PSYCHODYNAMIC SYNERGY PARADIGM
Master Spreadsheet (MS)
THE STARK METHOD

(August 2025)

Synopsis of
THE STARK METHOD
As a psychoanalyst,
I incorporate the five modes
outlined in THE STARK METHOD
into not only my long-term,
in-depth work with patients
but also the short-term,
intensive treatments
that I now often do.

The sandpile model
of chaos theory speaks
to the cumulative impact
– over time –
of environmental stressors
on open systems.

More specifically,
this simulation model offers
an elegant visual metaphor
for how all of us are
continuously refashioning
ourselves at ever higher
levels of complexity and
integration ...
not just "in spite of"
stressful input from the
outside but "by way of"
that input.

Amazingly enough,
grains of sand being
steadily added to a
gradually evolving sandpile
are the occasion for both
its disruption and its repair.

Not only do the grains of sand
being added precipitate
partial collapses of the sandpile
but they also become the
means by which the
sandpile will then be able
to build itself back up –
each time at a new level
dynamic balance.

The system will therefore

Model 1
THE STARK METHOD of PSYCHODYNAMIC SYNERGY:
The Five Dimensions of Resilience

The central organizing principle
of THE STARK METHOD is the idea that
the problem always holds elements of its solution.

By repeatedly generating, and working through,
optimally stressful, growth-incentivizing
"mismatch experiences"
(violations of expectation)
between "old bad" rigid defense
and "new good" more resilient adaptation,
psychodynamic psychotherapy
affords the patient
both impetus and opportunity
– albeit belatedly –
to master early-on toxic relational experiences
– both deprivation and neglect (absence of good)
and trauma and abuse (presence of bad) –
that had once been overwhelming
(and therefore defended against)
but that can now be
reactivated, relived, reprocessed,
grieved, and reframed –
such that growth-impeding defenses
(once needed for surviving)
will incrementally evolve
into growth-promoting adaptations
(now making thriving possible).

In essence, the transformation is
from conditioned and rigidly defended
to corrected and more resiliently adapted.

All five modes of therapeutic action
in THE STARK METHOD
involve graduated evolving of the patient
from rigid (conditioned) defense
to more resilient (corrected) adaptation –

(Model 1) from defensive resistance
to adaptive awareness
– the interpretive perspective
of classical psychoanalysis –
(a story about structural conflict)

(Model 2) from defensive relentless hope
to adaptive acceptance
– the corrective-provision perspective
of self psychology –
(a story about structural deficit)

(Model 3) from defensive re-enactment
to adaptive accountability

Model 2
FIVE MODES OF THERAPEUTIC ACTION
Also fundamental
to THE STARK METHOD is the idea that
superimposing an acute injury
on top of a chronic one
is sometimes exactly what the body
needs to heal.

... because if indeed deep embodied healing
is the ultimate goal,
then "no pain / no gain."

Just as setting on fire
a broad swath of withered grass
can stimulate it to grow back
greener, healthier, and lusher than before
– controlled burning / prescribed burning –
so, too, with respect to the body and the mind
controlled damage / dosed stimulation
can be used
to correct for previous damage done
or, more generally,
to optimize the overall functionality
and resilience of the MindBodyMatrix –
by provoking the innate healing cascade
and jumpstarting the system's
repair and optimization mechanisms.

With the therapist's finger ever on the pulse
of the level of the patient's anxiety
and capacity therefore to tolerate further challenge
(and in the interest of generating destabilizing
but growth-incentivizing mismatch experiences),
the therapist strategically juxtaposes
"corrective challenge" of the patient's defense
(in the form of introducing
a healthier, more adaptive alternative)
with "restitutive support" of the patient's defense
(in the form of providing
deep appreciation of the need for it) –

... which harkens back to
Alexander and French's (1946) concept
– groundbreaking at the time –
of the "corrective emotional experience."

The corrective challenge involves
introducing into the therapeutic space
any/all of the following –

(Model 1) new information
(Model 2) new experience
(Model 3) new relationship
(Model 4) a new beginning
(Model 5) new possibilities

Model 3
A C.A.R.E.S. Approach to Deep Embodied Healing
The optimally stressful, growth-incentivizing
mismatch experiences
(created by these strategically crafted
juxtapositions of
corrective challenge with restorative support)
take the form of –

(Model 1) cognitive dissonance
(worked through by interpreting the patient's
internal conflictedness between
resilient "yes" forces
and rigidly defensive / resistant "no" counterforces)

(Model 2) affective disillusionment
(worked through by facilitating the patient's
necessary grieving
of thwarted illusory desire
and disillusioned heartbreak)

(Model 3) relational detoxification
(worked through by negotiating with the patient
at the intimate edge of authentic relatedness)

(Model 4) existential dependence
(worked through by nurturing the patient's
existential surrender
to analytic oneness with the therapist)

(Model 5) quantum disentanglement
– synaptic deconditioning / energetic decoupling –
(worked through by prompting the patient
to envision the enlivening and quantum possibility of
"something new, different, and compellingly better"
than the sobering and conditioned reality of
"same old same old")

– "what could be" vs "what is" –

Ongoing working through
of these mismatch experiences
will generate iterative healing cycles
of disruption
(the defensive reaction to corrective challenge)
and repair
(the adaptive response to restorative support)
and, ultimately, evolution of
conditioned "old bad" into corrected "new good."

In essence,
we are precipitating disruption to trigger repair –
and we are doing it repeatedly,
judiciously, and strategically
to provoke transformation and growth.

Model 4
Cognitive / Affective / Relational / Existential / Synaptic
Indeed,
it is the working through
of mismatch experiences
between destabilizing challenge and restabilizing support
that constitutes the therapeutic action
in deep embodied psychotherapies
and incentivizes the graduated evolution of
psychological rigidity into psychological resilience –
much as a humble caterpillar
incrementally morphs,
over time, into a beautiful butterfly.

The journey from caterpillar to butterfly
teaches us that sometimes we must
go through darkness to find our light.

Indeed,
the caterpillar's struggle to break free
from its chrysalis is the very act
that strengthens its wings,
reminding us that growth often comes
through overcoming adversity.

We cannot avoid suffering –
but we can choose how we cope with it,
find meaning in it,
and move forward with renewed purpose.

Although often misattributed to
the existential psychiatrist Viktor Frankl,
the actual author of this well-known quote is unknown:
"Between stimulus and response is a space.
In that space is our power to choose our response.
In our response lies our growth and our freedom."

Applying this to the clinical situation:
"Between stressor and what follows is a space.
In that space is our power
either to react defensively
when the stressor is simply "too much"
for us to manage
(which will thwart our growth)
or to respond adaptively
when we are more easily able
to take that stressor "in our stride"
(which will promote our freedom).
Not only do we have the power to choose
how we make meaning of our lives,
but we also have the responsibility to do so."

At the end of the day,
psychodynamic psychotherapy aims
to set the patient free from her –

Model 5
mutually enhancing not mutually exclusive modes
In sum, THE STARK METHOD
embraces the idea that the problem
always holds elements of the solution
and contains the seeds of its own resolution.

In the beginning of the child's life are
toxic formative experiences
(developmental traumas)
from which so much else will derive
– both "bad" in the short term
but potential "good" in the long term.

These early-on traumatic relational experiences of
deprivation and neglect ("absence of good")
as well as trauma and abuse ("presence of bad")
– whether "little t traumas" or "Big T traumas" –
constituted traumatic stressors at the time
because they were
simply "too much" for the young child
– lacking both internal resources
and parental support –
to process, integrate, and adapt to,
thereby forcing her to react defensively
in order to survive.

But as an adult in treatment
– with now the benefit of both
greater internal resources
and the support of a skilled therapist –
those earlier traumatic relational experiences
can be evoked, reworked, and reframed.

... such that traumatically stressful experiences
once growth-impeding
– and to which the child had had
no choice but to react defensively –
can now be incrementally transformed
into optimally stressful experiences
to which the adult patient can respond adaptively.

Where once there had been
traumatic stress and defensive reaction,
now there can be
optimal stress and adaptive response.

... described in the literature as "post-traumatic growth"

Both simple and profound is this compelling idea
that therapeutic modalities
with deep and enduring psychodynamic change
as their ultimate goal
have the power to reconfigure the past
and thereby to transform the future –
as outdated and conditioned reaction evolves

have been able not only
to "manage" the impact
of the stressful input
but also to "benefit from"
that impact.

And as the sandpile evolves,
an underlying pattern
will begin to emerge,
characterized by iterative
cycles of disruption and
repair, destabilization and
restabilization, defensive
collapse and adaptive
reconstitution ...

at ever higher levels of
integration, balance,
resilience, and robust capacity.

"Without order
nothing can exist.
Without chaos
nothing can evolve."
Oscar Wilde

"There are only two ways
to live your life.
One is as though
nothing is a miracle.
The other is as though
everything is a miracle."
Albert Einstein

"The paradox of trauma
is that it has
both the power
to destroy
and the power
to transform
and resurrect."

"Therapy is a story
about experiences
waiting to happen,
not problems
needing to be solved."
Ron Kurtz

– the intersubjective perspective
of contemporary relational theory –
(a story about relational conflict)

(Model 4) from defensive retreat
to adaptive accessibility
– an existential-humanistic approach
to confronting the complexities of existence
and managing dark nights of the soul –
(a story about relational deficit)

(Model 5) from defensive refractory inertia
to adaptive actualizing action
– a quantum-neuroscientific approach
to reworking traumatic – somatic – memories
and updating disempowering mental schemas –
(a story about analysis paralysis,
synaptic conditioning, and neural entrenchment)

Witness Freud's young child
who once played recklessly with knives
but who is now a world-class surgeon
who cuts with mindful precision
and expert finesse.

"Out of your vulnerabilities
will come your strength." Freud

"Wholeness is not achieved
by cutting off a portion of one's being
but by integration of the contraries." Jung

"Healing does not mean
the damage never existed.
It means the damage
no longer controls our lives." Jessie E Sampson

So, too, in the realm of the physical,
the problem always holds elements of its solution.

By way of example –
A fever that develops as the body's
defensive reaction to pathogens
is both "the problem"
(who wants to have a fever?)
and, ultimately, part of "the solution"
(inasmuch as the fever will become part
of what enables the body to heal).

A study done in 1989
on children with chicken pox
not surprisingly found that those children
whose fevers went untreated
fared better than did those
who were treated with antipyretics
to reduce their fevers.

If done effectively by a courageous therapist
not afraid to go against the grain,
then juxtaposing "old bad" with "new good"
will generate growth-incentivizing
"optimal stress" –
that is, just the right balance
between anxiety-provoking
(but ultimately growth-promoting)
challenge of defense
and anxiety-assuaging
(but ultimately growth-impeding)
support of it.

In fact,
the therapist is ever busy deciding
whether to challenge
by directing the patient's attention
to where the therapist would want her to go
(disruptive attunement)
or to support
by being with the patient where she is
(homeostatic attunement).

As a result of the working through process,
what was once experienced
as traumatically stressful
(necessitating defense in order to survive)
will be gradually reworked and become reframed
as optimally stressful
(thereby enabling adaptive thriving).

The overarching goal of deep embodied treatments
– whether long-term or short-term –
is to help the patient evolve
– through iterative healing cycles of
disruption and repair –
from rigidity to resilience
– from defensive reaction to adaptive response –
– from defense to adaptation –
– from reaction to response –

... such that, moment by moment,
in the face of environmental stressors,
the patient will respond adaptively,
rather than reacting defensively.

– from mindless to mindful –
– from thoughtless to thoughtful –
– from reflexive to reflective –
– from impulsive to considered –
– from less evolved to more evolved –
– from conditioned to corrected –
– from outdated to updated –

– from symptom to ferreting out the underlying causes –

Indeed,
ongoing therapeutic provision
of just the right (optimally stressful) combination
of corrective challenge and restorative support
will jumpstart
profound and enduring (second-order) change
by tapping into "the wisdom of the body"
(its embodied intelligence
and innate capacity to adapt to stress).

Relevant here is the fact that
the intrinsic wisdom of the body
is such that it does not tolerate
disequilibrium for extended periods of time.

The body will continuously adapt
to the stress of homeostatic imbalance
– self-correcting and reorienting itself –
by reconstituting at ever more robust levels
of resilience and adaptive capacity.

This process is facilitated by
the dynamic synergy between
the body's innate intelligence
and the therapist's restorative support.

... which is why the old Japanese adage
"Fall down seven times, stand up eight"
does not do full justice by evolutionary processes.

More to the point would be
"Fall down seven times, work it through each time,
stand up ever more triumphantly eight."

"No mud, no lotus" Thich Nhat Hanh

The lotus is a powerful symbol of
spiritual growth, enlightenment, and purity.
The flower blooms from the mud,
representing the ability
to rise above difficulties
in order to achieve enlightenment and purity
despite challenging circumstances.

(Model 1) internal turmoil / anguished conflictedness
(Model 2) insatiable hunger / relentless pursuits
(Model 3) contentious entanglements /
noxious relatedness
(Model 4) harrowing loneliness / existential despair
(Model 5) procedurally organized, implicitly held
traumatic (embodied) memories

... such that she will be released
from the toxicity of her past
and empowered to embrace love, work, and play
to her greatest potential going forward.

Transformation is not just about change;
it's about becoming the truest version of yourself.

Very much to the point here is –
"Quantum science suggests the existence
of many possible futures
for each moment of our lives.
Each future lies in a state of rest
until it is awakened by choices
made in the present." Gregg Braden

"The future is just a memory
that has yet to be born." Dean Cavanagh

The wave-particle duality of quantum science
has it that particles (like electrons)
don't have fixed locations or defined states
until they are measured / observed.

Instead, they exist in a state of superposition,
whereby they are in multiple (possible) states at once.

The wave function
– which represents these probabilities –
"collapses" into a specific state upon observation.

By extension, the limitless possibilities
that are our birthright
and are simply waiting to be found
will "manifest" as specific realities
once intention is set.

into updated and corrected response
and as rigidity morphs into resilience.

In essence, the working through process
is a story about reshaping the past
to make new futures possible.

Albert Einstein
– who famously described
the quantum entanglement of quantum physics
as "spooky action at a distance" –
also wrote about timelessness
in the quantum realm –
"The past, present, and future
are only illusions."

Indeed, does not psychotherapy demonstrate
this very same "spooky action over time"
as well as "spooky action at a distance"?

At the end of the day
and in keeping with
Freud's metaphor of working through
as a story about
taming dysregulated horse
and strengthening inexperienced rider
(in order to transform neurotic internal conflict
into empowering and harmonious collaboration),
psychotherapy does indeed
appear to involve
reshaping the "old bad" past
to make "new good" futures possible.

This process of
resolving contentious internal conflict
and harnessing energies
that are now more effectively regulated
is accomplished by way of
"taming / modifying"
defensive reactions
and "strengthening / reinforcing"
adaptive responses.

... such that the past can indeed
– retroactively –
be rescripted, reframed, and refashioned ...

– from depression to sadness –
– from anxiety to accessing the underlying
narratives that are fueling the anxiety –

DATE DEVELOPED	1970 - 1980	1980 - 1990	1990 - 2000	2000 - 2010	2010 - 2020
THEORETICAL FRAMEWORK	classical psychoanalytic	self psychological	contemporary relational	existential-humanistic	quantum-neuroscientific
THERAPEUTIC PERSPECTIVE	the interpretive perspective of classical psychoanalysis with its focus on taming the id, strengthening the ego, and mitigating the severity of the superego – thereby resolving structural conflict – "Where id was, there ego shall be." Freud "OK. So Freud is the 'Father of Psychoanalysis.' But who is the 'Mother'?" Stark	the corrective-provision (deficiency-compensation) perspective of self psychology and those object relations theories that focus on internal "absence of good" and serial (relational) accretion of "new good" – thereby filling in structural deficit – "Pretending that it can be when it can't is how people break their hearts." Elvin Semrad "In chasing the impossible, you might lose track of what's possible." Stark	the intersubjective perspective of contemporary relational theory and those object relations theories that focus on internal "presence of bad" and its serial (relational) detoxification / dilution – thereby resolving relational conflict – Jessica Benjamin defines "intersubjectivity" as "a relationship of mutual recognition" – a relationship in which each subject is affectively attuned to the felt experience of the other even as the distinctness and separateness of the other is recognized – and accepted.	an existential-humanistic approach to facilitating benign regression to a new beginning and nurturing surrender to existential dependence – thereby correcting for relational deficit – "It is a joy to be hidden but a disaster not to be found." D W Winnicott "I gave you a part of me that I knew you could break, but you didn't." Anonymous	a quantum-neuroscientific approach to processing, completing, and integrating traumatic (embodied) memories · thereby overcoming psychic inertia / neural entrenchment – (neuroplasticity / therapeutic memory reconsolidation) "The body keeps the score." Bessel van der Kolk "Nothing happens until something moves." Einstein – working with "freeze" ("tonic immobility") – – sometimes simply need to get the body moving again – – from freeze (a survival reaction) to connection – "Memory is a verb, not a noun" – which highlights the reality that memory is not just a static, fixed entity but rather a dynamic, ongoing process that is continuously being reshaped / refashioned / reconstructed. "The body remembers even when the patient does not." van der Kolk
FUNDAMENTAL PSYCHOLOGICAL ISSUE	structural conflict – tripartite model of the mind (id, ego, superego) – Inevitably there will be internal psychic tension between id, ego, and superego.	structural deficit – impaired capacity for internal self-esteem regulation – thus fragile self-esteem that is easily disrupted by narcissistic injury – – inability to be a nurturing parent unto oneself – – thus the unrelenting need for validation, affirmation, acceptance, praise, and external reinforcement – Heinz Kohut writes that patients suffering from "disorders of the self" demonstrate "a specific vulnerability – their self-esteem is unusually labile and, in particular, they are extremely sensitive to failures, disappointments, and slights."	relational conflict – inevitable relational tension in the transference and, more generally, in all relationships – We re-enact what we don't remember! Stephen Mitchell uses the image of Penelope's loom – and the process whereby Odysseus's wife repeatedly weaves and then unravels the shroud for Laertes (her father-in-law) – as a metaphor for operation of the "relational matrix." Mitchell's claim is that this process of working and reworking, doing and undoing, is how relationships inevitably work. Mitchell writes that the therapist must be totally present and completely engaged in the therapeutic encounter – "Unless the therapist affectively enters the patient's relational matrix or, rather, discovers himself within it – unless the therapist is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses – the treatment is never fully engaged, and a certain depth within the analytic experience is lost."	relational deficit - a heart shattered, the impenetrable self, and a life unlived - – isolation, loneliness, existential despair / dread – Simons and Garfunkel's *I Am a Rock* " ... I have my books and my poetry to protect me I am shieled in my armour Hiding in my room safe within my womb I touch no one and no one touches me I am a rock, I am an island And a rock feels no pain, and an island never cries." It is the terror of being annihilated by the object that drives the patient to detach herself completely from the world of objects and to renounce all hope. But it is the terror of ego dissolution – when confronted with how utterly alone she then feels – that compels her to reach out once again for contact. On the one hand, the patient desperately needs objects but is terrified that she will be destroyed by them. On the other hand, she desperately needs her solitude but is terrified that she will then disappear. The net result is relentless despair and profound hopelessness.	analysis paralysis / intractability / synaptic conditioning – "old bad," outdated, immobilizing narratives – – deeply embedded, procedurally organized, implicitly held traumatic (somatic) memories – Neuroscientists had long believed that once a new experience – especially a traumatic one – had been stored in long-term memory, it would be permanently installed. Perhaps it could then be modified by subsequent experiences, but its essence would nonetheless remain intact, lurking just beneath the surface as a somatic memory, ever prone to being reactivated and re-experienced (thereby reinforcing its intensity) before once again returning to body consciousness. – cells that fire together, wire together – Donald Hebb Fortunately, that is not the whole story ... Cognitive researchers are discovering that the brain, in response to ongoing new experience and information, is continuously adapting – by modifying itself at the level of the neural synapse – in order to stay current and relevant. This "learning" process speaks to "the adaptive capacity of the brain" and "the dynamic nature of memory" – in essence, the brain's remarkable "neuroplasticity." Norman Doidge's *The Brain That Changes Itself*

"I suppose it is tempting, if the
only tool you have is a hammer,
to treat everything as if it
were a nail." Abraham Maslow

But with THE STARK METHOD
of PSYCHODYNAMIC SYNERGY,
you will have the comprehensive
tools and innovative strategies
needed to navigate a diverse
terrain of clinical challenges.

"DIAGNOSIS"	neurotic For the most part, Model 1 patients – with internal (1-person) conflicts – will be the only ones who "suffer," whereas Model 3 patients – with relational (2-person) conflicts – will make the people around them "suffer." Interestingly, many of the disorders that used to be called neuroses are now classified as anxiety disorders.	narcissistic When a therapist wants to highlight the patient's "narcissism," a patient-friendly way to name that is to suggest that the patient is being, say, "Michael-Centric." Patients will almost immediately understand and will eventually develop the capacity to recognize for themselves their "Michael-Centrism."	character disordered / borderline For the most part, Model 3 patients – with relational (2-person) conflicts – will make the people around them "suffer," whereas Model 1 patients – with internal (1-person) conflicts – will be the only ones who "suffer." By definition, Model 3 patients will have downloaded "pairs" of "pathogenic introjects" – (e.g., doer and done-to). More specifically, character disordered patients will then project onto the outside world one or the other pole of the introjective pairing and then "do battle" with the object. Borderline patients, however, will then project onto the outside world both poles of the introjective pairing and then "do battle" with the object.	schizoid "When past experiences of neglect and rejection haunt us, the thought of intimacy becomes fraught with fear and uncertainty – evoking a paralyzing dread and further psychic retreat from the world." Stark	"little t traumas" / "Big T traumas" When "distorted, outdated" narratives deriving from the patient's unmastered early-on relational traumas "kick in" and color the patient's (mis-)perception of self, others, and the world, then it can be clinically useful for the therapist to refer to those narratives as, say, "Michael thinking." Patients will almost immediately understand and will eventually develop the capacity to identify for themselves their "Michael Thinking." – the implicit self – "Our bodies are telling the stories we have avoided or forgotten how to hear." Hillary McBride
UNDERLYING STANCE	neurotic conflictedness	narcissistic vulnerability / woundedness / entitlement	noxious relatedness	nonrelatedness	nonaction / nonactivation / neural entrenchment
CHARACTER STYLE	the (neurotically) conflicted self Neurotic conflict is the result of a conflict of interests between the pleasure-seeking drives of the id, the moral imperatives of the superego, the harsh realities imposed by the external world, and a beleaguered ego – desperately attempting to make the peace.	the (narcissistically) vulnerable self Kohut writes about the narcissistically vulnerable self as desperate for recognition, affirmation, external validation, and praise.	the (noxiously) re-enacting self Benjamin writes about our struggle for recognition, whereby we will find ourselves engaged in a dance of power and submission, re-enacting the dysfunctional relational dynamics of our earliest wounding relationships.	the (nonrelated) retreating self John Bowlby writes that when past experiences of neglect and rejection haunt us, the thought of intimacy becomes fraught with fear and vulnerability – evoking a paralyzing dread and further distancing of ourselves.	the (nonactualized) intractable self Irvin Yalom writes that when we allow conditioning to dictate our actions, we become mere shadows of what we could be and remain trapped in patterns that prevent us from realizing our full potential. "It is never too late to be what you might have been." George Eliot
THERAPEUTIC ACTION	interpreting	grieving	negotiating	surrendering	rescripting
NUMBER OF PERSONS	1-person psychology the patient's internal landscape (1) the therapist as neutral observer (0)	1½-person psychology the patient's emotional experience (1) the therapist as empathic selfobject / good mother (½)	2-person psychology both patient (1) and therapist (1) contribute to the creation of conflict / meaning in the therapeutic encounter – mutuality of impact / co-construction of experience – – transference / countertransference entanglements – – projective identifications / mutual enactments – – mutuality of influence (both parties changing by virtue of being in relationship with each other) –	2-as-1 psychology – the emergence of analytic oneness – a blissful state of peaceful merger – – a harmonious interpenetrating mix-up – – mutual existential surrender – – treasured moments of meeting – – tolerating "aloneness" as long as it is "in the presence of" another –	3-person psychology – the "envisioned third" together patient (1) and therapist (1) co-create the patient's envisioned future and possible self (1) – working in concert to imagine alternative, compellingly better, emergent possibilities for the patient –
MARTIN BUBER	I – relatedness to the internal world	"I – It" transactional relatedness	"I – Thou" authentic relatedness	I – nonrelatedness	I – relatedness to the envisioned future self
A C.A.R.E.S. APPROACH to deep embodied healing	cognitive – "left brain" conscious cognition – Allan Schore highlights what he describes as "a paradigm shift," over the course of the years, from "left brain conscious cognition" (which corresponds to Model 1) to "right brain unconscious emotional processes" (which corresponds to Model 2) to "right brain unconscious relational dynamics" (which corresponds to Model 3).	affective – "right brain" unconscious emotional processes – Schore explains that the shift, across disciplines and for both clinicians and researchers, has been "from left brain explicit conscious cognition to right brain implicit unconscious emotional and relational functions." "Despite the designation of the verbal left hemisphere as 'dominant' due to its capacities for explicitly processing language functions, it is the right hemisphere	relational – "right brain" unconscious relational dynamics – Shore focuses his attention on (1) the right brain as affective / relational and the left brain as cognitive; (2) the right brain as intuitive / synthetic / integrative and the left brain as analytical / logical; (3) the right brain as subjective and the left brain as objective; (4) the right brain as unconscious / deep and the left brain as conscious / not-so-deep;	existential – the complexities of human existence and relationships – Yalom describes four major "ultimate concerns" ("givens of existence") – death, meaninglessness, isolation, and freedom. Every person must come to terms with these concerns through active choices if they are to realize their individual potential. And Martin Heidegger writes about the importance of "authenticity" as giving meaning, purpose, and direction to a person's life.	synaptic plasticity / superpositional / shapeshifting – engagement of both left brain and right brain – – therapeutic memory reconsolidation – In essence, treatment capitalizes upon the use of bilateral alternating stimulation to engage both sides of the brain, thereby bringing to bear the analytic wisdom of the present-focused left brain on the emotional knowledge and somatic wisdom harbored in the past-focused right brain.

		and its implicit homeostatic-survival and affect regulation functions that are truly dominant in human existence." Schore	(5) the right brain as nonverbal / imagistic and the left brain as verbal / linguistic; and (6) the right brain as implicit and the left brain as explicit. In essence, the right brain is artistic and the left brain is scientific.	On the one hand, authentic being-in-the-world refers to the attempt to live one's life according to the needs of one's inner being. Authentic being-in-the-world always involves this element of freedom and choice. On the other hand, "inauthenticity" refers to living one's life as determined by outside forces, expectations, pressures, and demands.	"Memory is a verb, not a noun; and it is in a continuous state of being reinterpreted and updated." Stark "Memory," Oscar Wilde (2005) once wrote, "is the diary that we all carry about with us." Daniel Lametti, after referencing Wilde's quote, quipped, "Perhaps, but if memory is like a diary, it's one filled with torn-out pages and fabricated passages." ... a clever way of describing the "quantum nature of memory" – the idea that memories are created / shaped by the act of remembering
from **DEFENSE – Rs** when the stressor is "too much"	resistance	relentless hope	re-enactment	relational absence / retreat (humanistic approach) nihilistic rejection of existence (existential approach)	refractory (intractable) inertia
to **ADAPTATION – As** when the stressor can be "more easily taken in stride"	awareness – introspective awareness –	acceptance – reality-based acceptance –	accountability – relational accountability –	authentic presence / availability / accessibility existential acceptance of life's dualities, polarities, complementarities, and complexities – vulnerable accessibility –	activation / action / actualization – from disempowered to empowered – – from deterministic to constructivistic – – empowering action –
by way of working through **OPTIMAL STRESSOR – Ds**	cognitive dissonance	affective (optimal) disillusionment	relational detoxification / dilution of pathogenic introjects detoxification of relational dissonance	existential / absolute / resourceless dependence	quantum disentanglement / synaptic deconditioning energetic decoupling
the net result of which is **TOTALLY RAD!**	a stronger, wiser, and more self-aware ego – illuminating the shadowed corners of the psyche –	a more compassionate and accepting self – cultivating a nurturing presence within –	a more accountable self-in-relation – reshaping identity from victim to empowered agent –	a more accessible private self – discovering and embracing the authentic self –	an action-oriented envisioned self – courageously stepping into one's potential –
CORRECTIVE CHALLENGE "The wound is the place where the Light enters you." Rumi	new corrective information – cognitive reframing / cognitive defusion – – dual awareness – "The forceful impact of knowledge about the self that is at odds with what's already believed will provide impetus for change." Stark	new corrective experience – corrective emotional (relational) experience – "Empathy is simply listening, holding space, withholding judgment, emotionally connecting, and communicating that incredibly healing message: You're not alone." Brene Brown	new corrective relationship – corrective emotional (relational) experience – Nancy McWilliams suggests that in the act of re-enactment, the past is not merely remembered but it is actually relived, which provides opportunity for healing through new relational experiences.	new corrective beginning – benign regression to redo – "The capacity to be alone [in the presence of another] is the capacity to love; in finding oneself, one can truly start anew." Winnicott	new corrective possibilities – from conditioned "old bad" to corrected "new good" – "When I let go of what I am, I become what I might be." Lao Tzu
MISMATCH EXPERIENCES – violations of expectation – the working through of which leads to **ITERATIVE HEALING CYCLES** of disruption (in reaction to the corrective challenge) and repair (in response to the restorative support)	BETWEEN the patient's defensive need to resist awareness of the forces / counterforces lurking beneath the surface of her consciousness AND her adaptive capacity to acknowledge their presence, take ownership of them, process them, and reframe / recontextualize them	BETWEEN the patient's defensive need to find a "new good" external object because of her impaired capacity to regulate internally her self-esteem AND her adaptive capacity to confront and grieve the reality that no one will ever be for her the good parent for whom she has spent a lifetime searching – the deficit creates the need to find in the here-and-now that which was not provided consistently and reliably in the there-and-then – – the deficit in self-loving capacity creates the need for external provision –	BETWEEN the patient's compulsive and unwitting re-enactment of her defensive need to re-find the "old bad" object both (1) because that's all she has ever known and having something different would make her too anxious (because it would highlight that things could be, and could therefore have been, different / better) and (2) because she is unconsciously attempting to achieve belated mastery of her introjected badness AND her adaptive capacity to take ownership of her contribution to the turbulence that will inevitably emerge at the intimate edge of relatedness with her therapist as she unconsciously struggles to recreate the early-on traumatic failure situation in the treatment	BETWEEN the patient's defensive need to remain hidden for fear of losing herself in another AND her adaptive capacity to take that risk BETWEEN the patient's defensive rejection of existence and fatalistic nihilism AND her adaptive capacity to accept its existential paradoxes, ambiguities, and uncertainties	BETWEEN the (conditioned) "old bad" that is being accessed by way of bottom-up "paying attention" AND the (envisioned) "new good" that is being introduced by way of top-down "setting intention" BETWEEN the sobering and conditioned (embodied) reality of "what is" AND the enlivening and quantum (envisioned) possibility of "what could be"
and **INCREMENTAL** **TRANSFORMATION** of "conditioned" into "corrected" as rigid (defensive) reaction eases into	resistance into awareness – jammed up into letting go once the cost is understood – "The therapist will repeatedly highlight both the price paid (pain) and the investment in (gain) that the patient has in her resistant stance.	relentless hope into acceptance – relentless hope into realistic hope – "We must all come to accept the sobering reality that we cannot make the people in our world change but that we can, and must, take ownership of,	re-enactment into accountability – sense of self as a victim into empowerment / agency – Model 3 conceives of the patient as an agent, as proactive, as intentioned in her activities – even if unwittingly so –	relational absence into authentic presence – retreat into accessibility – nihilistic rejection of existence into existential acceptance of life's dualities, polarities, complementarities, and complexities	refractoriness / refractory inertia into actualizing action – from entanglement with the woundedness of the past to liberation and the freedom to explore options – "You're under no obligation to be the same person you were five minute ago." Alan Watts

resilient (adaptive) response "We think that the point is to pass the test or overcome the problem, but the truth is that things don't really get solved. They come together and they fall apart. Then they come together again and fall apart again. It's just like that. The healing comes from letting there be room for all of this to happen: room for grief, for relief, for misery, for joy." Pema Chodron defensive reaction – depression adaptive response – sadness defensive reaction – anxiety adaptive response – recognizing and processing the underlying anxiety-provoking affect / impulse	But as long as the gain is greater than the pain (more ego-syntonic than ego-dystonic), the patient will maintain the defense and remain entrenched. Only once the pain has become greater than the gain (more ego-dystonic than ego-syntonic as a result of the patient's ever evolving awareness of the cost despite the benefit) will the stress and strain of the cognitive and affective dissonance thereby created be such that the impetus will be provided for the patient gradually to relinquish her attachment to the dysfunctional defense, thereby resolving the structural – neurotic / intrapsychic – conflict that had caused the patient to be jammed up in the first place." Stark	and responsibility for, all that we can change within ourselves. By the same token, we must come to terms with the sobering reality that we cannot change our history but that we can, and must, change how we position ourselves in relation to it." Stark "The bad news will be the sadness the patient experiences as she begins to accept the sobering reality that disappointment is an inevitable – but necessary and therefore desirable – aspect of relationship. The good news, however, will be the wisdom she acquires as she comes to appreciate ever more profoundly the subtleties and nuances of relationship and begins to make her peace with the harsh reality of life's many challenges – sadder she will be perhaps, but wiser too." Stark	and as therefore accountable and ultimately empowered. Although classical psychoanalysis concerns itself with harshly punitive superego introjects (where once the abusive parent had railed against the child, now that dynamic will get played out internally between superego and ego) relational theory concerns itself with pairs of pathogenic introjects that will inevitably be delivered into the transference – by way of projective identification – such that where once the abusive parent had railed against the child, now that dynamic will get played out relationally between patient and therapist. Once the therapist gets inducted into what then becomes a mutual enactment, both patient and therapist will end up railing against each other. But by collaboratively negotiating the turbulence that has emerged at their intimate edge, ultimately the patient will have a corrective relational experience that will eventually dilute the toxicity of her introjected badness.	– nihilistic despair into existential freedom – Masud Khan (1972) writes about the importance of giving patients who have emotionally withdrawn from the world of objects an opportunity to "overcome their dread of surrender to resourceless dependence" on the therapist – an emotional surrender that will hopefully be experienced by the patient as transcendent, liberating, and transformative – and not simply as a defeat. Khan specifies that so, too, the therapist must be able to overcome her own "dread of surrender to the therapeutic process," her own hesitation about bringing her authentic self into the treatment room, and her own anxiety about letting herself be controlled by the patient if there is ever to be hope that the patient, in *her* turn, will be able eventually to overcome *her* "dread of surrender to infantile dependence" on the therapist.	Model 5 conceives of memory as dynamic and as continuously updating itself on the basis of new experience (therapeutic memory reconsolidation). But Model 5 is also a quantum model because it is all about limitless possibilities, the observer effect, intentionality, and mystical entanglements. Quantum theory posits the existence of waves of energy that hold a boundless array of unrealized possibilities – any one of which can be "realized" once the observer sets the "intention" to "actualize" it, at which point the invisible wave of infinite potential will collapse into a visible particle that "manifests" in the real world. Potential will have become actual and envisioned will have become actualized – a concept that is at the heart of the quantum-neuroscientific Model 5.
OPTIMAL STRESS – Ds	dissonance	disillusionment	detoxification / dilution	dependence / dread	deconditioning / disentanglement / decoupling
PAYING GENERAL ATTENTION TO …	internal dynamics – internal conflictedness – – tension between defiance and compliance – – can I defy? or must I comply? – – can I be bad? or must I be good? –	affective (emotional) experience – affective experience of need / deprivation – – insatiable hunger for validation / affirmation external reinforcement / empathic resonance – – perpetual state of longing and dissatisfaction –	relational dynamics – relational toxicity / contentious entanglements – – dysfunctional relational expectations / introjective pairs – – transference / countertransference messiness – – "doer and done to" / victimizer and victim –	existential awareness – a heart shattered, a life unlived, and existential despair – – alienation, disconnect, and quiet desperation – – search for meaning, purpose, and direction –	somatic awareness adaptive capacity of the brain / dynamic nature of memory – conditioned (automatic) reactions / traumatic memories – – holistic understanding of bodily sensations – – interconnectedness of mind and body –
PAYING MORE SPECIFIC ATTENTION TO …	what is the patient thinking right now? – thinking / head –	what is the patient feeling right now? – feeling / heart –	what is the patient (re-)enacting in the transference right now? – doing / hands –	is the patient emotionally (dis-)engaged right now? – state of being-in-relationship –	what entrenched (somatic) mental schemas are immobilizing the patient right now? – state of intractability –
PRIVILEGING OF …	knowledge	experience	relationship Fairbairn highlights that the ego is "primarily object-seeking, not pleasure-seeking."	existence / meaning / purpose / freedom complexities of human experience	somatic memories / mental schemas / core beliefs procedurally organized, implicitly held traumatic memories narratives / conditioned reactions / visceral reactivity bodily sensations / sensorimotor perceptions / embodiment internal interoception – attunement to the therapist's own internal (bodily) experience / state vs. relational interoception – attunement to the patient's internal (bodily) experience / state
THERAPEUTIC ACTION	enhancement of knowledge "within"	provision of experience "for"	engagement in relationship "with"	nurturing of surrender "to" moments of meeting "between"	envisioning of possibilities "beyond"
THERAPEUTIC GOAL "History is not just an exploration of the past. It is an explanation of the present." *The Holdovers* (movie)	self-reflective / introspective knowledge – exposing to the light of day the powerful forces / counterforces secretly doing battle within the patient's psyche – Freud writes about psychoanalysis as a method designed to illuminate what's hidden in the dark recesses of the mind	corrective provision / deficiency compensation – capitalizing upon opportunities for adaptive transmuting (structure-building) internalizations in the aftermath of grieving the therapist's empathic failures – Failure to grieve is accompanied by defensive introjection of bad. But genuine grieving is accompanied by	harmonious relatedness – collaborative navigation of the treacherous intersubjective terrain that will inevitably emerge in the aftermath of the patient's efforts to recreate the early-on traumatic failure situation with the therapist (in a desperate attempt to achieve mastery of it) – Benjamin writes about the therapeutic relationship	fundamental trust – co-creation of a transitional space between patient and therapist into which the patient, who has emotionally shut down as a result of having had her heart shattered early on, can begin to deliver the parts of her "self" that are most vulnerable, most fragile, and most prone to breakage – A good-enough mother will be able to	relinquishing the past and embracing the future – updating "old bad" narratives with "new good" ones – The patient is asked to "hold" – in both her body and her mind – the reactivated memory of "old bad" (accessed by way of embodied mindfulness) in conjunction with

	so that the patient can become better able to understand the underlying forces / counterforces shaping her behavior – insight that involves not only the "cognitive" prefrontal cortex but also the "emotional" limbic system. The concept of "wise mind" was popularized by Marsha Linehan in her "dialectical behavior therapy" with borderline personality disorders and speaks to the harmonious convergence of "rational mind" and "emotional mind." More generally, however, because wise mind is the "sweet spot" between rational detachment and emotional intensity, I think it also has a place in the Model 1 approach, which privileges enhanced knowledge and dual awareness.	adaptive internalization of good. In other words, grieving and transmuting internalization go hand in hand and highlight the fact that even flawed relationships can leave an indelible mark of goodness in our lives.	as providing a dynamic space not merely for repeating the past but for redefining the future, as re-enacted wounds are transformed into opportunities for growth. "It is the things in common that make relationships enjoyable, but it is the little differences that make them interesting." John Gray	demonstrate her trustworthiness and engender fundamental trust by meeting her young child's age-appropriate need for omnipotent control. She does this by recognizing and responding to each and every one of her young child's needs, having often anticipated many of them prior even to the child's having signaled her desire. The dilemma for such patients is – how to be "a part of the world" without being destroyed but how to be "apart from the world" without disappearing.	the enlivening vision of "new good" (introduced by way of purposeful intentionality), thereby creating startling, jolting, decisive, and destabilizing mismatch experiences between "old bad" conditioned expectations and "new good" transcendent possibilities. When we "set an intention," we are directing our focused attention to the actualization of a particular reality. More specifically, we are consciously influencing our subconscious mind to manifest a latent possibility – hoping to replace an "old bad" conditioned reaction (mindfully retrieved from body consciousness) with a "new good" corrected response (intentionally introduced from brain consciousness). "I am not what happened to me. I am what I choose to become." Carl Jung
MORE SPECIFICALLY "No man ever steps in the same river twice, for it's not the same river and he's not the same man. There is nothing permanent except change. Heraclitus	enhancement of introspective knowledge "within" "The poor ego has a still harder time of it; it has to serve three harsh masters, and it has to do its best to reconcile the claims and demands of all three. The three tyrants are the external world, the superego, and the id." Freud "Nothing ever goes away until it has taught us what we needed to know." Pema Chödrön "Once we become conscious, we have more choices – although it's not always that easy!" Stark	provision of corrective experience "for" Some have suggested that the essence of a self psychological approach lies in the provision of an experience that nurtures the self and fosters healing. But there are those of us who believe that, – at the end of the day – it is the experience of surviving failures in the environmental provision that creates impetus and opportunity for deep structural transformation and change.	engagement in harmonious relationship "with" Bessel van der Kolk and others have suggested that re-enactments are a silent plea to change the narrative – an unconscious drive to find resolution in the in the very spaces that had once held trauma.	nurturing of existential surrender "to" treasured moments of meeting "between" In letting go of the false "intellectual" self and surrendering to absolute dependence upon another, we are forced to confront our deepest fears – but it is in that very surrender that we will find the possibility of true connection.	envisioning of transcendent possibilities "beyond" Whereas Models 1 – 4 focus on the relationship between the past and the present, Model 5 focuses on the relationship between the present and the future. Furthermore, whereas Models 1 – 4 are a story about our history as our destiny, Model 5 is a story about our destiny as our choice. "The only person you are destined to become is the person you decide to be." Emerson "We are the architects of our own destiny." Stark
THE LANGUAGE OF …	ego and achievement of ego strength – Freud's horse and rider / from conflict to collaboration as horse (id) is tamed and rider (ego) is strengthened – "One might compare the relation of the ego to the id with that between a rider and his horse. The horse provides the locomotor energy, and the rider has the prerogative of determining the goal and of guiding the movements of his powerful mount towards it." Freud	self-structure and achievement of self-cohesion, coherence, and stability – consolidation of the self – Kohut writes that the "self" is "the central organizing and motivating force" in human experience.	self-in-relation / relational self and achievement of accountability – empowerment / personal agency / center of initiative – Benjamin writes that "mutual recognition" is the "foundation of human connection." Mutual recognition is a developmental achievement that speaks to the process whereby "we" becomes the recognition of two individuals – each of whom is an "I."	true / authentic / private / hidden / impenetrable self vs false / "as if" / compliant / public / social self and finding meaning, purpose, and direction – a shattered heart repaired and a life reclaimed – a profound hopelessness that is kept hidden behind the "false self" mask presented to the world (a self-protective armor that conceals the deeply entrenched brokenness of the "true self" and its potential spontaneity / creativity / originality)	conditioned / entrenched / body self / implicit self and construction of an envisioned / future / possible self – neuroplasticity / therapeutic memory reconsolidation – "The ego is first and foremost a bodily ego." Freud "The body is your subconscious mind." Candace Pert "Body consciousness holds the conditioned memory of unresolved and dissociated traumas from the past. Brain consciousness holds the mental schemas deriving from those unprocessed and dissociated traumas." Stark
MOST PROMINENT EXEMPLAR **OTHER FAMOUS EXEMPLARS**	Sigmund Freud Anna Freud / Heinz Hartmann / Josef Breuer David Rapaport / Ralph Greenson / Rudolph Loewenstein James Strachey / Hans Loewald / Theodore Reik Melanie Klein / David Shapiro (*Neurotic Styles*) Karen Horney (*Neurosis and Human Growth*) Frieda Fromm-Reichmann / James McLaughlin Alfred Adler (*The Neurotic Character*)	Heinz Kohut Leston Havens / Paul and Anna Ornstein Arnold Goldberg / Howard Bacal / Michael Basch Estelle and Morton Shane / Joseph Lichtenberg Frank Lachmann / James Fosshage / Evelyne Schwaber George Atwood	Stephen Mitchell W R D Fairbairn / Otto Kernberg / Harold Searles Paul Russell / Philip Bromberg / Robert Stolorow Jay Greenberg / Donnell Stern / Jessica Benjamin Wilfred Bion / Peter Fonagy / Harry Stack Sullivan Darlene Ehrenberg / Dan Stern / Nancy McWilliams Karen Maroda / Irwin Hoffman / Donald Malin James Grotstein / Patrick Casement / David and Jill Scharff Christopher Bollas / David Malan / Heinrich Racker	D W Winnicott Harry Guntrip / Rollo May / Viktor Frankl / Carl Rogers Michael Balint / Martin Heidegger / Masud Khan Elvin Semrad / Arnold Modell / Thomas Ogden Andras Angyal / Jean-Paul Sartre / Albert Camus Irvin D Yalom / Abraham Maslow / R D Laing Erich Fromm, Virginia Satir	Bruce Ecker Dan Siegel / Allan Schore / Richard Schwartz Francine Shapiro / Robert Sapolsky / Antonio Damasio Joseph LeDoux / Jaak Panksepp / Al Pesso Joe Dispenza / Bruce Ecker / David Feinstein Norman Doidge / Pat Ogden / Peter Levine Frank Anderson / Sue Johnson / David Malan Habib Davanloo / Bessel van der Kolk / Diana Fosha Eugene Gendlin / Roy Schafer / Martin Seligman

			James Masterson / Margaret Mahler		Stephen Hayes
"DIAGNOSIS"	neurotic	narcissistic	character disordered / borderline	schizoid	"little t traumas" / "Big T traumas"
CELEBRITY EXEMPLARS	Woody Allen / Larry David / Tony Shalhoub (*Monk*) The Character of George Costanza (*Seinfeld*) The Character of Johnny Rose (*Schitt's Creek*)	Kim Kardashian (carpal tunnel syndrome from selfies) Kanye West / Simon Cowell / Bruno Tonioli / Pac-Man The Character Played by Nicole Kidman (*Expats*) Madonna	George and Martha (*Who's Afraid of Virginia Woolf?*) Ike and Tina Turner / Johnny Depp and Amber Heard *The War of the Roses* / *Fatal Attraction* / *Girl, Interrupted* Marilyn Monroe / Kurt Cobain / Amy Winehouse Princess Diana / Winona Ryder *A Streetcar Named Desire* (Tennessee Williams)	Bobby Fischer / Steve Jobs / John Nash (*A Beautiful Mind*) Vincent van Gogh / Susan Boyle / Prince / Sia / Henry Ford Emily Dickinson / Bill Gates / Sylvia Plath / Elon Musk Michelangelo / Temple Grandin / Lady Gaga / Eminem Thomas Edison / Alfred Hitchcock / Steven Spielberg John Denver / Bob Dylan / James Taylor / Carl Jung Thomas Jefferson / Isaac Newton / Mozart / Simon Baker Jane Austen / Jerry Seinfeld / Andy Warhol Toby Maguire / Benjamin Franklin / Sir Anthony Hopkins Lewis Capaldi / Ed Sheeran / Katharine Hepburn *The Heart Is a Lonely Hunter* (Carson McCullers)	Peter Pan / Holden Caulfield (*The Catcher in the Rye*) Britney Spears / Lindsay Lohan / Michael Jackson
CONDITIONED SELF	the resistant self Freud writes about the resistant self as one that clings to the familiar, fearing the unknown that lies beneath.	the relentless self Kohut writes about the relentless self as one that reflects an insatiable need for empathy, demanding acknowledgement in a world that often feels indifferent.	the re-enacting self Mitchell writes about the re-enacting self as one that brings the past into the present, shaping its interactions through the lens of previous wounds.	the retreating self Winnicott writes about the retreating self as one that represents a defense against the overwhelming demands of a controlling and intrusive environment.	the refractory (intractable) self Bruce Ecker writes that memory research has identified an innate type of neuroplasticity in the brain that can deconsolidate (and subsequently reconsolidate) neural encoding of the deeply embedded, traumatic emotional learnings that have been holding the patient hostage.
RELENTLESSNESS	relentless conflictedness / internal dividedness	relentless hope / entitlement	relentless outrage / self-righteous indignation – externalization of blame – – ever present sense of victimization –	relentless despair / existential dread	relentless nonaction / analysis paralysis
IN THE EXTREME …	anguished inner turmoil	insatiable hunger	tormented / tormenting entanglements	annihilating terror / harrowing loneliness	intractable inertia / thwarted potential
1-person vs 2-person **DEFENSES**	ego-protective (1-person) defenses – mobilized to protect an undeveloped ego from the threatened breakthrough of dangerous (dysregulated) id drives –	self-protective (2-person) defenses – mobilized to protect a narcissistically vulnerable self from the potential threat of encountering an intolerably painful unempathic object –	self-protective (2-person) defenses – mobilized to protect a noxiously relating self from the potential threat of encountering a dangerously victimizing object –	self-protective (2-person) defenses – mobilized to protect the private self from the potential threat of encountering an annihilatingly intrusive object –	immobilization to defend against being overwhelmed by reactivation of early-on relational (somatic) traumas – thus the intractability –
AUTONOMIC RESPONSE TO STRESS	force the stressor out of consciousness / forget – e.g., repression, suppression, dissociation, denial –	fawn / court favor	fight	flee	freeze
POINT OF EMOTIONAL URGENCY moment-by-moment Stress is when you wake up screaming and then realize you haven't fallen asleep yet. Anonymous "Cheer up, the worst is yet to come. Simply put, quit worrying over the little stuff and wait for something really big." Anonymous	jammed up / neurotically conflicted Neurotic conflicts are described as "convergent (both/and) conflicts" because they involve inner tension between healthy forces and unhealthy counterforces mobilized to defend against the anxiety provoked by the healthy forces. In contradistinction to these convergent conflicts, which involve tension between "yes" forces and defensive "no" counterforces, are "divergent (either/or) conflicts," which involve tension between two mutually exclusive forces (whereby the occurrence of one precludes the possibility of the other). These latter conflicts are not considered neurotic (structural) conflicts.	relentlessly hopeful and refusing to confront / grieve – an insatiable hunger for ever more – The structural deficit – and therefore the impaired capacity to be a good mother unto oneself – creates an unrelenting defensive need to find a "new good" object in the here-and-now to take the place of the unempathic and inconsistently available mother whose "emotional absence" was never fully grieved. It has been suggested that the tragedy of life is not that it ends so soon but that we wait so long to begin it because we are ever in pursuit of dreams that are but illusions.	compulsively re-enacting early-on relational traumas at the intimate edge of relatedness The patient's need to be relationally failed in ways specifically determined by her developmental history (internally recorded and structuralized as pairs of internal bad objects that will inevitably get played out on the stage of the treatment) is fueled by her compulsion to repeat (re-enact) these early-on dysfunctional dynamics – the unhealthy aspect of which involves the lure of the forbidden (because that is all she has ever known) but the healthy aspect of which speaks to the patient's deep-seated desire to achieve belated mastery of the introjected badness / pathogenic introjects.	psychic retreat / relational absence / schizoid withdrawal underlying which is existential dread / ontological insecurity harrowing loneliness / annihilating terror – an existence that is false, desolate, barren, internally impoverished, hollow, shallow, and desperately lonely – – the nascent true self (the potential source of spontaneity, creativity, and personal agency) has gone into hiding, avoiding at all cost the possibility of exposing itself without being met (recognized and response to) – – its essence thereby remains incommunicado, its core unseen, unacknowledged, undeveloped –	psychic inertia / deeply embedded traumatic memories Procedurally organized, implicitly held body memories (and the disempowering relational narratives to which they give rise) must ultimately be challenged with new, more relevant experiences – both real and simply imagined – that violate those ill-founded assumptions. The net result of these violations of expectation will be the overriding of "old bad," outdated, entrenched, and conditioned reactions by "new good," fresh, more reality-based, action-oriented, and future-directed mental schemas. "The only person you are destined to become

Some have suggested that compulsive re-enactments
are efforts to rewrite the script of an unfinished story.

is the person you decide to be." Ralph Waldo Emerson

CORE ISSUE "Reality is the leading cause of stress for those in touch with it." Jane Wagner	tormented internal conflictedness / tension	relentless pursuits "To grieve is to confront the reality of what was never ours – so that we can be liberated from our relentless pursuits in the present and embrace authentic possibilities for our future." Stark	compulsive re-enactments defensive introjection of bad – the result of "not grieving" – vs. adaptive internalization of good – the result of "grieving" – I	the need-fear dilemma about intimacy – paralyzing co-existence of intense longing and abject terorr – – a fear so extreme that it feels all-encompassing – – fear of a breakdown that has already occurred – Although a part of the patient yearns to be known and seen by the therapist, another part of the patient zealously guards the "sacrosanctity of her privacy," keeping hidden what most matters to her, unwilling to let anyone in.	traumatic (somatic) memories / immobilization "The body keeps the score; it remembers what the mind tries to forget." van der Kolk Pat Ogden and Peter Levine – both of whom are body-oriented therapists – highlight that trauma is not what happens to us but, rather, what we hold inside of us as a result of that trauma in the absence of a supportive witness. They note that somatic memories are etched in the body, waiting for the chance to be acknowledged and healed. – trauma can be trapped in the body as a "reflexive wince stuck in time" – Danielle Carr
TRIPARTITE CLASSIFICATION of **NEWBORNS**		some babies are born craving sensory experiences – hungry and clingy –	other babies are born angry with the world – irritable and contentious –	still others are born simply wanting to "go unconscious" and, when distressed, wanting to "go to sleep" – ignoring and shunning –	
CONDITIONED PATTERNS	internal conflictedness / imbalanced internal forces between dysregulated id, undeveloped ego, and harshly punitive superego – defiance vs compliance / can I defy? or must I comply? can I be bad? or must I be good? – Freud writes that neurosis is the result of tension between the id's desires and the ego's defenses – where the drive for instinctual gratification does battle against the moral imperatives of the superego and the constraints of external reality. – the tyranny of the shoulds – – narratives about the self that are invariably critical – Neurotic patients struggle with "intrapsychic (structural) conflict" between "forbidden (id) desires" – which get displaced onto the therapist – (thereby creating a positive – neurotic – transference) and "moral (superego) prohibitions" – which get projected onto the therapist – (thereby creating a negative – neurotic – transference). As id drives become tamed (and their energy harnessed) and as superego prohibitions become mitigated (and their harshness tempered), space will be created for the fueling of constructive pursuits and more meaningful endeavors.	relentless pursuit of admiration / praise validation / external reinforcement because of impaired capacity for internal self-esteem regulation – ever in search of a "new good" object in an unrelenting – and entitled – effort to fill in for missing self-structure – Brene Brown writes that the relentless pursuit of perfection and validation can make us lose track of the power of our own worthiness, trapped as we are in a cycle of striving	the need to be "failed" – ever in search of the "old bad" object in a desperate attempt to achieve belated mastery of the early-on traumatic failure situation – Contemporary relational theory postulates that it is not only inevitable but also necessary – and therefore desirable – that the therapist ultimately fail the patient and in the very ways that the patient most needs to be failed if she is ever to have the opportunity to modify her toxic introjects and the negative, self-sabotaging voices to which they have given rise. "A bad object is infinitely better than no object at all." Fairbairn – because then there can at least be hope that the "bad" object might someday become "good" –	desperate to remain hidden, but terrified of disappearing desperate to be known, but terrified of being found – supported by illusions of grandiose self-sufficiency, denial of object need, and the schizoid defense of affective nonrelatedness – Model 4 patients are characterized by a heart shattered, a life unlived, and a stance of self-protective isolation – their innermost self having secretly withdrawn and retreated into an objectless world. The attempt is to live in a detached fashion, untouched, without feeling, aloof, keeping people at bay, and avoiding at all costs commitment to anyone. Winnicott suggests that the fear is of impingement by a maternal environment (perceived as intrusive and potentially dangerous).	nonaction / intractable paralysis / refractory inertia – quantum entanglement / energetic coupling with "old bad" immobilizing narratives that have become the distorted filters through which the patient experiences self, others, and the world It has been suggested that the biggest tragedy of our lives is that freedom is possible, yet we often pass our years trapped in the same dysfunctional patterns. We might yearn to be able to love freely, to be authentic, to breathe in the beauty around us, to dance and to sing. And yet each day we listen to inner voices that keep our lives small. "The best way to predict your future is to create it." Abraham Lincoln
SPOTLIGHT ON …	the patient's internal conflicts between anxiety-provoking (but ultimately growth-promoting) "empowering" forces asserting "yes" and anxiety-assuaging (but ultimately growth-impeding) "obstructive" counterforces defending "no"	the patient's affective experience moment-by-moment and desperate longing for empathic resonance / attunement / understanding and narcissistic supplies to bolster tenuous self-esteem – insatiable hunger for input from the outside –	the patient's relational conflicts / noxious relatedness projective identifications / therapeutic impasses transference / countertransference entanglements – Fairbairn's seductive (exciting / rejecting) object – – Paul Russell's "crunch" –	the patient's affective nonrelatedness and struggle to find meaning / purpose in life – relational absence / rejection of existence – – tension between intense yearning to be known and abject terror of being found –	disempowering narratives / conditioned reactions – juxtaposing the reactivated memory of "old bad" (accessed by way of embodied mindfulness) with the enlivening vision of "new good" (introduced by way of purposeful intentionality) –

	"In every neurotic conflict there lies a truth waiting to be uncovered." Anonymous	It has been suggested that we are only as needy as our unmet needs.	Russell writes about crunch situations that develop in the treatment as forcing patient and therapist to encounter the "raw edges of their existence" – where "transformation beckons amidst the chaos."	Patients who struggle in this way compare their experience of being in the world to walking a tightrope – balancing glimmerings of hope with the ever-present threat of annihilation.	– juxtaposing "bottom-up" with "top-down" approaches –
EMERGENCE OF TRANSFERENCE	positive and negative transference as a story about the patient's there-and-then Freud writes that the relationship between the conscious mind and the unconscious is like that between a small island and a great ocean surrounding it. This metaphor illustrates the limited awareness of the conscious mind compared to the deeper, more expansive unconscious.	positive (idealizing) transference as a story about the patient's need to find "new good" in the here-and-now and her entitled sense that it is her due The "I can't, you can, and you should" dynamic is a story about those patients who experience themselves as so "damaged" from earliest childhood that they cannot imagine being held accountable for their lives now (a distorted sense of self as "not having"), who find themselves therefore looking to others to "compensate" them for the early-on "damage" (an illusory sense of the object as "having"), and who feel that this "compensation" is their due (the entitled sense that "getting" is their "right") – all of which are defensive reactions. It is inevitable, necessary, and therefore desirable that the therapist fail the patient every now and then – because such failures will offer the patient both impetus and opportunity for belated mastery of her early-on heartbreak and disappointment.	actualized negative transference as a story about the patient's need to re-find "old bad" in the here-and-now If the therapist never allows herself to be drawn in to participating with the patient in her transferential re-enactments, we speak of a failure of engagement and lost opportunity. If, however, the therapist allows herself to be drawn into the patient's internal dramas but then gets overwhelmed, loses her way, and cannot find her way out, we speak of a failure of containment and the potential for re-traumatization of the patient. In other words, the therapist should be neither impermeable to the force field created by the patient nor totally permeable to that force field. For optimal effectiveness, the therapist should strive to maintain a stance of semipermeability – a stance that will enable her to be both participant and observer. In these situations of mutual enactment, dual awareness on the part of the therapist is critically important for adaptive resolution.	self-protective cocoon transference as a story about the patient's psychic retreat from the world of objects in order to preserve the cohesiveness of a precariously established self from being shattered by an intolerably devastating response from the object Modell writes that to avoid potential "dissolution of the coherence" of a "fragile self," such patients will assume a "stance of self-protective isolation" – a defensive posture supported by "illusions of grandiose self-sufficiency" and "denial of object need." Neurodivergent Dr. Oliver Wolf (*Brilliant Minds*) is approached by a man who asks him out on a first date. Dr. Wolf –"I'm sorry, but I'm not available." The man – "Oh, I didn't realize you were seeing somebody." Dr. Wolf – "I'm not. I'm just [pause] un-available." "I grew to understand that people don't always build walls to keep others out. There are times it is done out of a necessity to protect whatever is left within." Anonymous	the therapist as a visionary alchemist – the therapist leads and the patient follows but together they co-create the patient's envisioned future – – and it takes both inspiration and perspiration – Ann Landers's (1996) simple but profound advice – "Nobody gets to live life backward. Look ahead. That is where your future lies." "Understanding life backwards" is a story about Models 1 – 4. "Living life forwards" is a story about Model 5. It is a story about analyzing to understand but envisioning possibilities to incentivize action. In the tradition of other action-based, solution-focused, goal-directed, future-oriented models, Model 5 focuses on envisioned possibilities, taking ownership of the need to change, setting coherent, purposeful, and embodied intention, committing to action, self-empowerment, personal agency, freedom, choice, creating one's destiny, realizing one's dreams, and actualizing one's potential. Model 5 is not determinstic – it is a constructivist model, one that is both empowering and inspiring of hope.
TRANSFERENTIAL FOCUS	movement backward – repressed memories, unresolved childhood issues, and unacknowledged desires –	movement toward – relentless pursuit of the unattainable – – insatiable hunger for narcissistic supplies –	movement against – contentious entanglements – – noxious engagement –	movement away – psychic retreat / emotional detachment – – isolation / disconnect –	movement forward – envisioned transcendent possibilities – – the brain that changes itself / neuroplasticity –
MECHANISM OF ACTION "The good life is a process, not a state of being. It is a direction, not a destination." Carl Rogers "The regrets that nag at you are the ones where you knew you had a choice." Tom Sellect (*Lost in Paradise*)	displacement and projection – both displacement of the infantile need for gratification onto the blank screen of a neutral therapist and projection of introjected badness onto the blank screen of a neutral therapist are thought to be stories about the patient's there-and-then and not about the here-and-now of the therapeutic engagement –	displacement (displacive identification) "Where once the target of the patient's thwarted desire was the infantile object, now the target is the selfobject therapist. As long as it is primarily a story about the patient and the patient's need, the mechanism of action is displacement. But once it becomes a story about both the patient and the therapist's actual participation as gratifier of the patient's infantile needs, the mechanism of action becomes displacive identification." Stark	projective identification – involves symbolic repetition of the original relational trauma but with a much healhier resolution this time – "The hallmark of a successful projective identification is the therapist's capacity to tolerate what the patient finds intolerable." Stark "Displacement is to displacive identification as projection is to projective identification. In the first instance, the therapist responds unconsciously to pressure from the patient to participate as a "new good" object. In the second instance, the therapist responds unconsciously to pressure from the patient to participate as some version of the "old bad" object." Stark	a delicate / fragile gossamer filament tentatively connecting patient to therapist "Relational deficits create a profound fear of vulnerability, where the risk of connection feels like a threat to our very existence." Unknown "Patients whose hearts were shattered early on walk a tightrope of existence between the longing to be known, to be understood, and to surrender to the object and the equally intense – but opposing – need to remain autonomous, self-sufficient, and not found." Stark	patient and therapist work side by side in an effort to mobilize the patient and extricate her from quantum entanglement with her traumatic past "If you do not change direction, you may end up where you are heading." Lao Tzu "The privilege of a lifetime is to become who you truly are." Jung "Freedom is what you do with what's been done to you." Jean-Paul Sartre "The future belongs to those who believe in the beauty of their dreams." Eleanor Roosevelt "It is not in the stars to hold our destiny but in ourselves." William Shakespeare "Would that we could stop doing what we know we should leave behind. And would that we could start doing what we know we should embrace." Stark

					– savor the aftermath of the completed action – – the importance of embodying a new narrative –
WORKING THROUGH THE TRANSFERENCE	positive and negative transference interpreted "The analysis of transference is the royal road to the understanding of the patient's unconscious." Freud The transference offers a valuable window into the patient's repressed and forgotten past. As such, it has been recognized as an essential element of psychoanalytic treatments since Freud officially introduced the term in his 1912 paper – "The Dynamics of Transference."	disrupted positive transference grieved in a deeply embodied fashion "Imagine you are three weeks old and your mother has to stop nursing to go answer the doorbell. That's a difficult moment, but somehow your body survives the microstress of mismatch and it becomes a moment of resilience." Ed Tronick	actualized negative transference collaboratively negotiated Mitchell writes that relational conflict between patient and therapist is not at all a hindrance. Rather, it is an opportunity for the development of new relational patterns.	holding / facilitating environment regression to redo / scalar reset / zero-energy field – a foundational state of consciousness that underlies all existence – Winnicott writes that the provision of a holding (facilitating) environment makes possible the emergence of a true self. Ofra Eshell write about the healing power of both "analytic oneness" and "witHnessing."	executive direction / envision, own (reposition), commit – the patient is directed to become more action-oriented – – to set coherent and embodied intention – – to take ownership of her need therefore to change – – to commit to action in alignment with her envisioned self – Whereas, for the most part, the patient takes the lead in Models 1 – 4, the therapist takes the lead in Model 5 as a visionary alchemist who, blending practical and mystical wisdom, transforms envisioned ideas into reality.
THERAPEUTIC STANCE	neutrality / objectivity of a surgeon / blank screen Freud believes that the analyst's neutrality is a necessary precondition for development of the transference.	empathy Kohut describes empathy as "vicarious introspection."	authenticity Benjamin believes that recognition of the other's subjectivity is the basis for all authentic relationships.	nurturance / devotion / accommodation / playfulness "The therapist's playfulness is a bridge to the patient's true self." Winnicott	vision Tara Brach describes the envisioning of a future replete with possibilities as an act of courage that "invites us to step into our potential."
THERAPEUTIC PROVISION	neutral observation Freud writes that the analyst's task is to listen and to observe, allowing the patient to unfold their story without interference.	empathic attunement Kohut writes that empathy itself has a "curative effect." He goes on to note that the therapist must be willing, if need be, to "relinquish the empathic attitude" in order to "maintain intellectual integrity." Kohut also cautions that when empathy is "surrounded by an attitude of wanting to cure directly," it often speaks to the therapist's unfortunate "fantasies of omnipotence."	authentic engagement The dance of therapy is one of authentic engagement and mutual vulnerability – where both patient and therapist open themselves to the rawness of what is and the possibility of what could be.	holding environment If all goes well, the holding environment provided by a good-enough therapist will enable the patient to regress to existential (ontological) dependence, – that is, to absolute reliance upon the therapist for her very existence, her very identity – which will give her a chance to start anew.	visionary alchemy The brain can change itself in response not only to experiencing something new but also to imagining something new. In fact, a growing body of evidence supports the finding that simply visualizing (envisioning) something – even though it occurs entirely in the mind – is sometimes almost as effective as actually doing it. According to research being done at the Cleveland Clinic (Ranganathan et al. 2004), participants were able to strengthen muscles just by visualizing physical movement. This impact simply required concentrated "mental practice" – the cognitive rehearsal of a physical activity without actual movement.
ROLE OF THERAPIST	the therapist as a neutral object / objective observer – a well-polished mirror that simply reflects – As we sit with our patients, we will often become aware of tension within ourselves – dialectical tension – between, on the one hand, our vision of who we think the patient could be (were she but able / willing to make healthier choices) and, on the other hand, our respect for the reality of who she is (and for the choices, no matter how unhealthy, that she is making). We are therefore always struggling to find within ourselves an optimal balance between wanting the patient to change (and therefore challenging her) and accepting the reality of who she is (and therefore supporting her).	the therapist as an empathic selfobject (self psychology) or a good mother (object relations theory) – selfobjects function to support the patient's self-cohesion and self-esteem, operating in loco parentis – With respect to empathy in its purest form – the therapist decenters from her own subjectivity, joins alongside the patient, and takes on the patient's experience (but only "as if" it were her own because it never actually becomes her own). Empathy is therefore a story about "resonance" and "attunement" – being with the patient exactly where she is – and not about collusion, alignment, or even validation – all of which carry the subtle implication that the therapist has her own subjectivity / judgments	the therapist as an authentic subject / relational object The therapist must have both the wisdom to recognize and the integrity to acknowledge – certainly to herself and perhaps to the patient as well – her own participation in the drama that is being play out between them on the stage of the treatment. In essence, the therapist must have the capacity both to relent and to hold herself accountable for her enactments – both of which will enable her to recover her therapeutic effectiveness.	the therapist as a holding / facilitating environment – the patient needs to discover that she can surrender what is most private, vulnerable, and precious without then being destroyed – – the therapist offers the patient an opportunity to "regress in order to redo" and to experience "moments of joyful meeting," "blissful, peaceful merger," and "harmonious interpenetrating mix-up" "One by one, piece by piece, filling the holes burned in me at six years old … " Kelly Clarkson Winnicott makes a distinction between interpretations that can be used by patients to "make good their lives" and interpretations experienced as "intrusive" to the secret self.	therapist as an action-oriented, goal-directed catalyst – targeted, action-oriented, solution-based, goal-directed, and future-focused – Freud's eventual (1919) acknowledgement that, in order to broaden its range of applicability, the "pure gold of analysis" might well need to be "alloyed" with the "copper of direct suggestion … and hypnotic influence." It is only when the therapist dons her Model 5 hat and puts herself in the driver's seat that she will be able to provide optimally stressful, growth-incentivizing challenge to the patient by directing her (1) to envision a better future for herself, (2) to own her need therefore to change, and (3) to commit to actualizing that vision. Envision / own / commit.

		and is observing from a position outside the patient's experience.			In Models 1 – 4, it is not generally thought to be desirable for the therapist to suggest that if the patient is ever to get better then she will need to change – or, at the least, reposition herself in relation to her life. Indeed, part of what enables Model 5 to be impactful is that generally both patient and therapist have come to appreciate the fact that the patient will need to start doing things differently or her life will never get better. Where attention and intention go, energy – as if magically – flows.
HOW THE THERAPIST POSITIONS HERSELF	the "interpretive" therapist does not "take on" the patient's experience but maintains a stance as a neutral observer outside the field Freud notes that one of the most difficult tasks for the analyst is to remain neutral in the face of feelings aroused in him that obscure the clarity he will need for true understanding of the patient.	the "empathic" therapist "decenters" from her own experience and "takes on" the patient's experience but only "as if" it were her own – it never actually "becomes" her own – Listening empathically involves letting go of the therapist's own narratives in order to understand the patient's narratives. Bion writes about the importance of listening to the patient without memory or desire.	the "authentic" therapist "remains centered" within her own experience and "takes on" the patient's experience "as" her own – the induction phase of a projective identification – (to be followed eventually by a resolution phase) – iterative healing cycles of induction and resolution – ("more of same" and then "something different and better") If therapist and patient are to be able to find each other as subjects, then both must dare to bring themselves into the room. To that end, the relational therapist uses her "authentic self" to participate in the therapeutic encounter – ever striving to remain centered in, and attuned to, her own "emergent process" or "subjectivity."	the "devoted" therapist is – experientially – "as one" with the patient – devoted presence / blissful state of peaceful merger – – harmonious interpenetrating mix-up – – therapeutic regression to absolute dependence – – the therapeutic action will involve the co-creation of a synergistic and mystical "space-between" containing interlocking aspects of both patient and therapist – Laura Paglin describes this transformative "in-between" as "a meeting-ground of potentiality and authenticity" – located neither solely within the patient nor solely within the therapist.	together patient and "visionary" therapist co-construct the enlivening and quantum possibility of "what could be" going forward The focus is on revisiting and completing traumatic (somatic) memories, releasing the toxicity of the past, setting coherent and embodied intention, taking ownership of the need to change, and, going forward, committing to action in alignment with one's vision. Ultimately, it's about freeing oneself from the ties that bind and, with courage, forging a path forward – because commitment to the future has become more powerful than entanglement with the past.
FUNDAMENTALLY WITH …	generosity and kindness in addition to objectivity	generosity and kindness in addition to empathy	generosity and kindness in addition to authenticity	generosity and kindness in addition to nurturance and playfulness	generosity and kindness in addition to vision
ROLE OF COUNTERTRANSFERENCE "A great many people think they are thinking when they are merely rearranging their prejudices." William James "Every transference situation provokes a countertransference situation." Heinrich Racker (1968)	the therapist's countertransferential loss of objectivity / neutrality was once thought to be not a good thing But the concept of countertransference has undergone considerable change since Freud first introduced the term in 1910 / 1912. He initially viewed it as a potential obstacle in the therapeutic process, emphasizing the therapist's emotional response to the patient as influenced by the therapist's own unresolved issues. "We have become aware of the 'counter-transference,' which arises in [the physician] as a result of the patient's influence on his unconscious feelings." Freud (1910) Over time, however, the understanding of countertransference has evolved, with later theorists recognizing its potential as a valuable tool for understanding the dynamics of the patient's unconscious world and the therapeutic relationship.	the therapist's countertransferential retreat from the patient's vantage point is not thought to be a good thing Schwaber explains that when the therapist withdraws into her own internal world, then she will risk losing connection with the patient's vantage point.	the therapist's countertransferential reactions / responses to the patient are sometimes the only way that the therapist can truly find the patient (which makes the countertransference a very useful tool) Benjamin explains that by remaining centered in her own "emergent process" or "subjectivity," the therapist will be able to use her countertransference (her "experience of self") to find, and to be found by, the patient. The therapist's attention is therefore always directed to both the here-and-now of her own "emergent experience" and the here-and-now of the ever evolving therapeutic encounter.	the therapist's countertransferential experience of disconnect and "trouble remembering" the session signals to the therapist that the treatment is only "as if" being done – because it is "actually" being done "interpretively" on the patient's (intellectual) false self and not ever reaching the patient's true self (which makes the countertransference a very useful tool) Winnicott writes that there were times in a treatment when he would believe that he was deeply engaged with his patient, only later to realize that actually he had only been engaged with the patient's false self – the false self a defense against exposing the vulnerability of the true self. The patient may end up analyzed – but never reached.	the therapist's countertransferential reaction of frustration, impatience, and feelings of helplessness signal that the time might be right for the therapist to assume a more directive stance (which makes the countertransference a very useful tool) Irvin Yalom explains that there are times when the patient's journey appears to be stalled out, at which junctures he will "take the reins" in the hope of being able to guide the patient toward deeper exploration. "As a therapist, I follow the trail of tears to healing [Models 1 – 4]; as a coach, I follow the trail of dreams to actualization [Model 5]." Carol Kauffman

THERAPEUTIC ACTION

It has been suggested that
the process of working through
requires the courage to face
what we have long avoided,
turning repetition into revelation.

interpreting
Freud suggests that "a dream not interpreted"
is like "a letter not read."

grieving
"Your joy is your sorrow unmasked.
And the selfsame well from which your laughter rises
was oftentimes filled with tears." Khalil Gibran (1923)
This quote speaks to the interconnectedness
of joy and sorrow, laughter and tears –
and the idea that emotional experiences
(positive and negative)
shape and deepen our capacity for life.

negotiating
Mitchell and others explain that by re-creating the past
in the transference, patients are attempting to
"reclaim agency over the narrative of their wounds."

surrendering
Winnicott has written that, as an analyst,
he has sometimes had
"to displace the mother in a big way
in order to enable the patient to get started
as a person."

disentangling / energetic decoupling / rescripting
relinquishing "old bad" and embracing "new good"
"By revisiting and reprocessing our old wounds
and reframing the internal narratives
to which those wounds have given rise,
we can rewrite the stories that have defined us." Stark
"Take a sad song and make it better." The Beatles
– repatterning at the level of body memory –
– embodied release of held trauma –
– from dysregulation to embodied safety –
– a bottom-up reset of the threat-response system –
– healing that lives in the tissues –
– updating of implicit emotional learnings –
– bottom-up transformation of core affective networks –
– new emotional reality replacing the old schema –
– transformational internal shift –

THERAPEUTIC INTERVENTIONS

conflict statements

disillusionment (grieving) statements

accountability statements / relational interventions
Rule of 3

facilitation statements

(co-constructed) quantum disentanglement statements

MUTATIVE INTERPRETATIONS
Transformational change
requires the introduction
of corrective challenge.

MISMATCH EXPERIENCES
create destabilizing
but growth-incentivizing
tension between conditioned
(defensive) reaction
and corrected
(adaptive) response
– leverage / choice points –
that are strategically
designed to galvanize
the therapeutic action

With the therapist's finger
ever on the pulse of the level
of the patient's anxiety
and capacity to tolerate
further challenge,
the therapist, whenever
the moment presents,
"challenges" the defense
by directing
the patient's attention
to where the therapist would
want the patient to go
(disruptive attunement)
and then "supports" the defense
by resonating empathically
with where the patient is
(homeostatic attunement).

The goal is to create

juxtapose the adaptive capacity to know
an anxiety-provoking psychological reality / truth
with the defensive need to resist knowing it

You know that …
but (made anxious) you find yourself …
thinking, feeling, or doing in order not to know …

By locating within the patient the conflict
between an anxiety-provoking
(but ultimately growth-promoting) "yes" force
and the anxiety-assuaging
(but ultimately growth-impeding) "no" force
mobilized to "counter" it,
the therapist is deftly sidestepping the potential
for conflict between herself and the patient.

More specifically, when the therapist introduces
her conflict statement with "You know that … "
she is forcing the patient to take responsibility for what
the patient – albeit begrudgingly – 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,
not only does the therapist run the risk
of forcing the patient to become
ever more entrenched
in her defensive stance of protest
but the therapist will also
be robbing the patient of any incentive
to take responsibility
for her own desire to get better.

juxtapose the adaptive capacity to confront, grieve,
and ultimately accept the reality of disillusionment
with the defensive need to cling to the illusion
of relentless hope

You had so hoped that …
but you are now beginning to confront
the disillusioning reality that …
and you are feeling devastated and enraged …

The "relentlessly hopeful" patient must ultimately
confront – and grieve – the reality of the object's
limitations, separateness, and immutability
(the fact that it cannot be forced to change).

Genuine grieving requires of the patient that,
at least for periods of time, she be fully present with
the anguish of her grief, the pain of her regret,
and the intensity of the rage she experiences
when faced with sobering realities about herself,
her relationships, and her world.

She must not absent herself from her grief.
She must enter into it and embrace it
in an embodied fashion.
She cannot effectively grieve when she is dissociated,
missing in action, or fleeing the scene.
She needs to be engaged, in the moment, mindful
of all that is going on inside of her, grounded,
focused, and in the here-and-now.

If she is in denial, shut down, closed, numb,
refusing to feel, or protesting the unfairness of it all,
then no real grieving can be done.

juxtapose the adaptive capacity to take ownership
of dysfunctional relational expectations
with the defensive need to recreate the early-on
traumatic failure situation in the here-and-now

highlight how the patient is getting the therapist
to do unto her in the here-and-now
some version of what the parent
had done unto her in the there-and-then
(direct negative transference)

or highlight how the patient is doing
unto the therapist in the here-and-now
some version of what the parent had done
unto her in the there-and-then
(inverted negative transference)

or if the therapist is aware of feeling conflicted
in relation to the patient, she might choose to share
the fact of this conflictedness with the patient –
I want to tell you X … , but my fear is that Y …

or the therapist can simply share an observation
about something she is experiencing in
the here-and-now of the therapeutic encounter

Rule of 3 for provocative enactments
How were you hoping I would respond? (id)
How were you fearing I might respond? (superego)
and/or How were you imagining I would respond?
(executive functioning of the ego)
– the dorsolateral prefrontal cortex –

juxtapose the adaptive capacity to yearn for connection
with the defensive need to withdraw into isolation

A part of you longs to be seen, heard, understood …
but another part of you is terrified of being found …

At their core, facilitation statements
reflect the paradox inherent in
the patient's struggle between
embracing authentic being-in-the-world and
surrendering to the crushing defeat
of existential despair.

Patients who have never fully confronted, and grieved,
the pain of their early-on heartbreak will often cling
tenaciously to their hope that perhaps someday the
"object of their desire" will be forthcoming.

But there are others who, in the aftermath of
their early-on heartbreak, will find themselves
withdrawing completely from the "world of objects" –
their hearts shattered …

To protect themselves from being
once again destroyed, these patients retreat,
emotionally detaching themselves from relationships,
from the world (schizoid withdrawal) –
only then to find themselves overwhelmed
by intense feelings of isolation, desolation,
alienation, and emptiness –
the competent, capable, accomplished, cheerful,
compliant "false (public) self" they present
to the world belying the "private" truth
of what lies buried deep within –

juxtapose the adaptive capacity to envision
the possibility of "new good"
with the defensive need to remain entrenched
in "old bad"

Quantum disentanglement statements are
strategically designed to capitalize upon
"bottom-up mindfulness," "top-down intentionality,"
and "bilateral alternating stimulation"
between two levels of consciousness
that work in tandem –
body consciousness and brain consciousness.

These statements bring to bear the analytic wisdom
of the patient's present- and future-focused
left brain on the belated processing of
reactivated traumatic (somatic) memories
stored in her past-focused right brain.

They insist that the patient hold in mind,
simultaneously, both the reactivated,
mindfully retrieved memory of "old bad"
and the envisioned possibility of "new good,"
introduced by way of purposeful
and coherent intentionality,
thereby creating jolting and decisive
mismatch experiences between
implicitly held "old bad"
learned expectations
and explicitly held "new good"
transcendent possibilities.

The therapist encourages the patient
to make explicit the somatic elements,
physical sensations, visceral reactivity,
and sensorimotor perceptions

an optimal level of
incentivizing anxiety between
destabilizing challenge
and restabilizing support.

The "wisdom of the body"
is such that it cannot tolerate
the distress of disequilibrium
for extended periods of time
and will therefore
be "provoked"
to take action in order to
resolve the internal tension
and
restore the homeostatic balance.

Poem by Christopher Logue
Come to the edge
We might fall.
Come to the edge
It's too high!
COME TO THE EDGE!
And they came,
And he pushed,
And they flew.

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

So she took the leap
and built her wings
on the way down.

Ongoing and judicious use
of conflict statements
will force the patient to become aware of,
and take responsibility for,
her own state of internal dividedness.

Model 1 conflict statements encourage
the "resistant" patient to step back from
the immediacy of the moment in order
to "become aware of" the conflict within her
between her "empowering"
(but anxiety-provoking) forces
and her "obstructive"
(but anxiety-assuaging) counterforces.

The Model 1 therapist will therefore
first challenge by speaking directly
to the patient's observing ego
and "adaptive capacity to know"
some "defended truth,"
which will increase the patient's anxiety,
but will then support
– always with compassion and never judgment –
by resonating empathically
with the patient's experiencing ego
and "defensive need to resist knowing,"
which will decrease the patient's anxiety.

Dual awareness is being fostered
when the patient is being asked
to direct her attention
to what she is experiencing in the moment
at the same time
that she is being encouraged
to step back from the immediacy
of the experience
in order to detach herself from it.
recover perspective, and reflect upon it.

In the psychoanalytic literature,
this distinction between
experiencing something and observing it
is described as a healthy "spilt in the ego"
between the experiencing (or participating) ego
and the observing (or reflecting) ego.

Dual awareness is one of the goals
of any treatment.

Although some Model 2 theorists believe that
it is the experience of gratification itself
that is compensatory and ultimately healing,
most believe that it is the "optimal stress"
created by the experience of frustration
against a backdrop of gratification
– frustration (disillusionment) properly grieved –
that most reliably promotes structural growth,
filling in structural deficit,
and development of adaptive capacity.

After all, if there is no thwarting of desire,
then there will be nothing that needs to be mastered
and therefore no impetus for adaptive
transmuting (structure-building) internalization.

NB –
The patient "adaptively internalizes good,"
which contributes to the therapeutic action in Model 2,
but "defensively introjects bad,"
which contributes to the pathogenesis in Model 3.

Although center stage in Model 3
are the "inevitable relational failures"
resulting from the therapist's inadvertent participation
in the patient's compulsive and unwitting re-enactment
of her need to re-find the "old bad" object,
center stage in Model 2
are the "inevitable empathic failures"
resulting from the fact that the therapist is not,
and cannot be expected to be, perfect.

Importantly, the focus in Model 2 is on
the patient's "perception"
of having been failed by the therapist
rather than on
the "reality"
of the therapist's failure of the patient.

And, of course, each such "empathic failure"
provides impetus and opportunity
for the accretion of "new good" self-structure.

The intersubjective perspective of Model 3 always
recognizes the mutuality of impact and influence –
both therapist and patient continuously changing
by virtue of being authentically engaged
with each other.

The therapeutic action in Model 3
is therefore a story
about negotiating the turbulence
that will inevitably emerge
at the intimate edge of authentic relatedness
between therapist and patient –
once the latter delivers,
by way of projective identification,
her unresolved early-on relational traumas
into the transference.

The induction phase of a projective identification
commences once the therapist accepts
the patient's projection;
the resolution phase is ushered in
once the therapist steps back from
her participation in what has become
a mutual enactment
and brings to bear her own, more evolved capacity
to process and integrate on behalf of
a patient who truly does not know how –
such that something now less toxic
can be re-introjected by the patient
and more easily assimilated
into healthy psychic structure.

Ongoing Model 3 negotiation
by therapist and patient
of each such therapeutic impasse
will result ultimately, for the patient, in
serial detoxification / dilution of "old bad"
("introjected badness" / "toxic introjects"),
just as ongoing Model 2 grieving
by the patient
of each optimal (affective) disillusionment
will result ultimately, for the patient, in
serial accretion of "new good"
("adaptive internalization" of the selfobject functions
that the therapist has consistently been providing

not only their tormented heartbreak,
harrowing loneliness, and annihilating terror
but also their thwarted creativity and
desperate – albeit ambivalent – longing
to be found.

This self-protective false self
obscures the underlying brokenness
and unrealized promise of the true self.

Model 4 facilitation statements are
specifically designed to highlight
– always with compassion and never judgment –
the intense ambivalence that the Model 4 patient has
about being "authentically engaged" in the world.

On the one hand, they speak to the patient's longing
to be known, to be understood,
and to surrender to the object.

On the other hand, they speak to
the patient's equally intense – but opposing – need
to remain autonomous,
self-sufficient, and not found.

These statements express an appreciation
for the complexity of the patient's experience
of "being-in-the-world"
and "being-in-relationship"
and, in speaking to different parts of the
patient's self-experience, they honor
the "collage" of selves that constitute the whole.

It is important that the therapist be ever
exquisitely attuned to the patient's
intense ambivalence about surrendering
herself to moments of meeting.

The therapist must therefore use her intuition
to decide whether (in the moment)
the patient is wanting to be found
or needing (at least for the time being)
to remain hidden, not known, not seen.

"I gave you a part of me that I knew you could break,
but you didn't … "

This is the "gift" that we must ultimately give
– without hesitation –
to those of our patients
whose hearts have been shattered
and who, at least on some level,
are now terrified that their hearts
will be once again broken.

that are being evoked as she begins to remember
what her body has never forgotten.

Over and over again,
in rapid-fire succession and with ever more
determined and embodied commitment,
the patient repeats the statement
and variants of it – alternately verbalizing
first the mindfully reactivated "old bad"
and then the intentionally introduced "new good."

At the heart of Model 5 is
the neuroplastic synergy of mindfulness
(reactivating and re-experiencing "old bad")
and intentionality
(introducing the possibility of "new good").

In other words,
simultaneously "paying attention" to "old bad"
(as the patient focuses bodily-felt awareness on the
present moment and all that is emerging from within)
and "setting intention" for "new good"
(as the patient leans into the edge between present
and future and focuses on emergent possibilities).

Against the backdrop of retrieving, reliving,
and articulating a targeted trauma
and the disempowering and distorted narratives
that were constructed as a result,
the patient is directed to envision a better future,
to own her need therefore to change,
and to commit to actualizing that vision going forward.

Model 5 conceives of the narratives
that the patient had constructed as a young child
in a desperate attempt to make sense
of the overwhelming world around her
as potentially able to be rewritten,
interpreted anew, and completely redone.
Once updated, these transcripts
need no longer seal the patient's fate.
Rather, they hold the potential for
reconfiguring her future and advancing her
from refractory inertia and thwarted potential
to action and actualization of her dreams.

Again (and a powerful reminder
of the transformative potential of our agency) –
"Quantum science suggests the existence
of many possible futures
for each moment of our lives.
Each future lies in a state of rest
until it is awakened by choices
made in the present." Gregg Braden

despite her occasional empathic lapses).

What the Model 4 patient most needs in the treatment
is to discover that she can "surrender"
what is most private, vulnerable, and precious –
without then being destroyed.

PATIENT BECOMES MORE ...	aware	accepting	accountable	accessible	action-oriented
THERAPEUTIC ACTION "If a new result is to have any value, it must unite elements long since known, but till then scattered and seemingly foreign to each other, and suddenly introduce order where the appearance of disorder reigned." Unknown	interpreting the patient's internal dividedness taming the unruly id and strengthening the unevolved ego by repeatedly highlighting force and (resistant) counterforce (graduated taming and strengthening) "The most fundamental aggression to ourselves, the most fundamental harm we can do to ourselves, is to remain ignorant by not having the courage and the respect to look at ourselves honestly and gently." Pema Chödrön	facilitating the patient's necessary grieving of heartbreak and loss to incentivize adaptive transmuting internalization and thereby internal preservation of a piece of the original experience of external goodness "In the depths of our grief, we sift through the ashes of loss, discovering the embers of love that continue to glow within us, transforming sorrow into a treasure of cherished memories." Unknown	collaboratively negotiating the inevitable emergence of turbulence at the intimate edge of authentic engagement "The repetition of early wounds in the present can be seen as a longing for resolution, a quest to transform pain into understanding." Unknown "In the middle of difficulty lies opportunity." Einstein	helping the patient overcome her dread of surrender to resourceless dependence upon the therapist (nurturing the patient's surrender to a new beginning) – benign regression in the service of the ego – – regression to absolute dependence – – ordinary regression to dependence – – surrender to resourceless dependence – – therapeutic provision of a potential space – Whether acquired as an infant or later in treatment, Winnicott's "capacity to be alone" is a developmental achievement resulting from the internalization of a good-enough caregiver, such that the individual will be able to tolerate the experience of "being alone" and access his capacity to play and to create.	prompting the patient to envision possibilities, own the need to change, and commit to action – envision / own / commit – – EMDR by day / REM by night – – serial updating by either the actual experience of something new or simply the envisioning of it – such that (when certain conditions are met) the "old bad" synapses can be rewired and the traumatic memories they encode reprogrammed – – internal tension created by the pain of contrast between the sobering (embodied) reality of "what is" and the enlivening (envisioned) possibility of "what could be" – "One door opens only once another door closes." Ethell
PROGRESSIVE EVOLUTION iterative healing cycles **The Journey by Mary Oliver** One day you finally knew what you had to do, and began, though the voices around you kept shouting their bad advice – though the whole house began to tremble and you felt the old tug at your ankles. "Mend my life!" each voice cried. But you didn't stop. You knew what you had to do, though the wind pried with its stiff fingers at the very foundations, though their melancholy was terrible. It was already late enough, and a wild night, and the road full of fallen branches and stones. But little by little, as you left their voices behind, the stars began to burn through the sheets of clouds, and there was a new voice which you slowly recognized as your own,	serial taming of the id, strengthening of the ego, and mitigating the severity of the superego (graduated resolution of internal conflict) Freud (1923) uses the "horse and rider" as a metaphor for the working through process whereby the id is tamed and the ego is strengthened – such that the patient's defenses become no longer as necessary and the conflict between id drive and ego defense can thereby be resolved. Initially, Freud's inexperienced rider (an undeveloped ego) will be made anxious by her untamed horse (a dysregulated id), which will prompt the rider to rein her horse in – the ego to mobilize its defenses in order to put a lid on the id. But as a result of working through, Freud's now more experienced and more empowered rider (a stronger and more insightful ego) will be now better able to manage her now tamer horse (a better regulated and more adaptable id). and more adaptable id). Indeed, as a result of this working through process	serial accretion of self-structure / adding of "new good" by grieving disillusionment and loss (graduated accretion of "new good") The therapeutic action in Model 2 involves working through positive transference disrupted. It is a story about confronting – and grieving – the reality of the limitations, separateness, and immutability of an empathic therapist who will nonetheless inevitably fail the patient from time to time (optimal disillusionment). The result of the patient's grieving this optimal disillusionment will be adaptive transmuting internalizations, that is, incremental filling in of structural deficit with self-structure such that there will be a more robust capacity to be a good (selfobject) parent unto herself. In essence, The therapeutic action in Model 2 involves serial accretion of "new good" by way of grieving disillusionment and loss, such that incrementally pieces of the therapist's external goodness will be preserved internally by the patient. Eventually, the patient's relentless desire and unrelenting pursuits of the unattainable	serial dilution of toxic structure / modifying of "old bad" by negotiating at the intimate edge of relatedness (graduated detoxification of "old bad") The therapeutic action in Model 3 involves working through negative transference. It is a story about collaborative negotiation of the various mutual enactments and therapeutic impasses that will inevitably emerge at the intimate edge of authentic relatedness with the therapist (projective identification). The therapist provides containment by virtue of her capacity first to "participate" in the patient's re-enactment (the induction phase) and then to "speak back" from it and then to "relent" (the resolution phase), thereby recovering her objectivity and therapeutic effectiveness. Although inevitably the therapist will fail the patient in many of the same ways that the parent had failed her, ultimately the therapist must challenge the patient's projections by lending aspects of her otherness or externality to the interaction, such that the patient will have the experience of something that is	serial accretion of trust by overcoming the dread of surrender to analytic oneness (graduated surrender to absolute dependence) "I gave you a part of me that I knew you could break, but you didn't." Anonymous It is only recently that I have come truly to appreciate how powerfully healing it can be for a patient, whose heart was shattered early on, to be given opportunity in the here-and-now engagement with her therapist to be in control as much as is possible... an opportunity to become absolutely dependent on someone whose stalwart reliability and unconditional predictability the patient is coming, over time, to trust. If all goes well, patient and therapist might even begin to experience occasional moments of pleasurable and joyful connectedness – precious moments of meeting that will eventually generalize to others as well (from the small to the all) – thereby giving meaning and authenticity to the patient's existence. ... an existence that might otherwise have remained desolate, barren, internally impoverished, and desperately lonely.	serial letting go of "old bad" and embracing of "new good" by way of therapeutic memory reconsolidation (graduated disentanglement and deconditioning) Model 5 quantum disentanglement statements capitalize upon the neuroplastic synergy of mindfulness (paying attention to body consciousness) and intentionality (setting intention with brain consciousness). It features co-constructed – by patient and therapist – optimally stressful, growth-incentivizing statements that are strategically designed (in keeping with the approach of the majority of short-term, intensive treatments) to juxtapose – repeatedly, joltingly, unexpectedly, dramatically, and forcibly – the two levels of the patient's consciousness (from her bottom-up body consciousness and her top-down brain consciousness) in an effort to advance the patient incrementally from analysis paralysis to actualizing action. The first part of a quantum disentanglement statement gives voice to the patient's mindful reactivation and re-experiencing of "old bad" – the sobering and conditioned (embodied) reality of "what is" / "same old same old."

that kept you company
as you strode deeper and deeper
into the world,
determined to do
the only thing you could do –
determined to save
the only life you could save.

– where by the horse (id) is tamed
and the rider (ego) is strengthened –
the defensive need to rein the horse in
will have become gradually transformed
into the adaptive capacity
to give the horse free rein
and skillfully to harness its power
such that its now more modulated energy
can be channeled into
more constructive endeavors
and healthier pursuits.

Horse and rider will now be able
to move forward harmoniously and in sync –
no longer in conflict but in collaboration.

will be transformed into
mature and serene acceptance
of sobering realities/truths about the therapist
and, more generally, the other objects
of her desire.

If the therapist gets caught up
in believing that she can, and should, be
an ideal mother who never fails the patient,
then she will be robbing the patient
of the opportunity to confront
the grief she harbors deep inside
about he actual mother.

The therapist will be colluding
with the patient's illusion
(that is, with the patient's defensive need
not to know the truth about her mother),
thereby perpetuating the patient's
refusal to grieve.

other-than-me and can take that in.

The therapist will challenge
the patient's projections
by lending aspects of her own, more evolved
capacity to process and integrate
on behalf of a patient who truly
does not know how,
such that the patient will have
the experience of being able
experience of being able to take in something
that is now more processed,
less toxic, and more manageable.

What the patient re-introjects
will then be an amalgam –
part contributed by the patient
(the original – unprocessed and toxic – projection)
and part contributed by the therapist
(something more processed and less toxic).

In essence,
the therapeutic action involves
serial dilution of "old" by way of
collaborative navigation of the
intersubjective in-between,
such that incrementally pieces
of the patient's introjected badness
will become relationally detoxified.

Eventually,
the patient's compulsive and unwitting
re-enactments will be transformed
into accountability for her noxious relatedness
and her dysfunctional
actions, reactions, and interactions.

Indeed,
I conceptualize the therapeutic action
in Model 4 as involving this co-creation
of a transitional space between
patient and therapist –
created in part by the patient
and her defensive need to be in total control
and in part by the therapist
and her adaptive capacity to delight
in being controlled –
a co-created potential space
into which the patient can deliver
the parts of her "self" that are
most vulnerable, most private,
and most prone to breakage.

... and can then gradually discover,
to her utter surprise and absolute delight,
that her therapist will be so intuitively sensitive,
gently attuned, lovingly present,
and tenderly devoted to her care
that she need no longer worry
quite so much about having her heart,
once again, shattered.

In essence,
the therapeutic action in Model 4
involves giving the patient an opportunity
to regress to the stage of absolute dependence –
but with a different, much better outcome
this time.

And the second part of the statement
gives voice to the patient's
intentioned embracing of the possibility
of "new good" –
the enlivening and quantum (envisioned) possibility
of "what could be" / "something new,
different, and compellingly better."

The patient is being encouraged
both to pay attention to "old bad"
by mindfully focusing on the present moment
(and the bodily-felt awareness
that is thereby emerging)
and to set intention for "new good"
by "leaning into the edge" between present and future
and "intentionally focusing"
to unlock emergent possibilities.

Model 5 quantum disentanglement statements
will therefore create jolting, startling,
and unexpected mismatch experiences
for the patient between
implicitly held "old bad" learned expectations
(harbored in body consciousness)
and explicitly held "new good" envisioned possibilities
(introduced by brain consciousness).

The embodied – felt sense – tension
generated by these dramatic violations
of expectation
(resulting from repeated
bilateral alternating stimulation)
will ultimately provide both impetus and opportunity
for quantum disentanglement
and energetic decoupling of the patient
from the toxicity of her past.

FROM RIGIDITY
TO RESILIENCE

Both simple and profound
is the compelling idea that
therapeutic modalities that
have deep and enduring
psychodynamic change
as their ultimate goal
have the power to reconfigure
the past and thereby to
transform the future – as
outdated and conditioned
reaction evolves into
updated and corrected response
and rigidity advances
to resilience.

FROM resistance
TO awareness of anxiety-provoking truths
about the self

FROM resistance to acknowledging
anxiety-provoking truths about one's internal world
TO awareness of those discomfiting
psychological truths / realities

FROM relentless hope
TO acceptance of anxiety-provoking truths
about the objects of one's desire

FROM the refusal to confront – and grieve – disillusioning
realities about the limitations, separateness, and
immutability of the objects of one's desire
TO sober acceptance of those disillusioning realities

FROM grievances (unmourned losses)
TO grieving and ultimately acceptance

FROM relentless hope
TO realistic hope

FROM the need for external provision of
TO the capacity to be internally self-regulating

FROM re-enactment
TO accountability for anxiety-provoking truths
about the relational self

FROM compulsive and unwitting re-enactment
of unmastered early-on relational traumas in the
(and, more generally, on the stage of one's life)
TO accountability for one's
dysfunctional actions, reactions, and interactions

FROM the need to recreate
the "old bad" traumatic failure situation
TO achievement of belated mastery
of the introjected badness (pathogenic introjects)

FROM relational absence
TO authentic access to anxiety-provoking truths
about the private / impenetrable self

FROM relational absence
TO authentic presence

FROM disconnect and alienation
TO burgeoning capacity to "be alone in the presence of"
(without losing one's identity or sense of self)

FROM psychic retreat and relentless despair
TO emotional accessibility
and treasured moments of meeting

FROM nihilistic rejection of existence
TO existential acceptance of its dualities, polarities,
complementarities, and complexities

FROM refractory inertia
TO actualization of anxiety-provoking truths
about the envisioned self

FROM "old bad" conditioned narratives
TO "new good" corrected narratives

FROM "old bad" learned expectations
TO "new good" envisioned possibilities

FROM psychic inertia and analysis paralysis
TO relinquishing "old bad," outdated, disempowering
narratives and embracing "new good,"
updated, and empowering ones going forward

FROM the conditioned (disempowered / immobilized) self
TO an envisioned (activated / future / possible) self

In essence,
the working through
process is a story about
reshaping the past to make
new futures possible.

FROM a life unlived
TO a life reclaimed

FROM "same old, same old"
TO "something new, different, and compellingly better"

FROM limited possibilities and restricted action
TO limitless possibilities and inspired action

FROM trauma victim TO trauma survivor

FROM neural entrenchment
and implicitly held traumatic (somatic) memories
TO synaptic plasticity, neuroplasticity,
therapeutic memory reconsolidation,
and post-traumatic growth

THERAPEUTIC GOAL	resistant self becomes dually aware self	relentless self becomes soberly accepting self	relational self becomes accountable and empowered self	impenetrable self becomes authentically present self	traumatized self becomes actualized self
WHAT CHANGES	experience of gain-become-pain (as ego-syntonic becomes ego-dystonic)	experience of good-become-bad (as illusion becomes disillusionment) (as positive misperception becomes more accurate)	experience of bad-become-good (as distortion becomes more realistic) (as negative misperception becomes more accurate)	experience of lost-become-found (as hidden becomes revealed) (as despair about existence becomes a life reclaimed)	experience of dissociated-become-embodied (as traumatic memories / scripts become rewritten)
SUMMARY	interpreting / cognitive dissonance conflict statements	grieving / affective disillusionment disillusionment statements	negotiating at the intimate edge / relational detoxification accountability statements	nurturing surrender / existential dependence facilitation statements	memory reconsolidation / synaptic deconditioning quantum disentanglement statements
FROM CONDITIONED TO CORRECTED	FROM conflict TO collaboration (as internal conflicts are resolved)	FROM holes TO wholesome (as structural deficits are filled in)	FROM contentious TO harmonious (as relational conflicts are resolved)	FROM hidden TO found (as relational deficits are corrected for) (as nihilistic fatalism becomes existential freedom)	FROM immobilization TO activation (as "old bad" conditioned and disempowering mental schemas are replaced by "new good" corrected and more empowering ones)
NET RESULT	a stronger, wiser, and more self-aware ego – no longer struggling with "compliance" vs "defiance" – – no longer resistant / now aware – "Everybody has at least one secret that would break your heart." Anonymous	a more consolidated, accepting, and compassionate self – no longer ever in search of the unattainable – - no longer relentlessly hopeful / now accepting – "Grieving for what might have been allows the heart to embrace the richness of what actually was – and is." Stark	a more accountable and empowered self-in-relation – no longer resentful, outraged, and feeling victimized – – no longer compulsively re-enacting / now accountable – "Messiness is the essence of relationships." Tronick	a more accessible private self – no longer relationally absent and disconnected from life – – no longer nonrelated / now authentically present – "Life begins on the other side of despair." Sartre	an action-oriented embodied self – no longer dissociated, immobilized, and entrenched – - no longer wedded to the past / now leaning into the future - "Tell me, what is it you plan to do with your one wild and precious life?" Mary Oliver

SUMMARY

In closing, I would like to borrow
from Stephen Mitchell (1988)
a wonderful anecdote that
captures the essence
of the quintessential struggle
in which all of us are engaged
as we attempt to master our art.

Mitchell writes –
"<Stravinsky> had written
a new piece with a difficult
violin passage. After it had
been in rehearsal for
several weeks, the solo
violinist came to Stravinsky
and said he was sorry, he
had tried his best, <but> the
passage was too difficult;
no violinist could play it.

Model 1, which features
enhancement of introspective knowledge "within,"
is the interpretive perspective
of classical psychoanalysis
and is a story about structural conflict.

Model 1 is an approach that focuses on
incremental transformation of
the patient's resistance (the defense)
to acknowledging anxiety-provoking truths
about her internal conflictedness
into awareness (the adaptation)
of those discomfiting truths
and insight into their underlying causes.

The cutting edge of the therapeutic action
involves working through
the cognitive dissonance (the optimal stressor)
that the patient will come to experience
between her defensive need to resist knowing
what lurks beneath the surface

Model 2, which features
provision of corrective experience "for,"
is the deficiency-compensation perspective of self
psychology and those object relations theories
emphasizing internal absence of good (deficiency)
and is a story about structural deficit.

Model 2 is an approach that focuses on
incremental transformation of
the patient's relentless hope (the defense)
and refusal to confront – and grieve – anxiety-provoking
truths about the limitations and imperfections
of the objects of her desire into
serene – albeit sober – acceptance (the adaptation)
of their separateness and immutability.

The cutting edge of the therapeutic action
involves working through
the affective disillusionment (the optimal stressor)
that the patient will come to experience
between her defensive need to hold on

Model 3, which features
engagement in authentic relationship "with,"
is the intersubjective perspective of contemporary
relational theory and those object relations theories
emphasizing internal presence of bad (toxicity)
and is a story about relational conflict.

Model 3 is an approach that focuses on
incremental transformation of
the patient's compulsive re-enactment (the defense)
of the unmastered relational traumas
she had sustained during her formative years
into accountability (the adaptation)
for her compulsive repetition in the here-and-now
of those dysfunctional relational patterns.

The cutting edge of the therapeutic action
involves working through
the relational detoxification (the optimal stressor)
that the patient will come to experience
as a result of her ever evolving adaptive capacity

Model 4, which features
nurturing of existential surrender "to"
treasured moments of meeting "between,"
is an existential-humanistic perspective
to mending brokenness and easing despair
and is a story about relational deficit.

Although existentialism and humanism
have distinct differences,
both posit relational deficit as
the underlying organizing principle.

Model 4 is an approach that focuses on
incremental transformation of the patient's
relational absence (the defense) –
because of early-on shattering heartbreak –
into authentic presence (the adaptation)
and an ever evolving adaptive capacity
to deliver those parts of herself
that are most private, most vulnerable,
and most precious into

Model 5, which features
the envisioning of transcendent possibilities "beyond,"
is a quantum-neuroscientific approach
to analysis paralysis and neural entrenchment.

Bruce Lipton likens our subconscious mind
to a quantum computer
containing massive amounts
of uncensored and unfiltered data
– most of which are negative, outdated,
maladaptive, self-defeating, and disempowering –

… implicitly held beliefs that
– during the formative years of our lives
(when our brains were primarily
in a "theta brainwave state") –
are swallowed whole and
– like software programs –
downloaded onto the hard drive
of the quantum computer
that is our subconscious.

Stravinsky said, "I understand
that. What I am after is
the sound of someone
trying to play it."

As therapists, our work
is exquisitely difficult
and finely tuned – and often
we will not be able to get it
just right. Perhaps, however,
we can console ourselves
with the thought that
it is the effort we make
to get it just right
that will ultimately count.

and her adaptive capacity to confront
the forces/counterforces
fueling the treacherous undertow.

Judicious and ongoing use of
optimally stressful, growth-incentivizing,
awareness-promoting conflict statements
will create destabilizing mismatch experiences
for the patient by highlighting both
how much her defenses serve her
and how much they cost her.

The patient's ever evolving awareness
of both the gain and the pain
of holding on to her defenses
will ultimately render them
more ego-dystonic than ego-syntonic,
at which point
the cognitive – and affective – dissonance
(created by the pain of contrast
between the benefit and the cost)
will be such that it provides
both impetus and opportunity for the patient
gradually to relinquish her attachment
to her rigidly defensive posture
in favor of a more flexible and adaptive stance.

In essence,
optimally stressful Model 1 conflict statements
are designed to encourage
the resistant patient
to step back from the
immediacy of the moment
in order to gain insight into
both her investment in maintaining
"same old same old"
(which is why it is ego-syntonic)
and the price she pays
for doing so
(in an effort to render it more ego-dystonic).

Releasing the patient from the tyranny
of her defenses
will resolve the internal dividedness
and restore the homeostatic balance –
each time at ever higher and ever more evolved
levels of adaptability and resilience.

to her relentless hope
and her adaptive capacity to confront – and grieve –
the futility of her relentless pursuits.

The patient's relentless hope
– which fuels her masochism –
is the stance to which she desperately clings
in order to avoid confronting intolerably painful realities
about the object and its immutability
and her relentless outrage
– which fuels her sadism –
is the stance to which she resorts
in those moments of dawning recognition
that, despite her best efforts and most fervent desire,
the object is indeed separate
and cannot be forced to be
something it isn't.

The masochistic defense of relentless hope
and the sadistic defense of relentless outrage
go hand in hand
and both speak to the patient's refusal to confront
the truth about the bad – immutable – object.

More specifically, masochism is a story about
the patient's relentless hope
(her hoping against hope)
that perhaps someday, somehow, some way
– were she to be but good enough, try hard enough,
be persuasive enough, persist long enough,
suffer deeply enough, or be masochistic enough –
she might yet be able to extract from the object
(sometimes the parent herself,
sometimes a stand-in for the parent)
the recognition and love denied her as a child.

In other words, the relentlessness of her pursuit
is fueled by her conviction that she might yet
be able to compel the immutable object to relent.

And so even in the face of incontrovertible
evidence to the contrary,
the patient will pursue the object of her desire
with a vengeance –
the intensity of this relentless pursuit
fueled by her entitled conviction
that the object could give it
(were the object but willing),
should give it
(because that is the patient's due),
and would give it
(were she – the patient – but able to get it right).

The relentless patient's investment
is not so much in the suffering per se
as it is in her willingness to suffer
to take ownership of her contribution
to the turbulence that will inevitably emerge
at the intimate edge of her authentic engagement
with the therapist.

Center stage in Model 3 are
projective identifications, which have two parts –
the induction phase and the resolution phase.

The induction phase commences
once the patient projects onto the therapist
some aspect of the patient's experience
that has been too toxic for the patient
to process and integrate
and then exerts pressure on the therapist
to accept that projection,
thereby inducting the therapist
into the patient's enactment.

The resolution phase is ushered in
once the therapist steps back from
her participation in what has become
a mutual enactment and brings to bear
her own, more evolved capacity
to process and integrate
on behalf of a patient who truly
does not know how –
such that what is then re-introjected
by the patient can be more easily assimilated
into healthy psychic structure.

And, if all goes well,
these iterative dilution cycles
will happen repeatedly,
the net result of which will be
graduated relational detoxification
of the patient's internal badness.

Although the emphasis throughout
has been on "paired" pathogenic introjects
– the result of traumatic early-on relational dynamics –
and on negotiating at the intimate edge of relatedness
to detoxify the pathogenicity of those introjects
(with the patient identifying with either
the more passive pole or the more active pole
of the introjective configuration
and then projecting onto the therapist
the complementary pole),
Model 3 also involves the therapist's use of self
to modify the pathogenicity of unpaired toxic boluses
that the patient has not yet been able
to assimilate into healthy psychic structure –
for example, overwhelming rage, excoriating guilt,
or intolerably painful grief.

A point of clarification with respect to the
intimate relationships and into life itself.

The cutting edge of the therapeutic action
will involve working through the optimal stress
of existential dependence as the patient
gradually overcomes her dread of surrender
to resourceless dependence upon her therapist,
relinquishes her denial of object need
and illusions of grandiose self-sufficiency,
and, despite her terror, allows herself
to be found, held, and nurtured.

Existentialism emphasizes that
every aspect of life is created
from a balanced interaction
of opposing and competing forces –
forces that are not just opposites
but complementary.

They do not cancel each other out;
they merely balance each other
like the wings of a bird.

"Both precious and absurd,
this tightrope of existence
we walk in both directions –
strung only on a rhythm
of heartbeats across a void." Dean Cavanagh

The therapeutic goal in Model 4 is
to cultivate the patient's adaptive capacity
to hold simultaneously in mind
both sides of her tormented ambivalence
about being-in-the-world –
despite the appeal of
surrendering to defeat
and succumbing to paralysis.

It is also important
that the patient eventually be able
to grab ahold of however many
precious moments of connectedness
she can possibly find –
moments of authentic meeting
that will afford her comfort,
peace of mind, and, at last,
a sense of belonging.

Thereafter,
and generally unbeknownst to us,
these subversive narratives
will organize our experience
of self, others, and the world
– and control most of what
we think, feel, and do –

I am a failure
I am not smart enough
I am a victim
I have already tried everything
I will never get better
I will always be sick
I will never be happy
I am too old
I have already made too many mistakes
It is too late
People just don't understand
People are always judging
I hate how critical people are
People always hurt you
People always disappoint
People never deliver
The world is a dangerous place
You shouldn't trust anybody

Model 5 is a perspective
that focuses on decisively transforming
the refractory inertia (the defense)
of a patient who,
despite her most fervent desire,
remains entrenched in her
traumatic memories
and conditioned narratives
into actualizing action (the adaptation)
designed to optimize her potential
for love, work, and play going forward.

The cutting edge of the therapeutic action
will involve working through the optimal stress
of quantum disentanglement
– synaptic deconditioning / energetic decoupling –
as "old bad" learned expectations
deriving from the toxicity
of the patient's traumatic past
and fueling her intractable inertia
in the present are challenged by
"new good" envisioned possibilities for the future.

The result of repeated and dramatic challenge
of "old bad," distorted, disempowering narratives
with "new good," more reality-based narratives
will be the locking in, or reconsolidation,
of more empowering mental schemas.

because of her passionate hope
that perhaps each next time …

As noted above,
sadism is then the relentless patient's reaction
to the loss of hope she experiences
in those moments of dawning recognition
that she is not actually going to get
what she had so desperately wanted
and felt she needed to have in order to go on –
moments of anguished heartbreak
and feelings of outraged betrayal
experienced in the face of being confronted
head-on with the inescapable reality
with the inescapable reality
of the object's separateness
and the limits of the patient's illusory omnipotence.

The healthy response to the loss of hope
is to confront the pain of one's disappointment,
grieve the loss of one's illusions about the object,
and adaptively internalize whatever good
there was in the relationship –
a growth-promoting process described as
transmuting (structure-building) internalization.

But the relentless patient does something else …

With the dawning recognition that the object
can be neither possessed and controlled
nor made over into what she would want it to be,
the relentless patient will react
– whether in actual fact or simply in fantasy –
with the sadistic unleashing
of a torrent of abused directed
either toward herself for having failed
to get what she had so desperately wanted
or toward the disappointing object
for having failed to provide it.

She will alternate between
enraged protests at her own inadequacy
and scathing reproaches against the object
for having thwarted her desire.

In essence, sadism is the relentless patient's
reaction to the loss of hope.

In any event,
the sadomasochistic cycle will be repeated once
the seductive (exciting/rejecting) object
throws the patient a few crumbs.

The patient
– ever hungry for such morsels –
will become once again hooked

processing and integration of unresolved grief –
I believe that there is an important distinction
to be made between empathic attunement
(in which the therapist decenters
from her own experiences,
joints alongside the patient,
and takes on the patient's experience,
but only "as if" it were her own
because it never actually becomes her own)
and authentic engagement
(in which the therapist allows the patient's
experience to enter into her
and takes it on "as" her own).

In the first instance, of empathic attunement,
the therapist will resonate with
the patient's experience of grief,
but it will be the patient who must do the actual grieving
as she, on her own, confronts the painful reality
of her devastating heartbreak.

In the second instance, of authentic engagement,
the patient will be sharing her experience of grief
with a therapist who is willing and able
– with shared mind and shared heart –
to feel, along with the patient, the pain of the
patient's devastating heartbreak,
such that the patient's experience of grieving
need no longer be such a lonely one.

In essence, new corrective possibilities
are being introduced by way of ongoing,
dramatic, and embodied challenging
of preconceived, ill-founded assumptions
with new, more relevant experiences
– both real and envisioned –
that violate those expectations.

The net result will be the disconfirmation
and overriding of outdated, conditioned reactions
by fresh, more realistic, solution-focused,
and future-oriented perspectives.

"There is more wisdm in your body than in
than in your deepest philosphy." Friedrich Nietzsche

"Our own physical body possesses a wisdom
which we who inhabit the body lack." Henry Miller

"This is your body, your greatest gift, pregnant with
wisdom you do not hear, grief you thought was forgotten,
and joy you have never known." Hillary McBride

"You'll know that you're aligned with the truth of
your deepest wisdom when you body feels
light and expansive." Kris Franken

and revert to her original stance of
suffering, sacrifice, and surrender
in a repeat attempt to get what she
so desperately wants and feels she must have.

In sum, Model 2 involves the insatiably hungry
and relentlessly hopeful patient's
facing, head-on, the excruciatingly devastating
reality of her disillusionment –
that it was what it was and is what it is
and that the elusive and illusory "thing"
for which she has spent a lifetime searching
is simply not to be had.