roll down his cheeks. He smiled sweetly at me through his tears and I, through my own, smiled back. A very special, tender moment that needed nothing more...

Thomas has stayed in touch over the years and periodically comes in for a touch-base session. He and Molly ended up going into business together and now run a chain of very successful, high-end restaurants. As Thomas, with a twinkle in his eye, recently observed, when first he had come to me, he had four women and one restaurant. Now he has one woman and four restaurants! We agreed that although you probably would not want to be writing a song about having four women, you could probably write a pretty interesting one about having four restaurants!

Thomas and Molly gave birth to two lovely girls, Christie and Samantha, and their beautiful lakefront house is now home to these girls, Thomas's two sons, and Autumn. Thomas is supremely happy and tells me that his life is now filled with moments of intense joy. He is aging gracefully. He is no longer afraid. His heart has healed, and he has found internal peace. He no longer has the loneliness, no longer feels alienated, no longer dissociates, and is no longer a "reporter." And sometimes he cries—when he feels like it. He still visits his dad's gravesite, but he now feels that he carries his dad inside of

him, and that, at the end of the day, he did kind of end up being a lot like his dad. Ever humble, Thomas tells me, with quiet, heartfelt gratitude and delight, that he knows his dad would be proud of him. And I, personally, am quite sure that Thomas is right about that.



## Conclusion

The therapeutic action in Model 4 involves the therapist's participation as a non-demanding, non-intrusive, devoted, loving, and absolutely dependable facilitating (or holding) environment—as a therapist who is able to accommodate herself to her patient's every need, even having anticipated most of them.

By recognizing and responding to the patient's traumatically thwarted and defensively reinforced self-protective ego need to be in omnipotent control, the therapist will foster a therapeutic regression to absolute dependence, thereby enabling the patient to relinquish her denial of object need and creating opportunity for a redo—with a much better resolution this time.

The moments of authentic meeting that emerge from the harmonious interpenetrating mix-up between patient and therapist will restore purpose, direction, and meaning to an existence that might otherwise have remained desolate, impoverished, and desperately lonely.

We had started with Kelly Clarkson's heartbreaking "Because of You," and I conclude with her hauntingly beautiful "Piece by Piece"—an incredibly vulnerable song that speaks to the damage Kelly (a Model 4 patient) sustained as a young child when her father left and headed to the airport to start another life—damage that is now being repaired by her lovingly devoted husband and the father of their child (here representing the Model 4 therapist)—a dear man who has been healing her by putting back together the pieces of her shattered heart, one by one, piece by piece, filling the holes burned in her at six years old...

Autobiographically, Kelly Clarkson (2015) sings of her heartbreak –

And all I remember is your back  
Walking towards the airport  
Leaving us all in your past  
I traveled fifteen hundred miles to see you  
Begged you to want me  
But you didn't want to

But piece by piece, he <her beloved husband> collected me  
Up off the ground where you <her father> abandoned things  
And piece by piece, he filled the holes  
That you burned in me at six years old

And no, he never walks away  
He never asks for money  
He takes care of me  
'Cause he loves me

Piece by piece, he restored my faith  
That a man can be kind and a father could stay

Piece by piece...  
Piece by piece...  
Piece by piece...

### **From a Life Unlived to Living Wide Open**

As the pieces of the Model 4 patient's shattered heart are coming back together again, she can advance—as captured in Dawna Markova's (1996) poem entitled "Living Wide Open"—from fear to freedom, from closed to open, from stagnation to generativity, and from a life unlived to living wide open.

I therefore close with Markova's inspiring and inspired poem –

I will not die an unlived life.  
I will not live in fear  
of falling or catching fire.  
I choose to inhabit my days,  
to allow my living to open me,  
to make me less afraid,

more accessible;  
to loosen my heart  
until it becomes a wing,  
a torch, a promise.  
I choose to risk my significance,  
to live so that which came to me as seed  
goes to the next as blossom,  
and that which came to me as blossom,  
goes on as fruit.

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