

The Transformative Power of Optimal Stress

From Cursing the Darkness to Lighting a Candle



Martha Stark M.D.

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Dedicated to My Dear, Sweet Gunnar

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Introduction

Freud's interest was in the internal conflict that exists between, on the one hand, untamed id drives (most notably sexual and aggressive ones) clamoring for gratification and release and, on the other hand, the defenses mobilized by an undeveloped ego made anxious by the threatened breakthrough of those drives – conflict that will create neurotic suffering and interfere with the capacity to derive pleasure and fulfillment from love, work, and play (Freud 1926).

Using as a springboard Freud's premises of drive-defense conflict as the source of a person's difficulties in life and of the goal of treatment as therefore transformation of id energy into ego structure so that primitive defenses can be relinquished and conflict resolved – “Where id was, there shall ego be” (Freud 1923), I will go on to broaden Freud's conceptualization of neurotic conflict to encompass, more generally, growth-impeding tension between anxiety-provoking but ultimately health-promoting internal forces pressing *yes* and anxiety-assuaging internal counterforces defending *no*.

The aim of treatment will then become (1) to tame the id so that its now more manageable energy can be redirected into more constructive channels and used to power the pursuit of healthier endeavors and (2) to strengthen the ego so that it will become both better able to cope with the multitude of anxiety-

provoking stressors (internal and external) to which it is being continuously exposed and more skilled at harnessing id energy to fuel actualization of potential. In essence, a tamer id and a stronger ego will enable the patient to cope with the stress of life (Selye 1978) by adapting instead of defending – “Where defense was, there shall adaptation be.”

In the treatment situation, the therapist will offer psychotherapeutic interventions specifically designed to precipitate disruption in order to trigger repair (Stark 2008, 2012, 2014). To be effective against dysfunctional defenses that have become firmly entrenched over time, despite having long since outlived their usefulness, these therapeutic interventions must be *optimally stressful*. In other words, they must be strategically formulated to offer just the right combination of challenge and support.

More specifically, these ongoing interventions must be sufficiently challenging that they provoke destabilization of the patient’s defensive structures but sufficiently supportive that they then offer the patient, forced to tap into her innate striving toward health and inborn capacity to self-repair in the face of environmental threat, opportunity to restabilize at ever-higher levels of functionality and adaptive capacity. In essence, the therapeutic action will revolve around the patient’s working through the stressful impact of these anxiety-provoking, and therefore disruptive, but ultimately growth-promoting, and therefore reparative, psychotherapeutic interventions.

The net result of inducing healing cycles of disruption and repair will be eventual relinquishment of unhealthy, rigid, unevolved defenses in favor of healthier, more flexible, more evolved adaptations;; and, instead of having the defensive need to curse the darkness, the patient will now have the adaptive capacity to light a candle. Adaptation is, after all, a story about making a virtue out of necessity.

Elsewhere (Stark 1994a, 1994b, 1999), I have elaborated upon what I describe as the three modes of therapeutic action in psychodynamic psychotherapy, approaches that are complementary and not in conflict:

Model 1, the interpretive perspective of classical psychoanalysis, emphasizes cognition; its goal is to prompt the patient to explore her inner workings and ultimately to evolve to a place of greater self-awareness so that she can make more informed decisions about her life and become more master of her own destiny.

Model 2, the corrective-provision perspective of self psychology and other deficit theories, emphasizes affect; its goal is to offer the patient an opportunity, in the here-and-now relationship with her therapist, both to grieve the early-on parental failures and to experience symbolic restitution. As the patient is forced to confront the pain of her grief, it is hoped that ultimately she will evolve to a place of serene, albeit sober, acceptance of the disillusioning reality that the people in

her world were not, and will never be, all that she would have wanted them to be.

Model 3, the intersubjective perspective of contemporary relational theory, emphasizes authentic engagement with others; its goal is to offer the patient an opportunity to play out, on the stage of the treatment, her unresolved childhood dramas and ultimately to encounter a response different from what she had both expected and feared. As the patient is confronted with the sobering reality of the dysfunctional dynamics that she unwittingly and compulsively delivers into her relationships, she will be forced to evolve to a place of greater accountability for her actions, reactions, and interactions.

All three modes of therapeutic action involve transformation of dysfunctional defense into more functional adaptation by way of the therapeutic induction of healing cycles of defensive collapse and adaptive reconstitution, whether the optimal challenge that precipitates the disruption is provided by (1) cognitive dissonance (Model 1), (2) affective disillusionment (Model 2), or (3) relational detoxification (Model 3).

More specifically, Model 1 involves transformation of resistance (a defense against taking ownership of dysfunctional internal dynamics) into awareness (an adaptation); Model 2 involves transformation of relentless hope (a defense against confronting disillusioning truths about the objects of one's desire) into acceptance (an adaptation); and Model 3 involves transformation of re-enactment (a defense

against taking ownership of dysfunctional relational dynamics) into accountability (an adaptation).

Later volumes will address Model 2 and Model 3, but the purpose of this current volume is to offer the reader an opportunity first to understand how the destabilizing stress of being optimally challenged by thoughtfully crafted therapeutic interventions can jumpstart the healing process, and then to learn about the variety of prototypical statements that can be constructed in order to optimize the effectiveness and impact of the therapist's optimally stressful input.

All such statements, rendered with compassion and without judgment, will reflect a deep appreciation for the patient's ambivalent attachment to her dysfunctional defenses.

By focusing on the direct translation of theoretical constructs into clinical practice, the latter portion of this book will serve as a reference guide. Numerous specific examples will be developed to demonstrate the therapeutic power of interventions strategically designed to locate the conflict within the patient and not within the relationship between patient and therapist.

In other words, by highlighting the presence of conflict within the patient between those growth-promoting forces pressing yes and those growth-obstructing counterforces protesting no, the therapist will adroitly avoid placing herself in the untenable position of being the one to give voice to anxiety-

provoking but ultimately empowering realities that the patient herself really does know to be true, although she would rather not.

In effect, by speaking to the presence of conflict within the patient between her adaptive capacity to attend to her inner voice of truth and her defensive need to silence it, the therapist will be able masterfully to sidestep the potential for getting locked into a power struggle with the patient, which can otherwise happen when the therapist positions herself as the healthy voice of reality. If the therapist overzealously advocates for the patient's growth and change, then she will be not only forcing the patient (made anxious) to protest her resistance to growth and change but also robbing the patient of the opportunity to access her own healthy desire.

PART ONE ("Where Id Was, There Shall Ego Be") develops the idea that the patient has a conflicted (that is, ambivalent) attachment to her dysfunctional defenses because they both benefit and cost her. Effectively working through the patient's resistance will require of the therapist that she call to the patient's attention both the latter's investment in having the defense, which fuels her libidinal cathexis of the dysfunction, and the price she pays for refusing to relinquish it, which fuels her aggressive cathexis of the dysfunction. The goal will be to tame the id and strengthen the ego such that there will no longer be the same need to defend, ultimately signaling resolution of drive-defense conflicts.

PART TWO (“Convergent Conflict”) elaborates upon the distinction between divergent conflict, characterized by two forces that are independent of each other, and convergent conflict, characterized by an anxiety-assuaging counterforce mobilized as a defensive reaction to the presence of an anxiety-provoking force (Kris 1985).

Although Freud’s emphasis was on conflict between, on the one hand, sexual and aggressive id drives and, on the other hand, defenses mobilized by an undeveloped ego made anxious, my focus will be more on the harnessing of anxiety-provoking but ultimately empowering forces such that once their energy has been tamed, modified, and integrated, those forces, in conjunction with the ego’s enhanced awareness of its inner workings, can be used to fuel healthy pursuits and realizable goals.

PART THREE (“Optimally Stressful Psychotherapeutic Interventions”) presents in some depth a number of prototypical therapeutic statements – for example, conflict statements, inverted conflicted statements, and path-of-least-resistance statements – that will both challenge the patient’s defenses (by speaking to the patient’s adaptive capacity to know the truth) and support them (by resonating empathically with the patient’s defensive need to deny such knowledge)..

Based on the principle that until a chronic condition is made acute, there

may not be enough impetus to jumpstart the process of healing, the therapist will attempt to perturb the dysfunctional status quo by challenging the patient with an attenuated version of the traumatogenic experience that had created the problem to begin with, thereby triggering the patient's intrinsic ability to self-renew.

With her finger ever on the pulse of the patient's level of anxiety and capacity to tolerate further challenge and using any of the variety of optimally stressful psychotherapeutic interventions within her armamentarium, the therapist will be able to titrate the level of the patient's anxiety. The therapist will *challenge when possible* (thereby increasing the patient's anxiety, destabilizing the system, and superimposing an acute injury on top of a chronic one) and *support when necessary* (thereby decreasing the patient's anxiety and creating the potential for adaptive restabilization of the system at a higher level of integration, functionality, and balance), all with an eye to creating growth-promoting tension within the patient between her dawning awareness of just how costly her dysfunction has become, which will make it increasingly ego-dystonic, and her new-found understanding of just how invested she is in holding on to it even so, which highlights why it is still ego-syntonic.

As long as the *gain* is greater than the *pain*, the patient will *maintain* the defense and *remain* entrenched in her dysfunction. But as the patient becomes ever more impacted by her awareness of the discrepancy between her knowledge of the cost and her experience of the benefit, the stress and *strain* created by this

cognitive dissonance will ultimately prompt her, in the interest of restoring homeostatic balance, to surrender her dysfunctional defenses in favor of more functional adaptations.

PART ONE – Where Id Was, There Shall Ego Be

Growing up is the task of the child, and getting better is the task of the patient.

Throughout what follows, I will be suggesting that both the developmental process and the therapeutic process are continuously evolving processes that involve transformation from something that is less evolved (and more defensive than adaptive) to something that is more evolved (and therefore more adaptive than defensive).

A Conceptual Framework for Understanding the Therapeutic Action

I have long been interested in what exactly it is that enables patients to heal their psychic scars. These scars are the internal price paid for early-on traumas never fully processed and integrated, traumas experienced usually at the hands of their parents. Although belatedly, psychotherapy offers such patients the opportunity to process and integrate these unmastered traumas. I have written several psychoanalytic books that speak to what constitutes the so-called therapeutic action (Stark 1994a, 1994b, 1999).

The conceptual framework that I have developed posits three schools of

thought:

Model 1, enhancement of knowledge, is the interpretive perspective of classical psychoanalysis, a drive-defense model that focuses on the patient's unmodulated drives and self-protective defenses, a model that offers the neurotically conflicted patient an opportunity to gain greater self-awareness and insight into her inner workings, so that she can make more informed decisions about her life and become more master of her own destiny.

Model 2, provision of corrective experience, is a more contemporary perspective, one that focuses on the patient's psychological deficiencies, these psychic scars the result of early-on absence of good in the form of deprivation or neglect. This deficiency-compensation perspective is one that offers the patient an opportunity in the here-and-now relationship with her therapist both to grieve the early-on parental failures and to experience symbolic restitution. As the patient makes her peace with the reality that the people in her world were not, and will never be, all that she would have wanted them to be, she evolves to a place of greater acceptance and inner peace.

And Model 3, engagement in relationship, is another contemporary perspective, one that focuses on the patient's psychological toxicities, these psychic scars the result of early-on presence of bad in the form of trauma or abuse. This third model of therapeutic action offers the patient a stage upon which

to play out, symbolically, her unresolved childhood dramas, but ultimately to encounter a different outcome this time because the therapist will be able to facilitate resolution by bringing to bear her own, more evolved capacity to process and integrate on behalf of a patient who truly does not know how. As the patient is confronted with the sobering reality of what she compulsively and unwittingly re-enacts at the *intimate edge* (Ehrenberg 1992) in her relationships, she will evolve to a place of greater accountability for her actions.

In essence, we might say that maturity involves developing the capacity to know and accept the self, including one's psychic scars (Model 1), to know and accept others, including their psychic scars (Model 2), and to take responsibility for what one delivers of oneself into relationship and, more generally, into one's life (Model 3). At the end of the day, psychological health is a story about awareness, acceptance, and accountability.

Where Defense Was, There Shall Adaptation Be

Well known is Freud's (1923) adage: "Where id was, there shall ego be." Using this premise as a springboard, I will be suggesting that "Where defense was, there shall adaptation be."

In fact, my contention will be that the therapeutic action of psychodynamic psychotherapy – whether the interpretive perspective of classical psychoanalysis (Model 1), the deficiency-compensation perspective of self psychology and those

object relations theories emphasizing internal absence of good (Model 2), or the intersubjective perspective of contemporary relational theory and those object relations theories emphasizing internal presence of bad (Model 3) – always involves the transformation of dysfunctional defense into more functional adaptation.

More specifically, Model 1 will facilitate the transformation of resistance (defense) into awareness (adaptation); Model 2 will facilitate the transformation of relentless hope (defense) into acceptance (adaptation); and Model 3 will facilitate the transformation of re-enactment (defense) into accountability (adaptation). Awareness, acceptance, and accountability are all adaptations and involve the working through of defenses reactively mobilized, as we shall later discuss, either to protect the ego (from the exigencies of the id, the imperatives of the superego, and the demands of external reality) or to protect the self (from a bad object).

The Complementarity of Defense and Adaptation

So what exactly is the relationship between defense and adaptation?

Although defenses are less healthy and less evolved and adaptations are more healthy and more evolved, both defense and adaptation are self-protective mechanisms that speak to the lengths to which a system will go in order to preserve its balance in the face of environmental challenge – be that challenge

external or internal and be it psychological, physiological, or energetic.

Defense and adaptation are actually flip sides of the same coin; defenses have an adaptive function and adaptations serve to defend. As such, they have a yin and yang relationship, representing, as they do, not opposing but complementary forces. In fact, 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 defense and adaptation are conjugate pairs demonstrating this same duality (both-and, not either-or).

Despite being flip sides of the same coin, however, defenses are generally thought to be at the less evolved, less complex, less healthy, less functional end of the spectrum, whereas adaptations are generally thought to be at the more evolved, more complex, more healthy, more functional end. In essence, defenses are low-level regulatory mechanisms, whereas adaptations are higher-level regulatory mechanisms; defenses are automatic and are mobilized almost immediately, whereas adaptations emerge only over time and are more evolved. We defend to survive; we adapt to thrive.

More specifically, whenever a challenge is simply *too much* (that is, too much to be processed and integrated), then the ego, in an effort to preserve its balance, will mobilize a defense. These defensive reactions kick in almost instantaneously; they are reflexive (knee-jerk), do not involve much aforethought, are automatic,

old standbys, habitual, generic, stereotypic, characteristic (same old, same old). And if the child is repeatedly enough confronted with challenges that cannot be mastered, then her defenses will crystalize out, over time, as her defensive stance, her standard way of reacting, a patterned reaction, her pattern of defense, her modus operandi, her default mode every time she is confronted with something that is simply too much to be managed.

As an aside: Whenever the therapist in a therapeutic intervention puts forth the idea that perhaps the patient “finds herself thinking/feeling/doing thus and such...,” the therapist will usually be speaking to something the patient is thinking, feeling, or doing that is defensive, reactive, knee-jerk in character.

On the other hand, if a challenge is *not too much* and can ultimately be processed and integrated, then the ego, in an effort to preserve its balance, will be said to have adapted. These adaptive responses require much more forethought; they involve processing and integrating (digesting/metabolizing/assimilating) the impact of the challenge. They only emerge over time and are more evolved and more complex. Adaptations tend to be more flexible – they are not reflexive but reflective; not stereotypic or habitual but customized, individualized, and personalized. They are not generic but specific.

In sum, defenses tend to be more rigid, unyielding, and unvarying. They are like a “one-trick pony” or “Johnny One-Note.” Adaptations tend to be more

versatile, malleable, and plastic. We speak of the need to defend but the capacity to adapt – defensive need but adaptive capacity.

From Defensive Reaction to Adaptive Response

The developmental and therapeutic processes replace a reaction that is more knee-jerk with a response that is more considered: from defensive reaction to adaptive response.

A prime example of defense: When the impact on a child of her parent's abusiveness is simply too much for the child to process, integrate, and adapt to, the child may find herself defensively reacting by dissociating. Over time, dissociation may emerge as her characteristic defensive stance in life whenever she feels threatened.

A prime example of adaptation: When a child is ultimately able to master the impact of her parent's abusiveness (that is, process and integrate it), the child may adaptively respond by becoming an advocate for the rights of her little sister and of others whom she senses might be at risk.

Clearly there will always be a price paid for psychological defenses because they are rigid and inflexible; and, by virtue of that rigidity and inflexibility, they limit one's options and potential for growth. By the same token, because defenses interfere with the harnessing of id energy for constructive purposes and

attainable aspirations and because they themselves require the expenditure of energy for their maintenance, defenses are tremendously energy consuming and therefore costly.

As we shall later discuss, less obvious, perhaps, is the fact that there is also always at least some price paid for adapting. Admittedly, adaptations are more evolved solutions than are defenses. As such, there is benefit. But in adapting to sobering realities (be it the development of awareness, acceptance, or accountability), the individual usually ends up feeling a little sadder, less innocent, more burdened, and less carefree. Robbing Peter to pay Paul – but at least Paul will then get paid.

An Evolutionary Process

The following are the various ways in which the transformation of defense into adaptation can be conceptualized:

From id to ego

From id drive to ego structure

From drive to structure

From id need to ego capacity

From defensive need to adaptive capacity

From need to capacity

From defensive reaction to adaptive response

From reaction to response

From defense to adaptation

I would now like to offer a few points of clarification with respect to the above.

What is the relationship between ego structure and ego capacity? Because structures perform regulatory functions that enable regulatory capacity, development of an ego with structure is tantamount to development of an ego with capacity.

What is the relationship between a reaction and a response? If the impact of a challenge has not, for whatever complex mix of reasons, been able to be processed and integrated, then we speak of a reaction; but if the impact of the challenge has been able to be more processed and integrated, then we speak of a response. Id-derived reactions (that is, defenses) are more reflexive (that is, immediate), and ego-derived responses (that is, adaptations) are more reflective (that is, considered).

More generally, what is the relationship between id and ego? Ego psychology (Hartmann 1958) is founded on the premise that the ego develops out of necessity, that is, that it evolves as an adaptation to the exigencies of the id, the

imperatives of the superego, and the demands of external reality – all of which are environmental stressors (whether internal or external).

In fact, it could be said that adaptation is a story about making a virtue out of necessity. Adaptation is a story about the ego – in its struggle to avoid being overwhelmed, broken, or defeated – evolving as best it can in order to be able to manage the impact of the myriad of environmental stressors to which it is being continuously exposed.

Processing and Integrating Stressful Experiences

Throughout this book, I will be suggesting that the ultimate goal of psychodynamic psychotherapy is to facilitate the processing and integrating of stressful experiences in both the there-and-then and the here-and-now, such that the patient can adaptively respond (rather than defensively react), can mobilize functional adaptations (rather than activating dysfunctional defenses), can adopt functional ways of being and doing (rather than resorting to dysfunctional actions, reactions, and interactions), and can demonstrate healthy capacity (rather than manifesting unhealthy need).

By way of examples: If all goes well, the patient will evolve from whining and complaining to becoming proactive, from cursing the darkness to lighting a candle, from externalizing blame to taking ownership, from dissociating to becoming more present, from feeling victimized to becoming empowered, from being

jammed up to mobilizing her energies in the pursuit of her dreams, from denial to confronting head-on, and from being ever critical to becoming more compassionate.

Expressed in the language of need and capacity: If all goes well, the patient will evolve from having the need for immediate gratification into having the capacity to tolerate delay; having the need for absolute gratification into having the capacity to derive pleasure from relative gratification; having the need for perfection into having the capacity to tolerate imperfection; having the need for external provision of good parenting into having the capacity to be a good parent unto herself; having the need for external regulation of the self into having the capacity for internal self-regulation; having the need to hold on into having the capacity to let go; having the need to deny awareness of her investment in maintaining her dysfunction into having the capacity to take ownership of her conflictedness about moving forward in her life; having the need to put a lid on her dysregulated id energies into having the capacity to harness those now better regulated id energies to power her movement forward in life; having the need to deny the reality of the object's limitations, separateness, and immutability into having the capacity to accept, and make her peace with, those sobering realities; and having the need to play out her unresolved childhood dramas in her relationships into having the capacity to hold herself accountable for what she had been compulsively and unwittingly re-enacting on the stage of her life.

Whether conceptualized as the transformation of defense into adaptation, of dysfunction into greater functionality, of knee-jerk reactivity into more considered responsiveness, or of need into capacity, the ever-evolving result of the working-through process of psychodynamic psychotherapy will be development of ever-greater awareness, acceptance, and accountability such that the patient will be ever-better equipped to manage the myriad of environmental challenges to which she will be continuously exposed over the course of her life.

Taming the Id and Strengthening the Ego

Freud (1926) formulates the goal of treatment as the resolution of internal conflict between id drive and ego defense by simultaneously (1) harnessing the id drives and (2) analyzing the ego defenses. The net result of both taming the id and strengthening the ego will be a working through of the patient's resistance to awareness of her inner workings and a simultaneous tapping into now more tamed and therefore more available id drives.

In fact, classical psychoanalytic theory is all about taming the id (by taming, modifying, and integrating its unmodulated energies) and strengthening the ego (by rendering conscious its internal dynamics through analysis, and ultimate dissolution, of its defenses) – all with an eye to resolving structural conflict and freeing up energy to power the patient's movement forward in life.

My understanding of the therapeutic action is very much informed by

Freud's psychodynamic formulations about the internal workings of the mind. His conceptualization of both the developmental process and the therapeutic process – as a story about the transformation of id (energy) into ego (structure) so that id and ego can work together collaboratively and not conflictually – is one that I find extraordinarily compelling. In what follows, however, my effort will be to translate Freud's time-honored, even if somewhat old school, theoretical constructs into a more contemporary language that I hope will make his ideas about the central importance of taming the id and strengthening the ego a little more accessible and clinically useful for the modern practitioner.

Freud's Horse and Rider

In writing about the conflictual relationship between id and ego, Freud (1923) likens it to the relationship that exists between a horse and its rider. He suggests that the horse represents the id and its rider the ego. The horse would like nothing better than to be able to run free, accountable to no one but himself. His energy, however, is needed to fuel the progression of horse and rider. It therefore behooves the rider to become skilled at harnessing the horse's energy so that the two of them can move forward as harmoniously as possible.

Once the horse becomes tamed and therefore better regulatable and its rider becomes stronger and therefore more adept at regulating, horse and rider will become better able to coordinate their efforts to create a collaborative, and no

longer a conflictual, relationship. Indeed, the defensive need to *rein the horse in* will have become transformed into the adaptive capacity to *give the horse free rein*.

When Does the Ego Develop?

In what follows, I will first attempt to make as compelling a case as I can for why I think it makes more sense to conceive of the id as the psychic agency responsible for mobilization of primitive defenses and of the ego as the psychic agency responsible for mobilization of healthier defenses. I will also be suggesting that a distinction be made not between primitive defenses and healthier defenses but between primitive defenses and healthier adaptations.

Admittedly, however, there is a major problem with my conceptualization of the intrapsychic situation as one in which it is the responsibility of the id to mobilize primitive defenses and the responsibility of the ego to mobilize healthier adaptations.

So, to continue the metaphor of the horse and rider, I will go on to change horses in midstream by presenting a counterargument for why it might indeed make more sense to conceive (as did Freud) of the ego as the psychic agency responsible for mobilizing both primitive and healthier defenses.

But I believe that there is then a major conceptual problem with this latter formulation of the intrapsychic situation as one in which it is the responsibility of

the ego to mobilize both primitive and healthier defenses.

Again, however, I am getting ahead of myself – putting the horse before the cart, so to speak!

So let me begin again.

Freud's contention is that the task of the child growing up and of the patient getting better is ongoing taming of the id and strengthening of the ego – an ever-evolving working-through process that allows for a gradual harnessing of ever-tamer id energies by an ever-more-capable ego and the eventual transformation of unhealthy defenses (like projection, denial, and dissociation) into healthier defenses (like sublimation, humor, and creativity).

In other words, as the id becomes more manageable and the ego more capable, the need to put a lid on the id (that is, simply to rein in the horse) will become transformed into the capacity to harness those energies (that is, to give the horse his head) to power forward movement. In essence, whether the situation is one of a child growing up or of a patient getting better, the unevolved need to mobilize primitive defenses to obstruct the flow of the id energy will be replaced by the more evolved capacity to mobilize healthier defenses to facilitate the flow of that id energy.

In contradistinction to Freud's way of formulating the intrapsychic situation,

however, my inclination is to conceive of a beleaguered and overwhelmed id as having the defensive need to muster up whatever primitive defenses it can in a desperate attempt to rein in the dysregulated energy and, as the child grows up and the patient gets better, of a more mature and more evolved ego as having acquired the adaptive capacity to mobilize healthier adaptations in the interest of directing the now-more-modulated energy toward the fulfillment of constructive purposes, worthy endeavors, and realistic goals (that is, actualization of inherited potential).

By way of examples: Earlier I had made reference to the idea that, as a result of development and treatment, the defensive need for immediate gratification becomes transformed into the adaptive capacity to tolerate delay. What I am now suggesting is that this is tantamount to saying not that the ego's defensive need for immediate gratification becomes transformed into the ego's adaptive capacity to tolerate delay but rather that the id's defensive need for immediate gratification becomes transformed into the ego's adaptive capacity to tolerate delay.

By the same token, earlier I had made reference to the idea that, as a result of development and treatment, the defensive need for perfection becomes transformed into the adaptive capacity to tolerate imperfection. What I am now suggesting is that this is tantamount to saying not that the ego's defensive need for perfection becomes transformed into the ego's adaptive capacity to tolerate imperfection but rather that the id's defensive need for perfection becomes

transformed into the ego's adaptive capacity to tolerate imperfection.

Again, I think it makes more sense to conceptualize the therapeutic action of psychodynamic psychotherapy as a story about "Where primitive (id) defense was, there shall healthier (ego) adaptation be" (my words) than to conceptualize the therapeutic action as a story about "Where primitive (ego) defense was, there shall healthier (ego) defense be," which would follow from what Freud hypothesizes.

In other words, if a central tenet of Freud's theory is that there is first id and then ego (a tenet that I wholeheartedly embrace), then it does not seem entirely in keeping with that fundamental construct to go on to hypothesize that there is first primitive ego defense and then healthier ego defense, especially when it is not clear, from Freud's point of view, that there is even much ego present at the beginning. I therefore believe that it is more inherently consistent to hypothesize that there is first primitive id defense and then, as the ego comes into being and gradually develops, healthier ego adaptation.

In sum: My choice is to propose that rather than primitive mechanisms (mobilized by an immature ego) and healthier mechanisms (mobilized by a more mature ego), there are primitive mechanisms (mobilized by the id) and healthier mechanisms (mobilized by the ego). Furthermore, rather than distinguishing between primitive defenses and healthier defenses, I find it more clinically useful

to make the distinction between primitive defenses and healthier adaptations. Accordingly, both the developmental task of the child and the therapeutic task of the patient then become a story about the gradual evolution not so much from unhealthy (ego) defense to healthier (ego) defense but rather from unhealthy (id) defense to healthier (ego) adaptation – as id is transformed into ego, id energy into ego structure, id need into ego capacity, need into capacity, defensive need into adaptive capacity, defense into adaptation.

Fairbairn's Conceptualization of the Endopsychic Situation

Interestingly, there have been others as well who have begged to differ a bit with Freud's conceptualization of the id as a story about energy and of the ego as a story about structure. In fact, W.R.D. Fairbairn (1954) has his own particular take on the endopsychic situation. For him, there is no id at all – only an ego with its own (libidinal and antilibidinal) energy. In essence, Fairbairn's ego is a dynamic structure with its own energy.

More specifically, for Fairbairn, there is only a split ego with both its libidinal and antilibidinal (that is, aggressive) attachments to a split internal bad object (a seductive – exciting/rejecting – object that has taken up residence in the ego because it has been defensively introjected by the developing child in an effort to rid the mother of her badness and thereby to preserve the child's relationship with her mother uncontaminated by the child's rage). I will later be elaborating in

much greater detail upon Fairbairn's brilliant conceptualization of the patient's intensely ambivalent relationship to her seductive objects as a story about this splitting of the ego.

In fact, Fairbairn's formulations about the patient's conflicted attachment to bad objects that are both loved (because they excite) and hated (because they reject) deeply informs my understanding of the therapeutic action in Model 3 – the contemporary relational model that focuses on the patient as ever busy compulsively and unwittingly playing out on the stage of her life (and in the treatment situation) her unresolved childhood dramas, the healthy part of this repetition compulsion fueled by her desire to achieve belated mastery of the early-on traumatic failure situation.

A Paradigmatic Shift

I hope that in the sections above I was able to make a fairly compelling case for the idea that the id could be conceptualized as the psychic agency responsible for the mobilization of primitive defenses prior to the ego's subsequent development and assumption of the responsibility for mobilization of self-protective mechanisms.

One of the major problems with my formulation, however, is that if anxiety is what prompts mobilization of defense (which is an idea that I wholeheartedly embrace) and if only the ego can experience anxiety (which is also an idea that I

wholeheartedly embrace), then how can I now be advancing the idea that the id is the psychic agency responsible for the mobilization of defense, albeit primitive?

On the other hand, Freud's conceptualization of the intrapsychic situation makes sense only if we posit the existence of at least a rudimentary ego from birth. Freud, who repeatedly emphasized the gradual development of the ego from the id ("Where id was, there shall ego be"), was much less clear about whether he thought there was an ego present at birth. So if there are defenses from the beginning but not yet an ego, how then can Freud claim that the ego is responsible for mobilization of those defenses?

We must therefore assume either that the id is able to experience anxiety (in which case I can make a case for the id as responsible for the mobilization of primitive defenses and for the ego, once it develops, as responsible for the mobilization of healthier adaptations) or that there is an ego – albeit a primitive one – present from birth (in which case Freud's formulation would be more accurate, namely, that an undeveloped ego is responsible for mobilizing primitive defenses and a more developed ego responsible for mobilizing healthier defenses).

So I am willing to concede. But, in order for our logic to have internal consistency, we shall have to posit the existence of *some* ego present from the time of birth – at least a rudimentary ego that, in reaction to anxiety (please note my

use of the word reaction instead of response) would then be able to activate defenses, albeit primitive ones.

I would still like to advance the idea, however, that we conceive of a more evolved ego as able to mobilize not so much healthier defenses as healthier adaptations. After all, in keeping with the paradigm advanced by Hartmann and other ego psychologists writing in the '60s and '70s, if the ego, governed as it is by the reality principle, is responsible for adapting to internal and external realities, does it not make more sense to describe the developmental and the therapeutic processes as involving the transformation not of primitive defense into healthier defense but of primitive defense into healthier adaptation?

I still embrace Freud's contention that "Where id was, there shall ego be" but I also find clinically useful the idea that "Where defense was, there shall adaptation be." Maybe, however, it really is an unevolved ego, (present, then, from birth) that is responsible for defense and a more evolved ego (the result of growing up and getting better) that is responsible for adaptation. And maybe it really is, after all, an inexperienced rider (an undeveloped ego prone to reactions) that defends and a more experienced rider (a more developed ego capable of responses) that adapts. Fair enough. I am satisfied.

Parenthetically, however, is it not a bit of a misnomer for Freud (and for me!) to be referring to the internal conflict that exists between id impulse and ego

defense as structural conflict when, although the ego is a structure, the id, allegedly, is not – that is, the id, according to Freud, is structureless?

To conclude my argument: I, for one, certainly understand why Fairbairn would have decided to resolve things for himself by suggesting that there is no id at all, only an ego with its own energy – and, of course, with structure!

In any event, because id and ego are, after all, abstractions and not realities, there are no specific regions in the brain that neuroscientists can prove house either an id or an ego. So no matter how a patient's internal dynamics (and the growth-disrupting, progress-impeding structural conflicts that constitute those dynamics) are conceptualized, each practitioner can pretty much choose for herself the formulation that makes the most theoretical and clinical sense to her.

What matters most is that whatever paradigm the therapist embraces, it will enable her to frame her understanding of the options she has, as she sits with the patient, about how she listens and how she then intervenes, the security of which should then translate into providing her with many degrees of freedom to deliver her very best into the treatment situation.

Irreversible Deletion or Reversible Transformation?

If we do posit as a given the fact that “Where defense was, there shall adaptation be,” then several questions inevitably arise with respect to this ever-

evolving process: Is defense transformed into adaptation? Is defense replaced by adaptation? Once there is adaptation, does defense still exist? Or once there is adaptation, is defense then gone for good?

I am here reminded of the interesting distinction, in the language of computers, between the *save* function and the *save as* function. On the one hand, when you *save* a document, only the most recent iteration is preserved and everything that had preceded this save is effectively deleted. On the other hand, when you *save as* a document, then both the old version and the new version (with a different name) now exist and nothing has been permanently deleted.

So to reframe my question in the language of computers, when defense becomes adaptation, is the defense *saved* as an adaptation (in which case the defense cannot be retrieved) or is the defense *saved as* an adaptation (in which case both defense and adaptation will be retrievable, depending upon the current level of the patient's capability)?

Perhaps these are semantic distinctions; but what seems most important to me is recognizing that, with respect to both the child growing up and the patient getting better, "Where once there was primitive and unevolved, there is now the potential for healthier and more evolved." In other words, once a patient has achieved the capacity to adapt, she will no longer have the same need to defend.

On the other hand, it should also be noted that although there is now

something healthier and more evolved, there is always the potential to revert to something less healthy and less evolved.

Primitive and Healthy Self-Protective Mechanisms

Please note that there will be times when I juxtapose unhealthy defense with healthier adaptation. By this juxtaposition I mean to be suggesting that there are unhealthy self-protective mechanisms (that is, defenses) and healthier self-protective mechanisms (that is, adaptations). Also I will sometimes juxtapose primitive defense with healthy adaptation. Here, too, I mean to be suggesting that there are primitive mechanisms (that is, defenses) and healthy mechanisms (that is, adaptations).

But sometimes I will juxtapose primitive defense with healthier adaptation. Although grammatically incorrect (like suggesting that a particular brand of cereal has 7% more iron – than what? one wonders), the reason I will be taking this liberty is that I want to highlight the fact that although adaptations are certainly healthier than the primitive defenses from which they derive, these adaptations might not yet be truly healthy (like suggesting that somebody on a diet who has lost 10 of her 30 pounds of excess weight is certainly thinner but still not thin).

Therapeutic Agents of Change

As noted earlier, I conceive of the therapeutic action as encompassing three

modalities: enhancement of knowledge *within*, provision of corrective experience *for*, and engagement in authentic relationship *between*. The prepositions (*within*, *for*, and *between*) further emphasize that whereas Model 1 is about what takes place *within* the patient, Model 2 is about what the therapist does *for* the patient, and Model 3 is about what takes place *between* patient and therapist.

Model 1 is a 1-person psychology (with the therapist, as *neutral object*, focused on the patient's internal dynamics); Model 2 is a 1½-person psychology (with the therapist, as *empathic selfobject*, focused on the patient's affective experience); and Model 3 is a 2-person psychology (with the therapist, as *authentic subject*, focused on the patient's relational dynamics).

Furthermore, whereas Model 1 involves the ego – an ego that will become ever stronger, wiser, and more empowered as a result of working through the patient's resistance to knowing the truth about the powerfully conflicted forces within her, Model 2 involves the self – a self that will become ever more consolidated and more compassionate as a result of working through the patient's refusal to confront, and grieve, the pain of her disappointment in her objects, and Model 3 involves the self-in-relation – a self-in-relation that will become ever more present as a result of patient and therapist, with shared mind and shared heart, detoxifying the dysfunction that will inevitably arise at the intimate edge of their authentic relatedness.

At the end of the day, as we shall shortly see, Model 1 is more cognitive, Model 2 is more affective, and Model 3 is more relational, but there is, of course, significant overlap among the three models. These three models are mutually enhancing, not mutually exclusive.

Paul MacLean's Triune Brain

I am here reminded of Paul MacLean's (1990) formulations about the Triune Brain: three evolutionarily distinct structures that are nonetheless thought to be interdependent and interactive with one another. More specifically, MacLean posits the existence of (1) the cognitive neocortex (new brain) – the top layer of the cerebral hemispheres – which corresponds to my Model 1; (2) the emotional mammalian brain (limbic system) – the hippocampus, amygdalae, and hypothalamus – which corresponds to my Model 2; and (3) the visceral/instinctual reptilian complex (old brain) – brainstem and cerebellum – which corresponds to my Model 3. Whether the therapeutic process goes from cognitive to emotional to visceral/instinctual (top-down processing of information and energy) or from visceral/instinctual to emotional to cognitive (bottom-up processing of information and energy), the net result will be the digesting and assimilating of environmental stimuli – including, especially, stressful therapeutic interventions – and the evolving to a higher level of integration, balance, and harmony.

Evolving to a Higher Level of Adaptive Capacity

In any event, as we shall explore in much greater detail later, the therapeutic action in all three modes involves transformation of defense into adaptation by facilitating the patient's processing and integrating of stressful experiences, both past and present. In other words, psychodynamic psychotherapy affords the patient an opportunity, albeit often a belated one, to process and integrate both unresolved early-on stressful life experiences (that, at the time, were never adequately processed, integrated, and *adapted to* but were instead *defended against*) and unresolved present-day stressful life experiences (that have not yet been adequately processed, integrated, and adapted to) – the net result of which will be transformation of dysfunctional defense into more functional adaptation.

Importantly, present-day stressful life experiences that need to be mastered will include not only stressful experiences that the patient is having in her current life and in her current relationships but also stressful experiences that she is having in the context of the relationship with her therapist. If the patient can work through the complex mix of transference feelings that she is having with respect to her therapist, then the patient will also be doing some critically important, even if long after the fact, processing and integrating of previously unmastered traumatogenic situations experienced at the hands of her early-on caregivers.

Optimally Stressful Therapeutic Interventions

The therapeutic action involves not only working through the transference (both negative and disrupted positive transferences) but also, more generally, working through the stress of therapeutic interventions specifically designed by the therapist to challenge the status quo of the patient's dysfunctional defenses, thereby destabilizing them enough that there will be opportunity, with ongoing support from the therapist and by tapping into the body's innate striving toward health, for the patient to restabilize at a higher level of functionality and adaptive capacity – in the process relinquishing her defenses in favor of adaptations.

If, over time, there are too many anxiety-provoking interpretations and not enough anxiety-assuaging empathic interventions, then the cumulative impact of this stressful therapeutic input may eventually compromise the health and vitality of the individual. On the other hand, if there is just the right balance between anxiety-provoking and anxiety-assuaging interventions, then the net result will be the precipitating of disruption in order to trigger repair and the replacement of unhealthy defense with healthier, more reality-based adaptation.

The Stress of Gain-Become-Pain, Good-Become-Bad, and Bad-Become-Good

As we shall see, more specifically, in Model 1, the therapeutic action will involve working through the stress occasioned by the patient's ultimate experience of gain-become-pain (that is, working through the cognitive dissonance created within the patient by her increasing awareness of the price she

is paying for remaining so attached to her dysfunction); in Model 2, the therapeutic action will involve working through the stress occasioned by the patient's ultimate experience of good-become-bad (that is, working through the disillusioning experience of having to relinquish an attachment to something in which, by virtue of her relentless hope, she had been positively invested); and in Model 3, the therapeutic action will involve working through the stress occasioned by the patient's ultimate experience of bad-become-good (that is, working through the gut-wrenching experience of having to relinquish an attachment to something in which, by virtue of her repetition compulsion, she had been negatively invested).

Ego, Self, and Self-in-Relation

In other words, whether the focus is on dysfunctional defenses involving her ego (for example, needing to protect her ego against having to know anxiety-provoking truths about her inner workings), her self (for example, needing to protect herself against having to know disillusioning truths about objects she has idealized), or her self-in-relation (for example, needing to protect her self-in-relation against having to take ownership of the toxicity she plays out in her relationships), letting go of the dysfunction will be stressful because of the patient's conflicted attachment to it. Although clearly the dysfunction benefits the patient in some way (or she would not be so invested in maintaining it), the dysfunction does also inevitably cost her.

Ambivalent Attachment to Dysfunctional Defenses

In essence, I am here suggesting that the patient's difficulty relinquishing her attachment to her dysfunctional defenses (and gradually replacing them with more functional adaptations) speaks to her intensely ambivalent attachment to those defenses – an attachment fueled by both libido (because the defense must *satisfy* in some fashion) and aggression (because the defense also *frustrates* in some fashion).

Adhesiveness of the Id

In fact, when Freud implicated the adhesiveness of the id as a major factor contributing to the patient's difficulty moving forward both in the treatment and in her life, I believe he was speaking to the patient's intensely ambivalent (id) attachment to her dysfunctional defenses – and thus her reluctance to relinquish them in favor of more functional adaptations.

Dysfunctional Systems Resist Change

It is therefore easy enough to understand why it would be so hard (1) for the Model 1 patient to relinquish her resistance to knowing the truth about her state of internal conflictedness and gradually to replace that resistance with awareness of just how attached she is to her dysfunction and of how responsible she therefore is for perpetuating it; (2) for the Model 2 patient to relinquish her

refusal to know the truth about her objects and gradually to replace her relentless hope with acceptance of just how powerless she really is to make the objects in her world into the good parent she never had reliably and consistently early on; and (3) for the Model 3 patient to relinquish her compulsive and unwitting need to play out again and again, on the stage of her life, her unresolved childhood dramas and gradually to replace those dramatic re-enactments with more responsible ways of acting, reacting, and interacting.

In other words, it will usually be only with great effort that the patient (1) works through her defensive need to hold on to her ambivalently cathected defenses and (2) replaces those dysfunctional defenses with more functional adaptations – as resistance is replaced by awareness, relentlessness by acceptance, and re-enactment by accountability.

Precipitating Disruption to Trigger Repair

And so it is that stressful therapeutic interventions that provide just the right mix of challenge and support should be a mainstay in the armamentarium of any psychodynamic psychotherapist who appreciates that dysfunctional systems resist change and that their inertia must be overcome if there is ever to be the possibility of transforming unhealthy defense into healthier adaptation. The therapist should be ever-busy challenging when possible (in order to initiate destabilization of the dysfunction) and supporting when necessary (in order to

provoke restabilization at a higher level of functionality and adaptive capacity).

In essence, by suggesting that the therapist precipitates disruption in order to trigger repair, I am here speaking to the therapeutic use of stress to provoke recovery – a principle that underlies the practice (well known in various healing circles) of superimposing an acute injury on top of a chronic one in order to mobilize the body’s intrinsic ability to self-heal.

Therapeutic Input

Stepping back for a moment in order to put things into perspective: I have long been interested in understanding how exactly it is that patients get better – in other words, what exactly it is that allows them to reverse underlying dysfunction and thereby to advance from defense to adaptation. Over the course of the years, I have come increasingly to appreciate something that is at once both completely obvious and quite profound, namely, that it will be *input* from the outside and the patient’s capacity to process, integrate, and adapt to its impact that will ultimately enable her to get better. In other words, there must be both environmental input (which will constitute the dose) and capacity of the system to manage that input (which will constitute the reaction/response).

Challenge Against a Backdrop of Support

As it happens, however, more often than not it will actually be *stressful input*

from the outside and the patient's capacity to process, integrate, and adapt to the impact of this stress that will provoke recovery. In other words, usually it will be not so much gratification as frustration against a backdrop of gratification – to which the psychodynamic literature refers as *optimal frustration* (Kohut 1966) – that will then provide the therapeutic leverage needed to provoke, after initial disruption, eventual revitalization of the system at a higher level of functionality and adaptive capacity.

Expressed in somewhat different terms, generally it will be not so much support as challenge against a backdrop of support (that is, optimal challenge) that, by virtue of the anxiety thereby elicited, will then provide the impetus needed to transform dysfunctional defense into more functional adaptation.

If the therapist offers only gratification and support – and neither frustration of primitive desire nor challenge to the patient's maladaptive ways of thinking, feeling, and doing, then there will be nothing that the patient needs to master and therefore little incentive for transformation and growth. Therapeutic input, however, that provides an optimal level of stress and anxiety (in the form of interventions that offer just the right balance of frustration and gratification and just the right combination of challenge and support) can ultimately provoke not only reversal of underlying dysfunction but also optimization of functionality by tapping into the patient's innate striving toward health and inborn ability to self-correct in the face of environmental perturbation.

The operative concept here is optimal stress.

The Concept of Optimal Stress

It is in order to highlight the clinical usefulness of optimal stress to provoke healing and revitalization of resilience that I am so boldly advancing the idea that if the patient is provided with only gratification and support, there will be insufficient impetus for transformation and growth. Let me now qualify that rather bold assertion by saying that, in most instances, gratification and support (although certainly pleasurable in their own right) will not, on their own, be enough either to reverse chronic dysfunction or to promote optimal health.

In other words, direct support is necessary but not always sufficient. Therefore a more accurate rendering would be the following: Usually reversal of underlying dysfunction and fine-tuning of functionality require therapeutic input that provides not only direct support but also optimal challenge. Whereas the therapeutic effectiveness of direct support is intuitively obvious, the therapeutic effectiveness of a combination of support and challenge is more counterintuitive.

In truth, direct support and optimal challenge work in concert. Here, too, there is a yin and yang relationship, with support and challenge demonstrating the same complementarity to which I had earlier made reference in discussing defense and adaptation. Whereas optimal challenge provokes recovery and revitalization by prompting the system to adapt, direct support facilitates healing

by reinforcing the system's underlying resilience and restoring its adaptation reserves, thereby honing the system's ability to adapt to, and benefit from, ongoing stressful environmental input.

Environmental Toxicities and Deficiencies

I find it clinically useful to think in terms of those environmental stressors as involving both the presence of bad and the absence of good in the early-on parent-child relationship (both too much that was bad between parent and child and not enough that was good; trauma and abuse on the one hand, deprivation and neglect on the other) – toxicities and deficiencies that were internally recorded and structuralized as psychic scars in the developing mind of the young child.

On the one hand, I define distortions (deriving from the internal presence of toxicities) as negative misperceptions of reality; on the other hand, I define illusions (deriving from the internal presence of deficiencies) as positive misperceptions of reality. Both distortions and illusions are dysfunctional defenses that result from inadequate processing and integrating of environmental stimuli and that will become filters through which the patient then views both her internal and her external world.

Bad Stuff Happens

Whether in the form of too much that was bad (trauma and abuse) or not

enough that was good (deprivation and neglect), stressful stuff happens. But it will be how well the individual is able to process and integrate its impact – psychologically, physiologically, and energetically – that will make of it either a growth-disrupting trauma (when the impact of the stress is simply too much to be processed, integrated, and adapted to) or a growth-promoting opportunity (when the impact of the stress, although initially destabilizing, is ultimately able to provoke restabilization of the system at a more evolved level of functionality and mature capacity).

Again, it will be how well the individual is able to master the cumulative impact of the environmental stimuli, be they past, present, or transference, that will determine the outcome, that is, whether there is a plummeting of the patient into further decline because the impact is simply too much to be managed or there is an evolving of the patient to a higher level of functionality and resilience because the impact is ultimately able to be mastered.

As we shall see, the villain in our piece will be traumatic stress, here defined as stressful input that overwhelms and disrupts because it is simply too much to be handled. The heroine in our piece will be optimal stress, here defined as ongoing stressful input that ultimately strengthens by triggering healing cycles of first disruption and then repair, first destabilization and then restabilization at ever-higher levels of complexity, integration, and adaptive capacity.

In essence, whether the primary target is mind or body and the clinical manifestation therefore psychiatric or medical, the critical issue will be the ability of the patient to manage stress through adaptation.

The Paradoxical Impact of Stress

This book addresses the paradoxical impact of stress most especially on the mind (here conceptualized as an open, self-organizing chaotic system) and advances the idea that an optimal dose of stressful input (that is, an optimal challenge), by tapping into the system's resilience and intrinsic ability to heal itself, can indeed provoke modest overcompensation and a strengthening at the broken places – thereby enabling the patient to evolve from defensive resistance to adaptive awareness, from defensive relentlessness to adaptive acceptance, and from defensive re-enactment to adaptive accountability.

Healing Cycles of Defensive Collapse and Adaptive Recovery

What patterns will emerge as the patient, here conceptualized as a self-organizing system, advances from chaos to coherence and from disorder to orderedness?

We could say that as the system evolves over time and in reaction/response to environmental input, the properties that emerge will be dysfunctional defenses (when the impact of the environmental stressor – whether past, present, or

transferential – cannot be processed, integrated, and adapted to and must instead be defended against) and more functional adaptations (when the impact can be processed, integrated, and ultimately mastered).

Alternatively, we could say that as the system evolves over time, the property that emerges will be healing cycles of disruption and repair, recursive cycles of disorganization and reorganization, defensive collapse and adaptive reconstitution at ever-higher levels of complexity and capacity as the patient reacts/responds – either defensively (prompting collapse) or adaptively (prompting reconstitution) – to the ongoing stressful input. By way of her stressful interventions, the therapist will precipitate rupture in order to trigger repair, and she will do this repeatedly.

Indeed, a patient's journey from defense to adaptation involves progression through these iterative cycles of disruption and repair as she evolves from chaos and dysfunction to coherence and functionality.

As noted repeatedly throughout this book, it will be ongoing exposure to environmental impingement (in the form of the therapist's stressful interventions) that will provide the therapeutic leverage – the impetus – for such transformation, thereby enabling the patient, as we shall see, to extricate herself from the bonds of her ambivalently cathected dysfunction and her infantile attachments.

The ever-evolving psychotherapeutic process can be conceptualized as a story about transforming unhealthy defense into healthier adaptation, whether it be the transformation of (1) resistance to acknowledging uncomfortable truths about one's inner workings into awareness of those truths (in the language of classical psychoanalysis); (2) relentless hope and refusal to confront – and grieve – painful truths about the object into sober acceptance of those truths (in the language of those psychological theories that focus on the internal absence of good); or (3) compulsive and unwitting re-enactment of unresolved childhood dramas into accountability for one's actions, reactions, and interactions (in the language of those psychological theories that focus on the internal presence of bad) (Stark 1999).

An Untamed Id and a Weak Ego

Model 1, then, is the interpretive perspective of classical psychoanalysis. It is a 1-person psychology, the focus of which is on the patient's internal (unconscious/conflictual) dynamics – dysregulated drives and dysfunctional defenses mobilized by a not-yet-fully-evolved ego in an effort to control/manage/regulate those drives.

More specifically, internal conflict is between a not-yet-fully-tamed id and a not-yet-fully-evolved ego, which is also described as intrapsychic (structural/neurotic) conflict. Expressed in somewhat different terms, the conflict

is between an untamed, anxiety-provoking id and a weak, anxiety-ridden ego that, in the face of environmental challenge – whether that challenge be internal (the exigencies of the id and the imperatives of the superego) or external (the demands of reality, including the therapist) – has a *need to defend* and not yet the *capacity to adapt*.

The Unconscious

In the psychoanalytic literature, the unconscious has been variously described as:

(1) *dynamic unconscious* (Freud 1926), whereby anxiety-provoking psychic contents are being defended against by an ego made anxious. In other words, the dynamic unconscious refers to that which is kept out of consciousness to avoid the experience of anxiety. Freud made the distinction between the dynamic unconscious (which involves defense) and nonconscious processes (which do not involve defense and can therefore usually be brought into awareness by calling attention to them). What is nonconscious is not specifically anxiety provoking; it just has not yet had occasion to be made conscious, that is, illuminated.

(2) *unconscious organizing principles* (Atwood and Stolorow 1984). These “pre-reflective” principles are thought to organize or shape the patient’s experience of reality; they serve as filters through which the patient gives meaning to the world around her and to herself in relation to it.

(3) *unthought known* (Bollas 1989). This concept speaks to experiences that are in some way known to the patient but about which she has not yet thought, that is, experiences that are in some way known to the patient but are waiting to be found. In other words, the *unthought known* speaks to early schemata (or templates for interpreting the object world) that will then preconsciously determine the individual's subsequent life expectations.

(4) *implicit relational knowing* (Lyons-Ruth 1998), that is, a form of procedural knowledge about *how to do things with intimate others*. Implicit relational knowing is an intuitive sense of how to be with another.

A Drive-Defense Model

Classical psychoanalysis was fundamentally a drive-defense model, the focus of which was upon conflict between anxiety-provoking drives and anxiety-assuaging defenses – these latter mobilized by an ego made anxious at the prospect of threatened breakthrough of the id drives and their associated (id-derived) affects.

Freud conceives of the therapeutic process as involving ongoing, gradual taming of the id and ongoing, gradual strengthening of the ego by way of working through the patient's resistance both to input from the id and input from the therapist, that is, resistance both to pressure from within (the inside) and pressure from without (the outside).

In an effort to render the patient's unconscious conscious, the classical therapist offers *experience-distant interpretations* specifically designed to tap into the patient's dynamic unconscious by penetrating the ego's resistance to awareness of its internal dynamics. The patient is thought to resist the therapist's interpretive efforts in much the same way that she resists knowing the contents of her anxiety-provoking unconscious.

Once exposed to the light of day by the therapist's interpretations, however, the therapeutic process is thought to involve the ongoing processing and integrating (that is, taming, modifying, and integrating) of not only the id contents, accessed by way of the therapist's interpretations, but also the interpretations themselves, resulting ultimately in both a taming of the id and a strengthening of the ego.

Resolution of Structural Conflict

The net result will be resolution of structural conflict by virtue of both a tamer (less threatening) id and a stronger (less threatened and therefore less vulnerable) ego, now better able to mediate between the pressures of the internal world and the demands of external reality.

In other words, as a result of working through the anxiety-provoking contents of the id, the ego will no longer have the same need to resist the id (or external reality) by mobilizing its anxiety-assuaging defenses; so, too, as a result of

being reinforced by the insight it has acquired into its inner workings, the ego will no longer have the same need to become defensive when challenged from inside by the id and the superego or from outside by reality and the therapist. After all, a tamer id means that there will be less to defend against, and a stronger ego means that there will be less need to defend.

Again, the net result will be resolution of structural conflict, harnessing of id energies for more constructive pursuits, and an ego better equipped to adapt to internal and external realities.

With ever-increasing awareness, the now-stronger ego will be ever-less anxious, ever-less in need of mobilizing its defenses, ever-less conflicted, ever-better-able to direct the now-more-modulated id energies toward more constructive pursuits, and ever-better-able to manage the demands of reality. In other words, where once the ego would have felt the need to mobilize defense, it now has the capacity to adapt.

In sum: Where id was, there shall ego be. Where unconscious was, there shall consciousness be. Where pre-reflective was, there shall reflective be. Where defense was, there shall adaptation be. Where reluctance to know thyself was, there shall knowledge of thyself (or insight) be. Where resistance was, there shall awareness be.

Threats From the Inside and Threats From the Outside

Importantly, the patient's (the ego's) resistance is to perturbation, challenge, or impingement by both threatened breakthrough of anxiety-provoking id impulses (and guilt-provoking superego dictates) and threatened intrusion by anxiety-provoking therapeutic interpretations (and the demands of external reality). In other words, the ego will feel threatened by challenges both from within (the id and the superego) and from without (the therapist and the real world).

Broadening the Focus of Intrapsychic Conflict

To summarize: Freud's classical model involves the concept of intrapsychic (structural/neurotic) conflict as a story about conflict between anxiety-provoking id drive and anxiety-assuaging ego defense mobilized in an effort to ease that anxiety, that is, conflict between untamed id and weak ego. In its barest bones, the classical psychoanalytic perspective focuses upon illuminating the patient's so-called structural conflict, that is, conflict between anxiety-provoking id forces and anxiety-assuaging ego counterforces; this structural conflict is between id drive and ego defense, that is, between id and ego.

I have found it clinically useful, however, to broaden the focus of the therapeutic endeavor in Model 1 to include, more generally, the illumination of conflict within the patient between any number of anxiety-provoking *sobering realities* (or *stressful challenges*) and anxiety-assuaging *defenses*, that is, conflict

between *reality* (or *stressor*) and *defense*.

In other words, I have widened the scope of Model 1 to include exposing to the light of day any underlying conflict between one force that is anxiety provoking and another one (a counterforce) that is anxiety assuaging.

All kinds of situations can make the patient anxious (whether, to name a few, dealing with untamed drives and their associated affects, being held accountable for dysfunctional lifestyle choices, or being reminded of the work to be done in order to get better). What all such *stressors* have in common, however, is that if their impact is too much to be managed, they will be not be processed, integrated, and adapted to and will instead be defended against.

Whereas adaptations are more flexible, more reality based, and more evolved, defenses are more rigid, less reality based, and less complex; and whereas adaptations enable the patient to take in her stride the impact of stressful realities as she journeys through her life, defenses speak to her inability to manage the impact of those stressors and they will divert her progression through life.

The Capacity to Cope with the Stress of Life

Everyone is being continuously bombarded by all manner of environmental stressors – psychological, physiological, and energetic – in the form of both

presence of bad (toxicities) and absence of good (deficiencies). It is therefore critically important that we be able effectively to manage the impact of these stressful environmental challenges. In other words, we must be able to cope with the *stress of life* (Selye 1978).

If we are able to process, integrate, and adapt to these stressors, then it will be growth promoting. But if, for whatever complex mix of reasons, we are not able to process, integrate, and adapt to these stressors and find ourselves, instead, needing to mobilize defenses to protect ourselves against the impact of the stress, then it will be growth disrupting. There is no need for defense when we are able to adapt; by the same token, we must resort to defending when we are unable to adapt.

It could also be said that we *defend against* stressors but *adapt to* them; we defend against reality but adapt to it. It is a variation on the theme of “If you can’t beat ‘em, join ‘em.” If you can’t defeat a formidable force, then strategically harness its energies to empower you.

Our defensive reactions will crystalize out, over time, as our modus operandi – a dysfunctional one, to be sure, but nonetheless our mode of operating. And the defenses that we find ourselves mobilizing when stressed will come to define us; they will become our signature.

Defenses Define One’s Stance in the World

What then is the relationship between the patient's dysfunctional defenses and her characteristic stance in the world? If a patient, when angered, defends by retreating because she cannot process and integrate her anger, her characteristic stance is said to be one of avoidance. If a patient, when upset, defends by somatizing because she cannot digest and assimilate her upset, her defensive stance is described as one of somatizing. If a patient, when confronted with the reality that the object of her desire does not love her, defends by redoubling her efforts to win him over even so because she cannot process and integrate the pain of her disappointment, her defensive stance is said to be one of relentless self-sabotage. If a patient, when feeling unloved, defends against the pain of her heartbreak by compulsive binge eating because she literally and figuratively cannot digest and assimilate her feeling of being unloved, she is described as having an eating disorder. Finally, if a patient, when actually disappointed and sad, defends against her awareness of those feelings by becoming angry, her self-protective stance in the world may well become one characterized by reaction formation.

In other words, when something (be it an environmental stressor, a sobering challenge, a painful disappointment, a heartbreaking loss, an upsetting reality, an uncomfortable feeling state, an impingement, a perturbation, or a disruption) cannot ultimately be processed, integrated, and adapted to, the patient may well become entrenched in a particular defensive posture that will then come to define her characteristic stance in the world. This defensive armor will come to define

her; it will crystalize out over time as her characterological armor.

In essence, the fact that a patient has become reclusive or tends to somatize or is ever in pursuit of the unattainable or has become eating disordered or tends to use reaction formation speaks to the defensive armor she has developed in an effort to protect herself from having to feel the pain or discomfort of things that are simply too much to be processed, integrated, and adapted to. Instead of processing and integrating the impact of the environmental challenge, the patient will *find herself* resorting to her by-now customary dysfunctional ways of defending, and of being.

This is all by way of saying that a person's dysfunctional ways of being signify her need to defend because of an impaired capacity to adapt.

Parenthetically, when either patient or therapist *finds herself* thinking, feeling, or acting in a certain way, it usually suggests *defensive* and *reactive*, that is, something over which she does not have complete control.

More generally, certain people will find themselves (1) withdrawing when insecure, (2) holding back for fear of being hurt or disappointed, (3) suspecting the worst when confronted with uncertainty, (4) sleeping to excess when overwhelmed, (5) eating and drinking compulsively when feeling deprived, (6) getting sick when too much is on their plate, (7) becoming relentless in their pursuit of the unattainable when challenged with a no, (8) becoming addicted to

television and living vicariously when lonely, (9) acting out when stirred up inside, (10) having temper tantrums when unable to get their way, or (11) dissociating when in too much pain – all of which speak to the inability of these people to *deal* and represent knee-jerk *reactions* to anxiety-provoking situations that are simply too much for them to handle.

In essence, the unhealthy patterns of behavior that develop are a story about the patient's defensive need to protect herself against having to deal with sobering realities, stressful challenges, disillusioning truths, and distressing affects that are simply too much to be processed and integrated, too much to be mastered. The unhealthy patterns of behavior to which patients resort when confronted with stressful challenges in their lives and which, over time, come to define their characteristic (dysfunctional) stance in the world speak to the unfortunate triumph of *defensive need* over *adaptive capacity*, and of id over ego.

In other words, the patient's dysfunctional behaviors speak to her defensive need to protect herself against the myriad environmental stressors to which she is being continuously exposed; the patient's dysfunctional behaviors speak to the failure of her adaptive capacity to master these stressors – capacity that would enable her to evolve to a higher level of functionality were she able to mobilize it. In the place of adaptive coping strategies that are flexible and appropriate for the occasion, there will be rigid and stereotypic defensive patterns of behavior that become the patient's dysfunctional signature.

To repeat: The various defenses unwittingly employed by the patient in an effort to handle sobering realities and stressful challenges that are simply too much for her to manage will come to define how the patient lives. In essence, how she *chooses* to live her life will ultimately be a story about the defenses she mobilizes (and to which she then clings) in order to avoid confronting anxiety-provoking stressors that are simply too much for her to process, integrate, and adapt to.

The patient's dysfunctional defenses mobilized in the face of unmastered experience will, of necessity, become the filters through which she then experiences both her internal world and external reality.

Investment in Dysfunctional Defenses

What I am here suggesting is at once both totally obvious and profoundly true, namely, that the patient's dysfunction is there for a reason. The dysfunction is there because the patient was exposed to experience early on that she was unable to process and integrate. Had the patient had adequate support at the time, she would not now need to protect herself in the dysfunctional ways that she does. Nor would she be making the dysfunctional choices that she is in an effort, albeit misguided, to manage the overwhelming impact of the stressors to which she is being continuously exposed. Even as the therapist is recognizing the patient's need to be challenged so that her inertia can be overcome, the therapist must

never lose sight of the patient's need for support.

Sobering Realities and Stressful Challenges

Clinically relevant sobering realities and stressful challenges include (1) anxiety-provoking, uncomfortable, painful, or distressing affects, (2) disillusioning truths about the object, (3) accountability for the dysfunctional choices the patient makes to protect herself, (4) the price paid for holding on to those dysfunctional defenses, and (5) the work to be done in order to let go of those dysfunctional defenses. These realities and challenges, if too much to be processed, integrated, and adapted to, will prompt the mobilization of dysfunctional defenses.

As an example of an uncomfortable or painful affect: Consider the patient who is made anxious when confronted with the reality that she is very angry at her husband. Let us imagine that she defends against the acknowledgment of just how angry she is by telling herself that she is not so much angry as disappointed.

As an example of a disillusioning truth about the object: Consider the patient who is made anxious when confronted with the reality that her husband, the object of her relentless desire, is never going to love her in the ways that she would have wanted him to. Let us imagine that the patient defends against the acknowledgment of her husband's emotional inaccessibility by redoubling her efforts to get him to be more tender and loving.

As an example of accountability for a dysfunctional choice the patient makes to protect herself: Consider the patient who is made anxious when confronted with the reality that she is responsible for choosing to stay married, year after year, to a man who is emotionally distant. Let us imagine that the patient defends against the acknowledgment of the part she is playing in the unfolding of her life's drama by telling herself that she has no choice but to stay married.

As an example of the price paid for holding on to a dysfunctional defense: Consider the patient who is made anxious when confronted with the reality that she will be consigning herself to a lifetime of chronic frustration and disappointment if she keeps hoping that maybe someday, somehow, some way, she will be able to persuade her husband to change. Let us imagine that the patient defends against the acknowledgment of just how empty her marriage is and just how unhappy she is by eating and drinking to excess.

As an example of the work to be done in order to let go of a dysfunctional defense: Consider a patient who is made anxious when confronted with the reality that before she can make a responsible decision about whether to stay married, she will need to experience, to the very depths of her soul, the pain of her grief about the emotionally limited man she had chosen to marry years earlier – and come to terms with that sobering reality. Let us imagine that the patient defends against the acknowledgment of her grief by settling into an immobilizing depression that leaves her feeling powerless, helpless, and hopeless – and for

which she takes antidepressant medication.

Price Paid for Dysfunctional Defenses

Again, although the patient's defensive measures serve her by easing her anxiety, they also limit her by making it more difficult for her to harness her energy so that she can direct it toward the pursuit of her dreams. First, the defenses, by virtue of the fact that they block the unobstructed flow of her energy, interfere with the taming, modifying, and harnessing of the vital energies needed to fuel her pursuit of her goals and aspirations. Second, the defenses themselves, by virtue of the fact that they require the expenditure of energy to be operational, reduce the amount of energy available for more constructive (that is, less defensive and more adaptive) pursuits.

“May the Force Be With You!”

Working through the patient's defenses – working through her resistance – will therefore allow for the freer flow of energy and its channeling into more life-affirming endeavors. Apt here are the words of Obi-Wan Kenobi to Luke Skywalker in the Star Wars movie – “May the Force be with you!” – which captures exquisitely the importance of freeing up energy to provide the propulsive fuel for the patient's movement forward in life.

Ferretting Out Underlying Forces and Counterforces

And so it is that the focus of the therapeutic endeavor in Model 1 must be to ferret out, on the one hand, the forces within the patient that are making her anxious (many of which, if properly tamed, modified, and integrated, would fuel her forward movement) and, on the other hand, the defensive counterforces she mobilizes in an effort to control the anxiety. Again, these defensive counterforces are interfering with the patient's advancement because they are obstructing the free flow of the energy needed to empower her as she moves forward.

Libidinal and Aggressive Cathexis

In essence, the patient's defenses both serve her (by making her anxiety more manageable) and cost her (by jamming her up). To the extent that the patient's defenses serve her, there will be gain; but to the extent that they defeat her, there will be pain. To the extent that there is gain, the defenses will become libidinally (positively) cathected and be considered ego-syntonic; to the extent that there is pain, the defenses will become aggressively (negatively) cathected and be considered ego-dystonic.

In other words, the patient is ambivalently attached to her dysfunctional defenses, and it is the ambivalence of this attachment to her defenses that makes it so difficult for her to relinquish them.

Neurotic Conflict vs. Conflicted Attachment

As noted earlier, my Model 1 approach is a derivative of Freud's more classical approach. In both approaches, internal conflict comes to the fore, that is, conflict between a force that provokes anxiety and a defensive counterforce that eases anxiety. But whereas Freud's classical approach emphasizes structural conflict between id impulse and ego defense (conflict that makes the patient neurotically conflicted and therefore jammed up), my Model 1 approach emphasizes the patient's conflicted attachment to the defense itself (conflict that makes the patient reluctant to relinquish the defense and therefore jammed up).

More specifically, on the one hand, I will be speaking to the conflict that exists within the patient between id energy and ego defense, that is, tension between a force that increases anxiety and a protective counterforce that decreases that anxiety. As defense is transformed into adaptation, this conflict between id and ego will be gradually replaced by collaboration between id and ego. As noted earlier, it will be as if the ego, over time, decides "If you can't beat 'em, join 'em," a shift that speaks to the ego's evolving capacity and marks the transitioning of the ego from the *defensive need to fight the id* to the *adaptive capacity to harness the id energies* to the mutual advantage (and relief) of both!

On the other hand, I will be speaking to the patient's conflicted attachment to her dysfunctional defenses. As we have been saying all along, the patient has a conflicted (or ambivalent) attachment to her dysfunction because it both serves

her (that is, provides gain) and costs her (that is, causes pain). In other words, there will be conflict within the patient between the satisfaction that she derives from maintaining the dysfunction (which fuels her positive cathexis of it) and the discomfort that she experiences as a result of refusing to relinquish that dysfunction (which fuels her negative cathexis of it).

As I shall later develop in greater detail, it will be the tension created within the patient between her awareness of the pain and her awareness of the gain (with the pain, over time, outweighing the gain) that will provide the impetus needed for the patient ultimately to relinquish her attachment to the defense.

Admittedly, the way in which conflict is conceptualized in the two approaches is a bit different, but the net result of being conflicted is the same, namely, an impaired capacity to direct one's energies toward the fulfillment of one's potential.

Rendering Conscious the Unconscious

Whereas Freud's classical approach emphasizes the rendering conscious of neurotic conflict between id impulse and ego defense and my Model 1 approach emphasizes the rendering conscious of the patient's ambivalent attachment to the defense itself, the therapeutic action in both instances is the same, namely, exposing underlying conflict to the light of day so that the forces and counterforces that give rise to that conflict can be tamed, modified, and integrated

– and defense can be gradually transformed into adaptation.

Dawning Awareness of Inner Workings

In Model 1, it is therefore illuminating the patient's ambivalent attachment to dysfunctional defenses that assumes center stage. We are here speaking, of course, to the critically important role of defense analysis and suggesting, more specifically, that before a defense can be tamed, modified, and integrated into an adaptation, both its libidinal and its aggressive components must be illuminated and analyzed.

One of the most clinically relevant conflicts for the patient will be the internal tension created over time between, on the one hand, her awareness of the price she pays for the dysfunctional defenses to which she clings and, on the other hand, her awareness of her investment, fueled by her repetition compulsion, in those defenses even so. The dysfunctional status quo to which the patient clings for dear life is, on some level, a story about lifestyle choices she has made, motivated by her unconscious need to avoid confronting the various sobering realities, stressful challenges, disillusioning truths, and distressing affects that she encounters in her everyday life. It is for the patient to recognize that these choices, although they had once served her, have long since outlived their usefulness.

If the patient's defenses (once necessary for her survival but now an impediment to her ability to thrive) are ever to be surrendered and her energies

thereby freed up, it will be critically important that she become aware of the price she pays for having those defenses, even as she is also coming to appreciate just how invested she is in maintaining them. It is the patient's dawning recognition of just how costly her defenses are that will ultimately provide the therapeutic leverage for her to relinquish them, in the process transforming them into adaptations. In essence, she will be transforming her need to defend against sobering realities into the capacity to adapt to those stressful challenges.

Illumination and Analysis of Conflicted Attachment to Dysfunction

In sum, the therapeutic action in Model 1 can be conceptualized as involving illumination and analysis of the intensely conflicted attachment that the patient has to her dysfunction (an attachment that, fueled as it is by both positive and negative energy, makes the defense both ego-syntonic and ego-dystonic). In other words, the therapeutic action involves working through the patient's intense attachment to her dysfunctional defenses. The patient will be able to move forward once she lets go of her dysfunction and is able to embrace less familiar but healthier coping strategies.

Refusal to Let Go

What fuels the patient's resistance to letting go of her dysfunction?

Freud offers us an answer. As noted earlier, Freud's proposal is that it is the

adhesiveness of the id that fuels the patient's resistance. More specifically, it is the adhesiveness of the id that fuels the patient's investment in holding on to the status quo – no matter how dysfunctional – of her defenses.

Let us now take a page from Fairbairn to flesh out our understanding of the patient's intense attachment to her defenses.

Ambivalent Attachment to Internal Bad Objects

Fairbairn (1954) speaks directly to the patient's intense attachment to her internal bad objects. He postulates that the patient's attachment to her internal bad objects is intensely ambivalent. The bad object is both longed for (and therefore libidinally cathected) because it excites and hated (and therefore aggressively cathected) because it rejects.

So it is to Fairbairn that we 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 both to separate from the infantile object and to extricate herself from the compulsive repetitions that impel her again and again to re-create the early-on traumatic failure situation in the hope that perhaps this time it will be different, this time the resolution will be better.

Ambivalent Attachment to Dysfunctional Defenses

Returning now to a consideration of the patient's intense attachment not just to the bad object but also, more generally, to her defenses, how might we understand what underlies her attachment to her defenses?

I will be suggesting that here, too, the intensity of the patient's attachment to her defenses is fueled by her ambivalence and speaks, in essence, to what Freud referred to as the adhesiveness of the id. After all, the id has both libidinal and aggressive energy, so any time the id grabs hold of something, that attachment – fueled as it will be by both libido and aggression – will, of necessity, be an ambivalent one.

More specifically, on the one hand, the patient's dysfunctional defenses benefit her because they protect her, thereby enabling her to survive; on the other hand, they cost her because they limit her, thereby interfering with her ability to thrive.

To the extent that the patient's defenses benefit her (and are therefore ego-syntonic), she will have a libidinal, or positive, attachment to them; to the extent that the patient's defenses cost her (and are therefore ego-dystonic), she will have an aggressive, or negative, attachment to them.

In other words, the tenacity with which the patient clings to her defenses will be a story about the adhesiveness of her id and will involve both libido and aggression. Whether described as defenses, dysfunctional defenses, dysfunctional

internal dynamics, dysfunctional patterns of behavior, dysfunctional stance in life, characteristic stance in the world, modus operandi, or dysfunctional status quo, the therapist must never lose sight of the fact that the patient will have an intensely conflicted attachment to the dysfunction – an ambivalence that must be deeply understood and appreciated if the patient is ever to be helped to tame and modify the adhesiveness of her attachment to her defenses.

The patient will be able to relinquish her unhealthy defenses in favor of healthier adaptations only once she understands that her defenses both serve her and cost her.

Inertia and Resistance to Change

All this is by way of saying that the adhesiveness of the id speaks to the patient's investment (an ambivalent one to be sure) in maintaining the status quo of her underlying dysfunction and that it is this ambivalent attachment to the dysfunction that will constitute her inertia and resistance to change.

As we all know, a patient does not simply let go of dysfunctional thoughts, feelings, and behaviors because those reactions are creating problems for her in her life. Rather, a patient will cling to her dysfunction because, at least on some level, thinking, feeling, and behaving as she does, no matter how costly, is also serving her.

Unwitting Re-enactments

By way of example: It is not merely happenstance that a patient who had an emotionally abusive parent will find herself choosing partners who are emotionally abusive. Clearly, something is being played out by way of this compulsive and unwitting re-enactment on the patient's part – something that is not only painful but also pleasurable, not only frustrating but also satisfying, not only costly but also beneficial. If the patient is ever to relinquish her dysfunction, both the price she pays for having the dysfunction and the investment she has in holding on to it must be recognized and worked through.

As further examples: A patient may compulsively overindulge in alcohol and drugs in a desperate attempt to deal with her emptiness and to overcome her longstanding feelings of deprivation and neglect. Her abuse of alcohol and drugs may temporarily satisfy by offering the promise of filling up the void inside, but her reckless overindulgence will also defeat her because it will make it hard for her to live a productive and fulfilling life. Her pattern of addiction and abstinence will continue until she is able to work through the libidinal and aggressive adhesiveness of her id to the dysfunctional, self-sabotaging behavior.

Or a patient may be relentless in her pursuit of an unattainable love object because she has never resolved the conflicted feelings she has about her first partner, namely, her parent. The patient's relentless pursuit of the perfect parent (be it in relation to either the actual parent or a parent substitute) serves her

because it enables her not to have to confront – and grieve – the reality that the actual parent was far from perfect; but the patient’s relentless pursuit also costs her because her heart is being constantly broken as a result of the dysfunctional object choices that she finds herself making again and again. The patient will continue to experience heartbreak until she begins to face the reality that the suffering she is causing herself (by choosing inappropriate love objects) far outweighs the protection she has secured for herself by not dealing with the early-on parental failure of her. Only once the pain of her heartbreak becomes greater than the gain of her self-protective refusal to grieve will the patient be able to overcome the adhesiveness of the id and relinquish her attachment to her relentless pursuit.

Or a patient may be drawn to partners who are critical and controlling because she has not yet worked through the complex mix of feelings she has about a critical and controlling parent; it is this that is most familiar to her and with which she is therefore, on some level, most comfortable – in essence, the lure of the familial and therefore familiar (Mitchell 1988). Her choice of critical and controlling partners serves her by fueling her hope that perhaps someday, somehow, some way, were she but to try hard enough, she might yet be able to find a critical and controlling partner whom she could force to be kind, gentle, and accepting of her, but her dysfunctional object choices also defeat her because they consign her to a lifetime of chronic frustration and feelings of defeat. The patient will continue to choose inappropriate and, sadly, all-too-familiar bad objects until

she has come to appreciate, deeply, both the lure of the familiar and the price she pays for refusing to let go of her compulsive and unwitting re-enactments.

In other words, it must never be forgotten that the patient's attachment to her dysfunction (be it in the form of her dysfunctional relationships or, more generally, her dysfunctional defenses) is ambivalent – costly even as she is invested in it. Until that ambivalence is deeply understood and worked through by highlighting both the pain and the gain, the patient will cling to her dysfunction and refuse to let it go.

Importance of Recognizing Both Cost and Benefit

In some instances, the patient will be more aware of the benefit than of the cost (as can happen, for example, when the patient, in denial about the reality of just how lonely she actually is, keeps hoping that her husband will change). Usually, however, the patient will be more aware of the cost than of the benefit (as can happen, for example, when, overwhelmed by all her responsibilities at work, she constantly gets migraines that force her to keep taking time off from her job). In the first instance, the patient is more aware of how hopeful she is that ultimately she will be able to get her husband to change than she is of the loneliness she experiences as a result of her dysfunctional object choice; in the second instance, the patient is more aware of how painful her constant migraines are than of how they enable her to avoid having to get serious about completing

her projects at work.

By the same token, sometimes the patient will be more in touch with the love she experiences in relation to a bad object than with the hatred that is also there; at other times, however, she will be more in touch with the hatred she experiences in relation to the bad object than with the love that is also there. Ultimately, the patient must be able to recognize both the love and the hatred, both the longing and the aversion if she is ever to be able to separate from the bad object and move on to a more appropriate object choice.

Relinquishment of the Defense

In sum: Working through the patient's resistance, therefore, requires a working through of her conflicted attachment to the resistance. It requires working through the adhesiveness of the id – working through both the libidinal component of that attachment (fueled by the patient's *investment in* having the defense) and the aggressive component of that attachment (fueled by the *price* the patient *pays* for clinging to the defense).

It is therefore the adhesiveness of the id to the defense that makes relinquishment of the defense so difficult; and, by the same token, the fact that the defense is so invested with both libido (because the defense benefits the patient) and aggression (because the defense costs the patient) that makes the transformation of defense into adaptation so challenging.

PART TWO – Convergent Conflict

Freud's interest, of course, is in the tension that exists between id and ego, id drive and ego defense, drive and defense – intrapsychic conflict to which he refers as neurotic, or structural, conflict. His, as we know, is a drive-defense model.

I would like now, however, to call upon a critically important distinction that Kris (1985) makes between *convergent conflict* (akin to Freud's structural conflict) and *divergent conflict* – a distinction that I believe is a clinically significant one because it offers a further level of refinement to our understanding of what exactly it is that needs to be worked through and resolved.

Conflict Between Anxiety-Provoking Stressor and Anxiety-Assuaging Defense

Convergent conflict speaks to conflict between a force that makes us anxious and the counterforce we defensively mobilize in an effort to *counter* that anxiety. Convergent conflict is therefore a story about conflict between an anxiety-provoking stressor (for example, having to confront the reality that the object of one's desire is not available) and an anxiety-assuaging defense (for example, redoubling one's efforts to win him over even so). There would be no need for the defense but for the fact of the stressor. In fact, the very existence of the defense depends upon the presence of the stressor.

Conflict within the patient between force and counterforce will, of necessity, impede the patient's forward movement in her life and will ultimately need to be resolved if the patient is ever to become her most authentic, actualized self. Convergent conflict ties up both the energy used to fuel the force and the energy used to fuel the counterforce – energies that could be put to much better use were a tamer id to be harnessed by a more mature ego able to direct the id's energy toward optimization of the ego's potential and realization of its dreams.

An example of convergent conflict is the conflict that exists within a patient between, on the one hand, her desire, albeit a conflictual one, to advance herself in her career (this desire an anxiety-provoking stressor) and, on the other hand, her holding back for fear of being judged and found inadequate (this holding back a defensive reaction to anxiety generated by her conflictual ambition to advance herself professionally). We are speaking here to conflict between *healthy desire* and its *neurotic inhibition*.

Or consider the convergent conflict that exists within a patient between, on the one hand, her begrudging recognition of the fact that, on some level, she is angry (this anger an anxiety-provoking stressor) and, on the other hand, her defensive need to deny such anger and to insist that she is, instead, simply disappointed (this disappointment a defensive reaction to anxiety generated by the presence of her anger). We are speaking here to conflict between *healthy affect* and its *neurotic denial*.

Conflict Between Empowering Forces and Obstructive Counterforces

Expressed in somewhat different terms, what convergent conflict often entails is progress-impeding tension between a healthy, empowering force that ultimately, were it to be tamed, modified, and integrated, would provide the impetus for the patient's movement forward in life, and a less healthy, defensive counterforce that the patient has reflexively mobilized to quell the anxiety generated by the presence of the conflictual healthy force. In essence, convergent conflict is between healthy but anxiety-provoking *yes* energies and less healthy but anxiety-assuaging *no* energies.

Feelings of Helplessness, Paralysis, and Victimization

Although a patient may be unable to identify the exact nature of the conflictual forces and counterforces at war within, she will probably be aware of the fact that she is in conflict and suffering; her experience will be that she feels stuck in her life and her relationships.

By their very nature, convergent conflicts make us feel helpless, powerless, and victimized. They make us feel that we have no control over not only what happens to us but also what we ourselves do. They paralyze us and make us unable to do that which we would rather and unable to stop doing that which we would rather not. Convergent (neurotic) conflicts interfere with our ability to harness our energies to power our pursuit of realistic and fulfilling goals.

In essence, unmastered convergent conflicts create dysfunction in our lives in the form of unhealthy thoughts, affects, and behaviors; they tie up our energies; and they interfere with the actualization of our most authentic selves and our fullest potential.

Privation, Deprivation, and Insult

Being neurotic means being jammed up because of unresolved experiences from one's childhood. Unmastered *privations* (absence of good), *insults* (presence of bad), and *deprivations* (had it, then lost it) suffered early on will give rise later in life to *illusions* (positive misperceptions of reality), *distortions* (negative misperceptions of reality), and *entitlement* (demanding insistence that something is one's due, despite evidence to the contrary) – illusions, distortions, and entitlement that will interfere, over time, with one's ability to experience reality as it is.

As an example, a child whose parent was rarely loving or accepting may well find herself playing out, in subsequent relationships, her infantile yearning to be loved in the way that only a perfect parent would love her child; these compulsive and unwitting re-enactments, deriving from an ambivalent attachment to the parent, will almost inevitably give rise to problematic love relationships for the patient later on in life. Never having confronted – and grieved – the reality of the parent's deficiencies, the patient will find herself making object choices that are

neurotic, inasmuch as those choices will be complicated by positive misperception or illusion, namely, the illusory hope that subsequent partners will be the good parent the patient never had consistently and reliably as a child and will therefore be able to make up the difference to her for the parental deficiencies. In essence, because of privation (absence of good) in the early-on parent-child relationship, the patient will play out her neurotic conflictedness about finding a loving and accepting life partner in subsequent relationships.

As another example, a child whose parent was critical and punitive may well find herself holding back, in subsequent relationships, for fear of being judged, found lacking, and punished; these compulsive and unwitting re-enactments, deriving from an ambivalent attachment to the parent, will almost inevitably give rise to problematic love relationships for the patient later on in life. Never having confronted – and grieved – the reality of the parent’s toxicities, the patient will find herself making object choices that are neurotic, inasmuch as those choices will be complicated by negative misperception or distortion, namely, the distorted fear and expectation that subsequent partners will be the *bad parent* the patient had as a child and will therefore cause her the same heartbreak as the parent had caused her. In essence, because of insults (presence of bad) in the early-on parent-child relationship, the patient will play out her neurotic conflictedness about finding a noncritical and nonpunitive life partner in subsequent relationships.

As a further example, a child whose parent was alternately exciting and then

rejecting may well find herself drawn, in subsequent relationships, to seductive partners who, just like the parent, appear to offer the enticing promise of a certain kind of relatedness only later to devastate by reneging on that promise. These compulsive and unwitting re-enactments, deriving from an ambivalent attachment to the parent, will almost inevitably give rise to problematic love relationships for the patient later on in life. Never having confronted – and grieved – the reality of the parent’s seductiveness, the patient will find herself making object choices that are neurotic, inasmuch as those choices will be based upon relentless entitlement, namely, the patient’s entitled sense that something is her due, despite the fact that a panel of 10,000 objective judges would probably agree that what the patient is wanting will never actually be forthcoming, even if it had been seductively promised by the partner and, before that, by the parent. In essence, because of deprivations (paradise lost and never recovered) in the early-on parent-child relationship, the patient will play out her neurotic conflictedness about finding a consistently present and reliable life partner in subsequent relationships.

In all three instances (whether of unmastered early-on parental privation, insult, and/or deprivation), because of the unprocessed and unintegrated feelings the patient still harbors in relation to her parent and the parent’s limitations, the patient will have underlying anxiety about allowing herself to find a good, solid, reliable relationship with a lovingly accepting life partner because it will threaten her attachment to the infantile (parental) object.

Anxiety-Provoking Recognition That Things Could Have Been Different

Part of what fuels the intensity of the patient's attachment to the object, albeit an ambivalent one, is the following: Were the patient to allow herself to have something other than what her parent had offered, she would become incredibly anxious because having something different would highlight the fact that things could be, and could therefore have been, different. Again, I am speaking to the power of the lure of the familial and therefore familiar, no matter how dysfunctional, that underlies the illusions, distortions, and entitlement to which patients so desperately cling and that prove to be so powerfully motivating in love relationships.

Convergent Conflict vs. Divergent Conflict

What all convergent conflicts have in common is a force that provokes anxiety and a counterforce that is mobilized (by an undeveloped ego) in an effort to ease that anxiety. Convergent conflicts are the meat and potatoes of psychodynamic psychotherapy, especially Model 1 (the classical psychoanalytic perspective). Ultimately, as a result of working through the convergent conflict, its resolution can be achieved and horse and rider can ride off into the sunset if the anxiety-provoking forces that had been too much to process and integrate can, at last, be harnessed and redirected by an ever-evolving and ever-more-empowered ego.

There is, however, another kind of conflict in addition to convergent conflict, namely, divergent conflict. Divergent conflict speaks to conflict between two forces that are independent of each other, an example of which is the conflict that exists within a patient between her anger at her husband and her love for him (neither one of which is a defensive reaction to the other). Another example would be the conflict that exists within a patient between her investment in her family and her investment in her career.

In short, whereas convergent conflict is about conflict between a force and a counterforce mobilized as a defensive reaction to the initial force, divergent conflict is about conflict between two forces that have no particular relationship to each other (but for the fact that they reflect two alternatives, two options, or two courses of action). And whereas convergent conflict involves “a” (an anxiety-provoking force) *but* “b” (an anxiety-assuaging counterforce), divergent conflict involves “a” (a force) *or* “b” (an alternative force).

Conflict Between Health-Promoting Forces and Health-Disrupting Counterforces

As the ultimately health-promoting yes forces become better regulated over time and the defensive health-disrupting no counterforces become more adept at regulating, the forces and counterforces – in keeping with Freud’s metaphor of the horse and rider – will begin to work in concert to power constructive pursuits. Freud aptly described the transitioning from primitive to healthy as a story about

transforming primitive defense into *sublimation*; my choice is to describe that transitioning from primitive to healthy as a story about transforming defense into adaptation.

Defusing Energy and Enhancing Awareness

As I have been suggesting throughout this book, defense is transformed into adaptation as a result of both defusing the id energies (thereby taming the wildness of the id) and enhancing the ego's awareness of its internal dynamics (thereby strengthening the capacity of the ego). Taming the id and strengthening the ego will transform a difficult situation characterized by an immature ego made intolerably anxious by the threatened breakthrough of dysregulated id energies into a more tolerable situation characterized by a more developed ego better able to adapt by directing now-modified id energies into more constructive channels. Where once an unevolved ego (made anxious) had the defensive need to put a lid on the id, now a more evolved ego (better able to deal) has the adaptive capacity to harness the id energies to fuel healthy pursuits and realistic goals.

From Unevolved to More Evolved

By way of more specific examples: Where once an unevolved ego could not tolerate acknowledgment of its anger, now a more evolved ego is able to channel its aggression into healthy competition in sports. Where once an unevolved ego

demanded immediate gratification, now a more evolved ego can tolerate delay. Where once an unevolved ego was relentless in its pursuit of the unattainable, now a more evolved ego is more realistic in its acceptance of limits. Where once an unevolved ego would lash out in anger when thwarted, now a more evolved ego is better able to tolerate frustration. Where once an unevolved ego was prone to experience others as critical, now a more evolved ego is able to recognize when someone is being critical and when not. Where once an unevolved ego needed to be right, now a more evolved ego can tolerate being sometimes wrong. When once an unevolved ego was impulsive and reactive, now a more evolved ego can better regulate its actions, reactions, and interactions.

Once the ego's dysfunctional defenses have been worked through by being, first, illuminated and, then, analyzed (that is, analysis of defense) and, as part of that working-through process, once the dysregulated – libidinal and aggressive – energies being held in check by those primitive defenses have had an opportunity to be tamed, modified, and integrated, there will no longer be the same need for the ego to mobilize primitive defenses in order to protect itself from being overwhelmed, and the energies themselves will now be more modulated.

From Overwhelming to More Manageable

In essence, as a result of the working-through process, primitive defenses (once mobilized in order to put a lid on the id) will no longer be as necessary. Two

things will have accrued: First, the ego will now be more adept at managing the anxiety-provoking forces within, and, second, the forces within will now be more manageable.

From the Need to Defend to the Capacity to Adapt

In other words, the ego will now be better equipped to direct the now-tamer energies of the id toward actualization of the patient's potential and realization of her dreams. The ego will no longer *need to defend* by putting a lid on the id (thereby robbing the ego of its supply of energy). Rather, the ego will now be better *able to adapt* by harnessing the id energy and directing this energy into more constructive channels.

From Unhealthy Defense to Healthier Adaptation

In essence, as the conflict between id energy and ego defense gradually resolves, unhealthy defense becomes transformed into healthier adaptation.

Harnessing the Id and Refashioning the Ego

To review: Neurotic conflict (convergent conflict, structural conflict, intrapsychic conflict) is a story about tension between id drive and ego defense, that is, between dysregulated id drive and primitive ego defense. If properly worked through, there will be a harnessing of the dysregulated id energy and a

refashioning of the primitive ego defense into a healthier ego adaptation such that where before a threatened and overwhelmed ego had the need to put a rigid lid on the id in an effort to prevent a runaway situation, now a more mature and adaptable ego has the capacity to work with the id by harnessing its energy and redirecting that energy to power more constructive pursuits.

Horse and Rider in Sync

Returning to Freud's metaphor of the horse and rider: Where before a threatened and overwhelmed rider had the need to rein in her horse sharply in an effort to prevent a runaway situation, now a more mature and adaptable rider has the capacity to work with the horse by harnessing its energy and redirecting that energy to power the progression of them both forward.

Efforts to Ease Anxiety

Our interest throughout this book will be primarily in convergent conflicts (and not divergent conflicts), that is, the neurotic conflicts that exist within all of us between intolerably painful realities and the defenses we mobilize in an effort to ease the anxiety generated by those realities (or, perhaps more accurately, the defenses we mobilize in an effort to ease the anxiety generated by our awareness and/or acknowledgment of those realities). In other words, our focus will be on the tension that exists between anxiety-provoking realities (the acknowledgment

and processing of which will ultimately empower us and fuel our movement forward) and anxiety-assuaging defenses (the presence of which is disempowering and thwarts our advancement).

Depending upon the context, neurotic conflict can therefore be variously described as speaking to conflict between (1) anxiety-provoking forces and anxiety-assuaging (defensive) counterforces, (2) empowering forces and disempowering (defensive) counterforces, or (3) health-promoting forces and health-obstructing (defensive) counterforces.

Intrapsychic conflict results from the ego's impaired capacity to process, integrate, and adapt to the impact of stressful (anxiety-provoking but ultimately empowering and health-promoting) challenge necessitating mobilization of stress-reducing (anxiety-assuaging but ultimately disempowering and health-obstructing) defenses. Such a conflicted patient will then be characterized as neurotic, jammed up, resistant, entrenched, immobilized, paralyzed, stuck.

The anxiety-provoking but ultimately empowering and health-promoting forces include, but are not limited to, such impactful stressors as (1) distressing affects, (2) dysregulated energies, (3) disillusioning truths, (4) sobering realities, (5) stressful challenges, and (6) the various and sundry privations, deprivations, and insults sustained over the course of one's life. If these impactful stressors can be processed, integrated, and adapted to, then their energy can indeed be

harnessed by an ever-evolving ego to provide the propulsive fuel for one's movement forward in life.

The anxiety-assuaging but ultimately disempowering and health-disrupting counterforces include, but are not limited to, such defensive countermeasures as (1) the well-known classical defense mechanisms (for example, repression, suppression, denial, compartmentalization, reaction formation, intellectualization, displacement, and projection, to name a few); (2) resistance (the signature defense in Model 1), relentlessness/refusal to grieve (the signature defense in Model 2), and re-enactment (the signature defense in Model 3); and (3) illusions, distortions, and entitlement. If these defensive countermeasures (mobilized by an overwhelmed ego unable to process and integrate) can be refashioned into healthier adaptations, then the ever-evolving ego can harness the id energies to provide the propulsive fuel for its forward movement.

Again, it is the simultaneous taming of the id and strengthening of the ego that enable the achievement of maturity as defense is transformed into adaptation, that is, as resistance is worked through and transformed into awareness (Model 1), relentlessness transformed into acceptance (Model 2), and re-enactment transformed into accountability (Model 3). It is, after all, horse and rider working in sync that allows the forward movement to be accomplished with speed and grace.

Dysfunctional Defenses

When I refer to the patient's defenses, my intention is to include all the various dysfunctional thoughts, dysfunctional feelings, and dysfunctional actions/reactions/interactions to which the patient clings in order to avoid confronting the myriad anxiety-provoking realities to which she is being continuously exposed, be they from the outside or from the inside. But whether the dysfunctional defenses involve thoughts, feelings, and/or behaviors, all three modes of therapeutic action address this dysfunction – it is just that the different modes do so in different ways.

Cognitive, Affective, and Relational Approaches to Healing

More specifically, Model 1 is a more cognitive approach to transforming defense into adaptation. It involves neutrality, detachment, objectivity, and rationality, and it conceives of the therapeutic action as a story about working through the patient's resistance in order to illuminate, and make more manageable, the underlying forces and defensive counterforces at play within the patient.

As we shall see, among many other interventions, path-of-least-resistance statements, conflict statements, and inverted conflict statements are used by the Model 1 therapist to facilitate working through the patient's resistance – the net result of which will be transformation of resistance into awareness. From defense

to adaptation.

Model 2 is a more affective approach to transforming defense into adaptation. It involves empathic attunement to the patient's moment-by-moment experience (including, especially, her refusal to confront the reality of the object's limitations, separateness, and immutability), and it conceives of the therapeutic action as a story about working through the patient's relentlessness by creating a supportive space within which she can confront – and grieve – the pain of her disillusionment about the object.

As we shall see, among many other interventions, disillusionment statements are used by the Model 2 therapist to facilitate the patient's grieving of intolerably painful realities about the object – the net result of which will be transformation of relentlessness into acceptance. From defense to adaptation.

Model 3 is a more relational approach. It involves authentic engagement between patient and therapist (also described as shared mind and shared heart), and it conceives of the therapeutic action as a story about negotiating – and resolving (by way of creating a different outcome this time) – the re-enactments that will inevitably arise at the intimate edge of dysfunctional relatedness between patient and therapist.

As we shall see, instead of calling upon prototypical statements, the Model 3 therapist will facilitate negotiation at the intimate edge by bringing to bear her

own, more evolved capacity to process and integrate, on behalf of a patient who truly does not know how, toxic boluses of the patient's unmastered experience – the net result of which will be transformation of re-enactment into accountability. From defense to adaptation.

So all three modes of therapeutic action deal with the patient's dysfunctional defenses, but each one does it in a way that distinguishes it from the other two. In sum, Model 1 involves working through the patient's (defensive) resistance in order to help her develop more awareness of her internal conflicts – and it does this primarily by engaging the patient's head; Model 2 involves working through the patient's (defensive) refusal to grieve in order to help her develop more acceptance of the object's limitations – and it does this primarily by engaging the patient's heart; and Model 3 involves working through the patient's (defensive) re-enactments in order to help her develop more accountability for her actions, reactions, and interactions – and it does this primarily by engaging patient and therapist at their intimate edge.

Rendering the Defenses Less Adaptive, Less Necessary, and Less Toxic

By illuminating the price the patient pays for holding on to her dysfunction, the therapeutic action in Model 1 renders the defense less adaptive (because the patient is finally appreciating how maladaptive it is for her to be clinging still to her dysfunction). By creating a safe space into which the patient can deliver the

pain of her grief about the loss of something to which she had been intensely attached, the therapeutic action in Model 2 renders the defense less necessary (because the patient is finally dealing with the pain of her grief). And by allowing for a more successful resolution, this time, of the patient's compulsive and unwitting re-enactments, the therapeutic action in Model 3 renders the defense less toxic (because the pathogenicity of the patient's dysfunction will be detoxified by a therapist able to lend aspects of her own more evolved capacity to a processing and integrating of the patient's internal badness).

PART THREE – Optimally Stressful Psychotherapeutic Interventions

By employing any of the various interventions within her repertoire (presented below), the Model 1 therapist is attempting to expose to the light of day the convergent conflicts underlying the patient's dysfunction. The therapist does this by way of interventions that encourage the patient to step back from her experience so that she can bear witness to it – with compassion and without judgment.

Paradoxically, it is sometimes only by way of encouraging the patient simply to observe what is going on inside of her – again, with compassion and without judgment – that she will be able truly to experience it and take ownership of it. The patient is being encouraged to bear witness to her inner process.

Ultimately, of course, the therapeutic goal is to render conscious what had once been unconscious so that the patient can begin to understand both what is making her anxious and what she is doing in a misguided attempt to alleviate that anxiety.

Here Too, Here Now, Once Again

The therapist, by calling the patient's attention again and again to both the anxiety-provoking stressor and the anxiety-assuaging defense mobilized as a reaction to the stressor, is hoping to increase the patient's level of awareness about the neurotic conflicts that are jamming her up and impeding her forward movement.

Ever-Increasing Awareness

It will be the patient's ever-increasing awareness of her internal conflict between healthy yes forces and unhealthy no counterforces (the goal in Model 1) – and, most especially, between the price the patient is coming to understand she pays for clinging to her defenses and her ever-evolving awareness of just how invested she is in holding on to them even so – that will ultimately provide the therapeutic leverage needed for her to relinquish her attachment to the defensive no forces in favor of a more adaptive harnessing of the yes forces to supercharge the realization of more realistic pursuits and aspirations.

Anxiety-Provoking But Ultimately Health-Promoting Interventions

As has been discussed throughout this book, it is hoped that psychodynamic psychotherapy will offer the patient an opportunity to do now what she was not able to do earlier in her life, namely, to process, integrate, and adapt to the impact of the various environmental stressors to which she has been exposed over time

and against which she has had to defend herself by clinging to all manner of dysfunctional defenses that have come to define her stance in life. Psychodynamic psychotherapy offers the patient a chance to do now whatever she must in order ultimately both to tame, modify, and integrate her dysregulated energies and to refashion her primitive defenses into healthier adaptations – such that no longer needing to put a rigid lid on an untamed id, she will now have the adaptive capacity to channel those tamed energies into more constructive pursuits.

Objective Knowledge vs. Subjective Experience

Because of its cognitive focus, Model 1 lends itself remarkably well to the use of a variety of prototypical anxiety-provoking but ultimately insight- (and health-) promoting interventions designed to heighten the patient's awareness of her internal dynamics, her internal process, her internal conflicts. These interventions, which juxtapose the patient's *objective knowledge* of various sobering and anxiety-provoking realities with her *subjective experience* of them, are designed to encourage, or, where appropriate, force the patient to take note of the discrepancy between what she knows to be real (for example, that the object of her desire is never going to love her in the way that she would have wanted him to) and what she finds herself experiencing as real (for example, that if she tries really hard she might yet be able to make him love her in that way).

With respect to the patient's objective knowledge: What she knows to be

real is something that could easily enough be confirmed by a panel of 10,000 judges; it is objectively verifiable. What she knows is informed by here-and-now realities, albeit sobering ones. Being reminded of various self-evident sobering realities will admittedly make the patient anxious (and prompt her to mobilize anxiety-assuaging – and dysfunctional – defenses); at least on some level, however, she will have to grant that she does truly know that thus-and-such is true.

With respect to the patient's subjective experience: What she finds herself experiencing as real is more subjective; it is not objectively verifiable. What she finds herself experiencing is often informed by unresolved issues from her past, represents a knee-jerk reaction to stressors that were simply too much to be processed and integrated at the time, and is therefore defensive in nature.

I have intentionally chosen the words *finds herself experiencing* (instead of, simply, *experiences*) because I want to highlight the knee-jerk – and, as is true for most defenses, often unconscious – reactivity of the patient to something that is overwhelming. When a defense kicks in, it is usually involuntary and with no forethought; the patient will literally *find herself thinking, feeling, or doing something without reflecting upon it in advance*. Again, whereas adaptations emerge only over time and are the result of processing and integrating an environmental stressor, defenses tend to be activated almost instantaneously and require little effort.

10,000 Objective Judges vs. a Party of One

Throughout this book, I sometimes refer to objective reality as something that could be verified by a panel of 10,000 objective judges; by the same token, I sometimes refer to subjective reality as, simply, a party of one (in order to highlight the me, myself, and I aspect of the patient's experience and the lack of openness to input from others).

With Compassion and Without Judgment

Challenging the patient by reminding her of a sobering reality (that she must ultimately confront if she is ever to get better) may well temporarily destabilize her psychological equilibrium; but the patient must ultimately be able to take healthy ownership of this sobering reality, even when such acknowledgment makes her anxious, if she is ever to harness the energy surrounding her awareness of that reality and use it to power her forward movement.

Supporting the patient by resonating with what she finds herself feeling when confronted with a sobering reality will enable the patient to feel understood. Even when what she is feeling is a result of the operation of dysfunctional defenses that she has mobilized in order to avoid having to face certain stressful challenges, it is still critically important that she be able to know that her subjective experience of reality has been *recognized* by the therapist and honored with compassion and without judgment.

Observing Ego and Experiencing Ego

Because Model 1 is more cognitive than either Model 2 (which is more affective) or Model 3 (which is more relational), Model 1 lends itself very comfortably to the use of these interventions geared specifically toward encouraging the patient to step back from her moment-by-moment experience in order to bear witness to it and to make note of the discrepancy between what she in all honesty really does know and what she finds herself defensively thinking, feeling, and doing instead.

The Model 1 therapist wants the patient to become ever more aware of her internal dynamics. The therapist wants to engage both the patient's observing (or reflecting) ego and her experiencing ego.

Knowledge of Reality vs. Experience of Reality

By making use of the various anxiety-provoking but ultimately insight- (and health-) promoting interventions in the Model 1 therapist's repertoire, the therapist must work assiduously to illuminate the discrepancy between the patient's knowledge of reality (informed by her adaptive capacity to sit with the anxiety she experiences when reminded of what she really does know to be true) and her experience of reality (informed by her defensive need to protect herself against having to acknowledge those sobering realities). The therapist does this by going back and forth between challenging the patient (by reminding her of the

sobering realities that she really does know, even if she would rather not) and supporting her (by resonating empathically with her experience of reality) – all with an eye to creating tension within the patient between her *knowledge of reality* and her *experience of it*.

Juxtaposition of What's Known With What's Being Experienced

As the therapist repeatedly juxtaposes the patient's knowledge of reality with the patient's experience of reality, the patient will be forced to see ever more clearly, even if reluctantly, the discrepancy between the sobering reality with which she is being confronted and her defensive need to protect herself against having to acknowledge it.

The Creation of Cognitive Dissonance

This ever-increasing awareness of the discord between her knowledge and her experience will ultimately create cognitive dissonance – dissonance that will ultimately force the patient to relinquish her attachment to a defense that, although once ego-syntonic because it eased her anxiety, has now become increasingly ego-dystonic as the patient comes to recognize the price she is paying for holding on to it.

In essence, we are creating cognitive dissonance between an anxiety-provoking reality (or at least the patient's awareness of that sobering reality) and

an anxiety-assuaging defense (the patient's reflexive reaction to being confronted with that sobering reality). Again, it will ultimately be the stress and strain created by the cognitive dissonance between what the patient knows (knowledge that is objective and informed by reality) and what she finds herself reflexively thinking, feeling, and doing instead (experience that is subjective and informed by defense) that will prompt her to relinquish her attachment to that which is creating problems for her, namely, her dysfunctional defenses.

Stress and Strain

In the final analysis, it will be the stress and strain created by the cognitive dissonance between the patient's ever-increasing awareness of the price she pays for clinging to her dysfunctional defenses and, as a result, her increasingly ambivalent attachment to those defenses that will ultimately force her to let go of the dysfunction – as she becomes ever more aware of the fact that defenses which had once served her (and in which she was therefore invested) are actually costly and progress impeding.

Again, the therapist repeatedly challenges (in order to destabilize the dysfunctional system) and supports (in order to tap into the system's resilience and adaptive capacity) – all with an eye to restoring psychological balance at a higher, more-evolved level.

In essence, the cognitive dissonance created by the patient's ever-increasing

recognition of the discrepancy between her knowledge and her experience can only be resolved once the patient, with the ongoing support of her therapist, has let go of the dysfunction that had informed her experience, thereby enabling her to reconstitute at a higher level of functionality, integration, and balance.

Inborn Capacity to Self-Heal in the Face of Optimal Challenge

In sum, it is under the sway of the repetition compulsion that dysfunction continues to be unwittingly played out, but it is under the sway of the system's innate ability to repair itself in the face of optimal challenge that the system, with enough support from the outside, will be able adaptively to reconstitute at ever-higher levels. The system's intrinsic ability to self-heal is, of course, ultimately a story about the system's resilience and capacity to cope with stress – not by defending against it but by adapting to it.

In the face of just enough challenge (challenge that is neither too much nor too little) and with the benefit of ongoing support from the therapist, the system's inherent capacity to self-correct when confronted with an environmental stressor – be it from the outside (in the form of a challenging psychotherapeutic intervention) or from the inside (in the form of threatened breakthrough of anxiety-provoking forces) – will allow the system not only to recover its balance but *then some*.

After all, evolutionary processes (like the developmental process and the

therapeutic process) advance the system not only by restoring homeostatic equilibrium but also by taking the system to a higher, more- evolved level.

The anxiety-provoking but ultimately insight-promoting psychotherapeutic interventions that I have developed are specifically designed to throw off the balance of the system just enough that this challenge, coupled with ongoing support from the therapist, will tap into the system's inherent resilience and capacity to cope with optimal stress by triggering the system's innate capacity to self-repair when confronted with an environmental stressor.

Defensive Collapse vs. Adaptive Reconstitution

The critical issue will be the system's ability to process and integrate the impact of that stressor. If the intervention cannot be adequately processed and integrated, then it will contribute to a compromised system's further decline; but if the intervention can indeed be adequately processed and integrated, then it will contribute to a resilient system's further strengthening.

Challenge When Possible and Support When Necessary

The various interventions that I will be discussing are both anxiety provoking (inasmuch as they initially serve to destabilize the system, albeit a dysfunctional one) and health promoting (inasmuch as they ultimately serve to restabilize the system at a higher level of awareness, functionality, and adaptive

capacity). The intent of these interventions is to provide an optimal mix of challenge (when possible) and support (when necessary), so that the processing and integrating of previously unmastered (traumatizing) experience can be facilitated and defense can be transformed into awareness and ever-evolving functional capacity.

After all, the more effectively unmastered experience can be processed and integrated, the less will there be need for reflexive mobilization of dysfunctional defenses (by an overwhelmed ego) and the greater will there be capacity for the utilization of more functional adaptations (by an ever-evolving ego).

And Then Some

More generally, as discussed in an earlier section, self-organizing systems resist perturbation, which means that the homeostatic balance of such systems needs to be sufficiently disrupted that there will be opportunity for the system's self-healing mechanisms to kick in. Activation of the system's intrinsic striving toward health by way of optimal challenge will be such that balance can indeed be ultimately restored and, it is hoped, at a higher, more-evolved level of functionality. When not only balance is restored but also the system is prompted to evolve to a higher level, I refer to this adaptive reconstitution as *and then some* (Stark 2008, 2012, 2014).

Destabilization and Restabilization

The various anxiety-provoking but insight-promoting psychological interventions that are staples in the Model 1 therapist's armamentarium do just this. First, the intervention must be able to provoke enough anxiety that the system will become temporarily destabilized; but the intervention must also be able to provide enough support that this input, in conjunction with the underlying resilience of the system, will trigger self-correcting mechanisms that enable the system to restabilize at a higher, more-evolved level.

In other words, the Model 1 therapist's interventions must alternately challenge in order to destabilize the system and then support in order to allow for its restabilization at ever-higher levels of functionality, balance, and adaptive capacity.

In essence, the system's capacity to right itself when destabilized, coupled with ongoing input from the therapist (in the form of interventions that alternately challenge and support), will become the means by which dysfunctional systems are able adaptively to reconstitute at ever-higher levels of integration, balance, and functionality. The reconstituted system will then be not only good as new but oftentimes better than new; the system will have restabilized – and then some!

Psychodynamic Equivalent of Homeopathic Remedies

E. McGuire (personal communication, September 15, 2013) has suggested that the anxiety-provoking but insight-promoting interventions in the Model 1 therapist's armamentarium are the psychodynamic equivalent of homeopathic remedies, which promote healing by challenging the system with an attenuated version of the pathogenic incitant that had created the problem to begin with, thereby triggering the system's intrinsic ability to self-heal.

In conventional medicine (also known as traditional or Western medicine), allopathic remedies treat symptoms of illness with anti-symptom medications (such as antitussives for coughs, antiemetics for nausea and vomiting; antipyretics for fevers; antihypertensives for high blood pressure; and antidepressants for depression). In other words, they offer the patient a different (allo-) substance to combat the illness (-path). Homeopathic remedies, however, treat the patient's illness with a tiny dose of a similar (homeo-) remedy, designed to reproduce the symptoms so that the system's self-healing mechanisms will be triggered.

So, too, the anxiety-provoking but insight-promoting interventions that are the mainstay of Model 1 do just this. These homeopathic psychological interventions promote health by offering the dysfunctional and symptomatic system a small dose of anxiety-provoking reality, designed to throw the system enough off balance that its innate ability to repair itself will become activated. As long as the patient's system is not destabilized too much, then the patient's underlying psychological resilience, coupled with ongoing support from the

outside, will enable her adaptively to reconstitute at a higher level of functionality, integration, and capacity. The patient will be even stronger for having dared to confront what had seemed like impossibly difficult challenges – indeed, stronger at the broken places.

The challenge is in the form of a small dose of anxiety-provoking reality (to which the patient's attention, despite her reluctance, is repeatedly directed) and the support is in the form of empathic resonance with how the therapist senses the patient will defensively react to being challenged with a highlighting of what she really does know to be true. Depending upon a multitude of factors, including the strength of the patient's resistance and the robustness of her resilience, the dose of reality will be offered either gently or firmly – or somewhere in-between. The therapist will be ever-busy assessing the level of the patient's anxiety, her need for support, and her capacity to tolerate further challenge.

Triggering Self-Repair Mechanisms

Psychotherapeutic interventions that provide optimal challenge in combination with ongoing support will be offered again and again, the net result of which will be a triggering of the patient's self-repair mechanisms – just as homeopathic remedies (if optimally challenging) will tap into the patient's intrinsic striving toward health and trigger her innate capacity to heal herself.

The interventions in the armamentarium of the Model 1 therapist are indeed

specifically designed to tap into the patient's internal reserves so that she can evolve from dysfunctional defense to more functional adaptation – as the need to defend against anxiety-provoking realities by not dealing is transformed into the capacity to adapt to them by confronting them head-on and doing whatever processing and integrating needs to be done in order to work them through. Indeed, the therapeutic work involves transforming defense into adaptation – the ever-evolving psychodynamic process.

The “I Can’t, You Can, and You Should” Dynamic

Patients who are caught up in compulsive and unwitting re-enactments in their lives (and in the treatment) demonstrate something that I call the “I can’t, you can, and you should” syndrome. Such a dynamic is both self-indulgent (by virtue of the fact that it affords gratification of libido) and self-destructive (by virtue of the fact that it affords relief of aggression). I believe that this three-pronged dynamic is responsible for much of the stuckness and paralysis that characterize a patient's stance in life; furthermore, this self-defeating dynamic creates many of the seemingly intractable therapeutic impasses – Russell's *crunch* situations (2006) – that will inevitably arise over the course of such a patient's treatment.

Such patients often have an underlying conviction (1) that they are so damaged from way back that they truly cannot be held accountable now (the “I

can't" portion of the dynamic); (2) that they will only get better by way of some kind of input from the outside (the "you can" portion); and (3) that, bottom line, they are therefore entitled to such input (the "you should" portion). The patient will be able to get on with her life only once she has relinquished (1) her distorted sense of herself as unable ("I can't"); (2) her illusory sense of her objects as able ("you can"); and (3) her entitled sense that this is her due ("you should"). Distortion ("I can't"); illusion ("You can"); and entitlement ("You should").

Only once the patient's (1) distorted sense of herself as irreparably damaged from way back; (2) illusory sense of her objects as able to compensate her now for the damage she sustained early on; and (3) entitled sense that this is her due have been exposed to the light of day, worked through, and relinquished will she become less conflicted and able to move forward in her life.

Until the oftentimes unconscious operation of such a dynamic within the patient has been made explicit, she may well make little real progress. There may be some external compliance on her part, but she will only be going through the motions. It will only be *as if* she is getting better, because in truth, deep down, she will not yet have relinquished her investment in seeing herself as a victim, as not accountable, and as therefore entitled, still, to some kind of recompense.

I have developed three prototypical interventions – the damaged-for-life statement, the compensation statement, and the entitlement statement –

specifically designed to highlight the underlying distortions, illusions, and entitlement to which patients cling as unconscious justification for their refusal to take responsibility for their lives.

As long as the patient holds fast to her distorted sense of herself as *unable* (which the damaged-for-life statement speaks to), her illusory sense of her objects as *able* (which the compensation statement speaks to), and her entitled sense that she *should* be provided for by those who are able because this is her due (which the entitlement statement speaks to), she will remain entrenched in her self-defeating pattern of waiting-for-Godot, hoping against hope that her objects will ultimately relent and come through with provisions. In the meantime, she will remain passive, paralyzed, a victim of circumstances beyond her control – and terribly stuck.

Damaged-for-Life Statements

In a damaged-for-life-and-therefore-not-responsible-now statement, the therapist articulates what she perceives to be the patient's convictions about her own deficiencies and limitations, convictions that the patient, perhaps unconsciously, uses to justify her refusal to take responsibility for her life in the here-and-now. The therapist highlights the patient's distorted perception of herself as irreparably damaged as a result of early-on experiences and as therefore unable to do anything now to correct for her psychological disabilities.

Examples of damaged-for-life statements include the following:

“Deep down inside you feel so damaged, because of the abuse you sustained as a child, that you cannot imagine being able to do anything now to make your life any better.”

“Because you feel that you got a bum deal as a kid, you can’t imagine that you’ll ever be able to compensate now for the damage that was done to you then.”

“You are so angry about all the bad luck you’ve had along the way that you feel you have no choice but to give up.”

“Because you were treated so shabbily as a child, you feel handicapped now in terms of your ability to get on with your life in any kind of self-respecting fashion.”

“You feel so incapacitated, so impaired, so handicapped, that you have trouble imagining how things could ever be any different.”

A damaged-for-life statement, then, attempts to make explicit some of the underlying distortions to which the patient clings as unconscious justification for her unwillingness to take ownership of the choices she is continuously making in her life.

Compensation Statements

Furthermore, many patients feel, on some level, that they become full only by way of input from the outside. They feel that because of early-on deprivation and neglect, they are now limited in terms of their own resources. Because they feel that there is nothing they themselves can do to better their circumstances, their unconscious belief then becomes that they are forced to rely upon input from the outside in the here-and-now in order to compensate for what was missed early on.

In a compensation statement, the therapist calls attention to the patient's wish to be compensated now for damage sustained then, the patient's wish to have the difference made up to her.

Whereas a damaged-for-life statement highlights the fact of the patient's distortions (her negative misperceptions of herself as a helpless victim), a compensation statement underlines the patient's illusions (her positive misperceptions of her objects as potential providers of the magic, the answers, the love, the reassurance, the narcissistic supplies she will need in order to heal herself, complete herself, and rectify the damage sustained early on). Compensation statements contextualize these illusions as an understandable response to early-on deprivation.

Parenthetically, if the therapist is in collusion with the patient's illusion, that is, if the therapist shares the patient's illusory belief that the patient will get better

only by way of input from the outside (namely, from the therapist), then it will be much more difficult for the therapist to facilitate the patient's grieving when the patient is confronted with the inevitable disillusionment she will experience once she comes to recognize the reality of the object's (the therapist's) separateness and immutability.

Examples of compensation statements include the following:

"You are feeling that you have come to the end of what you can do on your own and, at this point, are desperately wishing that somebody else would be willing to step up to the plate in order to help you out."

"At times like this, when you are feeling completely defeated, despairing, and exhausted, you begin to feel that you'll never, ever get better unless someone is willing to help you out for a change."

"When you are feeling desperate, as you are now, you find yourself wishing that someone would understand and would do something to help you ease the pain."

Eventually the patient must come to understand that what she is holding on to is an illusion. By having her wish for sustenance from the outside highlighted, the patient must eventually confront – and grieve – the truth, namely, that her desire to be healed by way of external provision is illusion and not reality.

Entitlement Statements

In an entitlement statement, the therapist makes explicit not only the patient's longing for input from the outside to complete herself but also her entitled sense that it is her right to have someone make up the difference to her. Because she feels so cheated from way back, she truly believes that she is now entitled to compensation in the here-and-now to make up for the early-on environmental failures.

Examples of entitlement statements include the following:

"Because you feel that what your father did to you was so unfair, deep down inside you harbor the conviction that the world now owes you."

"Your mother never understood you and left you very much on your own, and now you are feeling that unless someone is willing to go more than halfway, you're simply not interested."

An entitlement statement not only highlights the fact of the patient's entitlement but also sometimes contextualizes it as a reaction to early-on privation, deprivation, or insult at the hands of the parent.

"Your father never supported you and was always critical; at this point, you won't be satisfied until he can acknowledge that he was wrong and realize that he owes you an apology."

It is crucial that the patient's often unconscious sense of entitlement be recognized and made explicit. Many patients who have reached some kind of impasse in either their therapy and/or their lives have arrived at that impasse because, deep within their souls, they harbor the conviction that they have gone not only as far as they can go but as far as they should have to go – and that it is now up to someone else to help out, to give them the answers, to provide for them. They believe that since it was not their fault then, it should not have to be their responsibility now.

Admittedly, it was not their fault then, but it is their responsibility now. And if they don't do it, no one else will!

Again, the patient's distorted sense of herself as so damaged from early on that she is not now responsible, her illusory sense of her contemporary objects as having the wherewithal to compensate her for the original damage, and her entitled sense of being owed that compensation in the here-and-now must be uncovered and named, so that the patient will ultimately be able to relinquish her relentless hope and the relentless outrage that she experiences when the goodies are not forthcoming after all.

In Model 1, which is more cognitive, the focus will be on helping the patient overcome her resistance to acknowledging the truth about her distortions, illusions, and entitlement.

In sum: The patient's underlying distortions, illusions, and entitlement must be made explicit and the patient held accountable, which the therapist attempts to do by way of damaged-for-life, compensation, and entitlement statements. As the "I can't, you can, and you should" dynamic is worked through and relinquished, the healthy forces that had been held in check by these defensive counterforces will be freed up to provide the momentum for the patient's forward movement.

Path-of-Least-Resistance Statements

I would next like to introduce the path-of-least-resistance statement, an intervention that I have developed to illuminate another one of the patient's defenses, namely, her tendency to *take the easy way out* rather than to address an underlying, more anxiety-provoking reality. In other words, this intervention attempts to encourage the patient to observe her tendency to resort to thinking, feeling, or doing something that involves *not dealing* rather than to confront – and deal with – a sobering reality or stressful challenge.

As an example, a path-of-least-resistance statement might highlight the patient's choice to defend (for example, by clinging to a distorted sense of herself as ever the victim and therefore not responsible for her life) instead of to confront reality (for example, the fact that how her life unfolds is ultimately up to her). As another example, a path-of-least-resistance statement might highlight the patient's choice to watch television all evening instead of doing her homework

because she is afraid that no matter how hard she might study for her exam the next day, it would never be good enough – a recurring theme in her life (that no matter how hard she might try, it would never be good enough). Or a path-of-least-resistance statement might highlight the patient's choice to break her diet instead of sticking to a strict regimen of counting calories because she cannot stand feeling deprived (an all-too-painful reminder of how she so often felt growing up).

Like many of the psychotherapeutic interventions in the armamentarium of the Model 1 therapist, the path-of-least-resistance statement represents an effort to make explicit both the patient's investment in maintaining her defenses and the intolerably painful reality against which she is defending herself. It is particularly useful when the therapist wants to highlight the illusions, the distortions, and the entitlement to which the patient is holding on in order not to have to confront certain intolerably painful truths about the self and the object.

A path-of-least-resistance statement is also particularly useful when the therapist's aim is to make the patient more aware of the choices she is ever busy making between being present with the pain of her disappointment in the object and absenting herself from that pain. In essence, the therapist is highlighting that it is easier to defend against than to confront – and grieve – the pain of one's disappointment. It is easier to defend against the pain of one's grief than to process, integrate, and ultimately adapt to that pain.

In essence, a path-of-least-resistance statement encourages – or sometimes forces – the patient to take note of the fact that defending (by reacting without much forethought) is often the route she will unwittingly opt to go instead of confronting a sobering reality or disillusioning truth about the object. In fact, until the patient develops a keener awareness of the potential price she pays for resorting to defense instead of dealing with reality, she will indeed often find herself reacting defensively (and, therefore, dysfunctionally) to stressful situations.

After all, it is easier to mobilize a dysfunctional defense (when made anxious) than to confront – and deal with – a sobering reality, a stressful challenge, a disillusioning truth, or a distressing affect. It is easier to be dysfunctional than to take responsibility for being functional.

The format of a generic path-of-least-resistance statement is as follows:

“Easier to defend... than to acknowledge/confront the reality that...”

“Easier not to deal... than to deal with the underlying issue...”

“Easier to think, feel, or do the thing that represents the easy way out... than to think, feel, or do the healthier (and harder) thing...”

“Easier to take the easy way out... than to confront – and resolve – the underlying (conflictual) issue...”

“Easier to defend by holding on to illusion/distortion/entitlement... than to confront – and grieve – the reality...”

It's a matter of personal preference, but sometimes a path-of-least-resistance statement can begin with "It's."

The format of such statements would be as follows:

"It's easier to defend... than to acknowledge/confront the reality that..."

"It's easier not to deal... than to deal with the underlying issue..."

The following are examples of path-of-least-resistance statements:

"It's easier not to deal with how upset you are than to force yourself to stay present with just how much pain you are in."

"It's easier to indulge in overeating than to sit with the pain of your disappointment about Jim."

"It's easier simply to slam the door and leave than to rein in your anger and try to talk about how upset you're feeling."

"It's easier for you to pretend that it doesn't matter than to admit that it tears your heart out that Kevin has now moved on to find someone new."

"It's easier not to think about it much than to confront the reality that you've paid a terrible price for having had a mother who was always so resentful of you and your need for her to be your mother."

“It’s easier to decide that it’s just too painful to think about than to sit with the pain of your disappointment in Rick.”

The following is the format of a path-of-least-resistance statement that highlights how much easier it is to defend against an intolerably painful reality by holding on to an illusion than to confront it:

“It’s easier to hold on to the illusion... than to confront the reality...”

“It’s easier to cling to the hope that... than to confront – and grieve – the reality that...”

“It’s easier to cling to your hope... than to confront the pain of your grief...”

The following are examples of such path-of-least-resistance statements (which highlight the illusion to which the patient holds on in order not to have to face the disillusioning truth about the object of her desire):

“It’s easier to keep hoping that maybe, some day, somehow, some way, your father will understand just how much he has hurt you than to confront the intolerably painful reality that he might well never be ‘big enough’ actually to do that.”

“It’s easier to keep hoping that Eric will eventually learn that he needs to treat you better than to face the truth that that might well never happen.”

“It’s easier to hold on to the hope that Jane will change than to confront the

reality that she probably never will.”

“It’s easier to cling to the idea that maybe some day, somehow, some way, your mother will accept you for who you are than to face the truth that that might never happen, no matter what.”

The following is the format of a path-of-least-resistance statement that highlights how much easier it is to hold on to the distorted sense of oneself as a helpless victim than to take responsibility for the unfolding of one’s life:

“It’s easier to hold on to a distortion... than to confront the reality...”

“It’s easier to cling to a distorted sense of yourself as a victim... than to confront the reality that...”

The following are examples of such path-of-least-resistance statements (which highlight the patient’s tendency to hold on to the distorted sense of herself as a helpless victim rather than face the sobering reality that how her life unfolds is up to her):

“It’s easier to hold on to the distorted sense of yourself as a helpless victim than to recognize your responsibility for the unfolding of your life.”

“It’s easier to cling to your distorted sense of yourself as damaged than to confront the reality that it’s up to you to do with your life as you will.”

“It’s easier to experience yourself as having no accountability than to take responsibility for your life.”

“It’s easier to experience yourself as a victim than to take responsibility for the choices you have made to live the way you do.”

“It’s easier to experience yourself as having no choice than to confront the reality of just how steep a price you have paid for refusing to live responsibly and refusing to know the truth.”

“It’s easier to experience yourself as having no choice than to recognize that you do.”

“It’s easier to experience yourself as justified in behaving as you do than to confront the reality of just how costly such a stance has actually been.”

“It’s easier to hold on to this distorted sense of yourself as the injured party than to confront the reality of the price you pay for doing so.”

“It’s easier to hold on to this distorted sense of others as having been abusive to you than to confront the reality that you provoked it and, thereby, participated in what actually happened.”

“It’s easier to hold on to the distorted sense that you are a helpless victim than to confront the reality that you’re not.”

“It’s easier simply to hold on to the sense of yourself as a victim than to confront the reality of your accountability.”

“It’s easier simply to hold on to the sense of yourself as a victim than to confront the reality of the price you’ve paid for being so self-destructive.”

The following is the format of a path-of-least-resistance statement that highlights how much easier it is to defend against feelings of being victimized by lashing out than to deal with the hurt:

“It’s easier to lash out... than to deal with the pain...”

“It’s easier to retaliate by lashing out... than to confront the pain...”

The following are examples of such path-of-least-resistance statements (which highlight the patient’s tendency to victimize the object, or the self, by lashing out against it than to confront – and grieve – the pain of her own grief about how unfair it all is):

“It’s easier to think about ways to make him pay than to sit with your feelings of devastation at his betrayal of you.”

“It’s easier to punish her by withdrawing than to deal with how hurt you feel by what she said.”

“It’s easier to rail against the world than to take ownership of your own

culpability.”

“It’s easier to protest that it’s ‘not fair’ than to confront – and grieve – the pain of your disappointment that it would have turned out as it did.”

“It’s easier to cry ‘not fair’ than to let go of your sense of outrage and mobilize your own resources so that you can move forward in your life.”

“It’s easier to lash out at the world for being so unfair than to think about how your actions might have provoked the response you got.”

Conflict Statements

When patients are holding on to familiar but unhealthy defenses and are reluctant to embrace less familiar but healthier adaptations, the psychodynamic therapist can make liberal use of a psychological intervention that I have developed and to which I refer as a conflict statement.

Conflict statements, one of the staples in the Model 1 therapist’s armamentarium, are specifically designed to tease out underlying convergent conflicts, that is, conflict within the patient between her *voice of reality* (which is anxiety-provoking although ultimately insight- and, therefore, health-promoting) and the defenses she mobilizes in an effort to *silence that voice*. Model 1 interventions are geared to fostering the patient’s observing (or reflecting) ego so

that she can develop greater understanding and awareness of her internal conflict between what she really does know and what she finds herself thinking, feeling, and doing in order not to have to know. The aim of the conflict statement is ultimately to promote enough detachment from the experience that the experience can be reflected upon with compassion and without judgment for what it is, namely, an effort to avoid dealing with certain intolerably painful realities of which the patient really is aware but would wish she weren't.

Conflict statements are also useful in Model 2 and Model 3; but, as noted earlier, Model 2 (which is primarily affective and therefore more focused on what is experience-near, not experience-distant) and Model 3 (which is primarily relational and therefore more focused on the patient's relational dynamics than her internal dynamics) do not lend themselves quite as comfortably to the use of statements that encourage the patient to step back from her experience in order to gain perspective on both what she knows (by virtue of listening to her inner voice of reality) and what she feels (by virtue of her need to deny that inner voice).

There are many ways to describe the convergent conflicts that assume center stage in Model 1: (1) conflict between reality and defense; (2) conflict between anxiety-provoking reality and anxiety-assuaging defense; (3) conflict between reality-based forces and resistive counterforces; (4) conflict between anxiety-provoking, reality-based forces and anxiety-assuaging, defensive counterforces; (5) conflict between empowering forces and disempowering

counterforces; (6) conflict between yes forces and no counterforces; (7) conflict between health-promoting yes forces and health-disrupting no counterforces; (8) conflict between anxiety-provoking but health-promoting forces and anxiety-assuaging but health-disrupting counterforces; (9) conflict between the patient's awareness of the empowering forces within her and her awareness of the disempowering counterforces; (10) conflict between the patient's awareness of the price she pays for refusing to let go of her dysfunctional defenses and her awareness of the investment she has in holding on to them; (11) conflict between the patient's awareness of disillusioning realities about the object and her awareness of the defensive need she has to deny those disillusioning realities; and (12) conflict between the patient's awareness of the work she must do to evolve to a healthier place and her awareness of the reluctance she has to do that work – to name but a few!

Ultimately, however, and to operationalize things a bit, I believe we could say that the convergent (neurotic) conflicts upon which the Model 1 therapist is most focused are those between the patient's *knowledge* of reality and her *experience* of it.

How so? We had earlier noted that the neurotic conflict with which the patient struggles can be conceptualized as the tension that exists within her between reality and defense. Certainly reality (verifiable by a panel of 10,000 judges) informs objective knowledge; by the same token, defense (mobilized by a

party of one and therefore lacking consensual validation) informs subjective experience. As we shall see, the neurotic conflict with which the patient struggles can also be conceptualized as the tension that exists within her between objective knowledge and subjective experience.

As an example: If the object of a patient's desire is married and has indicated that he has no intention whatsoever of leaving his wife, then, at least on some level, the patient has to know that, realistically, the object of her desire will never truly be hers in the way that she would have wanted him to be. We could say that reality (as verifiable by the panel of 10,000 judges) informs her recognition of the fact that the object of her desire will never be available, that is, reality informs her objective knowledge. And yet, despite her knowledge to the contrary, we might well find that the patient continues to hold on to the unrealistic hope that perhaps, were she but to try hard enough and suffer deeply enough, she might yet be able to get him to leave his wife. And so the patient's refusal to confront the reality of his unavailability and her defensive need to cling to her relentless hope inform her subjective experience.

On an objective level, the patient (along with the panel of 10,000 judges) realizes that the object of her desire will never truly be hers; but, on a subjective level, she (as a party of one without receptivity to input from the outside) finds herself continuing to hope that maybe, some day, he will. She knows that the object of her desire will never truly be hers, but she finds herself continuing to

experience hope even so.

As another example: Let us imagine that the patient has been in treatment for many years and has enjoyed a very positive relationship with her therapist. Through thick and thin, the therapist has remained steadfast in his commitment to the patient and to their work; and, consistently, the therapist has proven himself to be indestructible, every time managing to negotiate successfully whatever turbulence arises at their intimate edge. And yet, periodically, the patient finds herself fearing that maybe she'll be too much for her therapist and that maybe the therapist will decide suddenly that their relationship should be terminated.

On an objective level, the patient's knowledge of reality is that her therapist would never do that (after all, he has never threatened to do that over the course of all their time together); but, on a subjective level, the patient's experience of reality is that maybe her therapist (a stand-in for her father, who had abandoned the family when the patient was age 3) would.

But whether the neurotic conflict jamming the patient up is described as involving tension between reality and defense, tension between empowering forces and disempowering forces, tension between yes energies and no energies, or tension between objective knowledge and subjective experience, what all such convergent conflicts have in common is internal tension between an anxiety-provoking force that, were it to be taken ownership of and its energies tamed,

would provide the propulsive fuel for the patient's forward movement and an anxiety-assuaging (resistive) counterforce – mobilized as a defensive reaction to the original force – that, were it to be analyzed and reworked, would become the means by which the empowering energies, now tamer and more controllable, could be harnessed and used to power constructive, more adaptive pursuits.

We are, of course, describing the ever-evolving psychodynamic process as an evolutionary one whereby primitive defense is transformed into healthier adaptation. Harkening back to Freud's metaphor, we are highlighting the therapeutic action in Model 1 as involving the (id) horse becoming ever more manageable and the (ego) rider becoming ever more adept at harnessing the horse's (now more controllable) power to move horse and rider forward – and off into the sunset. Simultaneously, the (id) horse is becoming tamer as the (ego) rider is becoming ever more skilled, such that the synergy of a tamer id and a stronger ego allows for the optimization of potential.

Before we move forward, I want to address a fine point. As you might well have noticed, on the one hand, sometimes I speak to the conflict that exists between reality and defense; on the other hand, sometimes I speak to the conflict that exists between the patient's *knowledge* of reality and her defense.

For example, sometimes I will be speaking to the conflict that exists between, on the one hand, the reality of the price the patient pays for clinging to

her relentless hope and, on the other hand, her defensive need to cling to that hope even so, because confronting the truth would simply hurt too much. At other times, however, I will be speaking to the conflict that exists between, on the one hand, the patient's awareness of the price she pays for clinging to her relentless hope and, on the other hand, her defensive need to cling to that hope even so, because confronting the truth would simply hurt too much.

As another example, sometimes I will be speaking to the conflict that exists between, on the one hand, the reality of the patient's anger (as evidenced, perhaps, by her faster pulse and/or her accelerated respirations) and, on the other hand, her defensive need to protest that she is not angry, just disappointed. At other times, however, I will be speaking to the conflict that exists between, on the one hand, the patient's begrudging recognition of the reality that she is angry and, on the other hand, her defensive need to protest that she is not angry, just disappointed.

I am indirectly speaking here to the issue of how conscious the patient must be of a sobering reality in order to warrant her mobilization of a defense. Does the mere fact of the sobering reality suffice to trigger activation of the defense? Or must it be the patient's awareness of the sobering reality that is required to trigger activation of the defense?

Closely related to this important question is the following: Is it the price paid

(that is, the pain) that makes a defense ego-dystonic or is it the patient's knowledge of the pain that makes it ego-dystonic? By the same token, is it the investment in (that is, the gain) that makes the defense ego-syntonic or is it the patient's knowledge of the gain that makes it ego-syntonic?

For that matter, is it the pain that makes a defense ego-dystonic or is it the patient's experience of the pain that makes it ego-dystonic? By the same token, is it the gain that makes the defense ego-syntonic or is it the patient's experience of the gain that makes it ego-dystonic?

By way of an answer: Perhaps I'm equivocating a bit here, but my own sense is that sometimes the mere fact of the anxiety-provoking reality is enough to trigger the defense. At other times, however, I believe that what is needed to trigger the defense is for the patient to be *aware* of the anxiety-provoking reality. Quite frankly, the context will usually be enough to determine whether the mere fact of the reality or the patient's conscious awareness of that reality is serving as the trigger.

But whether it is the reality itself or the patient's awareness of the reality that activates the defense, the Model 1 therapist, in an effort to get the patient to relinquish her attachment to the dysfunctional defense in favor of a more functional adaptation, can use carefully formulated and individualized conflict statements to make the patient ever more aware of both the price she pays for

holding on to her dysfunction and her investment in clinging to the dysfunction even so. And, as we know, once the patient has come to recognize that (1) it is she who is responsible for having mobilized the defense, (2) she has a need for it, and (3) she pays for price for refusing to let it go, the patient will ultimately be forced to relinquish the unhealthy defense in favor of a healthier adaptation.

Again, the conflict that exists within the patient between reality and defense is a convergent one because it speaks to the conflicted relationship that develops between an anxiety-provoking reality and an anxiety-assuaging defense mobilized in an effort to quell the anxiety generated by the presence of the reality. In contradistinction to this is the divergent conflict that exists within the patient between her positive cathexis of the dysfunctional defense (fueled as it is by her investment in holding on to it) and her negative cathexis of the dysfunctional defense (fueled as it is by the price she pays for holding on to it). The patient's attachment to her dysfunction will therefore be an ambivalent, or conflicted, one because the dysfunction both costs her and benefits her.

Unlike the convergent conflict characterizing the relationship between reality and defense (where an anxiety-assuaging counterforce is mobilized as a reaction to the presence of an anxiety-provoking force), the divergent conflict characterizing the relationship to the defense itself involves forces that are independent of each other.

But this is where it gets really interesting. By design, conflict statements juxtapose two opposing forces: (1) an anxiety-provoking reality and (2) the anxiety-assuaging defense mobilized as a reaction to the anxiety-provoking reality.

Conflict statements do something else as well. More specifically, they juxtapose the patient's knowledge of reality (for example, her awareness of the reality that she pays a price for holding on to the defense, even if doing so does also assuage her anxiety) and her experience of reality (for example, her investment in holding on to the defense, even if doing so does also create anxiety). But conflict statements do not simply name the cost ("you pay a price for abusing drugs") and the benefit ("doing drugs helps to numb the pain") – two opposing forces that are independent of each other. Conflict statements first name what the patient knows is the cost of abusing drugs (the naming of which will make her anxious) and then resonate with what the therapist senses is the patient's rationale for using drugs in the way that she does, the articulation of which will ease the patient's anxiety. "You know that you pay a price for abusing drugs, but doing drugs helps to numb the pain."

In essence, conflict statements convert what would otherwise have been a divergent conflict between two independent forces, namely, both sides of the patient's conflicted attachment to the defense (pain and gain, cost and benefit, risk and reward, price paid and investment in, negative cathexis and positive cathexis,

cons and pros) into a convergent conflict between two forces that are no longer independent of each other.

By way of a subtle sleight of hand, two forces that had been independent of each other will now be linked by a conflict statement that first reminds the patient of what she really does know to be the cost of holding on to her dysfunction and then articulates, on the patient's behalf, what the therapist has come to understand is the benefit the patient experiences herself as deriving from clinging to her dysfunction. The therapist is giving voice to what she senses will be the patient's knee-jerk (defensive) reaction to being confronted with the sobering reality of the price the patient knows she is paying for refusing to let go of her dysfunction.

Divergent conflict: "You could choose to do drugs, or you could choose not to do drugs."

Convergent conflict: "You know that you pay a price for doing drugs, but doing drugs helps to numb the pain."

With this latter intervention, the therapist is suggesting: "You know that you pay a price for doing drugs, but *<it makes you so anxious to confront this reality that you find yourself feeling the need to protest that>* doing drugs helps to numb the pain."

By way of a thoughtfully formulated conflict statement, the patient's conflicted (ambivalent) attachment to her dysfunction – which represents a divergent conflict between two independent, equally (albeit oppositely) balanced forces (namely, pain and gain) – has been transformed into a convergent conflict between the patient's anxiety-provoking knowledge of the pain and her anxiety-assuaging experience, mobilized in response to that knowledge, of the gain.

But I am getting ahead of myself.

The Model 1 therapist is intent upon illuminating the patient's underlying dynamics, which she will be able to do by way of a series of carefully formulated conflict statements.

As we shall see, conflict statements encourage the patient to step back from the immediacy of the moment in order to focus on the underlying forces and counterforces within her that are tying up her energies and interfering with her forward movement in life. Conflict statements prompt the patient to take note of her internal process and to bear witness to it with compassion and without judgment.

By calling the patient's attention to both her own voice of reality (that is, to what she herself, at least on some level, already knows) and the resistive counterforces she mobilizes in an effort to silence that voice (that is, what she then experiences because of her refusal to listen to her inner voice of reality),

conflict statements are intended to heighten the patient's awareness of her internal dynamics (including, especially, the price she pays for refusing to pay attention to her inner voice of truth and for persisting, instead, in her dysfunctional choices). Over time and with repeated use, conflict statements will advance the working-through process, resulting ultimately in transformation of primitive defense into healthier adaptation, that is, resistance into awareness (or insight).

Throughout this book, I have been highlighting the therapeutic task as one of transforming defense into adaptation. In Model 1, the transformation, as we know, is of resistance into awareness.

It is easy enough to appreciate that resistance is a defense, mobilized as a reaction to the patient's anxiety-provoking inner voice of reality.

But how is it that awareness is an adaptation?

Awareness is an adaptation because (as is true for all adaptations) it is arrived at only over time and with effort! We do not have to work hard to become aware of our strengths – for example, that we are honest, that we are courageous, that we are loving, that we are patient, or that we are compassionate. But we do have to work hard to become aware of, and to take ownership of, our weaknesses and limitations – for example, that we still have unresolved oedipal feelings about our mother, that we are intensely fearful of being abandoned, that underlying our

polite exterior is tremendous rage, that we have insatiable hunger, or that we are clingy and dependent. In other words, we have to work through our resistance to acknowledging these painful truths about ourselves and our psychic scars in order to get to a place of being able to work with them instead of against them (for example, by denying them).

This is all by way of saying that awareness is an adaptation because, as is true for all adaptations, it is arrived at only as a result of an evolutionary process. More specifically, by way of the ever-evolving psychodynamic process, we arrive, albeit begrudgingly, at awareness of our internal dynamics only by way of evolving through cycles of destabilization (as our resistance is being challenged by psychotherapeutic interventions that provoke anxiety) and restabilization at ever-higher levels of awareness and nuanced understanding (as our underlying resilience is being supported by psychotherapeutic interventions that ease anxiety and promote insight).

In other words, awareness is an adaptation because it is the result of an evolutionary journey through cycles of defensive collapse (in response to therapeutic challenge) and adaptive reconstitution (in response to therapeutic support), the net result of which is the transformation of unhealthy defense into healthy adaptation as awareness supplants resistance.

As we know, conflict statements highlight both the health-promoting forces

within the patient and the health-disrupting (resistive) counterforces within her that are interfering with the harnessing of those growth-promoting energies. The use of ever-evolving conflict statements is intended to facilitate the working-through process so that ultimately the empowering forces can be harnessed to provide the propulsive fuel for forward movement at the same time that the disempowering counterforces are being refashioned into healthier, more adaptive ways of thinking, feeling, and doing.

The net result of both reining in the id and refashioning the ego will be the channeling and redirecting of now more tamed, modified, and integrated energies toward more worthy and realistic pursuits.

As we shall see, critically important will be the creation within the patient, by way of a series of conflict statements that highlight both pain and gain, of ever more tension – tension that will ultimately make the patient’s dysfunctional choices ever less ego-syntonic and ever more ego-dystonic. Again, as long as the defense is more ego-syntonic than ego-dystonic, the patient will hold on to it; but once the defense becomes more ego-dystonic than ego-syntonic (which will happen as the patient becomes ever more aware of the price she is paying for holding on to her dysfunction), the tension created within the patient by that awareness will eventually provide the fulcrum of therapeutic change. The internal tension (between the patient’s awareness of the price she is paying for refusing to let go of her dysfunction and the benefit she is coming to understand that she

derives from having it) can only be resolved once the patient relinquishes her attachment to her dysfunction – an attachment that, as we know, is intensely ambivalent by virtue of the fact that it both benefits the patient and costs her.

By their very nature, conflict statements are intended to highlight the conflict that exists within the patient between, on the one hand, anxiety-provoking realities that the patient must eventually confront if she is ever to evolve to a higher level of complex understanding and emotional maturity and, on the other hand, anxiety-assuaging defenses that she has mobilized in an effort to avoid confronting those discomfiting realities (that is, anxiety-assuaging defenses that have come, over time, to characterize the patient's dysfunctional stance in life).

Conflict statements are therefore specifically designed to tease out, on the one hand, sobering realities, stressful challenges, painful truths, and distressing affects, the impact of which the patient has not yet processed and integrated, and, on the other hand, defenses that the patient has mobilized in an effort to avoid facing those stressful realities. The first half of a conflict statement highlights realities that are anxiety provoking but ultimately health promoting; the second half of a conflict statement highlights defenses that are anxiety assuaging but ultimately health disrupting.

More simply, conflict statements are designed to illuminate the patient's conflict between reality and defense; they make explicit the tension that exists

within the patient between her knowledge of reality and the defenses she mobilizes to protect herself against having to confront that knowledge (that is, her resistance to knowing).

A conflict statement, in which the therapist first speaks to the patient's observing (or reflecting) ego by highlighting what the patient knows (which will increase her anxiety) and then speaks to the patient's experiencing ego by resonating with what the patient "feels" (which will decrease her anxiety), has the basic format of:

"You know that..., but your experience is that...,"

"You know that..., but you find yourself thinking that...,"

"You know that..., but you find yourself feeling that...,"

"You know that..., but you find yourself doing..., or"

"You know that..., but you tell yourself that..."

In other words, a conflict statement first addresses the patient's knowledge of reality (informed by her inner voice of reality) and then addresses her experience of reality (informed by her defensive need to silence that inner voice). It speaks to first the patient's objective knowledge and then her subjective experience – first what the panel of 10,000 judges would be able to verify and then what the patient finds herself thinking, feeling, and doing in an effort to deny what she knows is real.

Alternatively, but with the same intent, the therapist can offer any of the following:

“Even though (although) you know that..., (nonetheless) your experience is that...,”

“Even though (although) you know that..., (nonetheless) you find yourself thinking that...,”

“Even though (although) you know that..., (nonetheless) you find yourself feeling that...,”

“Even though (although) you know that..., (nonetheless) you find yourself doing...,” or

“Even though (although) you know that..., (nonetheless) you tell yourself that...”

First the therapist highlights the patient’s knowledge of reality (for the most part informed by the present); then the therapist highlights the patient’s experience of reality (for the most part informed by unresolved issues from the past). The patient’s knowledge of reality has to do with what she really does know, even though she might rather not have to acknowledge it. The patient’s experience of reality has to do with what she is feeling in the here-and-now and will often be a reflection of her unmastered experiences in the there-and-then (experiences that were never fully processed, integrated, and made sense of at the time).

In the first part of a conflict statement, the therapist does not say “If you are ever to work through your fear of intimacy, you will have to let someone in...”; rather, the therapist carefully frames her intervention as follows: “You know that if you are ever to work through your fear of intimacy, you will have to let someone

in..." The therapist does not want to become the voice of reality for the patient; rather, he wants to highlight what, at least on some level, the patient herself already knows. The therapist therefore speaks to the patient's own voice of reality and does this by way of the three powerful words "You know that..."

Among other things, "You know that..." speaks to the issue of the patient's accountability for what she really does know. If the therapist, in a misguided attempt to urge the patient forward, resorts simply to telling the patient what the therapist knows and what the therapist therefore thinks the patient must do in order to get better, not only does the therapist run the risk of forcing the patient to become ever more entrenched in her defensive stance and therefore ever more resistant, but she also robs the patient of the opportunity to take ownership of her own desire to get better. In other words, the therapist does not want the conflict to be played out in the space between patient and therapist, with the therapist representing the healthy (adaptive) voice of yes and the patient representing the unhealthy (defensive) voice of no. It is important therefore that in the first part of a conflict statement the therapist highlight not what she knows but rather what the patient knows.

By locating the conflict within the patient, the therapist is not only avoiding the potential for the creation of conflict between patient and therapist but also creating space for the patient to elaborate upon either the anxiety-provoking realities that she really is beginning to face or her investment in holding on to the

anxiety-assuaging defenses to which she clings in order not to have to go there. In other words, in response to a conflict statement, the patient can go on to talk more about either what she really does know, even though talking about it makes her anxious, or what she finds herself thinking, feeling, or doing in order not to have to experience too much anxiety.

In any event, by way of serial conflict statements that build upon the patient's response to the earlier ones, the patient is being given the opportunity to explore both sides of her conflicted (ambivalent) attachment to her dysfunction so that she can understand more about its underpinnings.

“You know, deep in your heart, that your mother will never be the kind of mother you would so desperately have wanted her to be, but you find yourself holding on, even so, to the hope that perhaps someday, somehow, some way, were you but to try hard enough, you might yet be able to make her change.”

In response to this statement, the patient can elaborate upon either what she really does know to be the truth about her mother's limitations or her relentless hope that she might yet be able to get her mother to come through for her. In any event, the patient is being forced neither to talk about things that make her anxious nor to defend her choice to protect herself in the ways, albeit dysfunctional, that she does.

“Although you know that eventually you will need to confront – and grieve –

the reality that your mother was never really there for you and that you won't get better until you let go of your hope that eventually you'll be able to make her change, you're not quite ready to deal with all that because you're afraid you might not survive the heartbreak and the despair you would feel were you to have to face that devastatingly painful truth."

In the second part of a conflict statement, the therapist, by immersing herself empathically in the patient's experience, demonstrates to the patient her understanding of what she senses the patient is feeling in response to having her accountability challenged. The therapist does this by naming, in as nonjudgmental and compassionate a fashion as possible, the defensive stance the patient appears to resort to when made anxious.

By way of example, "You're coming to understand that your anger can put people off, but you tell yourself that you have a right to be as angry as you want because of how much you have had to suffer over the years." First the therapist increases the patient's anxiety by naming the patient's knowledge of an uncomfortable truth ("You're coming to understand that your anger can put people off..."); then the therapist decreases the patient's anxiety by resonating empathically with the patient's unconscious justification for being that way ("...but you feel that you have a right to be as angry as you want because of how much you have had to suffer over the years.")

More generally, the therapist speaks first to what the patient knows and then to what the patient finds herself reflexively feeling, thinking, doing, or telling herself. Again, what the patient knows will certainly be anxiety-provoking but ultimately insight- (and health-) promoting realities that must eventually be confronted if the patient is ever to evolve to a higher level of mental and physical well-being; what the patient finds herself feeling, thinking, doing, or telling herself instead will be a story about the defensive posture she assumes when made anxious.

“You know that if you are ever to get on with your life, you will have to let go of your conviction that your childhood scarred you for life, but it’s hard not to feel like damaged goods when you grew up with a horribly abusive father who was always calling you a loser.” The therapist first highlights what the patient knows to be real; in this situation, the therapist speaks to the therapeutic work she believes the patient really does know she must do if she is ever to move beyond the psychic scars she developed as a child. Then the therapist resonates empathically with the defensive stance the therapist is coming to appreciate is the stance the patient has assumed in order to avoid having to take responsibility for her life. In essence, the therapist, with compassion and no judgment, is making explicit the patient’s distorted perception of herself as damaged goods, a defensive stance the patient uses as unconscious justification for remaining stuck in her life.

In the form of a conflict statement, therefore, the therapist first challenges,

by directing the patient's attention to what the patient really does know on some level, even though the patient would rather not, and then supports, by coming down on the side of what the patient finds herself feeling when confronted with that knowledge.

"You know that eventually, if you are ever to work through your fears of intimacy, you will have to let someone in, but right now you're feeling that you simply cannot afford to be that vulnerable. In the past, when you were vulnerable, especially with your dad, you always got hurt."

The following is an almost universal conflict with which patients struggle, namely, their wish for the object of their desire to be something it isn't. A hallmark of maturity is the capacity to accept the reality of the object as it is, no longer needing it to be something it isn't.

To the extent that the patient is still hoping that the object of her desire will change, the following are anxiety-provoking challenges that the therapist might offer the patient in an effort to encourage her to confront certain intolerably painful realities: (1) truths that are simply too painful for the patient to acknowledge (for example, the pain of her grief about disillusioning realities); (2) the price the patient pays for holding on to her defenses (for example, chronic frustration in the face of her relentless pursuit of the unattainable); and/or (3) the work the patient must do in order to let go of her relentlessness (for example,

grief work as she begins to confront disillusioning realities about the object of her desire).

By the same token, the patient's anxiety will be eased as the therapist comes to appreciate, on ever-deeper levels, the patient's need for her defenses and supports her by articulating, on the patient's behalf and in as nonjudgmental a fashion as possible, the patient's investment in holding on to her defenses (for example, protection from the pain of her grief about those disillusioning realities).

The sobering realities and stressful challenges that are most usefully addressed in the first half of a conflict statement include, but are not limited to, such stressors as the following: (1) anxiety-provoking, uncomfortable, painful, or distressing affects; (2) disillusioning truths about the object; (3) accountability for the dysfunctional (and, at least initially, unconscious) choices the patient is continuously making in a misguided attempt to protect herself; (4) the price she pays for clinging to those dysfunctional choices; and (5) the therapeutic work she must do in order to let go of those dysfunctional choices and adopt more adaptive coping strategies.

The defenses that are most usefully addressed in the second half of a conflict statement include all those (usually unconscious) defensive mechanisms – like denial, avoidance, compartmentalization, rationalization, self-justification, pretending, ignoring, dismissal, refusal to acknowledge, refusal to confront, and

refusal to accept – utilized by the patient in an effort to avoid the anxiety she would experience were she to let herself truly feel the full impact of her inner voice of reality, namely, what she knows to be the various sobering realities in both her inner and outer worlds. In essence, the defenses include everything the patient thinks, feels, and does in an attempt to avoid confronting – and grieving – intolerably painful realities that have been too much for her to process, integrate, and adapt to. Again, when the patient is unable to adapt in response to challenge, she defends.

The following conflict statements speak, first, to anxiety-provoking realities and, then, to the defenses the patient mobilizes in an effort to protect herself against having to confront those realities:

“You know, deep down inside, that you are furious at Bob for having broken your heart, but you tell yourself that he is doing the best he can and that you are experiencing not so much anger as sadness.” (anxiety-provoking affect/rationalization)

“You know that Bob can sometimes be very cruel, but then you find yourself remembering all those times when he was so very loving and all those precious moments of deep, tender connection.” (disillusioning truth about the object of one’s desire/rationalization)

“You know that it really is up to you whether you keep holding on to Bob or

you decide to let him go, but your experience is that you really don't have a choice because you simply can't imagine a life without him. Being with Bob would ease the pain of the loneliness from which you have suffered your entire life, and without him in your life, you feel you have nothing to live for." (accountability for dysfunctional choice/distorted sense of self as powerless)

"You know, on some level, that you are consigning yourself to a lifetime of chronic frustration and heartache as long as you cling to your hope that maybe some day, somehow, some way, Bob will change his mind and come back to you, but, in the moment, all you can think about is how good it had felt to be loved so deeply and so passionately." (price paid for clinging to dysfunction/denial)

"You know that you must eventually confront the reality that Tom will never change his mind and come back to you, but, for now, you cannot imagine being able to survive the pain you would feel were you to let yourself face that unbearable truth." (work to be done in order to let go of dysfunction/refusal to grieve)

The first half of a conflict statement can challenge the patient by highlighting more than one sobering reality:

"You know that until you come to understand why your first reaction to being disappointed is to become angry, you will continue to have trouble in your intimate relationships with men..." in which the therapist highlights both the work

to be done (that is, coming to understand) and the price paid for clinging still to her defensive anger as a self-protective reaction to disappointment (that is, continuing to have trouble in her intimate relationships with men).

“You know that because of the way your father mismanaged his finances your family was left with feelings of insecurity and a sense of doom and that you probably won’t be able to feel in charge of your own life and finances until you have worked through more of your feelings about how traumatizing it was for you to grow up in that household...” in which the therapist highlights both the price the patient pays for her failure to master unresolved feelings from her childhood (that is, her inability now to feel in charge of her life and finances) and the work the patient must do in order to feel more in control (that is, processing and integrating traumatizing experiences from her childhood).

A path-of-least-resistance statement (preceded by “after all”) can follow a conflict statement. First a conflict statement: “You know that you should be studying for your exam and that you’ll feel terrible if you do poorly on it, but you just can’t seem to get yourself motivated right now.” Then the path-of-least-resistance statement: “After all, it’s easier to tell yourself that there’s always tomorrow than to force yourself to do something that you just don’t feel like doing right now even though you know that you might later regret your decision to delay.”

In addition to the defenses referenced above (like denial, avoidance, self-justification, pretending, ignoring, and refusal to acknowledge), other defenses mobilized specifically to fend off disillusioning truths about reality include illusions (positive misperceptions of reality), distortions (negative misperceptions of reality), and entitlement (the refusal to take no for an answer). Illusions, distortions, and entitlement all represent misperceptions of reality and are resorted to by a patient desperate to protect herself against having to confront certain intolerably painful realities about the object's limitations, separateness, and immutability.

An example of defensive illusion is addressed with the following: "...but it hurts so much to think that maybe Victor will never be willing to take ownership of the part he plays in the fights the two of you have that you find yourself clinging to the hope that maybe, if you try really hard to explain to him just how important it is to you, he might someday understand and be willing to take more responsibility for how provocative he can be."

An example of defensive distortion is addressed with the following: "...but you can't imagine that any effort you might make would ever make any real difference anyway because you feel so powerless and ineffective."

An example of defensive entitlement is addressed with the following: "...but you are determined to make him admit that he is wrong and to apologize, and you

won't stop fighting with him until he does.”

Conflict statements encourage the patient to step back from the moment in order to observe, with compassion and without judgment, not only her dysfunctional thoughts but also her dysfunctional feelings and her dysfunctional behaviors. Although the most cognitive of the three approaches, Model 1 is still a story about challenging the patient to bear witness to, and take ownership of, any defense she mobilizes (whether thought, feeling, or behavior) in an effort to avoid the anxiety she experiences when confronted with the various sobering realities to which she is being continuously exposed.

At the end of the day, Model 1, along with the conflict statements that are its staple, is about enhancing the patient's knowledge of her internal dynamics and transforming anxiety-provoking resistance to taking ownership of those dynamics into awareness of those dynamics such that the patient can use her ever-evolving awareness and self-understanding to redirect her energies into more positive channels and toward the pursuit of more realistic goals. Conflict statements address whatever dysfunctional thoughts, feelings, or behaviors are interfering with the patient's momentum.

Throughout, the therapist is ever respectful of the patient's defensive need to maintain things as they are (no matter how dysfunctional) because the therapist deeply appreciates that what is most comfortable for the patient will be

that with which she is most familiar. Even the thought of change makes most people anxious. And so it is that people feel compelled to do the same things over and over again, driven to enact the same scenarios in their lives again and again – the repetition compulsion. The repetition is compulsive but usually unwitting, the patient not fully recognizing that it is she who is choosing to play out, again and again, unresolved childhood dramas in the hope of a better resolution this time.

Back and forth, back and forth, between engaging first the patient's observing (or reflecting) ego and then her experiencing ego – naming first the patient's knowledge of reality and then resonating with her experience of it. First challenging the patient, then supporting her. First increasing the patient's anxiety by highlighting, for example, a painful reality (“You know that your mother will never be the kind of mother you would so desperately have wanted her to be...”), or the work to be done (“You know that eventually you will need to confront – and grieve – the reality that your mother was never really there for you...”), or the price paid (“...and you know that you won't get better until you let go of your hope that eventually you'll be able to make her change”). And then decreasing the patient's anxiety by resonating with her investment in maintaining the status quo of things, no matter how dysfunctional (“...but you're not quite ready to deal with all that because you're afraid that you might not survive the pain and the despair you would feel were you to have to face that truth.”).

“You know that Justin ended up being a big disappointment to you, much as

your dad, before that, had broken your heart by initially offering you the seductive promise of a certain kind of deep connection only later to devastate you by failing to deliver, but you are not yet convinced that Justin won't some day come to his senses, see the light, and come back to you."

"You know that it is ultimately up to you to decide what you want to do with respect to losing those last 30 pounds, but, in the moment, even though you recognize how self-sabotaging it is, you're just not sure that you have it in you to go that extra mile. You are already feeling so deprived, you can't imagine having to experience even further deprivation."

Back and forth, back and forth, between highlighting first the patient's capacity to reflect upon her internal process and then her rationale for maintaining the dysfunctional status quo. First increasing the patient's anxiety by articulating, for example, a disillusioning truth about the object of her desire ("You know that Justin ended up being a big disappointment to you, much as your dad, before that, had broken your heart by initially offering you the seductive promise of a certain kind of deep connection only later to devastate you by failing to deliver...") or accountability for dysfunctional choices ("You know that it is ultimately up to you to decide what you want to do with respect to losing those last 30 pounds..."). And then decreasing the patient's anxiety by resonating with her investment in maintaining the status quo of things ("...but you are not yet convinced that Justin won't some day come to his senses, see the light, and come

back to you”) or (“...but, in the moment, even though you recognize how self-sabotaging it is, you’re just not sure that you have it in you to go that extra mile. You are already feeling so deprived, you can’t imagine having to experience even further deprivation”).

By their very nature, conflict statements tease out and, over time, amplify the tension that exists within the patient between, on the one hand, her awareness of the anxiety-provoking realities that she must eventually confront if she is ever to evolve to a higher level of awareness, acceptance, and accountability and, on the other hand, anxiety-assuaging defenses that she has mobilized in an effort to avoid confronting those painful realities.

“You know that by clinging to your hope that someday Justin will come through, you are setting yourself up for a lifetime of chronic frustration and heartbreak, but, in the moment, you’re feeling that you need to be able to cling to that hope or you won’t have anything left.”

“You know that you must ultimately confront the reality that Justin is never going to be available in the way that you would have wanted him to be, but you are not quite prepared to accept that – it would just hurt too much.”

“You know that you must someday confront – and grieve – the reality that Justin is never coming back, but, for now, you can’t imagine getting through each day unless you can hold on to the hope that someday, somehow, some way he will

see the light and come back.”

“You know that as long as you refuse to let go of Justin, you will be unable to open your heart to anyone else, but, right now, none of that matters because all you care about is having Justin back.”

Again and again, the therapist articulates the conflict that exists within the patient between the health-promoting positive forces that will provide the propulsive fuel for her movement forward (even though, initially, the patient’s awareness of them makes her anxious) and the health-disrupting negative counterforces, (unconsciously) mobilized in response to the first set of forces, that constitute the patient’s resistance to change.

Again, conflict statements are specifically designed to tease out, on the one hand, sobering realities and stressful challenges with which the patient is struggling and, on the other hand, the defenses she reflexively mobilizes in order not to have to deal with the impact of those anxiety-provoking realities.

“You know that your need for your children to understand your perspective might be a bit unrealistic, but you tell yourself that you have a right to their respect, and their forgiveness.” (sobering reality/entitlement)

As noted earlier, the unspoken portion of a conflict statement has to do with the patient’s reactive mobilization of a self-protective defense because being

reminded of what she really does know has made her so anxious.

“You know that your need for your children to understand your perspective might be a bit unrealistic, but *<it makes you so anxious to acknowledge this reality that>* you tell yourself that you have a right to their respect, and their forgiveness.” (sobering reality/entitlement)

The italicized words, which make explicit the connection between acknowledgment of the anxiety-provoking reality and mobilization of the anxiety-assuaging defense, can be included in a conflict statement, but are not necessary.

“You know that there’s work to be done if you really want to move ahead with getting yourself a good job (completing your CV, gathering your references, etc.), but when you’re feeling like the failure your mother always said you were, it’s hard to mobilize your resources to advance yourself.” (work to be done/distorted sense of self as a failure)

“You know that there’s work to be done if you really want to move ahead with getting yourself a good job (completing your CV, gathering your references, etc.), but when you’re feeling like the failure your mother always said you were, *<it makes you so anxious that>* it’s hard to mobilize your resources to advance yourself.” (work to be done/distorted sense of self as a failure)

“You know that for you to have the experience of authentic connection with

someone, you will need to be more open, but you hold back for fear of being rejected, abandoned, hurt. Protected, yes, but never known, never seen. Safe, but desperately alone.” (accountability/distorted sense of others as hurtful and abandoning)

“You know that there is an element of choice in living your life in the self-defeating ways that you do and that eventually you will need to understand why you are so invested in sabotaging yourself, but, for now, you cannot imagine giving up your various self-indulgences because they are what enable you to get through each day.” (accountability and work to be done/self-justification for dysfunctional choices)

“You know that you run the risk of doing permanent damage to your already-diseased esophagus by taking additional medication, but there are times when you find yourself feeling just so depressed, anxious, empty, helpless, and alone, that you feel you have no choice but to take more of the drug so that you can try to make it stop hurting so much inside.” (price paid/distorted sense of self as a victim)

“You know what you would need to do in order to get yourself back on track, but, for the life of you, you just can’t seem to mobilize your resources to do it.” (accountability/rationalization)

“You know that no matter what you do, it probably won’t make any

difference anyway because your wife has made it clear that she stopped loving you years ago, but you find yourself still trying to please her, hoping that maybe, this time, you'll be able to get through to her, and then devastated when, yet again, you end up being told that you will always be a disappointment to her." (sobering reality/relentless hope)

"You know that by smoking pot every day, you are missing out on all sorts of opportunities to make your life more meaningful, but you are not yet prepared to confront the internal demons that you attempt to keep in check by being high all the time." (accountability and price paid/avoidance)

"You desperately want to be able to free yourself from feeling so drawn to Brian and know that you're wasting your life pining for him, but you just can't seem to break free of his stranglehold." (price paid/distorted sense of self as powerless)

"You know that because of the way your father mismanaged his finances that your family was left with feelings of insecurity and a sense of doom and that you probably won't be able to feel in charge of your own life and finances until you have worked through more of your feelings about how traumatizing it was for you to grow up in that household, but the thought of actually getting back into the pain of all that fills you with such a sense of futility that you find yourself feeling that, at least for now, you simply cannot afford to go there." (price paid and work to be

done/avoidance and rationalization)

“You know that you if you are really serious about finding yourself a partner, then you will need to put yourself out there in a way that you don’t ordinarily, but you find yourself holding back because you have an underlying conviction that no matter what you might try, it wouldn’t really make any difference anyway.” (accountability and work to be done/distorted sense of self as ineffective)

“You know that you’re going to be very lonely as long as you keep yourself so isolated, but the thought of putting yourself out there is absolutely overwhelming right now – and terrifying.” (price paid/avoidance)

“You know that your need to keep what really matters to you hidden, incommunicado, private, means that you will never really be able to have deep connection or real intimacy with someone, but you have felt betrayed so many times in the past that you are not sure you will ever dare to put yourself out there again.” (accountability and price paid/self-justification)

“You know that you won’t feel truly fulfilled until you are able to get your long-anticipated manuscript completed, but you continue to struggle, fearing that whatever you might write just wouldn’t be good enough or capture well enough the essence of what you are attempting to convey.” (sobering reality/self-justification)

“Although you know that Jane probably won’t ever be able to support you in the ways that you so desperately would want to be supported, nonetheless you find yourself continuing to hope that she will and outraged when she doesn’t.” (sobering reality/relentless hope and relentless outrage)

“You know that as long as you keep getting bogged down in trying to take care of everyone else you will have little energy left over to attend to your own business, but it’s hard to extricate yourself because you were taught that taking care of people was to be your role in life.” (accountability and price paid/distorted sense of self as mandated caregiver)

“You know that you want desperately to get yourself healthier and that you will therefore need to commit yourself to doing whatever you must in order to pursue that path, but your sense of helplessness and the despair that never lets up make it hard for you to get motivated.” (accountability and work to be done/self-justification)

“You know that tomorrow you will regret having binged today, but, right now, all you can think about is how deprived you feel and how good it would feel to be able to have that ice cream sundae.” (price paid/distorted sense of self as deprived and entitled sense that one is therefore owed compensation)

“Even though you know that she’ll probably never change and that she’ll never want to have sex with you no matter how hard you try to please her, you

find yourself feeling surprised when she says particularly unkind things that make it clear how little regard she has for you.” (disillusioning truth about the object of one’s desire/denial)

“You know that someday you will have to forgive yourself for the mistakes you’ve made, but, in the moment, all you can think about is how disappointed you are in yourself.” (accountability and work to be done/distorted sense of self as always a disappointment)

“You know that if you are ever to move forward in your life you will need to figure out why you are constantly sabotaging yourself, but you don’t want to have to get back into all that right now and find yourself hoping that things will simply get better.” (price paid and work to be done/avoidance and relentless hope)

“You want to be able to do something to make yourself feel better, but you are feeling so damaged from way back that you cannot imagine ever being able to do anything that would really make a difference.” (sobering reality/distorted sense of self as damaged goods)

“Deep in your heart you know that probably what Victor gives you will never be enough, but you tell yourself that maybe you could learn to live with what he does do.” (sobering reality/denial)

“You know that there is stuff inside of you that’s not very pretty and that

someday you will need to expose it to the light of day so that you can better understand why you keep doing the self-destructive things that you do, but, in the moment, you can't imagine ever being able to do that." (work to be done and price paid/avoidance)

"You are finally letting yourself know that you would really love to be able to find a life partner, but you are not entirely sure that you have the right to ask for one." (anxiety-provoking reality/distorted sense of self as undeserving)

"Even though you know that you should be so much kinder to yourself and more forgiving, you find yourself feeling powerless to do anything differently." (work to be done/distorted sense of self as powerless)

"You find yourself getting a little bit panicked at the thought that your life might continue to be this empty until the end, but you just can't imagine what you could do to make it different. You feel that you are already doing as much as anybody could possibly expect you to be doing." (sobering reality/distorted sense of self as powerless)

"You know that you will need to do something different if the direction in which your life is going is ever to change, but you can feel yourself shutting down when confronted with that sobering reality." (work to be done/defensive self-protective retreat)

“You know that not everybody is going to have the same level of thoughtfulness and sensitivity that you have; even so, whenever you are confronted with yet another instance of someone’s thoughtlessness, you find yourself feeling outraged and indignant.” (disillusioning truth/defensive response of outrage and self-righteousness)

“Even though you know that you can’t continue to pretend that you had nothing to do with the mess that your life is now in, you find yourself desperately wishing that you could just forget about all the mistakes you’ve made and move on with a clean slate.” (accountability/relentless hope and denial)

Accountability (Conflict) Statements.

As we know, before the patient can relinquish a defense, she must first take ownership of the defense and then be able to understand both her investment in holding on to it and the price she pays for refusing to let it go. But if she is ever to relinquish her attachment to the dysfunctional defense, she must first be able to hold herself accountable for the dysfunctional choices that she has made, and is continuing to make, in her life. Obviously, she cannot choose to surrender her dysfunction until she is able to recognize that it is she who has chosen to live as she does!

Especially useful, therefore, will be a particular type of conflict statement that highlights the patient’s internal conflict between, on the one hand, her

recognition of her accountability for the choices she is continuously making about how she lives her life and, on the other hand, her resistance to being held accountable for such choices. Again, many of the patient's choices will be dysfunctional ones because what underlies those choices will be her defensive need to protect herself from having to deal with the impact of certain stressful challenges that have been simply too much for her to master.

As an example of a dysfunctional choice, consider the situation of a patient who is entrenched in an unrelenting depression (because she has not yet dared to confront – and grieve – the reality of her heartbreak about her father's emotional abusiveness) and clings to that depression as an excuse for not moving forward in her life. The patient's resistance to being held accountable for her choice to avoid dealing with the impact of her father's abusiveness on her life will obviously need to be addressed if she is ever to move beyond her seemingly intractable depression.

I refer to conflict statements that highlight first the patient's accountability for the choices she is making and then her resistance to acknowledging the element of choice in how she is living as accountability statements. The format of an accountability statement is the same as that of any other conflict statement, except that the therapist specifically focuses her interpretive efforts on both the patient's accountability and her resistance to being held accountable.

Of course, on some level, every conflict statement has, embedded within it, a highlighting of the patient's accountability for her life; but accountability statements aim to highlight the volitional component in the patient's choice to live as she does.

"You know that if your relationship with Victor is to survive, you will need to take at least some responsibility for the part you play in the horrid fights that you and he have, but you tell yourself that it isn't really your fault because if he weren't so doggone provocative, then you wouldn't have to be so reactive!"

"You know that a part of you wants desperately to be able to feel connected to me and authentically engaged with me, but another part of you is so terrified at the prospect of making yourself that vulnerable that you find yourself holding back for fear of more heartbreak."

"Even though you know that if your relationship with Victor is to survive you will need to relent and let go of your investment in being right, in the moment of upset and anger, all you can think about is making him admit that he was wrong."

"Although you know that you're probably really angry at your mother for her constant judging of you and finding fault with everything you did, in the moment, you don't want to have to deal with whatever residual anger you might have from those many years of being criticized – and all you can really feel is disappointment."

Parenthetically, it is hoped that the therapist's articulation, on the patient's behalf, of both what the patient really does know and what she finds herself feeling (and doing) in order to avoid knowing will make the patient feel not only held accountable but also held.

Both parts of a thoughtfully constructed accountability statement – both the therapist's highlighting of what the patient does know to be the sobering truth about her own responsibility for the dysfunctional choices she is continuously making and the therapist's empathic resonating with the patient's defensive reactivity to the naming of that sobering truth – will convey to the patient the therapist's deep understanding of, and appreciation for, the patient's internal struggle between clinging to the old and embracing the new. By their very design, accountability statements first challenge, by reminding the patient that she is ultimately responsible for the choices she is continuously making, and then support, by resonating empathically with her (often unconscious) need to deny such responsibility.

I am here reminded of a *Saturday Night Live* skit in which two guys are sitting around a fire talking, and one says to the other: "You know how when you stick a poker in the fire and leave it in for a long time, it gets really, really hot? And then you stick it in your eye, and it really, really hurts? I hate it when that happens! I just hate it when that happens."

It is a truism but, nonetheless, one worth repeating: People must be able to accept responsibility for their lives and for the choices they are continuously making before they can change the direction in which their lives are going. In other words, the flip side of accountability is, of course, empowerment. The patient cannot possibly become empowered until she is able to recognize that how she is living her life is a story about choices she has made. Although many of those choices may well be unconscious ones, they are nonetheless the patient's responsibility – and the work of Model 1 is to render conscious those unconscious (defensive) counterforces that are interfering with the patient's progression in life so that they can be refashioned into healthier adaptations.

Work-to-Be-Done (Conflict) Statements.

I refer to conflict statements that bring to light the conflict that exists within the patient between what she knows she must do in order to evolve to a higher level and what she finds herself feeling (and doing) instead as *work-to-be-done statements*. By their very design, work-to-be-done statements first challenge, by reminding the patient of the therapeutic work she knows, at least on some level, that she must do in order to advance in her life, and then support, by resonating empathically with the patient's (often unconscious) need to protest that she is not yet prepared to do that.

“You know that if you are ever to get better, you will ultimately need to

understand why you are so unrelentingly self-sabotaging and that the answer might well have to do with working through some of the feelings you have about how undermining your mother always was, but, in the moment, you are feeling so overwhelmed and discouraged that you can't imagine ever being able to get back into all of that now."

"You know that you will continue to feel like a fraud as long as you keep what's really going on inside of you a secret, but, for now, you feel you need to keep the bad parts of yourself hidden because you can't imagine ever being loved simply for who you are."

"Although you know that you will need to do something different if you are ever to advance yourself in your life, you just don't know where to start and find yourself feeling confused about what you do – and what you don't – actually have control over."

"You know that eventually you will have to learn to let things roll off your back more easily, but, in the moment, you find yourself filled with so much rage inside that you can't imagine ever being able just to let things go."

"You know that someday you will have to stop hiding behind that cynical, sarcastic mask if you ever expect to be close to somebody, but, for now, you feel you have to be tough and can't afford to let down your guard. Over time your heart has been so badly broken that you're not sure you will ever let yourself love

again.”

Pain-Gain (Conflict) Statements.

By way of a series of conflict statements (and, most especially, accountability and work-to-be-done statements), the therapist will be attempting to generate tension within the patient between her adaptive capacity to hold herself accountable for what she knows she must do in order to get on with her life and her defensive need to avoid taking that responsibility.

Also within the therapist’s repertoire will be *pain-gain statements* that juxtapose , on the one hand, what the patient really does know to be the price she pays for having her maladaptive defenses and, on the other hand, how having those defenses serves her. Pain-gain statements are specifically designed to highlight, on the one hand, the patient’s dawning awareness of the price she is paying for holding on to her maladaptive defenses (which will make her feel pain) and, on the other hand, how having those defenses works for her (which will enable her to understand the gain).

The format of a pain-gain statement is the same as that of any other conflict statement, except that now the therapist focuses her interpretive efforts on both the pain and the gain of having the dysfunctional defense, the stress and strain of which will ultimately require the patient to do something in order to ease the tension that is building up inside of her. In other words, by way of a series of pain-

gain statements that juxtapose both the pain and the gain of living as the patient does, the therapist is striving to generate sufficient tension within the patient that the cognitive dissonance between the cost and the benefit of living as she does will eventually prompt her to take some action – which she can do by surrendering the dysfunctional defense – in order to restore internal order, balance, and harmony.

The therapist will alternately challenge by highlighting what the patient really does know to be the price she pays for clinging so tenaciously to her dysfunction and support by resonating empathically with what the therapist senses is the patient's need to be holding on so tightly to it. And the therapist does this again and again – alternately engaging, on the one hand, the patient's observing ego by appealing to her capacity to know and, on the other hand, the patient's experiencing ego by appealing to her need to deny that knowledge; alternately increasing the patient's anxiety by challenging and decreasing it by supporting; alternately highlighting what the patient knows to be reality and resonating empathically with her experience of reality.

“Even though you know that you probably won't feel totally authentic, present, or engaged until you have dared to expose the deepest, darkest parts of your soul to Jane, you find yourself holding back for fear that were you to be that vulnerable, Jane would lose interest and pull away from you.”

“You know that in the morning you will regret having cut your wrists, but,

right now, all you can think about is how good it would feel to get that release.”

“Although you know that until you dare to deal with your internal demons you will probably continue to feel like a hypocrite, the thought of exposing some of the darkness inside is simply too terrifying and, for now, not worth it.”

“You know that you will be lonely until you can dare to trust again, but you are feeling so tattered and bruised from previous efforts that you are not sure you’ll be putting yourself out there again any time soon.”

Repetitive use of these pain-gain statements, in conjunction with the other kinds of conflict statements, will create more and more tension within the patient between the pain and the gain of holding on to the dysfunctional defense – dissonance that will ultimately provide the impetus for the patient to relinquish the defense.

Holding on to the dysfunction will become increasingly untenable as the patient is being challenged, again and again, to remember what she knows is the price she pays for clinging to her dysfunction (even as the therapist, in order not to make the patient too anxious, is supporting the patient by resonating empathically with her investment in having the dysfunction).

Inverted Conflict Statements

Where once being reminded of how the dysfunction was serving her would have decreased the patient's anxiety, there will come a time when being confronted with how invested she is in having the dysfunction will increase the anxiety. By the same token, where once being reminded of how costly it was for her to have the dysfunction would have increased her anxiety, there will come a time when being confronted with how costly it would be for her were she to continue to cling to her dysfunction will decrease the anxiety – because that knowledge will be consonant with her ever-evolving recognition of the fact that she really does need to let go of her dysfunction.

At the point when being reminded of how invested she is in her dysfunction is what the patient finds intolerable (and, by the same token, being confronted with the price she pays for refusing to let go of her dysfunction is something she can now tolerate), the therapist can introduce an inverted conflict statement. Such a statement inverts the order: *first* the patient's investment in holding on to the defense is highlighted (because now it is this reminder of how invested she has been in having the defense that makes her anxious) and *then* the price the patient pays for refusing to let go of the defense is highlighted (because now it is the reminder of just how costly it has been for her to cling to the defense that will galvanize her to action, prompting her ultimately to relinquish the now anxiety-provoking defense).

As examples of inverted conflict statements:

Instead of “You know that by smoking pot everyday, you are missing out on all sorts of opportunities to make your life more meaningful, but you are not yet prepared to confront the internal demons that you attempt to keep in check by being high all the time,” the therapist offers the following: “You had not felt prepared to confront the internal demons that you were attempting to keep in check by being high all the time, but you are beginning to recognize that by smoking pot everyday, you are missing out on all sorts of opportunities to make your life more meaningful.”

Instead of “You know that no matter what you do, it probably won’t make any difference anyway because your wife has made it clear that she stopped loving you years ago, but you find yourself still trying to please her, hoping that maybe, this time, you’ll be able to get through to her, and then you’re devastated when, yet again, you end up being told that you will always be a disappointment to her,” the therapist offers the following: “You still try sometimes to please your wife in the hope that she’ll fall back in love with you, but you are coming to see that no matter what you do, it probably won’t make any difference anyway because your wife has been saying for a long time now that she stopped loving you years ago.”

Instead of “You know that you’re going to be very lonely as long as you keep yourself so isolated, but the thought of putting yourself out there is absolutely overwhelming right now – and terrifying,” the therapist offers the following: “The thought of putting yourself out there is absolutely overwhelming – and terrifying,

but you are coming increasingly to appreciate that you're going to be very lonely as long as you keep yourself so isolated."

Whereas a conflict statement highlights first the patient's knowledge of reality and then the defense, an inverted conflict statement highlights first the defense and then the patient's knowledge of reality.

The intent of an inverted conflict statement is to help the patient articulate what she is becoming increasingly aware of, namely, that she is not doing herself any favors by clinging so tenaciously to her dysfunction and that if she wants to move forward in her life, then she really will need to take seriously some of the painful realities, including sobering truths about the object of her desire, that she had been refusing to see and take some action to free herself from the stranglehold of her dysfunctional choices.

Where once holding on to the defense would have been ego-syntonic (because it was easing the patient's anxiety), there will come a time when letting go of the defense will become ego-syntonic (because doing so will ease the patient's anxiety).

In essence, the therapeutic action in Model 1 is very much a story about highlighting the discrepancy between what the patient knows to be real (most especially, the price she pays for clinging to her defensive dysfunction) and what she finds herself thinking, feeling, and doing in order not to have to know (which

fuels her investment in holding on to her defensive dysfunction).

Relinquishing her attachment to the dysfunctional defense will be the way the patient adapts to the challenge of being confronted with the cognitive dissonance between her dawning recognition of just how costly it is for her to be living as she does – despite the benefit she derives from living that way. In essence, as the patient comes to appreciate that the net cost of her dysfunction is outweighing the net benefit, her surrendering the defense will constitute an adaptation to the stress created by her awareness of that cognitive dissonance, which will enable her to adopt healthier, more functional ways of thinking, feeling, and doing, including more effective coping strategies.

Defense will effectively have been refashioned into an adaptation, that is, resistance to recognizing one's internal process will have been refashioned into awareness of one's internal process.

In sum, the patient will be able to let go of her dysfunction only when she has worked through her ambivalent attachment to the dysfunction. We are speaking, of course, to the adhesiveness of the id, that is, both the libidinal attachment to the defense (which speaks to the benefit of having the defense) and the aggressive attachment to the defense (which speaks to the cost of having the defense). Only when the patient has worked through her ambivalence will she be able to transform her need to defend into a capacity to adapt (that is, her

resistance into awareness).

Stress and Strain as a Fulcrum for Therapeutic Change

With her finger ever on the pulse of the patient's anxiety and the patient's capacity to tolerate further challenge, the therapist will therefore alternately confront (by reminding the patient of what she really does know) and support (by resonating with what the patient finds herself feeling and doing in order not to have to know).

Moment by moment, the therapist can therefore titrate the level of the patient's anxiety, ever appreciating that just the right amount of anxiety (optimal anxiety, optimal stress) – created by just the right balance of challenge and support – will provide the impetus needed to advance the patient's evolution to ever-higher levels of integration and complex understanding.

With enough support, the patient will become more aware of how invested she is in preserving her self-protective defenses – how they have served her (in essence, the *gain*). But, with enough challenge, the patient will be forced to recognize how self-sabotaging her defenses have now become – the price she has paid (in essence, the *pain*).

As long as the gain is greater than the pain (that is, as long as the defenses are more ego-syntonic than ego-dystonic) then the patient will maintain her

defenses and remain entrenched.

Only when the pain becomes greater than the gain will the discrepancy between the pain and the gain create the requisite strain – stress and strain that will then provide the impetus needed for the patient ultimately to surrender her unhealthy defenses in favor of healthier adaptation, signaling the transformation of defensive need into adaptive capacity (the defensive need to hold on into the adaptive capacity to let go).

In essence, the therapeutic goal is to give the patient the experience of cognitive and affective dissonance between her awareness of the investment she has in maintaining her defenses and her awareness of just how costly her defenses have become over time. This dissonance will then function as an optimal stressor – a fulcrum for therapeutic change – by prompting first destabilization and then restabilization at a higher level of awareness, acceptance, and accountability.

Consider the situation of a patient whose tendency is to withdraw emotionally whenever she finds herself getting romantically close to a man. Her fear of commitment (the result of sexual molestation by her stepfather, the impact of which she has never fully processed and integrated) is such that she has been in a number of relationships that have had real potential, but each time she has either shut down emotionally or taken flight because of her fear that if she were to get too close she would be taken advantage of and abused. But now the patient is

in her late thirties and beginning to panic that maybe she will never find a man whom she can really love and with whom she can start a family.

As the patient becomes more and more aware of the pain (that is, the price she is paying for her defensive self-protective retreat) and this eventually outweighs the gain (that is, the insulation she gets from having to deal with the horror of her abusive stepfather's betrayal of her), then it becomes more and more difficult for her to cling to her defensive retreat as her *modus operandi*. In essence, the cognitive dissonance created by the tension within her between her heightened awareness of the price she pays for having the defense and her ever-diminishing investment in having the defense prompts gradual relinquishment of the defense – again, a defense that had once served her but that has long since outlived its usefulness.

In sum: The therapeutic action in Model 1 can therefore be conceptualized as focusing attention on the conflict that exists within the patient between, on the one hand, anxiety-provoking but health-promoting forces that will ultimately facilitate letting go (as the patient becomes ever more aware of the price paid for the dysfunctional defense) and, on the other hand, anxiety-assuaging but health-disrupting counterforces that are promoting holding on (as the patient becomes ever more aware of her investment in the dysfunctional defense). The cognitive dissonance between pain (which will make the defense ego-dystonic) and gain (which will make it ego-syntonic) will provide the therapeutic leverage for a

relinquishing of the defense.

Listening to One's Inner Voice vs. Silencing It

The conflict that exists within the patient can be conceptualized as either internal tension between health-promoting forces that will ultimately facilitate letting go of dysfunction and health-disrupting counterforces that are fueling the holding on to that dysfunction or, more generally, as internal tension between health-promoting forces that will ultimately facilitate accountability for dysfunction and attentiveness to one's inner voice of reality and health-disrupting counterforces that are fueling resistance to accountability and a silencing of that inner voice.

In other words, the therapeutic action can be conceptualized as focusing attention on the conflict that exists within the patient between healthy letting go and unhealthy holding on, between healthy accountability and unhealthy resistance or healthy listening to one's inner voice of reality and unhealthy quelling of that voice.

By way of a series of conflict statements, the therapist articulates the conflict that exists within the patient between the health-promoting yes forces that will provide the propulsive fuel for the patient's movement forward and the health-disrupting no forces, mobilized in response to the first set of forces, that constitute the patient's resistance to change. In essence, with conflict statements the

therapist is highlighting first the patient's refusal to let go and then her investment in holding on, first the patient's accountability for her choices and then her resistance to taking ownership, first the patient's adaptive capacity to attend to her inner voice of truth and then her defensive need to silence it.

Optimal Stress as Providing Therapeutic Leverage

And, as we have been suggesting all along, the therapeutic process itself (whether the classical interpretive perspective of Model 1, the deficiency-compensation perspective of Model 2, or the contemporary relational perspective of Model 3) is all about transforming defense into adaptation. In essence, the therapeutic process progresses by virtue of the fact that there will be optimal stressors with which the patient must contend – stressors that not only must be managed but also can become the means by which the patient is able to evolve to a higher level of awareness, acceptance, and accountability.

In other words, the patient will get better not just in spite of the stress but by way of that stress. And it will be her innate striving toward health and her intrinsic ability to self-heal in the face of optimal stressful challenge and environmental perturbation that will enable her to evolve from dysfunctional to functional as she evolves from defense to adaptation.

Holding On vs. Letting Go

To review: Working through the patient's investment in holding on and resistance to letting go is an ongoing process that involves both challenging the adhesiveness of the id (in order to tame, modify, and integrate its libidinal and aggressive energies) and supporting the ego (in order to strengthen its regulatory capacity by promoting awareness of its internal process and underlying dynamics).

In Model 1, therefore, the therapeutic action involves expanding the patient's awareness of her internal dynamics, that is, knowledge of her internal conflict between holding on and letting go of defenses that were mobilized in the face of realities simply too much to be processed and integrated. It involves increasing the patient's awareness of the dissonance between holding on to her defenses and letting them go – the dissonance between holding on to her defensive patterns (the dysfunctional status quo) and letting them go in order to adopt more adaptive patterns, more functional ways of being, and healthier coping strategies.

Consider a situation in which the patient is relentless in her pursuit of a man who is clearly not all that interested in having a relationship with her. In this instance, the therapeutic action in Model 1 will involve the cognitive dissonance that develops once the patient comes to recognize that the price she pays for holding on to her refusal to relent outweighs the benefit she derives from persisting even so. More specifically, the patient must become aware of the fact

that, by clinging to her relentless pursuit, she is able to avoid having to confront – and grieve – the reality of the man’s lack of romantic interest in her but that, by refusing to relinquish her pursuit, she is also consigning herself to chronic frustration and devastating heartbreak. The patient becomes ever more aware of the fact that desperate unhappiness will be her cross to bear because of her refusal to grieve and come to terms with certain immutable realities, unless she can begin to face those painful realities and mourn them.

Of note is the fact that initially the patient is made more anxious at the thought of having to let go than of being able to hold on. But our hope is that ultimately, as the patient comes to appreciate ever more clearly the price she pays for refusing to let go, it will make her more anxious to hold on than to let go.

Again, as long as the gain is greater than the pain, the patient will maintain the defense and remain entrenched in her dysfunction. But once the pain becomes greater than the gain, the stress and strain created by the tension within the patient between the price she pays and the benefit she derives from holding on to the defense will provide the impetus needed for the patient to relinquish the dysfunctional defense.

Ultimately, as we have said previously, the goal is to transform the need to hold on into the capacity to let go – the defensive need to hold on into the adaptive capacity to let go.

Alternatively, we could say that the therapeutic goal is to transform the need to deny accountability for one's choices into the capacity to take ownership of those choices.

In both instances, the therapeutic action will involve the transformation of unhealthy defense into healthier adaptation, dysfunctional defense into more functional adaptation.

Neurotically Conflicted About Healthy Desire

In sum, the patient comes to us desperate to get better but deeply conflicted. She knows that she cannot go on living the way she has been, but she is intensely attached to her (dysfunctional) defenses – defenses that had once enabled her to survive but that now impede her movement forward.

In truth, the patient is conflicted about getting better, about changing, and about letting go of her less healthy defenses in favor of more healthy adaptations. She is not entirely committed to taking ownership of the fact that she is choosing to live her life as she does and that she is therefore accountable for her often dysfunctional choices.

Ultimately, the patient must become aware of both her investment in holding on to her defensive stance in life and the price she pays for refusing to let it go; that is, she must become aware of both her investment in holding on to her

defenses and how costly such refusal to let go actually is. The ever-increasing discord between her awareness of the cost and of the benefit will provide the therapeutic leverage for her ultimately to let go and move on.

Consider the situation of a patient who withdraws whenever she feels overwhelmed by the many stressors in her life. With exploration and analysis of that defensive reaction, the patient comes to appreciate how retreating protects her from having to deal with the discomfort occasioned by various anxiety-provoking situations in her life; she comes to understand that her defensive retreat serves to insulate her from having to deal.

But, over time, the patient comes also to appreciate the down side of retreating in this way. First of all, she becomes more and more aware of the fact that her tendency to withdraw in the face of challenge speaks to an unconscious identification with her alcoholic mother who was always retreating to the bottle, a sobering insight that fills the patient with horror. Second of all, she becomes more and more aware of the fact that her tendency to withdraw in the face of challenge has meant that she herself is becoming increasingly isolated and lonely in her own life.

Once the pain becomes greater than the gain, the stress and strain of that discrepancy will provide the therapeutic impetus for the patient to relinquish her attachment to the defense in favor of a more adaptive strategy. Letting go of the

defense (her tendency to withdraw) will ease the tension she feels and allow for the adoption of healthier, more functional coping strategies (a willingness to take more risks and to put herself more out there).

Or consider the situation of a patient who clings to unrealistic expectations about her narcissistic mother's ability to be empathic, supportive, and attuned to her daughter's experience. With exploration and analysis of the patient's illusory expectations about her mother, the patient comes to appreciate how holding on to her relentless hope with respect to her mother serves to protect her from having to confront the pain of her disappointment about the mother's very real limitations, separateness, and immutability.

But, over time, the patient comes also to appreciate that her attachment to the unrealistic hope she has with respect to her mother's emotional availability means that she is consigning herself to a lifetime of chronic disappointment and pain in relation to her mother because what she's wanting from her mother can never be.

Only by working through the adhesiveness of the patient's id to her relentless hope – that is, both the libidinal attachment to that defense (which speaks to the benefit of having the unrealistic hope) and the aggressive attachment to it (which speaks to the cost of having the unrealistic hope) – will the patient be able to relinquish her ambivalent attachment to illusory expectations

about her mother and replace them with a more reality-based recognition that her mother, a very damaged woman to be sure, is actually doing the best she can.

Again, once the pain becomes greater than the gain, the stress and strain of that discrepancy will provide the therapeutic impetus for the patient to relinquish her relentless hope in favor of more realistic expectations and a more reality-based assessment of her mother's capabilities. Letting go of her relentless hope will ease the tension she experiences and enable her to adopt a healthier, more reality-based acceptance of her mother's very real limitations.

The patient's defense of relentless hope (which enabled her to disregard certain disillusioning realities about the object of her infantile yearnings) becomes transformed into more realistic hope and sober acceptance of the reality of the mother's limitations, separateness, and immutability. The patient ends up sadder perhaps, but wiser too.

You adapt to a difficult situation by creating a compromise solution. When you adapt, you take reality into consideration. You don't get caught up in your need for things to be different; rather, you take stock of what is and then behave accordingly.

In another situation: From time to time, the patient sleeps through her alarm, which means that, upon occasion, she has been late to important meetings. Instead of feeling victimized by, and continuing to complain about, an alarm clock

that doesn't work, she adapts to the situation by strategically placing her alarm clock on the other side of the room so that she won't ever again be in the position of sleeping through the alarm. If that doesn't work, then she uses two alarm clocks, putting one on the other side of the room and the other in the next room! She has replaced a defensive reaction (raging at the alarm clock for being defective) with an adaptive response (confronting the reality that it is she who has trouble getting up in the morning and that she should therefore do something to ensure that she never again sleeps through an alarm).

The Wisdom of the Body

In essence, I am speaking here to the innate ability of the body – in the face of environmental challenge – to make whatever adjustments it must in order to maintain its dynamic equilibrium, that is, its homeostatic balance. Walter B. Cannon (1932) referred to this self-righting (or self-correcting) ability of the living system as the *wisdom of the body*.

The concept applies to both body and mind.

With respect to the body: If the living system has enough resilience and there are adequate adaptation reserves, the living system will be able to adapt. In fact, it is critically important for the health and vitality of the system that it be able, in response to ongoing stressful challenges, to adapt and that it be able to manage the impact of the myriad of environmental stressors to which it is being

continuously exposed, in the process, evolving through cycles of defensive collapse and adaptive reconstitution at ever-higher levels of integration and functionality. That's the good news.

But there are no free lunches. The bad news about adaptation will be the significant damage sustained by the system over the long haul because of depletion of the system's adaptation reserves (both its nutrient and its energetic resources), the net result of which will be excess wear and tear on the system and accelerated aging. Robbing Peter to pay Paul. Paul will indeed get paid, but at Peter's expense.

In the physiological realm, a prime example of adaptation is collateralization. The coronary arteries supply nutrients and oxygen to the myocardium (the heart muscle). If they become blocked, the flow of blood becomes obstructed. To compensate for the disrupted flow, the body, in its infinite wisdom, can develop new (collateral) arteries to supply the heart with the nutrients and oxygen that it needs to function. Although the price paid for such collateralization may be suboptimal perfusion of the myocardium, this adaptive collateralization may enable the patient to avert a potential myocardial infarction (heart attack).

As another example: When the thyroid is poisoned by environmental pollutants and becomes compromised in its functioning, one of the ways the body adapts is to redistribute circulatory flow, thereby reducing blood supply to the

skin and other nonessential areas in favor of the body's more essential systems – thus the thin fragile skin, dry brittle hair, and telltale loss of the outer third of the eyebrows so typical of thyroid dysfunction.

Furthermore, if the thyroid is functioning suboptimally (and the metabolism is therefore depressed), the adrenals may kick in to make up the difference by upregulating their production of the stress hormone cortisol. The price paid, however, will include eventual adrenal fatigue and short-term memory loss from neuronal cell death in the hippocampus (a limbic structure in the brain that is particularly vulnerable to the neurotoxic effects of excessive and prolonged cortisol secretion).

When the body is exposed to endocrine-disrupting, neurotoxic, and carcinogenic toxins, it attempts to cope with this challenge by sequestering the lipophilic (fat-loving) chemicals in its fat cells, the better to reduce oxidative stress by keeping these electron-scavenging free radicals out of circulation. The bad news, however, will be that the body is now loaded with toxic chemical substances foreign to the body (often referred to as xenobiotics) that can potentially wreak havoc on the system.

During intense exercise, when aerobic respiration has depleted the oxygen supply, the body adapts by shifting from aerobic to anaerobic respiration, an adaptation that will enable the cells to continue functioning, but their level of

functioning will be suboptimal because of decreased production of adenosine triphosphate (ATP).

Or when the internal environment of the body becomes too acidic (perhaps secondary to the accumulation of metabolic waste products and toxicant pollutants), the body may adapt by leaching calcium from its bones in an effort to buffer the acidity. The good news will be restoration of the body's acid-base balance, which is necessary for optimal health and vitality; but the bad news will be the potential for demineralization of the bones and development of osteopenia/osteoporosis.

When the body is sleep deprived, one of the ways it responds is to activate the sympathetic nervous system. This adaptation speaks to the body's efforts to compensate for its fatigue. The result will be the experience of being wired but tired, the plight of so many in these modern stressful times. Here the good news will be the body's ability to continue functioning, but the bad news will be the price paid in terms of depleting the body's adaptation reserves (that is, its nutrient and energetic resources) and gradually wearing out its regulatory systems.

As another (more humorous) example of adaptation: If you and your friend are out hiking and unexpectedly encounter a bear in the woods, it is important that you be able to outrun not the bear but your friend! The good news will be that you live; the bad news will be that you lose your friend.

In other words, in the face of environmental challenge, the system can either react defensively (the less healthy alternative) or respond adaptively (the more healthy alternative). Although defenses are more costly than are adaptations, in both instances there will be some cost to the system. Again, there are no free lunches. In the face of stress, the system must do something in order to go on being; defenses enable it to survive but adaptations enable it to thrive.

With Adaptation There Is Always a Small Price Paid

If there is enough support from the outside (in the form of the therapist's empathic interventions) and the patient has enough internal resilience, then the patient will be able to transform defense into adaptation, although always at some cost. With awareness comes a certain sobriety; with acceptance comes a certain sadness; and with accountability comes a certain burden. But this is a small price to pay if the adaptation enables the patient to harness her resources and move forward in her life – no longer resistant, relentless, or re-enacting but now aware, accepting, and accountable.

Repeated Juxtaposition of Pain with Gain

So the process of working through the patient's attachment to her dysfunction involves repeated juxtaposition of cost with benefit. Each time the patient is reminded of what she really does know to be the price she pays for

clinging to defenses that have long since outlived their usefulness, then, in order to restore her balance, she must either redouble her defensive efforts to deny that reality or move a step closer toward relinquishing her attachment to the dysfunctional defense.

Over time, as the patient is confronted ever more directly with the price she pays for choosing to live as she does, and her investment in having the dysfunctional defense becomes ever more tenuous, it will become ever more difficult for her to cling to something that is so clearly creating such internal discord.

It is hoped that with enough support from a therapist who also appreciates the patient's investment in living as she does, the patient will ultimately be prompted to relinquish the defense in order to restore her homeostatic equilibrium. The wisdom of the body is such that the system will take action in order to preserve its internal order and optimize its functionality. This self-correcting ability will enable the patient to evolve to ever-higher levels of integration, balance, and maturity.

Constant juxtaposition of the pain and the gain will eventually become intolerable for the patient and she will be forced to do something in order to relieve the internal tension so created. Again, the wisdom of the body is such that it cannot tolerate disequilibrium for extended periods of time and will therefore

be prompted to take action in order to resolve the tension and restore the order.

Maintenance of Homeostatic Balance

We are speaking, of course, to the body's self-righting (that is, self-correcting) mechanisms, whereby the body, in an ongoing fashion, is ever busy adjusting itself – in the face of challenge – in an effort to maintain its homeostasis, which is simply another way of describing the body's innate capacity to heal itself in the face of environmental stressors – in essence, the body's innate capacity to cope with stress by adapting to it.

Conclusion

Whether the transformation is of resistance (a defense) into awareness of painful truths about one's inner workings (an adaptation) or whether the transformation is from cursing the darkness (a defense) to lighting a candle (an adaptation), the process by which a less functional defense is transformed into a more functional adaptation can best be described as one in which an acute injury (in the form of optimally stressful psychotherapeutic interventions) is superimposed upon a chronic injury, thereby tapping into the innate wisdom of the body and its capacity to self-heal in the face of optimal challenge.

The process of working through the disruption occasioned by the therapist's optimally stressful input (in the form of interventions that provide just the right

combination of destabilizing challenge and restabilizing support) will result ultimately in a taming of the id and a strengthening of the ego. A tamer id will provoke less anxiety in the ego and a stronger ego will have less need to defend and greater capacity to adapt.

Furthermore, the now stronger, wiser, and more capable ego will be better able to manage the id by re-directing the id's now tamer and better regulated energies into more constructive channels.

As the id energies are harnessed and the ego empowered, the patient's neurotic conflictedness and obstructed progression through life will gradually become transformed into mobilization of healthy ambition and actualization of realizable potential.

In essence, as a result of working through resistances that had *reined in* both awareness and actualization of potential, Freud's rider (a now stronger and more empowered ego by virtue of its greater awareness of its inner workings) will be more skilled at harnessing the power of the horse (a now tamer, better regulated id) such that horse and rider will be able to move forward harmoniously and in sync – no longer in conflict but in collaboration.

Indeed, as the id is tamed and the ego strengthened (whether as a result of the developmental process or the therapeutic process), what had once been an adversarial relationship between wild horse and overwhelmed rider becomes a

much more collaborative and harmonious one. And where once an overwhelmed ego would have cursed the darkness to protest its feelings of frustration and helplessness in the face of being thwarted, a now stronger ego adapts to the darkness by lighting a candle.

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